DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			<u></u> ON	<u>//B NO. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		345130	B. WING			C 12/11/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	I E	12/11/2024
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	κυ.		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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	complaint investigation 12/02/24 through 12/ in compliance with the	ertification survey and on survey was conducted on 11/24. The facility was found e requirement CFR 483.73, ness. Event ID: ITBP11.	F 00	00		
	An onsite recertification and complaint survey was conducted from 12/02/23 through 12/05/24. Additional information was obtained on 12/11/24. Therefore, the exit date was changed to 12/11/24. The following intakes were investigated NC00209803, NC00214284, NC00215244, NC00216985, NC00217647, NC00218277, NC00218641, NC00219775, NC00222180, NC00223459, NC00224006, NC00224817, and NC00224818. Intake NC00224006 resulted in immediate jeopardy. 10 of the 24 complaint allegations resulted in deficiencies. Immedicate Jeopardy was identified at:					
	CFR 483.12 tag F600 CFR 483.12 tag F607	S scope and severity of J. Scope and severity of J. Scope and severity of J.				
	Quality of Care.	607 constituted Substandard				
	removed on 12/5/24. completed.	began on 10/4/24 and was An extended survey was				
F 583 SS=J		nfidentiality of Records -(3)(i)(ii)	F 58	33		12/11/24
	confidentiality of his c	yht to personal privacy and or her personal and medical				
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					12/27/2024

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING				C 11/2024
	ROVIDER OR SUPPLIER	RD	1	51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LAKE CONCORD ROAD NE CONCORD, NC 28025	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	records. §483.10(h)(I) Persona accommodations, me telephone communica and meetings of famil this does not require private room for each §483.10(h)(2) The fac residents right to pers right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to including those delive than a postal service. §483.10(h)(3) The res and confidential perso (i) The resident has th of personal and medii provided at §483.70(h federal or state laws. (ii) The facility must a Office of the State Lo to examine a resident administrative records law. This REQUIREMENT by: Based on observatio responsible party, Lie Investigations and staf failed to protect a resi residents (Resident # NA # 2 provided perso	al privacy includes dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a resident. Solity must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened , packages and other the facility for the resident, ered through a means other sident has a right to secure onal and medical records. the right to refuse the release cal records except as n)(2) or other applicable llow representatives of the ng-Term Care Ombudsman t's medical, social, and s in accordance with State the is not met as evidenced n, record review, and	F	583	#1 On 12/2/24 at 1:35pm, the DON suspended NA #1 pending outcome of abuse investigation and notified the Medical Director (MD) of allegation. Because the resident was unknown at time and the presence of a witness was	this	

Facility ID: 953050

If continuation sheet Page 2 of 65

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/14/202 ORM APPROVE NO. 0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING _			C 12/11/2024		
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	-	
				51	5 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCO	RD		C	ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 583	Continued From page	- 1		-00				
F 303			F 5	83				
	•	ate who was watching the			notifications to Resident #2's residen	t		
		e resident while the resident			representative or initiate immediate			
		vaist up and while care was owed this live streaming			suspension of NA #2. On 12/2/24 at 2:15pm, the Social Worker (SW) noti			
		vere observed in the open			the local police department and adult			
		Resident #2 was severely			protective services (APS). A police re			
		the reasonable person			number was obtained. On 12/2/24 at			
		A reasonable person would			3:30pm, the Administrator submitted			
		ed and have feelings of			initial allegation report to North Carol	ina		
	worthlessness, powe	rlessness and			Department of Health Human Service	es		
		ugh people that were not			(NCDHHS).			
		em naked and while care			On 12/4/24 at 3:30pm, additional			
	was provided without	consent.			information was provided to the facili	•		
					include identification of resident (Res			
		began on 10/4/24 when			#2) and addition of a witness (NA #2			
		/ was violated. Immediate ed on 12/5/24 when the			response to this new information, the Director of Nursing (DON) immediate			
		a credible allegation of			suspended NA #2, notified Resident	-		
		emoval. The facility will			resident representative(s) and the M			
		ance at the scope and			the Vice President of Risk and Qualit			
		tual harm with potential for			Assurance (VPRQA) notified local la	-		
		arm that is immediate			enforcement and APS with updated			
	jeopardy) to ensure e	education is completed and			information to initial 12/2/24 reports.	The		
	monitoring systems p	out into place and are			Vice President of Clinical Operations			
	effective.				(VPCO) assessed Resident #2 for			
					physical injury, pain and signs or			
	The findings included	1:			symptoms of psychosocial distress a			
					concerns were observed, and reside			
		nitted to the facility on			was pleasantly confused at baseline.			
	-	ses which included anxiety, a, and mood disturbance.			On 12/4/2024 the VPCQA, VPCO an	Ч		
		ล, ลาน ทางงน นารเนามิสิทิงฮ.			DON attempted to obtain information			
	Review of Resident #	2s quarterly Minimum Data			regarding the location of the prison.			
		10/24 revealed the resident			receipt of this information, the facility	•		
	was severely cognitiv				ensured the security of the recording			
	, <u>-</u>				ensure Resident #2 remains protecte			
	Review of video foota	age provided by the Sheriff			from any additional violation of privation			
		the following events took			others who are unauthorized to have			
		10:30 PM. The video			information. No further concerns			

Facility ID: 953050

If continuation sheet Page 3 of 65

DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED
							0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _			
		345130	B. WING				
		545150			TREET ADDRESS, CITY, STATE, ZIP CODE	12/	11/2024
NAME OF PI	ROVIDER OR SUPPLIER						
ACCORDI	US HEALTH AT CONCOR	RD			315 LAKE CONCORD ROAD NE CONCORD, NC 28025		
					·		(X5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM		
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
			1				
F 583	Continued From page	9 3	F :	583			
	revealed NA #1 and N	IA #2 located in a facility in			identified.		
	the resident's room or	n live stream video through					
		ison inmate. The inmate			On 12/2/24 and on 12/4/2024, the DOM	١,	
		into a telephone receiver in			VPCO, VPRQA, Administrator and		
		veral other inmates behind			Medical Director held an Ad Hoc meeti	ng	
	him. The inmate was	looking at the live stream.			to discuss incident to determine root		
	-				cause analysis of the facility's failure to)	
		red on 12/4/24 at 4:45 PM.			maintain privacy for a resident while		
		Ind and documented by the	personal care was being provided. Root cause analysis determined that the facility				
		colon seconds) where "mm" nd "ss" represents seconds.		failed to implement an effective system to			
	represents minutes a	iu ss represents seconds.			ensure strict enforcement and monitori		
	01 Video starts with	NA #1 walking down the			measures to prohibit cellular phones a	-	
		Is Resident #2's room. No		video recording devices in resident care			
	residents were shown				areas.		
	-:33 NA #1 entered R	esident #2's room.			On 12/4/24 the facility was made awar		
					immediate jeopardy and an acceptable	•	
		Il phone down. The video			plan of correction was provided and		
		tes walking around the			jeopardy removed effective 12/5/24.		
		speaking to NA #1 and			On 12/6/24 upon completion of		
		ble sitting in the wheelchair 2 present in the resident's			On 12/6/24, upon completion of investigation, NA #1 and NA #2 were		
		erved undressing Resident			terminated indefinitely and reported to	the	
		shirt. It was observed that			nurse aide registry.	uic	
		a guard walked by the					
	inmate during this tim				#2 On 12/2/24 at 4:00pm, the		
	Ŭ				Administrator completed an observatio	nal	
	-:53 NA #2 was obser	ved jerking the resident's			round of facility residents and staff to		
		2's hands aggressively.			ensure that resident's right to privacy is	6	
	Residents #2's bare s	houlders were observed to			maintained. Observations include 1) ca		
	be showing.				being provided only be authorized staff	⁻ , 2)	
					use of privacy curtains, closed doors		
	-	he live stream video at			during personal care and covering/drag	•	
		dent #2 was visible in the			to prevent exposure of body parts, 3) n		
		hirt removed and NA # 1			cellular or other video devices used by		
		her bra from her right arm;			staff in resident care areas and 4) any	un al	
		owing. The inmate stated,			other violation of resident right to perso	onal	
	come on man, come	on man." The inmate	1		privacy not only of a residents' own		

Facility ID: 953050

If continuation sheet Page 4 of 65

						D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	E SURVEY PLETED
						С
		345130	B. WING		12	/11/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
ACCORDI	US HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE		
				CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE
F 583	Continued From page	e 4	F 58	33		
		ye." NA #1 states "no we're		physical body, but of his	s or her personal	
		eplies, "that s just p		space. No additional co	-	
		s in the live video frame and		Effective 12/2/2024, que		
		this time multiple inmates		also completed followin		
	were behind the inma	ate in an open public area.		current facility staff to va		
	-3.02 NA #1 was hold	ling the cell phone and		competency of education identify if additional inci		
		niling and laughing into the		privacy had been violate		
		owledged again she is on a		concerns reported.		
	live video stream call					
				#3 Effective 12/2/24, a	•	
		ved fastening Resident #2's		staff were in-serviced o		
	•	k and the inmate states, crazy as hell. Y'all two		Rights Policy, CMS guid and the Cell Phone Poli		
	together is trouble."	crazy as nen. T an two		Development Coordinat		
	logother to trouble.			licensed nurse manage	. ,	
	-3: The inmate stated	l, "you just put anything on		included examples of vi	-	
		stop that s" NA #1 replied		residents' privacy to inc		
	"I don't give a damn."			limited to 1) privacy of r		
	4.00 NA #4			residents' own physical		
	side of the bed and N	erved standing on the right		her personal space, inc accommodations and p	•	
		's beds with Resident #2		only authorized staff dir		
		cal lift sling suspended. NA		providing care and serv	-	
		e streaming Resident #2 and		resident may be presen		
		y curtain was not pulled		provided, unless the res		
		s. The roommate was not		other individuals being		
	visualized at this time	9.		delivery of care, 3) duri	•	
	-4·42 NA #1 turned th	e cell phone camera, and		personal care and servi remove residents from		
		pended in the mechanical		privacy curtains or close		
		sing by behind the inmate		provide clothing or drap		
	that was watching.			exposure of body parts,		
		• • • • • • •		recordings of a resident		
		is being transferred to her		body or private space w		
		al lift and there was another		resident's, or designate		
		n the opposite bed. The ot pulled while Resident #2		written consent, is a vio resident's right to private		
	was being transferred				aking unauthorized	

Facility ID: 953050

If continuation sheet Page 5 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/14/2025 MAPPROVED D: 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMP	SURVEY PLETED		
		345130	B. WING			C 12/11/2024		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				51	15 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCO	RD		С	ONCORD, NC 28025			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 583	Continued From page 5		F	583	photographs of a resident's room or			
	-6:01 NA #1 laid the c	cell phone down still showing			furnishings (which may or may not inc	lude		
		lent #2 aggressively on to			the resident), or a resident eating in th			
		g up by the lift pad. Resident			dining room, or a resident participating			
	•	rom the camera with her full			an activity in the common area, 6) tak			
	•	mate stated, "damn, don't NA #1 looked back at the			unauthorized photographs or recordin	gs		
		IA #2 was still present in the			of residents in any state of dress or undress using any type of equipment	(for		
		le of the bed assisting with			example, cameras, smart phones, and			
		nates were observed in the			other electronic devices), 7) keeping o			
	back in the open area				distributing them through multimedia			
					messages or on social media network	s is		
	-6:08 NA #1 stated, "	patient confidentiality" and			a violation of a resident's right to priva	су		
	•	he side of the bed pointing			and confidentiality, 8) potential effects			
		not viewing the resident but			residents whose privacy is not mainta			
	still live streaming wh	ile giving care to the			to include, humiliation, dignity, respec			
	resident.				and feelings of dehumanization, 9) st			
	7.47 NA #4 stated to	ussident Venerausunland			prohibition and NO TOLERANCE to u			
	girl". NA #1 stated to	resident, "open your legs			cellular phones or any type of audio o video device in resident care areas,	r		
	discernable.				resident rooms, common areas such a			
					hallways, dining rooms, courtyards,	45		
	-8:45 NA #1 and NA #	#2 exited the resident's room			etc.,10) cell phones are allowed to be	kept		
		facility hall and continued to			in staff possession in the facility on a	•		
	talk to the inmate on				silenced or vibrate mode to allow for			
					emergency alerts but may only be use			
	-9:46 Video ends.				breakrooms or other non-resident are			
	.				and 11) staff are responsible to interve	ene		
		nducted with the Lieutenant			if witnessing any violation of the Cell	h.t		
	-	ions on 12/2/24 at 11:30 AM			Phone Policy and/or the Resident Rig			
		ined video footage of an ving a video call where NA			Policy and immediately remove risk fr resident and notify Administrator and			
		nate view of an elderly			violation of the Cell Phone Policy or)		
		air. The Lieutenant stated			Resident Rights Policy will result in			
		concerns to Adult Protective			disciplinary action up to and including			
	-	vas concerned NA #1 had			termination of employment and/or			
	exploited Resident #2				notification to licensing boards and law	v		
					enforcement where applicable to ensu			
	A follow up phone inte	erview with Lieutenant of			resident privacy is maintained. The SI	C		

Facility ID: 953050

If continuation sheet Page 6 of 65

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONNECTION	DEIMINOATION NOMBER.	A. BUILDING		
		245420			С
		345130	B. WING		12/11/2024
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORDI	US HEALTH AT CONCO	RD		15 LAKE CONCORD ROAD NE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 583	Continued From pag	e 6	F 583		
		ns on 12/05/24 at 9:20 AM		will be responsible for ensuring all s	taff
		occurred on 10/4/24 and the		are trained by tracking and reviewin	
	· ·	vas Home WAV which is a		daily schedule and ensuring training	•
		orded of both parties. The		provided. Newly hired staff and staff	not
		when a video call occured		receiving education by 12/2/2024 w	
		one receiver to hear the		receive education prior to first worke	
		l a computer size screen		by the SDC, DON or licensed nurse	
		to see who they are face		supervisor.	- 4 4
	-	nr stated other inmates were		#4 Effective 12/2/2024, the Admini DON or designee will complete	strator,
	see the video becaus	onversation but could visually		observational rounds of facility resid	lente
		other inmates present.		and staff to ensure that resident's ri	
				privacy is maintained. Observations	•
	An interview conduct	ed with NA #1 on 12/02/24 at		be completed daily for one (1) week	
	2:35 PM revealed sh	e had worked in the facility		(3) times weekly for four (4) weeks,	
	for two years. NA #1	further revealed she had		(2) times weekly for four (4) weeks,	
	-	rice on resident privacy and		weekly for four (4) weeks and as ne	
		calls were prohibited in care		thereafter. Monitoring to include 1) of	
		she had never taken any		being provided only by authorized s	
	pictures or videos of	any resident in the facility.		use of privacy curtains, closed door	
	A shase interview of	and under all writtle Nilvane a Alinia		during personal care and covering/c	
	'	nducted with Nurse Aide it 6:00 PM revealed she had		to prevent exposure of body parts, 3	
		le facility for approximately		cellular or other video devices used staff in resident care areas and 4) a	
		ther revealed she had been		other violation of resident right to pe	-
		ts' privacy. NA #2 stated she		privacy not only of a residents' own	
		any staff or had taken a		physical body, but of his or her pers	onal
		resident. NA #2 indicated if		space.	
		a staff member record a			
	resident that she wou	•		The Administrator will report fin	-
		denied any staff videoing		of the monitoring to the Quality Assu	urance
	Resident #2 while giv	/ing care.		Performance Improvement (QAPI)	
	An intonviour conduct	ad with the Director of		Committee during monthly QAPI me	•
		ed with the Director of Administrator on 12/02/24 at		and will make changes to the plan a necessary to maintain compliance w	
		ey both had been recently		resident rights to personal privacy.	
		ity. The interview revealed			
		concerns about staff having		Compliance Date: 12/11/2024	
		are areas and taking pictures			

DEPARTMENT OF HEAL CENTERS FOR MEDICA							FORM): 01/14/2025 MAPPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>				(X3) DATE SURVEY COMPLETED		
		345130	B. WING			_		C 11/2024	
NAME OF PROVIDER OR SUPPL	IER		•	ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
ACCORDIUS HEALTH AT C	ONCO	RD			15 LAKE CONCORD ROA ONCORD, NC 28025	D NE			
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
nursing staff ha and anytime or phones were n rooms. The video was at 5:45 PM. Th Nursing (DON) Operations, an (quality assura improvement). video was revie #2 were identif revealed nursir personal cell p permitted to re resident. The I the privacy of F report the exple An interview co Responsible P revealed the fa video on 12/04 was upset this was glad it was justice would b An interview co 12/9/24 at 4:00 employed by th but assisted wi Administrator f had denied bei call with a resid	e of a ad bee n residu ot allow share nose p , Vice d Vice nce an The f ewed, ied by ng staf hones cord al OON st Reside bitation onducte arty (R cility h /24. Th had has being e serve onducte the facil th the urther ng in a dent pr d she e	resident. Both indicated n in-service at hire, annually, ent privacy and person wed to be out in resident d with facility staff on 12/4/24 resent were the Director of President of Clinical President of Risk and QAPI	F 58	33					

Facility ID: 953050

If continuation sheet Page 8 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		345130	B. WING				C 11/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	11/2024
A00000				5	15 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOF	νD		C	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 583	Continued From page	8	F	583			
	Clinical Operations, a and QAPI were notified	ng (DON), Vice President of Ind Vice President of Risk ed of immediate jeopardy on The Administrator was not					
	The facility provided t jeopardy removal pla	he following immediate n.					
	The facility failed to maintain privacy for Resident # 2 while personal care was provided. NA # 1 used her personal cell phone while in the residents' room to facetime with a male inmate which allowed Resident # 2 to be observed sitting in a wheelchair, naked, with no shirt or bra on, with her breasts exposed without her consent. The observation was provided in real time through the use of a wall mounted screen in a common area of an incarceration center while other people in the prison were also observed walking past the screen.						
	#1 pending outcome of notified the Medical D Because the resident and the presence of a facility was unable to	t representative or initiate					
	notified the local polic	n, the Social Worker (SW) e department and adult PS). A police report number					
	On 12/2/24 at 3:30pm submitted the initial a	n, the Administrator llegation report to North					

Facility ID: 953050

If continuation sheet Page 9 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345130	B. WING				C / 11/2024	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	. <u> </u>		
					515 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCOR	RD			CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ЗE	(X5) COMPLETION DATE	
F 583	Carolina Department (NCDHHS). On 12/2/24 at 4:00pm completed an observa- residents and staff to to privacy is maintain care being provided of use of privacy curtain personal care and cor- exposure of body par- video devices used by and 4) any other viola- personal privacy not of physical body, but of No additional concerr On 12/2/24 and on 12 VPRQA, Administrato an Ad Hoc meeting to determine root cause failure to maintain priv- personal care was be analysis determined to implement an effective enforcement and mor cellular phones and v resident care areas. On 12/4/24 at 3:30pm provided to the facility resident (Resident #2 (NA #2). In response DON immediately sus Resident #2 resident MD and the VPRQA re-	of Health Human Services a, the Administrator ational round of facility ensure that resident's right ed. Observations include 1) only be authorized staff, 2) s, closed doors during vering/draping to prevent ts, 3) no cellular or other y staff in resident care areas ation of resident right to only of a residents' own his or her personal space. as identified. 2/4/2024, the DON, VPCO, or and Medical Director held o discuss incident to analysis of the facility's vacy for a resident while ing provided. Root cause hat the facility failed to e system to ensure strict nitoring measures to prohibit ideo recording devices in A, additional information was y to include identification of) and addition of a witness to this new information, the spended NA #2, notified representative(s) and the notified local law S with updated information to	F	58	3			
	initial 12/2/24 reports.	The VPCO assessed call injury, pain and signs or						

Facility ID: 953050

If continuation sheet Page 10 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				RINTED: 01/14/2025 FORM APPROVED MB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345130	B. WING			C 12/11/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
				515 LAKE CONCORD ROAD N	IE		
ACCORDI	US HEALTH AT CONCOR	RD		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 583	Continued From page	• 10	F 583				
	symptoms of psychos concerns were observ pleasantly confused a	ved and resident was					
	attempted to obtain in location of the prisor information, the facilit security of the recordi	y plans to inquire on the ing and ensure that ted from any additional others who are					
	process or system fai	entity will take to alter the lure to prevent a serious n occurring or reoccurring, will be complete.					
	in-serviced on the Re guidance 483.10(h) a the Staff Development licensed nurse manage examples of violation include, but not limiter residents' own physic personal space, inclu- personal care, 2) only involved in providing of resident may be prese unless the resident co being present during to during the delivery of staff must remove ress privacy curtains or clo clothing or draping to parts, 4) photographs and/or his or her body	current facility staff were sident Rights Policy, CMS and the Cell Phone Policy by t Coordinator (SDC) and ger. Training included of residents' privacy to d to 1) privacy of not only a al body, but of his or her ding accommodations and v authorized staff directly care and services for the ent when care is provided, onsents to other individuals the delivery of care, 3) personal care and services, sidents from public view, pull ose doors, and provide prevent exposure of body or recordings of a resident v or private space without gnated representative's					

Facility ID: 953050

If continuation sheet Page 11 of 65

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	D: 01/14/2025 MAPPROVED D. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345130	B. WING				C 11/2024
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			5	15 LAKE CONCORD ROAD NE		
ACCORDIUS HEALTH AT CONCORD)		с	CONCORD, NC 28025		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
unauthorized photograp furnishings (which may resident), or a resident or a resident participatii common area, 6) taking photographs or recordin state of dress or undres equipment (for example and other electronic der distributing them throug or on social media netw resident's right to privad potential effects on resi maintained to include, h and feelings of dehuma prohibition and NO TOL phones or any type of a resident care areas, res areas such as hallways courtyards, etc.,10) cell kept in staff possession silenced or vibrate mod alerts but may only be u other non-resident area responsible to intervene violation of the Cell Pho Resident Rights Policy risk from resident and r 12) violation of the Cell Rights Policy will result and including terminatio	blation of the resident's fidentiality, 5) staff taking physical of a resident's room or or may not include the eating in the dining room, ng in an activity in the g unauthorized ngs of residents in any ss using any type of e, cameras, smart phones, vices), 7) keeping or gh multimedia messages vorks is a violation of a cy and confidentiality, 8) idents whose privacy is not humiliation, dignity, respect anization, 9) strict LERANCE to use cellular audio or video device in sident rooms, common s, dining rooms, I phones are allowed to be n in the facility on a de to allow for emergency used in breakrooms or as and 11) staff are e if witnessing any one Policy and/or the and immediately remove notify Administrator and Phone Policy or Resident in disciplinary action up to on of employment and/or boards and law olicable to ensure resident	F	583			

If continuation sheet Page 12 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG			C
		345130	B. WING				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT CONCOP	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 583	facility staff to validate received and to identi resident privacy had b concerns reported. Th for ensuring all staff a reviewing the daily sc is provided. Newly hir receiving education b education prior to first DON or licensed nurss Effective 12/2/2024, t designee will complet facility residents and s resident's right to priv Observations to inclue only by authorized sta curtains, closed doors covering/draping to pri parts, 3) no cellular or by staff in resident ca violation of resident ri only of a residents' ov or her personal space nurses were educated of their responsibility rounds each shift for I Effective 12/2/2024, t ultimately responsible completion of this rem Alleged Date of IJ Re On 12/10/2024, the fa immediate jeopardy w was observed in the o smiling with other rest	e competency of education fy if additional incidences of been violated. No additional he SDC will be responsible re trained by tracking and hedule and ensuring training red staff and staff not y 12/2/2024 will receive t worked shift by the SDC, se supervisor. The Administrator, DON or the observational rounds of staff to ensure that acy is maintained. de 1) care being provided aff, 2) use of privacy is during personal care and revent exposure of body r other video devices used re areas and 4) any other ght to personal privacy not vn physical body, but of his e. On 12/2/24, licensed d and notified by the VPCO to complete observational his/her unit as above. he Administrator is e for the implementation and noval plan.	F	583			

Facility ID: 953050

If continuation sheet Page 13 of 65

Statistics of the product of the second s		-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
345130 B. WING 12/11/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ISE LAKE CONCORD ROAD NE CONCORD, NC 28025 CONCORD, NC 28025 VALUE TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MIST PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX TAG PROVIDERS FLAN OF CORRECTION MOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTINUED FOR DATE OF CORRECTION MOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTINUED FOR DATE OF DEFICIENCIES ID OWNET OFFICIENCY CONTENT CONSTRUCTION OF CORRECTION MOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTENT CONSTRUCTION OF CORRECTION MOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTENT CONSTRUCTION OF CORRECTION MOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CONTENT CONSTRUCTION DATE F 583 Continued From page 13 have their doors closed for care and curtains were seen pulled to cover for privacy. There were no signs of staff cell phone use, including notification of any resident's behavior changes, and increased rounding observations of residents and staff. Staff interviews confirmed education was received for abuse, privacy, resident rights, and cellphone use. The facility provided psych evaluation follow up for Resident 12: regarding the incident. The facility provided evidence of daily Quality Assurance auditing of all residents for inderview and cognitively intact residents for interview and cognitively intact residents for inderview and cognitively intact residents for inderview and cognitively intact residents for inderive wad correctiew were	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT CONCORD SIJMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CONSERVEREENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH ORRECTIVE (EACH ORRECTIVE APPROPRIATE DEFICIENCY) WID RESIDENT COMPLETION OR AP			345130	B. WING				-
ACCORDUS HEALTH AT CONCORD CONCORD, NC 28025 (M) ID PREPIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WISTERMENT OF DEFICIENCIES) (EACH DEFICIENCY VISTEMENT OF DEFICIENCIES) (EACH DEFICIENCY VISTEMENT OF DEFICIENCIES) REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000	NAME OF PI	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMELTION DATE F 583 Continued From page 13 have their doors closed for care and curtains were seen pulled to cover for privacy. There were no signs of staff cell phone use in the hallways and in resident care areas. The in-services by the facility included information on abuse, privacy, resident rights, and cellphone use, including notification of administration for any resident's behavior changes, and increased rounding observations of residents and staff. Staff interviews confirmed education was received for abuse, privacy, resident rights, and cellphone use. The facility provided psych evaluation follow up for Resident #2 regarding the incident. The facility provided evidence of daily Quality Assurance auditing of all residents divided on cognitively intact residents for interview and cognitively intact residents for interview and cognitively intact residents for ondy audits, the auditing for the observational rounds every shift, staff abuse questionnaires, and new on-hire screening process and employee handbook review were executed. The facility showed evidence of communication with the sheriff's office that the video was encrypted and secured with only authorized person could access and	ACCORDI	US HEALTH AT CONCOP	RD					
have their doors closed for care and curtains were seen pulled to cover for privacy. There were no signs of staff cell phone use in the hallways and in resident care areas. The in-services by the facility included information on abuse, privacy, resident rights, and cellphone use, including notification of administration for any resident's behavior changes, and increased rounding observations of residents and staff. Staff interviews confirmed education was received for abuse, privacy, resident rights, and cellphone use. The facility provided psych evaluation follow up for Resident #2 regarding the incident. The facility provided evidence of daily Quality Assurance auditing of all residents for interview and cognitively intact residents for body audits, the auditing for the observational rounds every shift, staff abuse questionnaires, and new on-hire screening process and employee handbook review were executed. The facility showed evidence of communication with the sheriff's office that the video was encrypted and secured with only authorized person could access and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
The IJ removal date if 12/05/24 was validated.F 600F 200F 20012/11/24F 600F 600F 60012/11/2412/11/2412/11/24SS=JSS=JSS=JSS=JSS=JSS=J12/11/24§483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion andF 60012/11/24	F 600	have their doors close were seen pulled to c no signs of staff cell p and in resident care a facility included inform resident rights, and can notification of adminis behavior changes, an observations of reside interviews confirmed abuse, privacy, reside use. The facility provide up for Resident #2 real facility provided evide Assurance auditing of cognitively intact reside cognitively intact reside cognitively intact reside auditing for the obser staff abuse questionn screening process an review were executed evidence of communi office that the video w with only authorized p view the footage. The IJ removal date if Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim	ed for care and curtains over for privacy. There were shone use in the hallways ireas. The in-services by the nation on abuse, privacy, ellphone use, including stration for any resident's d increased rounding ents and staff. Staff education was received for ent rights, and cellphone ded psych evaluation follow garding the incident. The nce of daily Quality f all residents divided on dents for interview and esidents for body audits, the vational rounds every shift, aires, and new on-hire d employee handbook d. The facility showed cation with the sheriff's vas encrypted and secured berson could access and f 12/05/24 was validated. Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from					12/11/24

Facility ID: 953050

If continuation sheet Page 14 of 65

					CONSTRUCTION			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY IPLETED	
			A. DOILDII	<u> </u>		с		
		345130	B. WING			1:	2/11/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				51	15 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCO	RD		C	ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 600	Continued From page	e 14	F	600				
	treat the resident's m							
	§483.12(a) The facili	ty must-						
ph inv Th by B Liu int rig	physical abuse, corp involuntary seclusion This REQUIREMEN							
	by: Based on observation Lieutenant of Crimination interviews, the facility right to be free from a (Resident #2). Nurse			#1 On 12/2/24 at 1:35pm, the DON suspended NA #1 pending outcome o abuse investigation and notified the Medical Director (MD) of allegation. Because the resident was unknown at				
	provided personal ca streaming on a cell p	re to Resident # 2 while live hone, the resident was up, the staff and the prison			time and the presence of a witness wa unknown, the facility was unable to ma notifications to Resident #2's resident	IS		
	profanity and vulgarit resident; the staff did	live stream spoke with y without any regard for the not explain care as it was			representative or initiate immediate suspension of NA #2. On 12/2/24 at 2:15pm, the Social Worker (SW) notifi	ed		
	aggressive during ca	ent; the staff were physically re; the staff allowed an ching the live stream to view			the local police department and adult protective services (APS). A police rep number was obtained. On 12/2/24 at	oort		
	allowed this live stream	ak to the resident; the staff aming while other inmates open area behind him. As			3:30pm, the Administrator submitted th initial allegation report to North Carolir Department of Health Human Service:	na		
	the reasonable perso	erely cognitively impaired, on concept was applied. A ould have been traumatized			(NCDHHS). On 12/4/24 at 4:00pm, the DON, VPC and VPRQA were notified of additiona			
	by being abused by o environment making	caregivers in their home them feel worthless, angry,			information and observed video surveillance provided by the survey te	am		
	dehumanized and po				identifying Resident #2 as a resident of the facility and of mental and sexual			
		began on 10/4/24 when sed. Immediate jeopardy 5/24 when the facility			abuse by NA #1 in the presence of NA DON immediately suspended NA #2 pending investigation. The VPRQA	₩∠.		
	implemented a credit	ble allegation of immediate the facility will remain out of			notified police and provided additional information and left a message with Al			
			1		I IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		1	

Facility ID: 953050

If continuation sheet Page 15 of 65

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/14/202 FORM APPROVE OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345130	B. WING		C 12/11/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	
ACCORD	US HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE CONCORD, NC 28025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 600	actual harm with pote harm that is immedia education is complete put into place and are The findings included Resident #2 was adm 03/21/23 with diagno Alzheimer's disease, disturbance. Review of Resident # Set (MDS) dated 08/ was severely cognitive extensive assistance mobility and transfers Resident #2 had ade was able to understation indicated no behaviou Review of Resident # revealed the resident living (ADL) self-care to Alzheimer's diseas muscle weakness. Th to maintain its curren the review date. Resident #2's care pl revealed the resident refused to see the de directors at time due for the resident to coo the next review date. Resident #2 to make regime and to give ch	ential for more than minimal te jeopardy) to ensure ed and monitoring systems e effective. I: nitted to the facility on ses which included anxiety, dementia, and mood t2's quarterly Minimum Data 10/24 revealed the resident vely impaired and required with two-person for bed s. The MDS further revealed quate hearing and vision and	F 6	 representative (RP) and updated information recation 12/4/2024 at 6:00pm, the Resident #2 for physical signs or symptoms of pset distress and no concern and was pleasantly conform 12/2/2024 and on 12 DON, VPCO, VPRQA, A Medical Director held and to discuss incident to de cause analysis of the face protect a resident's right abuse. Root cause analysis of the face protect a resident's right abuse. Root cause analysis of the face protect a resident's right abuse. Root cause analysis of the face protect a resident's right abuse. Root cause analysis of the face protect a resident's right abuse. Root cause analysis of the face protect a resident's right abuse. Root cause analysis of the face prohibit cellular phones arecording devices in resion 12/4/24 the facility wimmediate jeopardy and plan of correction was prijeopardy removed effect On 12/6/24, upon complinivestigation, NA #1 and terminated indefinitely and nurse aide registry. #2 On 12/2/24 at 4:00p Administrator completed round of facility resident ensure that resident righ freedom from abuse is m Observations included 1 provided only by authori privacy curtains, closed personal care and cover prevent exposure of boot 	eived. On e VPCO assessed injury, pain and sychosocial s were observed fused at baseline. 2/4/2024, the Administrator and h Ad Hoc meeting termine root cility's failure t o be free from ysis determined implement an the strict oring measures to and video ident care areas. Tas made aware of an acceptable rovided and tive 12/5/24. letion of d NA #2 were nd reported to the om, the d an observational s and staff to nts to privacy and naintained.) care being zed staff, 2) use of doors during ring/draping to

Facility ID: 953050

If continuation sheet Page 16 of 65

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I LAN OF	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG_			
							C
		345130	B. WING			12/	11/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	15 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOF	RD		C	CONCORD, NC 28025		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	Х	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		ATE	DATE			
					BEHOLENOT)		
F 600	Continued From page	9 16	F	600			
					cellular or other video devices used by		
	Review of video foota	ge provided by the Sheriff			staff in resident care areas and 4) any		
		the following events took			other violation of resident right to perso	nal	
	place on 10/04/24 at				privacy not only of a residents' own		
		A #2 located in a facility in			physical body, but of his or her persona	al	
		n live stream video through			space and 5) observations to ensure		
		ison inmate. The inmate			residents have no physical signs or		
		into a telephone receiver in			behaviors indicative of potential abuse.	No	
		veral other inmates behind			additional concerns identified.		
		looking at the live stream.					
		5			Effective 12/2/2024, licensed nurses		
	The video was review	/ed on 12/4/24 at 4:45 PM.			completed resident abuse questionnair	es	
		ind and documented by the			with cognitively intact residents and bo		
		colon seconds) where "mm"			audits with cognitively impaired resider	•	
		nd "ss" represents seconds.			to identify any additional concerns of		
		·			resident abuse. No additional concerns	;	
	-:01 Video starts with	NA #1 walking down the			reported or observed.		
		ls Resident #2's room. No			Effective 12/2/2024, abuse questionnal	res	
	residents were showr	n at this time.			were also completed with current facilit	y	
					staff to validate competency of education	on	
	-:33 NA #1 entered R	esident #2's room.			received and to identify any additional		
					allegations or incidence of resident abu	ise.	
	-:45 NA #1 laid the ce	ll phone down and shook			No additional concerns reported.		
	her rear in the camera	a as the inmate states, "that					
	damn ass is fat. Look	at that ass.			#3 Effective 12/2/2024, all current fac	ility	
	That mother f is fa	at." The video showed			staff were in-serviced on the Abuse,		
	several inmates walki	ng around the inmate while			Neglect and Exploitation Policy, Reside	ent	
	he was speaking to N	A #1 and Resident #2 was			Rights Policy and Cell Phone Policy by		
		heelchair with NA #1 and NA			Staff Development Coordinator (SDC)	and	
	-	dent's room. NA #2 was			licensed nurse manager. Abuse trainin	-	
	•	Resident #2 and taking off			topics included preventing, reporting an		
		ved that multiple inmates			identifying what constitutes abuse and	NO	
		y the inmate during this			TOLERANCE for failure to comply and		
	time. Staff were not o	observed to be explaining			ensure resident protection. Identificatio	n	
	their actions related to	o care to the resident.			examples included; physical, mental,		
					sexual, verbal, neglect, exploitation and		
		ved jerking the resident's			signs of mental or emotional abuse suc	h	
		#2's hands aggressively.			as, sudden unexplained changes in		
	Residents #2's bare s	houlders were observed to			behavior, changes in eating habits,		

Facility ID: 953050

If continuation sheet Page 17 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/14/2025 RM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345130	B. WING			1	C 2/11/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				51	15 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCO	RD		С	ONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 17	F	600				
F 600	 F 600 Continued From page 17 be showing. NA #2 was not observed to explain care to the resident. -1:28 NA #1 picked up the cell phone and spoke to the inmate walking throughout the resident's room. -2:07 NA #2 was observed waving and smiling at the inmate through the cell phone acknowledging the inmate. -2:09 NA #1 pointed the live stream video at Resident #2 and Resident #2 was visible in the wheelchair with her shirt removed and NA # 1 was trying to remove her bra from her right arm; both breasts were showing. The inmate stated, "come on man, come on man." NA #1 pointed the live stream video at NA #2, and she is observed smiling and laughing. The inmate stated, "I got to go, bye." NA #1 states "no we're talking." The inmate replies "that s just p me off." NA #2 comes in the live video frame and was laughing. During this time multiple inmates were behind the 			500	withdrawal from care, fear of certain persons or expressions of guilt or sha and staff obligation of reporting abuse immediately to the Administrator and prevention of abuse by the immediate intervention of removing the harm or potential for harm from the resident b removing the perpetrator or threat. To protect resident's right to privacy, the facility is adopting a NO TOLERANCI Cell Phone Policy focusing on the str prohibition of cellular phones and any of electronic recording device use in resident care areas, especially while providing personal care. Training incl examples of violation of residents' pri to include, but not limited to 1) privac not only a residents' own physical bo but of his or her personal space, inclu accommodations and personal care, only authorized staff directly involved providing care and services for the resident may be present when care is provided, unless the resident consen	e y E ict v type vacy y of dy, uding 2) in		
	pointed it to NA #2 sr camera. NA #2 ackno live video stream call -3:07 NA #2 was view gown behind her bac "y'all are crazy., y'all together is trouble." care being provided t -3:32 NA #1 stated, "f this resident in the her	ved fastening Resident #2's k and the inmate stated, crazy as hell. Y'all two Staff did not explain the		other individuals being present duri delivery of care, 3) during the deliver personal care and services, staff m remove residents from public view, privacy curtains or close doors, and provide clothing or draping to preve exposure of body parts, 4) photogra recordings of a resident and/or his body or private space without the resident's, or designated represent written consent, is a violation of the resident's right to privacy and confidentiality, 5) staff taking unaut photographs of a resident's room o		y of st ull hs or her ive's		

Facility ID: 953050

If continuation sheet Page 18 of 65

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-03 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	. ,	MPLETED
				-		С
		345130	B. WING			12/11/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		-
				515 LAKE CONCORD ROAD NE	E	
ACCORD	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 600	Continued From page	a 18	F 60	00		
1 000					dant acting in the	
		." The inmate stated, "you amera you need to stop that		the resident), or a resid dining room, or a resid	-	
	s" NA #1 replied "I			an activity in the comm		
				unauthorized photogra		
	-4:05 NA #1 stated, "I	Resident #2 (Name of		of residents in any stat		
		nim," and put the camera in		undress using any type	e of equipment (for	
	the resident's face wh	nile sitting in the lift sling		example, cameras, sm		
		esident #2 was moving her		other electronic device		
		heavy. NA #1 and NA #2		distributing them throu	-	
	-	resident they were putting		messages or on social		
		l lift. NA #1 stated, "she is		a violation of a residen	• • •	
	trying to focus on going into the lift. She is scared as hell." The inmate stated, "are yall about put her	-		and confidentiality, 8) residents whose privac		
		plied "hell yeah she will be		to include, humiliation,		
		I know I am not lifting her		and feelings of dehuma		
	-	e was speaking to NA #1		prohibition and NO TO	-	
		bserved behind him in the		cellular phones or any		
	open area.			video device in resider	nt care areas,	
				resident rooms, comm		
		erved standing on the right		hallways, dining rooms		
	side of the bed and N			10) cell phones are allo	•	
		's beds with Resident #2		staff possession in the	-	
		cal lift sling suspended. NA streaming Resident #2 and		silenced or vibrate mod emergency alerts but r		
		y curtain was not pulled		breakrooms or other no		
		s. A roommate was not		and 11) staff are respo		
	visualized at that time			if witnessing any violat		
				Phone Policy and/or th		
		phone pointed towards her		Policy and immediately	y remove risk from	
		f shoes she got on (NA		resident and notify Adr		
		#1 and NA #1 started to		violation of the Cell Ph		
		ted, "this is not this ladies'		Resident Rights Policy		
		d the cell phone camera, and		disciplinary action up to	•	
		pended in the mechanical lift de her. Inmates were		termination of employn notification to licensing		
		e inmate that was watching.		enforcement where ap		
		a minate that was watering.		resident privacy is mai		
	-5:01 Resident #2 wa	s being transferred to her		resident's remain free		
		I lift and there was another		SDC will be responsibl		

Facility ID: 953050

If continuation sheet Page 19 of 65

		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	. ,	E SURVEY
			A. BUILDING	3		
		245420	B WINC			С
		345130	B. WING			2/11/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ACCORD	US HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE		
				CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 19	F 60	00		
		in the opposite bed. The		staff are trained by track	king and reviewing	
		ot pulled while Resident #2		the daily schedule and e		
	was being transferred	•		provided. Newly hired s		
				receiving education by 2		
	-5:09 Resident #2 wa	as still in the mechanical lift		receive education prior		
	sling and NA #1 put t	he camera in the resident's		by the SDC, DON or lice	ensed nurse	
		hey." Resident's face was		supervisor.		
		mate stated, "why you		On 12/2/24, licensed nu		
		peaking about the resident's		educated and notified by		
		#1 stated, "she is mad, but		their responsibility to co		
	she doesn't even und	derstand what we are		observational rounds ea		
	saying."			unit and observe reside interactions as above.	nt and staff	
	-5.18 NA #1 laid the r	ohone down while she was		interactions as above.		
		ive video stream and the		Effective 12/4/24, the fa	cilities new hire	
		nat camera down a little more		screening process has l		
		er f (inaudible words)."		include additional meas		
		hone and lowered it showing		determine the candidate		
		ate stated, "that mother f"		providing excellent resid		
	NA #1 and NA #2 beg	gan to laugh.		ensure residents are fre	e from abuse.	
				Updates include improv	ed interview	
	-6:01 NA #1 laid the o	cell phone down still showing		process, a minimum of	two professional	
		lent #2 aggressively on to		references, screening o		
		g up by the lift pad. The		content for inappropriate		
		ed to the resident. Resident		improved screening of b	-	
		rom the camera with her full		checks. Human Resour		
	-	mate stated, "damn, don't		the Administrator, DON		
		NA #1 looked back at the IA #2 was still present in the		responsible for the inter screening reference che	-	
		le of the bed assisting with		screening social media		
		nates were observed in the		the guidance of our lega	-	
	back in the open area			template including a set		
				be used during the inter	-	
	-6:08 NA #1 stated, "	patient confidentiality" and		which include the categ		
		the side of the bed pointing		background, interpersor		
		not viewing the resident but		qualifications and a tem		
	still live streaming wh	nile giving care to the		checks will be used. Sci	-	
	resident.			media platforms will be		
				search to provide inform	nation related to a	

Facility ID: 953050

If continuation sheet Page 20 of 65

		MEDICAID SERVICES			OMB NO. 0	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		345130	B. WING		C 12/11/	2024
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP		
				515 LAKE CONCORD ROAD NE		
CCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE C THE APPROPRIATE	(X5) COMPLETIC DATE
F 600	Continued From page	20	F 60			
1 000			FOU		ractor Tho	
		ited, "oh, oh," while NA #1 and NA # 1 stated, "you		candidate's personal cha Human Resource (HR) D		
	aren't about to fight m	-		process and review crimi		
				checks and forward to the	9	
	-6:20 Resident #2 gra	abbed NA #1's left pant leg		or DON for approval if a c		
	-	ack and then stepped		identified. The Administra		
	forward, and the resid	dent swatted at NA #1. NA		consider all screening res	sults to make a	
		era and laughed while		final determination. Howe		
	continuing care. The			will NOT extend employm		
		u move the phone?" NA #1		candidate with conviction		
		is trying to fight me. F		convictions involving elde	er abuse, neglect	
	she is trying to fight u ass whooped by an o	s. I am not going to get my ld lady."		or exploitation.		
	7.17 NA #1 stated to	resident "open your legs		#4 Effective 12/2/2024, DON or designee will con		
	girl". NA #1 stated to			observational rounds of fa	-	
	discernable.			and staff to ensure that re	-	
				from abuse and resident		
	-7:30 NA #1 stated "g	ood night (residents name)		is maintained, including s		
		e a mother f" Then stated		of staff cellular phone use		
		ed "go to sleep (residents		audio or video device use		
	name)."			areas. Observations will b	-	
				daily for one (1) week, thi		
		erved taking off two sets of		weekly for four (4) weeks		
	-	e asked, "why you put on		weekly for four (4) weeks	-	
		tated "this mother f be sh stated "and pissin'." NA #1		(4) weeks and as needed Monitoring to include obs		
	agreed and stated, "p	-		care being provided only		
	agreed and stated, $ $			staff, 2) use of privacy cu		
	-7:54 NA #1 picked u	p phone and turned towards		doors during personal ca		
		wed the resident in bed with		draping to prevent exposi-		
	covers up to her neck	and stated, "good night		3) no cellular or other vide		
	boo". Resident #2 ha	ad facial grimacing.		by staff in resident care a		
				other violation of resident	÷ .	
		he way she pissed is like she		privacy not only of a resid		
		day." NA #1 replied and		physical body, but of his		
		n hold her piss all day. Like		space, 5) observations of	-	
	a waterfall." NA #2 re	plied "yep."		physical, sexual or emotion		
				include but are not limited	to a ensuring	

Facility ID: 953050

If continuation sheet Page 21 of 65

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		B NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:		G		COMPLETED
						С
		345130	B. WING			12/11/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
ACCORDI	US HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE	1	
				CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE
F 600	Continued From page	e 21	F 60	00		
		I'm fixing to clock out." NA	1.00	residents are not harm	ed physically or	
		e pointed towards her with		handled roughly during		
		NA #2 stated "it's not even		provided with care that		
		f are you going?" NA #1		dignified; b. residents a		
		go I'm tired as a mother f		offensive comments, p		
		d towards the resident's door		form of verbal abuse ar		
	to leave.			to ensure residents are	-	
				signs of mental anguis		
		#2 exited the resident's room		tearfulness, withdrawal		
		e facility hall and continued to		aggressiveness and ot		
	talk to the inmate on	the cell phone.		changes in resident be		
	0.401/64.5.5.5.4			The Administrator		
	-9:46 Video ends.			of the monitoring to the Performance Improven		
	A nhone interview co	nducted with the Lieutenant		Committee during mon		
	-	tions on 12/2/24 at 11:30 AM		and will make changes		
		ained video footage of an		necessary to maintain		
		aving a video call where NA		ensuring residents are		
		nate view of an elderly		0		
	resident in a wheelch	nair and completed a phone		Compliance Date: 12/1	1/24	
	call where NA #1 dise	cussed abusing residents				
		es on them. The Lieutenant				
		ed the concerns to Adult				
		APS) and was concerned NA				
	#1 had exploited Res	sident #2.				
	A follow up phone int	erview with Lieutenant of				
		ns on 12/05/24 at 9:20 AM				
	•	occurred on 10/4/24 and the				
	-	vas Home WAV which is a				
	video call that is reco	orded of both parties. The				
		when a video call occured				
		one receiver to hear the				
		l a computer size screen				
		to see who they are face				
		nr stated other inmates were				
		onversation but could visually				
	see the video becaus	se uie screen is in a				

If continuation sheet Page 22 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	15 LAKE CONCORD ROAD NE		
ACCORD	US HEALTH AT CONCOR	۲D		0	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	22	F	600			
	 2:35 PM revealed she for two years. NA #1 to completed an in-servit and was educated to the administrator. NA taken any pictures or facility. A phone interview corr (NA) #2 on 12/4/24 at been employed by the two years. NA #2 furtheducated on abuse uprandomly. NA #2 state any staff or had taken resident. NA #2 indicastaff member record a report it to the Administaff videoing Resider An interview conducter Nursing (DON) and A 2:45 PM revealed the employed at the facilit no staff had reported their phones out in cas or video footage of a nursing staff had beer and anytime on resider phones were not allow rooms. The video was shareed at 5:45 PM. Those provide (DON), Vice 	ed she had never observed a a video or picture of a ated if she was to observe a a resident that she would strator. NA #2 denied any nt #2 while giving care. ed with the Director of dministrator on 12/02/24 at y both had been recently ty. The interview revealed concerns about staff having are areas and taking pictures resident. Both indicated n in-service at hire, annually, ent privacy and person wed to be out in resident d with facility staff on 12/4/24 resent were the Director of					

Facility ID: 953050

If continuation sheet Page 23 of 65

	-	D HUMAN SERVICES					FORM	01/14/2025
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	D. 0938-0391 SURVEY PLETED
		345130	B. WING					C 11/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COL	DE	•	-
		_		5	15 LAKE CONCORD ROAD NE			
ACCORDI	US HEALTH AT CONCOF	(D		c	CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 600	the video was reviewed NA #2 were identified revealed NA #1 and N on abuse and neglect annually, and during a was indicated Resider oriented and could be care. The DON revea walk away and get he frustrated or combativ nursing staff were not cell phones in care ar to record any audio on DON stated NA #1 fai Resident # 2 and NA # exploitation and privat An interview conducte Responsible Party (RI revealed the facility ha video on 12/04/24. The was upset this had ha was glad it was being justice would be served An interview conducte 12/9/24 at 4:00 PM re employed by the facilit but assisted with the i Administrator further r had denied being in a call with a resident pro- further revealed she e prevent abuse and ne The Director of Nursir	d performance y staff were crying. After ed, Resident #2, NA #1, and by the DON. It was further IA #2 had been in-serviced and reporting upon hire, any abuse investigations. It in #2 was not alert and combative and resistive to led she expected staff to lp if the resident becomes re. It was further revealed allowed to have personal eas and it was not permitted image of a resident. The led to protect the privacy of #2 failed to report the cry of Resident #2's P) on 12/5/24 at 3:15 PM ad notified the family of the re RP further revealed she ppened to Resident #2 but investigated and hoped ed to NA #1 and NA #2. ed with the Administrator on vealed she had been ty for a short period of time nitial investigation. The revealed NA #1 and NA #2 ny video or on a telephone esent. The Administrator expected nursing staff to glect and report.	F	600				
		ng (DON), Vice President of nd Vice President of Risk						

Facility ID: 953050

If continuation sheet Page 24 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/14/2025 APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE COMP	SURVEY LETED
		345130	B. WING		_		C 11/2024
NAME OF PR	OVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
				515 LAKE CONCORD ROA	D NE		
ACCORDI	JS HEALTH AT CONCOR	RD		CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	12/5/24 at 12:35 PM. present. The facility provided th jeopardy removal plan Identify those recipient are likely to suffer, a se a result of the noncon The facility failed to put free from mental and On 10/4/24 Resident is compromised position phone call from Nursin male individual who we audiovisual through th screen in a common at center while other peot observed walking pass audiovisual surveillant show Resident #2 to the camera, the resident se naked, with no shirt of exposed. There were two NAs we #1 and NA #2. The National resident before each se NA # 1 shoved the rest aggressively; NA # 1 at inappropriately, using f**k and sh*t, about the resident while NA # 1 their own private, foul discussion of NA #1's the presence of the rest	ed of immediate jeopardy on The Administrator was not The Administrator was not the following immediate h. the following immediate h. the following immediate h. the following immediate h. the who have suffered, or the serious adverse outcome as apliance. Totect a resident's right to be sexual abuse (Resident #2). #2 was shown in the during an audiovisual ing Assistant (NA) #1 with a tras witnessing the the use of a wall mounted area of an incarceration tople in the prison were t the screen. During the ce, NA #1 was observed to he male through her phone sitting in a wheelchair, the transform on the side and the inmate talked vulgar language including e resident and to the and the inmate carried on mouthed (including buttocks), conversation in	F 60				

Facility ID: 953050

If continuation sheet Page 25 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	-
ACCORDI	US HEALTH AT CONCOR	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	 (DON), Vice Presideri (VPCO) and Vice Pre Assurance (VPRQA) during a recertification a complaint was rece alleging an inappropri unknown elderly fema female identified as N On 12/2/24 at 1:35pm #1 pending outcome of notified the Medical D Because the resident and the presence of a facility was unable to Resident #2's resident immediate suspensio On 12/2/24 at 2:15pm notified the local police protective services (A was obtained. On 12/2/24 at 3:30pm submitted the initial a Carolina Department (NCDHHS). On 12/2/24 at 4:00pm completed an observations included only by authorized static curtains, closed doors covering/draping to pip parts, 3) no cellular of by staff in resident cational 	t of Clinical Operations sident of Risk and Quality were notified by a surveyor in and complaint survey that ived from the community iate photo or video of an ale, partially unclothed and a IA #1was witnessed. In, the DON suspended NA of abuse investigation and birector (MD) of allegation. was unknown at this time a witness was unknown, the make notifications to at representative or initiate in of NA #2. In, the Social Worker (SW) are department and adult IPS). A police report number Ilegation report to North of Health Human Services In, the Administrator ational round of facility ensure that resident rights in from abuse is maintained. d 1) care being provided	F	600			

Facility ID: 953050

If continuation sheet Page 26 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/14/2025 1 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345130	B. WING		_	(12/ [,]	; 11/2024
NAME OF P	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ACCORDI	US HEALTH AT CONCOP	RD		515 LAKE CONCORD ROA CONCORD, NC 28025	AD NE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	or her personal space ensure residents have behaviors indicative of additional concerns in On 12/2/2024 and on VPCO, VPRQA, Adm Director held an Ad H incident to determine facility's failure protect from abuse. Root cau the facility failed to im to ensure strict enfort measures to prohibit of recording devices in r Effective 12/2/2024, li resident abuse questi intact residents and b impaired residents to concerns of resident a concerns reported or On 12/4/24 at 4:00pm VPRQA were notified and observed video s survey team identifyir of the facility and of m NA #1 in the presence immediately suspend- investigation. The VP provided additional in message with APS. T #2's resident represent provided updated infor	vn physical body, but of his e and 5) observations t e no physical signs or of potential abuse. No lentified. 12/4/2024, the DON, inistrator and Medical oc meeting to discuss root cause analysis of the t a resident's right to be free se analysis determined that plement an effective system cement and monitoring cellular phones and video esident care areas. Icensed nurses completed onnaires with cognitively ody audits with cognitively identify any additional abuse. No additional observed. A, the DON, VPCO and of additional information urveillance provided by the og Resident #2 as a resident nental and sexual abuse by e of NA #2. The DON ed NA #2 pending RQA notified police and formation and left a he DON notified Resident native (RP) and MD was	F 60	0			

If continuation sheet Page 27 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ACCORDI	US HEALTH AT CONCOR	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	symptoms of psychos concerns were obser- confused at baseline. Specify the action the process or system fai adverse outcome from and when the action were Effective 12/2/2024, at in-serviced on the Abu Exploitation Policy, R Cell Phone Policy by Coordinator (SDC) an Abuse training topics reporting and identify and NO TOLERANCE ensure resident prote examples included; p verbal, neglect, explo or emotional abuse such changes in behavior, withdrawal from care, expressions of guilt o of reporting abuse im Administrator and pre- immediate intervention potential for harm from the perpetrator or three Education of proper mexamples such as en harmed physically or but are provided with dignified and that resi- offensive comments, verbal abuse. To prot privacy, the facility is	social distress and no ved and was pleasantly a entity will take to alter the lure to prevent a serious in occurring or reoccurring, will be complete. all current facility staff were use, Neglect and esident Rights Policy and the Staff Development ad licensed nurse manager. included preventing, ing what constitutes abuse E for failure to comply and ction. Identification hysical, mental, sexual, itation and signs of mental uch as, sudden unexplained changes in eating habits, fear of certain persons or r shame and staff obligation mediately to the evention of abuse by the n of removing the harm or m the resident by removing eat. esident care includes suring residents are not handled roughly during care care that is gentle, kind, dents are free from profanities or other form of ect resident's right to	F	600			

Facility ID: 953050

If continuation sheet Page 28 of 65

	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY
		BERTHIOGHON NOWBER.	A. BUILDING	<u> </u>		
			D 14/100			С
		345130	B. WING	·····		2/11/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT CONCO			515 LAKE CONCORD ROAD NE		
ACCORDI	US REALTH AT CONCO			CONCORD, NC 28025		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From pag	o 29	E CO			
F 000	Continued From pag		F 60			
		ellular phones and any type				
		ng device use in resident care				
		ile providing personal care.				
		amples of violation of				
		include, but not limited to 1)				
		residents' own physical body,				
		onal space, including				
		d personal care, 2) only				
		tly involved in providing care				
		resident may be present				
		d, unless the resident				
		lividuals being present during				
		3) during the delivery of				
	-	ervices, staff must remove				
	-	view, pull privacy curtains or				
		vide clothing or draping to				
		body parts, 4) photographs				
		sident and/or his or her body				
	or private space with					
		tative's written consent, is a				
		ent's right to privacy and				
		ff taking unauthorized				
		ident's room or furnishings				
		ot include the resident), or a dining room, or a resident				
	-	tivity in the common area, 6)				
		photographs or recordings of				
	. .	e of dress or undress using				
		nt (for example, cameras,				
		ther electronic devices), 7)				
	-	ig them through multimedia				
		al media networks is a				
		t's right to privacy and				
		tential effects on residents				
		maintained to include,				
		respect and feelings of				
		strict prohibition and NO				
		cellular phones or any type				

Facility ID: 953050

If continuation sheet Page 29 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
					515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR	ξD			CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 600	dining rooms, courtya are allowed to be kep facility on a silenced of emergency alerts but breakrooms or other r staff are responsible t violation of the Cell Pl Resident Rights Policy risk from resident and 12) violation of the Cel Rights Policy will resu and including termina notification to licensin enforcement where a privacy is maintained from abuse. Effective 12/2/2024, a also completed with of validate competency identify any additional resident abuse. No ac The SDC will be resp are trained by tracking schedule and ensurin hired staff and staff no 12/2/2024 will receive worked shift by the SI supervisor. Effective 12/2/2024, t designee will complet observational rounds to ensure that resider resident rights to priva strict prohibition of sta type of audio or video	non areas such as hallways, ards, etc., 10) cell phones t in staff possession in the pr vibrate mode to allow for may only be used in non-resident areas and 11) to intervene if witnessing any hone Policy and/or the by and immediately remove I notify Administrator and ell Phone Policy or Resident alt in disciplinary action up to tion of employment and/or g boards and law pplicable to ensure resident and resident's remain free abuse questionnaires were current facility staff to of education received and to I allegations or incidence of dditional concerns reported. onsible for ensuring all staff g and reviewing the daily g training is provided. Newly of receiving education by e education prior to first DC, DON or licensed nurse	F	600			

Facility ID: 953050

If continuation sheet Page 30 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
ACCORDI	US HEALTH AT CONCOR	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	privacy curtains, close care and covering/dra body parts, 3) no celle used by staff in reside violation of resident ri only of a residents' ov or her personal space form of physical, sexu include but are not lin residents are not harr roughly during care b that is gentle, kind, di from offensive comme form of verbal abuse ensure residents are mental anguish such fear, guarding, aggres changes in resident b licensed nurses were the VPCO of their res observational rounds	aping to prevent exposure of ular or other video devices ent care areas, 4) any other ght to personal privacy not vn physical body, but of his e, 5) observations of any ual or emotional abuse which nited to; a. ensuring med physically or handled ut are provided with care gnified; b. residents are free ents, profanities or other and c. observations to not exhibiting signs of as tearfulness, withdrawal, essiveness and other unusual	F	600			
	process has been up measures to better de probability of providin further ensure resider	facilities new hire screening dated to include additional etermine the candidate's g excellent resident care to nts are free from abuse. oved interview process, a					
	minimum of two profe screening of social m inappropriate content background checks. I and/or the Administra responsible for the int reference checks and	essional references, edia content for and improved screening of Human Resources (HR)					

Facility ID: 953050

If continuation sheet Page 31 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345130	B. WING				C 2/11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR	RD			CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	used during the interventhe categories of back and qualifications and checks will be used. S platforms will be used provide information re- personal character. T Director will process a background checks a Administrator or DON record is identified. The consider all screening determination. However extend employment the convictions or pendin- abuse, neglect or exp Effective 12/2/2024, the ultimately responsible completion of this rem Alleged Date of IJ Re- On 12/10/2024, the fa- immediate jeopardy w was observed in the of smiling with other res- the tour of the facility have their doors closed were seen pulled to c no signs of staff cell p and in resident care a facility included inform resident rights, and co notification of adminis- behavior changes, an observations of reside	a set of questions will be view process which include kground, interpersonal skills d a template for reference Screening of social media d via internet search to elated to a candidate's he Human Resource (HR) and review criminal nd forward to the I for approval if a criminal he Administrator or DON will g results to make a final ver, the facility will NOT o any candidate with g convictions involving elder oloitation. he Administrator is e for the implementation and noval plan. moval: 12/5/2024 acility's credible allegation for vas validated. Resident #2 dining room pleasant and idents in the table. During residents were observed to ed for care and curtains over for privacy. There were ohone use in the hallways areas. The in-services by the nation on abuse, privacy, ellphone use, including stration for any resident's ad increased rounding	F	600			

Facility ID: 953050

If continuation sheet Page 32 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345130	B. WING				C 11/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	15 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOF			c	CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 602 SS=D	use. The facility provid Assurance auditing of cognitively intact resid cognitively impaired re- auditing for the obser- staff abuse question screening process an review were executed The immediate jeopar was validated. Free from Misappropri CFR(s): 483.12 §483.12 The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemi- treat the resident's me This REQUIREMENT by: Based on record revi- staff, the facility failed right to be free from n controlled medication reviewed for misappro- property (Resident #6 her pain medication a Findings included:	ent rights, and cellphone ded evidence of daily Quality f all residents divided on dents for interview and esidents for body audits, the vational rounds every shift, aires, and new on-hire d employee handbook d. rdy removal date of 12/5/24 riation/Exploitation right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. is not met as evidenced ew, and interviews with to protect the resident's hisappropriation of s for 1 of 3 residents opriation of a resident's b). The resident received s scheduled.		600	Past noncompliance: no plan of correction required.		
	Policy, last updated o	Veglect, and Exploitation n 10/22/24, was reviewed propriation in part was the					

Facility ID: 953050

If continuation sheet Page 33 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
ACCORD	US HEALTH AT CONCOR	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 602	protection of resident deliberate misplacem wrongful, temporary of resident's belongings resident's consent." Resident #6 was adm 3/17/20 with a diagno Resident #6 had an o milligrams (mg) every dated 2/13/24. A pharmacy packing s documented dispense of oxycodone 10 mg at tablets for a total of 40 A review of the medic record received by Nu between 3/25/24 thro oxycodone 10 mg ad ordered, signed with o The remaining amour one. There were thre mg cards with 10 tabl monitoring/control record The daily nursing sch Nurse #2 scheduled of Resident #6 on day s responsible for this has The shift change narco on Hall B medication was documented by N sheets. Four sheets A 6 was written with a	property "means the ent, exploitation, or or permanent, use of a or money without the hitted to the facility on sis of chronic pain. rder for oxycodone 10 r 6 hours for chronic pain slip dated 3/25/24 e date of 3/25/24 of 4 cards and each card had 10 0 tablets. ation monitoring/control urse #4 documented ugh 3/27/24 there were 10 ministered every 6 hours as correct descending amount. In twas "0" for card number eremaining oxycodone 10 ets each with a medication cord. edule dated 3/27/24 had on B-Hall assigned to hift, and she was	F	602			

Facility ID: 953050

If continuation sheet Page 34 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		-
ACCORDI	US HEALTH AT CONCOR	RD			515 LAKE CONCORD ROAD NE		
-					CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	The "8" appeared to b number that was not column documented oxycodone cards on 3 on this sheet. A new shift change na sheet was started dat "oncoming nurse" sig going" nurse was blan "narcotic sheets" colu narcotic count verifica dated 3/27/24 11 pm "off going nurse" colu a signature of Nurse number in the "narcot handwriting of the sig appeared to be the sa signatures. The Director of Nursin with Resident #6's na investigation dated 3/ On 3/27/24 the 2nd si Resident #6 was miss oxycodone 10 mg tha The DON completed verification count she count number had be investigation revealed control record and 1 of tablets were missing. were notified. All othe narcotic counts were concerns were noted. pending investigation that 4 cards of oxycot	be written on with another legible. The comments Resident #6 had 4 3/26/24. All rows were filled arcotic count verification red 3/27/24 3 pm shift nature Nurse #2 and "off nk. Number 36 was in the imm. A new row on the ation sheet was started shift "oncoming nurse" and mns were both signed with #3's name. There was no tic sheets" column. The natures on this sheet ame for both names, all 3 hg (DON) provided a folder rcotic misappropriation 27/24 documentation: hift nurse reported that sing 1 of 4 cards of t were delivered on 3/25/24. a review of the shift et and noted that the sheet en altered. Further d 1 medication monitoring card of 10 oxycodone 10 mg The pharmacy and police er facility medication carts of audited, and no other . Nurse #2 was suspended . The pharmacy confirmed done 10 mg were delivered	F	60;	2		
	pending investigation that 4 cards of oxycoo	. The pharmacy confirmed					

Facility ID: 953050

If continuation sheet Page 35 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT CONCOR	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	that 4 cards of oxycod tablets on each card was contacted by pho statement related to or reported to the North on 4/3/24. Education nurses regarding the correcting errors in th properly. Corrective a contacted by the DON replacement refill card tablets was obtained The police were conta facility they were unal phone or the address Nurse #2 will not be a On 4/8/24 a urine spe Nurse #3. The test w including opiate. Nurse #2 was left me 3/28/24 twice. A retu her on 3/29/24 at 10:2 wanted her pay appro- to come to the facility statement was not pro- All residents that had reviewed for accuracy count. All medication reviewed and medica misappropriation of m Audits were complete 5/1/24 weekly for 4 w were identified. Goal will be properly handl	done 10 milligrams with 10 were delivered. Nurse #2 one and refused to provide a oxycodone. Nurse #2 was Carolina Board of Nursing was initiated with licensed narcotic count and e medication record actions: The pharmacy was N on 3/28/24 and a d of oxycodone 10 mg 10 at the expense of the facility. acted, and they informed the ble to reach Nurse #1 by on file by the agency. allowed to work in the facility. ecimen was obtained from ras negative for all drugs ssages on 3/27/24 and rn call was received from 40 am. She stated that she oved. Nurse #2 was asked and provide a statement. A ovided.	F	602	2		

Facility ID: 953050

If continuation sheet Page 36 of 65

		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDIN	G		С
		345130	B. WING		1	2/11/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/11/2024
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 602	Continued From page	e 36	F 60	02		
1 002		udits were completed, and	FU			
	counts were correct.	duits were completed, and				
	An in-service roster of	of nurses signed for				
		policy "controlled substance				
		ccountability" revision				
	November 2017 had					
Additional information to correct mistakes appropriately was included.	n to correct mistakes					
	appropriately was inc	cluded.				
	On 12/5/24 at 2:54 pi	m an interview was				
		e #2. She stated on 3/25/27				
		s with 10 tabs each were				
	•	t #6 and Nurse #3 and #4				
	observed, documente	ed, and counted that this was				
	added to the shift cha	•				
		there was a medication				
	0	cord for each oxycodone				
	card. Both nurses sig					
	•	v cards were added to the count verification sheet, and				
	•	of that sheet with a date of				
		t change narcotic count				
		s started and signed by				
		rse #2 was on day shift				
		or the narcotics and counted				
		change 3:00 pm. The				
		g control record that was				
		rate. There were the correct ge narcotic count verification				
		urse #3 stated she went to				
		lone at the beginning of her				
		ecked the paperwork. She				
		shift change narcotic count				
		s not the sheet she and				
		and signed on 3/26/24. The				
	-	heirs and both appeared to				
		ne person. A check of the				
		e narcotic count verification				

Facility ID: 953050

If continuation sheet Page 37 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	-
ACCORDI	US HEALTH AT CONCOP	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 602	sheet ending date 3/2 had completed to the the number of narcoti number of narcotic sh changed. The number were not the correct r written by Nurse #3 th Nurse #3 noticed that was missing. There s remaining and now th had left immediately a and narcotic count an by telephone. On 12/5/24 at 2:40 pr conducted with the Vi She stated the Admin the DON employed M working at this facility look for additional nur sheets, QAPI (Quality Improvement) minute Administration notifica On 12/5/24 at 4:20 pr Quality provided a QA 3/27/24 with the topic team roster. Nurse # 4 was intervie pm. Nurse #4 stated mg were received for Nurse #3 and Nurse # and signed for the rec 3/25/24 at 7:00 am. O 10 mg was used and 3/27/24. The count w left after night shift 3/2	26/24 that Nurse #3 and #4 last row of the sheet had c sheets added and total neets on the cart were ers were written over and numbers, the numbers ne evening before 3/26/24. c one of the oxycodone cards should have been 3 cards nere were only 2. Nurse #2 after report at shift change d was unable to be reached m an interview was ce President of Quality. istrator was not present and larch 2024 was no longer . She also stated she would rsing education roster (Assurance/Performance s, and Drug Enforcement	F	602	2		

Facility ID: 953050

If continuation sheet Page 38 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
		_			515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR	RD			CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 602	change narcotic coun signed and dated 3/20 Nurse #2 at the begin at 7:00 am and the na The sheet Nurse #4 st there were 3 full cards remaining. On 3/27/2 change narcotic coun Nurse #4 started was was started by an age Nurse #4's name was Nurse #3 and Nurse # sheet and the handwr On 12/10/14 the Vice provided the remainin and a statement that Administration was no previous name and id document was not ob The facility provided t action plan with a con F602 1. Corrective action for alleged deficient prac Resident #6 was affect her schedule oxycodor resident received her The medication was no potential to be affected practice: All residents with a na potential to be affected completed an audit of narcotics to verify tha	t sheet with Nurse #3 and 6/24. Nurse #4 counted with ning of her day shift 3/27/24 arcotic count was correct. tarted was present and s of oxycodone 10 mg 4 at 3:00 pm the shift t sheet that Nurse #3 and missing. Another sheet ency nurse (Nurse #2). a not on this new sheet. #2's name were on the new riting looked the same. President of Quality gnurse education roster the Drug Enforcement otified under the facility's lentification number and the tainable. he following corrective npletion date of 4/7/24: pr resident(s) affected by the tice: cted by misappropriation of one pain medication. The medication as scheduled. eplaced by the facility.	F	60;	2		

Facility ID: 953050

If continuation sheet Page 39 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT CONCOP	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 602	identified. The audit v 3. Measures/Systemic recurrence of alleged On 3/27/24 through 4 following topics for all medication aids regar personal property that count, verifying medic misappropriation, and Director of Nursing ar continue to maintain a medication records to accountability. Educat 4/7/24 for all nursing s Monitoring of the medication. The weekly for 4 weeks. notified on 3/27/24. 4. Monitoring procedd of correction is effectified deficiency cited remaind compliance with regulation The Director of Nursing carts weekly for 4 weeks Improvement) Commin Compliance Date: 4/8 Validation of the correction completed on 12/11/2	was completed on 3/27/24. c changes to prevent deficient practice: /7/24 training on the licensed nurses and ding misappropriation of t focused on shift-to-shift cations on hand, I documentation. The hd/or designee would and monitor controlled o ensure consistency and ation was completed by staff, including agency staff. Lication carts began on I audit after the e monitoring continued The QA members were ure to ensure that the plan ve, and that specific ins corrected and/or in latory requirements. Ing audited all medication eks. There were no adverse ropriation was reported to surance/Performance ittee) on 3/27/24.	F	602	2		

If continuation sheet Page 40 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT CONCOP	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 602	that was completed w medication aides who administer narcotic m controlled substances administration, and sh completed. The educ 3/27/24 through 4/7/2 On 12/5/24 interviews with Nurse #1 and #3 #4. The Nurses state education for narcotic reporting, count, and The compliance date Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(4) Establis QAPI program require §483.12(b)(5) Ensure occurring in federally- facilities in accordance	with 33 nurses and had responsibility to edication and had access to a covered drug loss or theft, hift-to-shift drug count was cation took place between 4. were conducted individually and on 12/10/24 with Nurse d they participated in misappropriation, storage, documentation. of 4/8/24 was validated. buse/Neglect Policies -(5)(ii)(iii) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures ch allegations, and training as required at sh coordination with the ed under §483.75.		602			12/11/24

Facility ID: 953050

If continuation sheet Page 41 of 65

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/14/202 MAPPROVEI O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345130	B. WING _			12	C 2/ 11/2024
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT CONCO	PD		51	5 LAKE CONCORD ROAD NE		
ACCORDI	US REALTH AT CONCO			C	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From page		F	607			
	but are not limited to	the following elements.					
		ting a conspicuous notice of lefined at section 1150B(d)					
	retaliation, as defined (2) of the Act.	bhibiting and preventing at section 1150B(d)(1) and is not met as evidenced					
	Based on observatio responsible party, Lie Investigations and sta	aff interviews, the facility			#1 On 12/4/24 at 4:00pm, the Direct Nursing (DON), Vice President of Clir Operations (VPCO) and Vice Preside	iical nt of	
	the area of identificat for 1 of 3 residents (F Resident # 2 was bei two nurse aides (NA	ng abused, neither of the #1 and NA #2) in the room			Risk and Quality Assurance (VPRQA were first made aware of the presence NA #2 during the incident on 10/4/202 The DON immediately suspended NA pending investigation. The VPRQA	e of 24.	
	abuse, and neither of	nmediately to licensed staff			notified police and provided additiona information and left a message with A The DON notified Resident #2's resid representative (RP) and MD was prov	.PS. ent	
		began on 10/4/24 when			updated information received. On 12/4/2024 at 6:00pm, the VPCO asse Resident #2 for physical injury, pain a	ssed	
	identification, interver jeopardy was remove facility implemented a	ntion or reporting. Immediate ed on 12/5/24 when the a credible allegation of			signs or symptoms of psychosocial distress and no concerns were obser and was pleasantly confused at base	/ed ine.	
	remain out of complia	emoval. The facility will ance at the scope and tual harm with potential for			On 12/4/2024, the DON, VPCO, VPR Administrator and Medical Director he an Ad Hoc meeting to discuss incider	ld	
	more than minimal ha jeopardy) to ensure e monitoring systems p	ducation is completed and			determine root cause analysis of the facility's failure to protect a resident ri to be free from abuse when NA #2 die	•	
	effective.				identify, prevent or report the incident 10/4/2024. Root cause analysis	on	
	The findings included	l:			determined that the facility failed to 1 implement an effective system to ens		

Facility ID: 953050

If continuation sheet Page 42 of 65

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '	G	· · · ·	MPLETED
						С
		345130	B. WING			12/11/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO			CONCORD, NC 28025		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From pag	le 42	F 6	07		
		ty policy and procedure titled		staff knowledge of the Abus	se Neglect and	
		d Exploitation", with a revised		Exploitation Policy to includ		
		ad in part "it is the policy of		examples of how to identify	, prevent and	
		e protection for the health,		report abuse and validation		
	•	each resident by developing		understanding and 2) the fa	•	
		ritten policies and procedures		enforce a strict NO TOLER		
		vent abuse, neglect, and appropriation of resident		phone use and video recor in resident care areas per t		
	property." As read in			Policy.	ne Cell Phone	
		mpliance Guidelines," reads		On 12/4/24 the facility was	made aware of	
	-	vent abuse, neglect, and		immediate jeopardy and an		
		ents and misappropriation of		plan of correction was prov		
	resident property.			jeopardy removed effective	12/5/24.	
	This tag is cross refe	erred to F600		On 12/6/24, upon completio		
	Pasad on observatio	n, record review, and family,		investigation, NA #1 and N		
	Lieutenant of Crimin	al Investigations and staff y failed to protect a resident's		terminated indefinitely and nurse aide registry.		
		abuse for 1 of 3 residents		#2 On 12/2/24 at 4:00pm,	the	
		e aide (NA) # 1 and NA # 2		Administrator completed ar		
	provided personal ca	are to Resident # 2 while live		round of facility residents a	nd staff to	
		phone, the resident was		ensure that resident rights		
		t up, the staff and the prison		freedom from abuse is mai		
		live stream spoke with ty without any regard for the		Observations included 1) c	•	
		d not explain care as it was		provided only by authorized privacy curtains, closed do		
		ent; the staff were physically		personal care and covering	•	
		are; the staff allowed an		prevent exposure of body p		
		ching the live stream to view		cellular or other video devid		
		ak to the resident; the staff		staff in resident care areas	· •	
		aming while other inmates		other violation of resident ri		
		e open area behind him. As		privacy not only of a reside		
		verely cognitively impaired,		physical body, but of his or		
		on concept was applied. A vould have been traumatized		space and 5) observations residents have no physical		
		caregivers in their home		behaviors indicative of pote	•	
		them feel worthless, angry,		additional concerns identifie		
	dehumanized and po		1			

Facility ID: 953050

If continuation sheet Page 43 of 65

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/14/2025 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	-	
400000				51	5 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR			C	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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
					Derfolenory		
F 607	Continued From page	2 43	F 6	607	Effective 12/2/2024, licensed nurses		
	Immediate ieonardy h	egan on 10/4/24 when			completed resident abuse questionnair	es	
		sed. Immediate jeopardy			with cognitively intact residents and bo		
	was removed on 12/5				audits with cognitively impaired resider	2	
		le allegation of immediate			to identify any additional concerns of		
	-	e facility will remain out of			resident abuse. No additional concerns	5	
	compliance at the sco	ope and severity of "D" (no			reported or observed.		
	actual harm with pote	ntial for more than minimal			Effective 12/2/2024, abuse questionnal	ires	
	harm that is immediat				were also completed with current facilit	•	
	-	ed and monitoring systems			staff to validate competency of education	on	
	put into place and are	effective.			received and to identify any additional		
					allegations or incidence of resident abu	ise.	
		ng (DON), Vice President of			No additional concerns reported.		
		(PCO), and Vice President			Effective 12/2/24, abuse questionnaire		
		RQA) were notified of			were completed with current facility sta	Ħ	
		n 12/5/24 at 1:45 PM. The			to validate competency of education		
	Administrator was not	i present.			received and to identify any additional allegations or incidence of resident abu	100	
	The facility provided t	he following credible			No additional concerns reported.	ise.	
	allegation of immedia				No additional concerns reported.		
	anogation or minouta	to jooparay removal.			#3 Effective 12/2/2024, all current fac	ilitv	
	Identify those recipier	nts who have suffered, or			staff were in-serviced on the Abuse,	-7	
	•	serious adverse outcome as			Neglect and Exploitation Policy, Reside	ent	
	a result of the noncon				Rights Policy and Cell Phone Policy by Staff Development Coordinator (SDC)	the	
	The facility failed to fe	ollow their abuse policy in			licensed nurse manager. Abuse trainin		
	the areas of identifica				topics included preventing, reporting ar		
		witnessed NA #1 conduct			identifying what constitutes abuse and		
		call where NA #1 showed			TOLERANCE for failure to comply and		
	-	omised positions during a			ensure resident protection. Identificatio		
	recorded call NA #1 w	vas having with a male			examples included; physical, mental,		
	individual who was wi				sexual, verbal, neglect, exploitation and		
		vall mounted screen in a			signs of mental or emotional abuse suc	ch	
		carceration center. During			as, sudden unexplained changes in		
		rsation NA #1 was observed			behavior, changes in eating habits,		
	to show Resident #2 t				withdrawal from care, fear of certain		
		mera, the resident sitting in			persons or expressions of guilt or shan	ne	
		with no shirt or bra on, with NA #2 failed to intervene to			and staff obligation of reporting abuse immediately to the Administrator and		
	ner breasis exposed.				minioriatory to the Authinioriator and		

Facility ID: 953050

If continuation sheet Page 44 of 65

		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/14/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	COMF	SURVEY PLETED
		345130	B. WING				C / 11/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	US HEALTH AT CONCO			51	15 LAKE CONCORD ROAD NE		
ACCORDI	US REALTH AT CONCO			С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 607	Continued From pag	e 44	F	607			
		device and protect the			prevention of abuse by the immediate	`	
		g mental abuse, and did not			intervention of removing the harm or	•	
		sed staff or administrative			potential for harm from the resident b	v	
		stop it, nor did she notify			removing the perpetrator or threat. To		
	administration, or a s				protect resident's right to privacy, the		
					facility is adopting a NO TOLERANCE	Ξ	
	On 12/4/24 at 4:00pr	n, the DON, VPCO and			Cell Phone Policy focusing on the stri	ct	
		ade aware of the presence of			prohibition of cellular phones and any	' type	
		ident on 10/4/2024. The DON			of electronic recording device use in		
	immediately suspend				resident care areas, especially while		
		PRQA notified police and			providing personal care. Training inclu-		
	provided additional in				examples of violation of residents' pri	-	
		The DON notified Resident entative (RR) and MD was			to include, but not limited to 1) privacy not only a residents' own physical boo		
	provided updated inf				but of his or her personal space, inclu		
		officiation received.			accommodations and personal care,	-	
	On 12/4/2024 at 6:00)pm, the VPCO assessed			only authorized staff directly involved	,	
		ical injury, pain and signs or			providing care and services for the		
		social distress and no			resident may be present when care is	;	
		rved and was pleasantly			provided, unless the resident consent		
	confused at baseline				other individuals being present during	the	
					delivery of care, 3) during the delivery	/ of	
		PCQA, VPCO and DON			personal care and services, staff mus		
		nformation regarding the			remove residents from public view, pu	ll	
	-	on. Upon receipt of this			privacy curtains or close doors, and		
		ity plans to inquire on the			provide clothing or draping to prevent		
	security of the record	cted from any additional			exposure of body parts, 4) photographic recordings of a resident and/or his or		
	violation of privacy b				body or private space without the		
	unauthorized to have	-			resident's, or designated representati	ve's	
					written consent, is a violation of the		
	On 12/4/2024, the D	ON, VPCO, VPRQA,			resident's right to privacy and		
		edical Director held an Ad			confidentiality, 5) staff taking unautho	rized	
		uss incident to determine root			photographs of a resident's room or		
	cause analysis of the	e facility's failure to protect a			furnishings (which may or may not inc	clude	
		free from abuse when NA #2			the resident), or a resident eating in the		
		ent or report the incident on			dining room, or a resident participatin	-	
		se analysis determined that			an activity in the common area, 6) tak	•	
	the facility failed to 1) implement an effective			unauthorized photographs or recordir	ngs	

Facility ID: 953050

If continuation sheet Page 45 of 65

		MEDICAID SERVICES				<u>VO. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
			A. BOILDING			С
		345130	B. WING		1	2/11/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
E 607	Continued From non	- 45		~~		
F 607	Continued From page		F 60			
		ff knowledge of the Abuse,		of residents in any state of dre		
		tion Policy to include detailed		undress using any type of equ		
		dentify, prevent and report		example, cameras, smart pho		
		of staff understanding and		other electronic devices), 7) ke		
	2) the facility failed to	l phone use and video		distributing them through mult messages or on social media		
		in resident care areas per		a violation of a resident's right		
	the Cell Phone Policy	-		and confidentiality, 8) potentia		
		/.		residents whose privacy is not		
pro	Specify the action the	e entity will take to alter the		to include, humiliation, dignity		
		ilure to prevent a serious		and feelings of dehumanizatio		
		m occurring or reoccurring,		prohibition and NO TOLERAN		
	and when the action			cellular phones or any type of		
		·		video device in resident care a		
	Effective 12/2/2024, a	all current facility staff were		resident rooms, common area	s such as	
	in-serviced on the Ab			hallways, dining rooms, courty	/ards, etc.,	
	Exploitation Policy, R	esident Rights Policy and		10) cell phones are allowed to	be kept in	
	Cell Phone Policy by	the Staff Development		staff possession in the facility	on a	
		nd licensed nurse manager.		silenced or vibrate mode to al	ow for	
	Abuse training topics			emergency alerts but may onl		
		ring what constitutes abuse		breakrooms or other non-resid		
		E for failure to comply and		and 11) staff are responsible t		
	ensure resident prote			if witnessing any violation of th		
		hysical, mental, sexual,		Phone Policy and/or the Resid		
		bitation and signs of mental		Policy and immediately remov		
		uch as, sudden unexplained changes in eating habits,		resident and notify Administra		
		u		violation of the Cell Phone Po	-	
		, fear of certain persons or or shame and staff obligation		Resident Rights Policy will res disciplinary action up to and ir		
	of reporting abuse im			termination of employment an		
		evention of abuse by the		notification to licensing boards		
		on of removing the harm or		enforcement where applicable		
		m the resident by removing		resident privacy is maintained		
		eat. Education of proper		resident's remain free from ab		
	resident care include			SDC will be responsible for er		
		e not harmed physically or		staff are trained by tracking ar		
		ng care but are provided with		the daily schedule and ensurin		
		nd, dignified and that		provided. Newly hired staff an		
		m offensive comments,		receiving education by 12/2/24		

Facility ID: 953050

If continuation sheet Page 46 of 65

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB 1 (X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	Ćco	MPLETED
						С
		345130	B. WING		1	2/11/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI		
				515 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCO	RD		CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 607	Continued From pag	e 46	F 60	7		
		orm of verbal abuse. To		education prior to first we	orked shift by the	
		nt to privacy, the facility is		SDC, DON or licensed n		
		RANCE Cell Phone Policy		supervisor. The SDC will		
		prohibition of cellular		for ensuring all staff are	trained by	
		of electronic recording		tracking and reviewing th		
		t care areas, especially		and ensuring training is		
		onal care. Training included		hired staff and staff not r		
		of residents' privacy to		education by 12/2/24 will		
		ed to 1) privacy of not only a cal body, but of his or her		education prior to first wo SDC, DON or licensed n		
		iding accommodations and		Effective 12/4/24, the fac		
		y authorized staff directly		screening process has b		
		care and services for the		include additional measu		
		ent when care is provided,		determine the candidate		
		onsents to other individuals		providing excellent reside		
	being present during	the delivery of care, 3)		ensure residents are free	e from abuse.	
		personal care and services,		Updates include improve		
		sidents from public view, pull		process, a minimum of t		
		ose doors, and provide		references, screening of		
		prevent exposure of body		content for inappropriate		
		s or recordings of a resident		improved screening of ba	-	
		y or private space without ignated representative's		checks. Human Resource the Administrator, DON of		
		violation of the resident's		responsible for the interv		
		onfidentiality, 5) staff taking		screening reference che	•	
		raphs of a resident's room or		screening social media p		
		ay or may not include the		the guidance of our legal		
		nt eating in the dining room,		template including a set	of questions will	
	or a resident participa	ating in an activity in the		be used during the interv	view process	
	common area, 6) tak	-		which include the catego		
		dings of residents in any		background, interperson		
		ress using any type of		qualifications and a temp		
		ple, cameras, smart phones,		checks will be used. Scre		
		devices), 7) keeping or ough multimedia messages		media platforms will be u search to provide informa		
	-	etworks is a violation of a		candidate's personal cha		
		vacy and confidentiality, 8)		Human Resource (HR)		
		esidents whose privacy is not		process and review crim		
			1			

Facility ID: 953050

If continuation sheet Page 47 of 65

		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	· · · · ·	E SURVEY PLETED
			A. BUILDING	<u> </u>		
		345130	B. WING			С
		345130				2/11/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
ACCORDI	US HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE		
	1			CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From pag	e 47	F 60	07		
	and feelings of dehu			or DON for approval if a	criminal record is	
		OLERANCE to use cellular		identified. The Administra		
	phones or any type o	of audio or video device in		consider all screening re-	sults to make a	
		resident rooms, common		final determination. Howe		
	areas such as hallwa			will NOT extend employn	-	
		cell phones are allowed to be		candidate with conviction	1 0	
		ion in the facility on a		convictions involving elde	er abuse, neglect	
		ode to allow for emergency le used in breakrooms or		or exploitation.		
		reas and 11) staff are		#4 Effective 12/2/2024,	the Administrator	
	responsible to interve			DON or designee will cor		
		Phone Policy and/or the		observational rounds of f	•	
	Resident Rights Poli	cy and immediately remove		and staff to ensure that re	esidents are free	
		d notify Administrator and		from abuse and resident		
		ell Phone Policy or Resident		is maintained, including s	-	
		ult in disciplinary action up to		of staff cellular phone us		
	-	ation of employment and/or		audio or video device use		
	notification to licensi	applicable to ensure resident		areas. Observations will daily for one (1) week, th	•	
		applicable to ensure resident		weekly for four (4) weeks		
	from abuse.			weekly for four (4) weeks	. ,	
				(4) weeks and as needed		
	Effective 12/2/24, ab	use questionnaires were also		Monitoring to include obs		
		nt facility staff to validate		care being provided only	be authorized	
		ation received and to identify		staff, 2) use of privacy cu		
		tions or incidence of resident		doors during personal ca		
		concerns reported. The		covering/draping to preve		
	-	ible for ensuring all staff are		body parts, 3) no cellular		
		nd reviewing the daily ng training is provided. Newly		devices used by staff in r areas, 4) any other violat		
		not receiving education by		right to personal privacy		
		education prior to first worked		residents' own physical b	-	
	shift by the SDC, DC	-		her personal space, 5) ol		
	supervisor.			any form of physical, sex		
				abuse which include but		
		use questionnaires were also		a. ensuring residents are		
	-	nt facility staff to validate		physically or handled rou		
		ation received and to identify tions or incidence of resident		but are provided with car kind, dignified; b. residen		

Facility ID: 953050

If continuation sheet Page 48 of 65

		MEDICAID SERVICES					D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING	G			С
		345130	B. WING				/11/2024
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	12/11/202	
					5 LAKE CONCORD ROAD NE		
ACCORDI	JS HEALTH AT CONCO	RD			DNCORD, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	a 18	F 60	72			
1 007		concerns reported. The	FUC	51	offensive comments, profenities or ethe	r	
		ble for ensuring all staff are			offensive comments, profanities or othe form of verbal abuse and c. observation		
		nd reviewing the daily			to ensure residents are not exhibiting		
		ng training is provided. Newly			signs of mental anguish such as		
		ot receiving education by			tearfulness, withdrawal, fear, guarding,		
		ducation prior to first worked			aggressiveness and other unusual		
	shift by the SDC, DO	N or licensed nurse			changes in resident behaviors.		
	supervisor.				The Administrator will report finding	10	
	Effective 12/2/2024	the Administrator, DON or			The Administrator will report finding of the monitoring to the Quality Assuran		
	designee will comple				Performance Improvement (QAPI)		
		of facility residents and staff			Committee during monthly QAPI meetir	ngs	
		nts are free from abuse and			and will make changes to the plan as	0	
	resident rights to priv	acy is maintained, including			necessary to ensure the facility maintain	ns	
	-	aff cellular phone use or any			an effective Abuse and Neglect program	n.	
	••	o device use in resident care					
		to include 1) care being			Compliance Date: 12/05/24		
		norized staff, 2) use of ed doors during personal					
		aping to prevent exposure of					
	-	ular or other video devices					
		ent care areas, 4) any other					
		ight to personal privacy not					
	-	wn physical body, but of his					
		e, 5) observations of any					
		ual or emotional abuse which					
	include but are not lir						
		med physically or handled out are provided with care					
		ignified; b. residents are free					
	-	ents, profanities or other					
		and c. observations to					
		not exhibiting signs of					
		as tearfulness, withdrawal,					
		ssiveness and other unusual					
		behaviors. On 2/2/24,					
		e educated and notified by					
	the vecto of their res	sponsibility to complete					1

Facility ID: 953050

If continuation sheet Page 49 of 65

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 345130 BVIING C ACCORDIUS HEALTH AT CONCORD STREET ADDRESS, CITY, STATE, ZIP CODE 515 LAKE CONCORD, NC 28025 12/11/2024 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH OPERCIENCY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX CONCORD, NC 28025 COMPLETC (EACH OPERCIENCY ACTION SHOULD BE CONCORD, NC 28025 COMPLETC (EACH OPERCIENCY COMPLETC (EACH OPERCIENCY <t< th=""><th></th><th>-</th><th>ID HUMAN SERVICES MEDICAID SERVICES</th><th></th><th></th><th></th><th>FORM</th><th>M APPROVED 0. 0938-0391</th></t<>		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT CONCORD STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY TAG OWNTETR DEFICIENCY F 607 Continued From page 49 and observe resident and staff interactions as above. F 607 F 607 Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT CONCORD 515 LAKE CONCORD ROAD NE CONCORD, NC 28025 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETC DATE F 607 Continued From page 49 and observe resident and staff interactions as above. F 607 F 607 Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media F 607			345130	B. WING				-
ACCORDUS HEALTH AT CONCORD CONCORD, NC 28025 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT COMPLETIC DATE F 607 Continued From page 49 and observe resident and staff interactions as above. F 607 F 607 Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media III	NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 49 and observe resident and staff interactions as above. F 607 Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media F	ACCORDI	US HEALTH AT CONCOP	RD					
and observe resident and staff interactions as above. Effective 12/4/24, the facilities new hire screening process has been updated to include additional measures to better determine the candidate's probability of providing excellent resident care to further ensure residents are free from abuse. Updates include improved interview process, a minimum of two professional references, screening of social media content for inappropriate content and improved screening of background checks. Human Resources (HR) and/or the Administrator, DON or SDC are responsible for the interview process, screening reference checks and screening social media	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
a template including a set of our legar conset, a template including a set of questions will be used during the interview process which include the categories of background, interpersonal skills and qualifications and a template for reference checks will be used. Screening of social media platforms will be used via internet search to provide information related to a candidate's personal character. The Human Resource (HR) Director will process and review criminal background checks and forward to the Administrator or DON for approval if a criminal record is identified. The Administrator or DON will consider all screening results to make a final determination. However, the facility will NOT extend employment to any candidate with convictions or pending convictions involving elder abuse, neglect or exploitation. Effective 12/2/2024, the Administrator is ultimately responsible for the implementation and completion of this removal plan.	F 607	and observe resident above. Effective 12/4/24, the process has been upon measures to better de probability of providin further ensure resider Updates include impro- minimum of two professore screening of social me inappropriate content background checks. If and/or the Administra responsible for the inter- reference checks and platforms. With the gu a template including a used during the inter- the categories of back and qualifications and checks will be used. S platforms will process a background checks a Administrator or DON record is identified. The consider all screening determination. However extend employment to convictions or pendin- abuse, neglect or exp Effective 12/2/2024, t ultimately responsible	and staff interactions as facilities new hire screening dated to include additional etermine the candidate's g excellent resident care to ints are free from abuse. oved interview process, a ssional references, edia content for and improved screening of Human Resources (HR) tor, DON or SDC are terview process, screening screening social media uidance of our legal counsel, a set of questions will be view process which include kground, interpersonal skills d a template for reference Screening of social media l via internet search to elated to a candidate's he Human Resource (HR) and review criminal nd forward to the for approval if a criminal he Administrator or DON will g convictions involving elder doitation. he Administrator is e for the implementation and	F	607	7		

Facility ID: 953050

If continuation sheet Page 50 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345130	B. WING				C 11/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	15 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR	RD		С	ONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 607	immediate jeopardy w was observed in the o smiling with other resi- the tour of the facility have their doors close were seen pulled to c no signs of staff cell p and in resident care a facility included inform resident rights, and co notification of adminis behavior changes, an observations of reside interviews confirmed abuse, privacy, reside use. The facility provi- meeting discussion of the facility failure to in of their abuse policy. evidence of daily Qua residents divided on co for interview and cogr for body audits, the au rounds every shift, sta and new on-hire scree employee handbook n The facility's IJ removi- validated. Notice Requirements	moval: 12/5/2024 acility's credible allegation for vas validated. Resident #2 dining room pleasant and idents in the table. During residents were observed to ed for care and curtains over for privacy. There were shone use in the hallways treas. The in-services by the nation on abuse, privacy, ellphone use, including stration for any resident's d increased rounding ents and staff. Staff education was received for ent rights, and cellphone ded evidence of an Ad Hoc f the root cause analysis of nplement effective systems The facility provided lity Assurance auditing of all cognitively intact residents intively impaired residents uditing for the observational aff abuse questionnaires, ening process and reviewed. ral date of 12/05/24 was Before Transfer/Discharge		607 623	DEFICIENCY)		12/20/24
SS=B		(6)(8) before transfer. fers or discharges a nust-					

Event ID: ITBP11

Facility ID: 953050

If continuation sheet Page 51 of 65

		-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/14/2025 MAPPROVED). 0938-0391
345130 B. WING 12/11/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT CONCORD STREET ADDRESS, CITY, STATE, ZIP CODE (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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (%) F 623 Continued From page 51 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in F 623	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,				COMP	LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ACCORDIUS HEALTH AT CONCORD 515 LAKE CONCORD ROAD NE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLET (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 623 Continued From page 51 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in F 623			345130	B. WING			_		
ACCORDIUS HEALTH AT CONCORD CONCORD, NC 28025 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) (COMPLET DATE F 623 Continued From page 51 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in F 623	NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE F 623 Continued From page 51 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in F 623	ACCORDI	US HEALTH AT CONCOR	RD		-		ND NE		
representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRE) CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		(X5) COMPLETION DATE
 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section 	F 623	representative(s) of the the reasons for the me language and mannee facility must send a cor- representative of the Long-Term Care Omb (ii) Record the reason discharge in the reside accordance with para- and (iii) Include in the noti- paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un- made by the facility a resident is transferred (ii) Notice must be ma- before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea- allow a more immediate under paragraph (c)(7 (D) An immediate tran- required by the reside under paragraph (c)(7 (E) A resident has nor- days. §483.15(c)(5) Content	the transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the Nate oudsman. Its for the transfer or lent's medical record in igraph (c)(2) of this section; ice the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would er paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30	F	623				

If continuation sheet Page 52 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/14/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345130	B. WING			_		C 11/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
400000	US HEALTH AT CONCOR			5	15 LAKE CONCORD ROA	D NE		
ACCORDI	US REALTH AT CONCOR			c	CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	(iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal fo completing the form a hearing request; (v) The name, addres telephone number of t Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of t the protection and adv developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilitt disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individu	wing: nsfer or discharge; of transfer or discharge; ich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how rm and assistance in ind submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental abilities, the mailing and ephone number of the or the protection and Is with a mental disorder Protection and Advocacy uals Act.	F	623				

Facility ID: 953050

If continuation sheet Page 53 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				5	15 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR	RD			CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	> 53	F	623			
	In the case of facility the administrator of the written notification pri- to the State Survey A State Long-Term Card the facility, and the re- well as the plan for the relocation of the reside 483.70(k). This REQUIREMENT by: Based on record revi- facility failed to notify Representative and F transfers to the hospi- reviewed for hospitali- Resident #28). The findings included 1. Resident #27 was a 6/20/23. Resident #27 facility on 3/7/24, 8/4/ The most recent quar assessment dated 11 #27 to be severely co- a. Review of Residen revealed a progress r documented Residen hospital for difficulty s dated 3/7/24 docume from the hospital with sodium level.	is not met as evidenced ew and staff interviews, the Resident #27's Resident #28 in writing, of tal for 2 of 3 residents zation (Resident #27 and : admitted to the facility on 7 was readmitted to the 24, and 11/9/24. terly Minimum Data Set /20/24 assessed Resident gnitively impaired. t #27's medical record note dated 2/28/24 that			 #1 Resident #27 representative and Resident #28 will receive timely written notice for any future facility-initiated transfer or discharge. #2 On 12/19/24, the Vice President o Risk (VPR) completed an audit of resid hospital transfers occurring during previous two weeks (12/4/24 - 12/18/24 for evidence of timely written notice to Resident/Representative. Eight (8) of 8 resident transfers reviewed had written notice of transfers provided to Resident/Representative by the SW. #3 On 12/5/24, the Administrator provided education to the SW and Director of Nursing (DON) on the requirements of the facility to notify the resident and the resident's representative(s) prior to any facility-initiated transfer or discharge and the reasons for the move in writing and a language and manner they understati (form NC Medicaid-9050). The facility must send a copy of the notice to the ko Ombudsman representative. The SW view 	f lent 4) 3 I I I I I I I I I I I I I I I I I I	

Facility ID: 953050

If continuation sheet Page 54 of 65

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345130	B. WING	NG			С
		345130		0.7		12/	11/2024
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT CONCOR	RD			5 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 PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	 b. A progress note da Resident #27's transf and complaints of hea dated 8/4/24 docume readmission to the fac fall. Review of the medica notification. c. A progress note da Resident #27 was exp vomiting, and he was evaluation. A progres documented Residen hospital. The hospital 11/9/24 documented to the hospital for intra vomiting. Review of the medica notification. The Social Worker (S 12/5/24 at 3:25 PM. T previous administrato provide a written notic sent to the hospital, b provide the written notice not provided a written 	ted 8/3/24 documented er to the hospital after a fall ad pain. A progress note inted Resident #27's cility after hospitalization for I record revealed no transfer ted 11/6/24 documented beriencing nausea and sent to the hospital for s note dated 11/9/24 t #27's return from the discharge note dated Resident #27 was admitted actable nausea and I record revealed no transfer W) was interviewed on	F	523	notices prior to transfer/discharge or as soon as practical and will maintain a Transfer/Discharge Notice Log with da and method written notices are provide Newly hired SW□s will receive educati upon hire. #4 The Administrator or DON will complete quality assurance monitoring facility-initiated transfers and discharge for accurate, timely notifications. Monitoring will be completed three (3) times weekly for four (4) weeks, two (2 times weekly for four (4) weeks, weekly for four (4) weeks and as necessary thereafter. The Administrator will repor findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAF meetings and will make changes to the plan as necessary to maintain complia with notice requirements before transfer/discharge. Completion date: 12/20/2024	te ed. on of es y y t y	

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT CONCOP	RD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	 their representatives their representatives their representatives the transfer. 2. Resident #28 was a 8/27/24. The most recent quarassessment dated 11 Resident #28 was cogonal of the solution of	to receive a written notice of admitted to the facility terly Minimum Data Set /13/24 documented gnitively intact. d 12/3/24 documented ht to the hospital for cellulitis ssue) of the leg, elevated l elevated kidney function. ed hospitalized during the l record revealed no transfer ht #28. W) was interviewed on	F	62:	3		

Facility ID: 953050

If continuation sheet Page 56 of 65

S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	E SURVEY
	IDENTIFICATION NUMBER:	· · ·		· · ·	IPLETED
					С
	345130	B. WING		12	2/11/2024
ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
US HEALTH AT CONCOR	RD				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
Continued From page	e 56	F 677	,		
	or Dependent Residents	F 677	, ,		12/20/24
out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio interviews with Reside failed to provide nail of dependent resident (R deficient practice affe dependent residents. Findings included: Resident #65 was add	iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced ns, record review, and ent #65 and staff, the facility care and hand hygiene for a Resident #65). This cted 1 of 4 sampled		 ensure nails were clean, trimmed an of jagged edges. Resident #65 will continue to receive nail care during routine daily care and prior to meals needed for hygiene. #2 On 12/13/24, the Unit Manager (UMs) completed an observational a of resident nail care. All resident na clean, trimmed and free of jagged e unless care plan reflects refusal of of the second se	nd free s as rs audit ils vdges,	
documented her cogr resident required assi member for bathing a	nition was intact. The istance from one staff nd personal grooming.		#3 Effective 12/20/24, the Director Nursing (DON) and UMs provided education to licensed nurses and nu aides on providing nail care to deper residents. Nurse aides will be response	urse Indent Insible	
included the resident activities of daily living	required assistance with all g. The intervention was nail		routine daily care to ensure nails and clean, trimmed and free of jagged en Nails will be cleaned prior to meals	e dges. as	
interview was comple Resident was sitting i gown. The Resident	ted of Resident #65. The n her bed in a hospital s nails were noted to be		assigned to the resident will monito proper nail care during routine shift observations and assist nurse aides needed. Newly hired licensed nurse	r for s as es and	
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain of personal and oral hyo This REQUIREMENT by: Based on observatio interviews with Resid failed to provide nail of dependent residents. Findings included: Resident #65 was ad 1/10/22 with the diago motion. Resident #65's Minim documented her cogor resident required ass member for bathing a The care plan for Resi included the resident activities of daily living care to be provided w On 12/2/24 at 11:40 a interview was comple Resident was sitting i gown. The Resident	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345130 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 56 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) §483.24(a)(2) §483.24(a)(2) Services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with Resident #65 and staff, the facility failed to provide nail care and hand hygiene for a dependent resident (Resident #65). This deficient practice affected 1 of 4 sampled dependent residents. Findings included: Resident #65 was admitted to the facility on 1/10/22 with the diagnosis of limited range of	CORRECTION IDENTIFICATION NUMBER: A. BUILDING. 345130 B. WING ROVIDER OR SUPPLIER J US HEALTH AT CONCORD JD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) JD Continued From page 56 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) F 677 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: F 677 Based on observations, record review, and interviews with Resident #65 and staff, the facility failed to provide nail care and hand hygiene for a dependent resident (Resident #65). This deficient practice affected 1 of 4 sampled dependent residents. Findings included: Resident #65's Minimum Data Set dated 9/13/24 documented her cognition was intact. The resident required assistance from one staff member for bathing and personal grooming. The care plan for Resident #65 dated 9/13/24 included the resident required assistance with all activities of daily living. The intervention was nail care to be provided with showers or bathing. On 12/2/24 at 11:40 am an observation and interview was completed of Resident #65. The Resident was sitting in her bed in a hospital gown. The Resident's nails were noted to be In thospital gown. The Resident's nails were noted to be	CORRECTION IDENTIFICATION NUMBER: A. BUILDING A BUILDING B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREMIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SOUTH APPRO DEFICIENCY) Continued From page 56 F 677 F 677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) F 677 Continued From page 56 F 677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) F 677 S483.24(a)(2) F 677 S483.24(a)(2) F 677 Based on observations, record review, and interviews with Resident #65 and staff, the facility failed to provide nail care and hand hygiene for a dependent resident (Resident #65). This dependent resident (Resident #65). This dependent resident (Resident #65) and staff, the facility failed so provide nail care during four to meals needed for hygiene. Findings included: #1 On 12/6/24, Resident #65 was provided nail care during four to meals needed for hygiene. Findings included: WIM Sompleted an observational of resident nail care. All previsional routine daily care and prior to meals needed for hygiene. The care plan for Resident #65 dated 9/13/24 included the resident requir	CORRECTION IDENTIFICATION NUMBER: A BUILDING COM 345130 B: WING 12 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 21 <t< td=""></t<>

Facility ID: 953050

If continuation sheet Page 57 of 65

	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MUUTU		CONSTRUCTION		D. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	PLETED
							С
		345130	B. WING				/11/2024
IAME OF PF	ROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
CCORDI	US HEALTH AT CONCO	RD		51	5 LAKE CONCORD ROAD NE		
				CC	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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 677	Continued From page	e 57	F 6	77			
		g Assistant (NA) to provide		· · ·	first shift worked.		
		nt stated she would like nail			#4 The DON or UMs will complete q	uality	
		t refused care. The resident			assurance monitoring of five (5)		
		asked an NA to cut her nails,			dependent residents to ensure nails a	re	
		turned to provide care a			clean, trimmed and free of jagged edg	jes,	
	couple of days earlier	r.			unless care plan reflects refusal of ca		
					preference for long nails. Monitoring v		
	On 12/5/24 at 1:50 pr				be completed three (3) times weekly t		
Resident's nails remained long, uneven but had four (4) weeks	four (4) weeks, two (2) times weekly f						
					four (4) weeks, weekly for four (4) we and as necessary thereafter. The DO		
		ack matter underneath. The			will report findings of the monitoring to		
		was taken to the dining room			Quality Assurance Performance		
		or yesterday for an activity.			Improvement (QAPI) Committee durir	na	
		ormed she was going to			monthly QAPI meetings and will make	-	
	receive a manicure in	cluding nail polish. The			changes to the plan as necessary to		
		nad not gotten her nails done			maintain compliance with nail care for		
		o her room and had not			dependent residents.		
	-	dent stated she had a bed			Compliance Date: 12/20/24		
		ne NA assigned had not d she did not know why.					
	•	t asked for nail care. The					
		required assistance with all					
		. She could not cut her own					
		ess to wash her hands/nails					
	without staff assistant	ce.					
	An interview was con	ducted with NA #4 on					
	12/5/24 at 1:55 pm.						
	•	to Resident #65 on 12/4/24					
	• •	stated he provided a bed					
		ad not provided nail care.					
		ed nail care because his					
		vy." NA #4 stated he ran					
		ad not offered or provided					
		24) but would provide care					
	now. NA #4 stated he	e was aware and had t place her hand inside her					
	observed the residen			- 1			1

If continuation sheet Page 58 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/14/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345130	B. WING				C 11/2024
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				51	5 LAKE CONCORD ROAD NE		
ACCORDI	US HEALTH AT CONCOR	RD		cc	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 677	Continued From page hygiene before meals skin all over her body had not informed the On 12/5/24 at 1:45 pm conducted with NA #3 assigned to Resident The NA stated she pm resident and her bath stated on rounds this observed to have her scratching what appe area. The resident to scratching her leg. Th offered to clean the re- scratching and before known why the reside uneven, and dirty und would provide nail can On 12/5/24 at 1:55 pm conducted with the Ad there was an activity She stated the activity dining room was need was not able to have of time. The Activity D would clean/cut a resi Activity Assistant state another manicure activity	e 58 . The resident had itchy . NA #4 further stated he nurse about the scratching. n an interview was 3. NA #3 stated she was #65 on 12/5/24, day shift. ovided morning care for the was yesterday. The NA morning the resident was hands in her brief ared to be her "private" Id the NA that she was he NA stated she had not esident's hands after the lunch. The NA had not ent's nails were long, terneath. The NA stated she re following the interview. In an interview was ctivity Assistant. She stated yesterday for manicures. / ran out of time and the ded for lunch. Resident #65 her manicure due to a lack birector was also an NA and dent's nails if needed. The ed she was going to have ivity on Saturday but could	F 6	77		ATE	
	She further stated Re to the list for manicure On 12/4/24 at 3:39 pm conducted with Nurse were responsible to p care during the showe	#1. She stated the NAs rovide the residents with nail					

Facility ID: 953050

If continuation sheet Page 59 of 65

		ND HUMAN SERVICES			FOR	D: 01/14/20 M APPROVE <u>D. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		СОМ	E SURVEY PLETED C
		345130	B. WING			/11/2024
IAME OF PF	ROVIDER OR SUPPLIER	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT CONCO	RD	51	5 LAKE CONCORD ROAD NE		
			c	ONCORD, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	Continued From page	e 59	F 677			
		ad not notified her Resident				
	#65 had refused care	e, including nail care. Nurse				
	#1 was not aware that					
	know.	ould let the NA scheduled				
		ducted with Nurse #1 on				
	-	She was not aware that the				
		not cared for yesterday with				
		he resident sometimes a shower but had not				
	refused care. She wa					
	resident was observe	ed by NA #3 and NA #4				
		her brief and scratching.				
	She could not remembed bath yesterday.	ber which NA provided the				
	bed balli yesterday.					
	On 12/5/24 at 3:45 p					
		irector of Nursing (DON).				
		vare Resident #65 had not d was scratching her skin,				
		indergarment. The DON				
	would want staff to pr	rovide hand hygiene before				
		as scratching inside an				
F 689	undergarment.	ards/Supervision/Devices	F 689			12/20/24
SS=D	CFR(s): 483.25(d)(1)	-	F 009			12/20/24
	§483.25(d) Accidents	5.				
	The facility must ensu					
		sident environment remains azards as is possible; and				
	as thee of accident ha	azarus as is possible; and				
	§483.25(d)(2)Each re	esident receives adequate				
	supervision and assis	stance devices to prevent				
	accidents.	L is not mot as suideneed				
	by:	Γ is not met as evidenced				
			1			

Event ID: ITBP11

Facility ID: 953050

If continuation sheet Page 60 of 65

		MEDICAID SERVICES				MB NO. 0938-0	
				LE CONSTRUCTION	(×	(X3) DATE SURVEY COMPLETED	
						С	
		345130	B. WING			12/11/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
ACCORDIUS HEALTH AT CONCORD			515 LAKE CONCORD ROAD NE CONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
F 689	Continued From page	e 60	F 68	9			
		lete a quarterly smoking			updated smoking		
		³ 3 residents reviewed for			or Resident #31 and		
		smoking (Resident #31 and Resident #72).			Smoking assessments will		
				completed for Resident			
	The findings included	1:			dent #72 quarterly and with		
	10 Decident #21 we	a admitted to the facility on			ndition or smoking status. 24, the Unit Managers (UMs		
	01/12/20 with diagno	s admitted to the facility on			dated smoking assessment		
		e weakness, dementia, and			facility residents to		
	blindness in one eye				ect resident smoking status	5.	
				#3 Effective	12/20/24, the Director of		
		≴31's annual MDS dated) and UMs provided		
	05/10/24 revealed the			censed nurses on			
	smoking.				oking assessments upon arterly and with changes in		
	Review of Resident #	#31's quarterly Minimum			tion or smoking status.		
		d 10/16/24 revealed the			ssments will be completed		
	resident was severely	y cognitively impaired and		-	d nurse assigned to the		
		nt on staff for most activities			nonitored by the Unit		
	,	Resident #31 was coded for		-	mely, accurate completion.		
	-	airment. The MDS indicated		-	censed nurses and those no	ot	
	Resident #31's mobility device was a wheelchair				cation by 12/20/24 will		
	use.			prior to first sh	tion during orientation or		
	Review of Resident #	#31's care plan revised on		·	or UMs will complete quali	tv	
		resident was a smoker and			nitoring of five (5) residents		
	was supervised beca				king assessments are		
		moking policy and witnessed			on admission, quarterly and	1	
		The goal was for Resident			in condition or smoking		
		d injuries to be minimized			ring will be completed three	e	
	with intervention thro	d smoking assessment to be			kly for four (4) weeks, two kly for four (4) weeks,		
	completed per facility	-			r (4) weeks and as		
				-	reafter. The DON will repor	t	
	Review of Resident #	#31's smoking assessments		findings of the	monitoring to the Quality		
	revealed the only sm				rformance Improvement		
	-	last recertification dated			ittee during monthly QAPI		
	07/08/23 was on 09/2	0			will make changes to the		
	assessment dated 09	9/17/24 concluded Resident		pian as neces	sary to maintain compliance	e	

Facility ID: 953050

If continuation sheet Page 61 of 65

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 01/14/2025 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345130		B. WING			C 12/11/2024			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE				
ACCORDI	US HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE					
ACCORDI				С	ONCORD, NC 28025				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 689	Continued From page	- 61	Í -	689					
		smoker because he was		003	with resident smoking assessment				
		te and understand the			requirements.				
		s, and place to smoke.			Compliance Date: 12/20/24				
		-							
	1b. Resident #72 was originally admitted to the								
	hypertension and uns	ith diagnoses which included steadiness of feet.							
		72's annual MDS dated e resident was not coded for							
	Data Set (MDS) date resident's cognition w required supervision further revealed Resi	72's quarterly Minimum d 09/20/24 revealed the vas moderately impaired and for most ADL. The MDS dent #72 had adequate was coded for wheelchair e.							
	completed on 12/02/2 assessment was not	smoking assessment 23 and the next smoking conducted until 06/02/24 dent #72 as an independent							
	07/24/24 revealed the independent smoker.	72's care plan revised on e resident was an The goal was for Resident y from unsafe smoking							
	a supervised smoker unsupervised smoker nurses assigned to re complete smoking as	eted with Nurse #6 on I revealed Resident #31 was and Resident #72 was an r. Nurse #6 further revealed esidents were expected to esessment quarterly. The computer system notified							

Facility ID: 953050

If continuation sheet Page 62 of 65

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
	345130 B. WING			(11/2024			
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
ACCORDIUS HEALTH AT CONCORD							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 689 F 761 SS=D	staff when a residents completed. Nurse #6 why they were not co- have been. Interview conducted w on 12/05/24 at 1:20 P assessments were ex- quarterly. UM #1 indic by the computer what and needed to be cor and they were expect indicated she was not Resident #72's smoki been completed quart Interview conducted w on 12/05/24 at 3:10 P been employed with t expected quarterly sh completed. The DON not aware Resident # several months witho being conducted. Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling co Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable.	HEALTH AT CONCORD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 62 aff when a residents' assessment needs to be ompleted. Nurse #6 revealed she does not know hy they were not completed on time but should ave been. terview conducted with Unit Manager (UM) #1 h 12/05/24 at 1:20 PM revealed smoking ssessments were expected to be completed uarterly. UM #1 indicated nurses were pending hd needed to be completed during their shift, hd they were expected to do so. UM #1 dicated she was not aware Resident #31 and esident #72's smoking assessments had not been completed quarterly. terview conducted with the Director of Nursing h 12/05/24 at 3:10 PM revealed she had not been completed quarterly. terview conducted with the Director of Nursing h 12/05/24 at 3:10 PM revealed she had not been employed with the facility for long but spected quarterly smoking assessments to be ompleted. The DON further revealed she was of aware Resident #31 and Resident #72 went ever al months without a smoking assessment ing conducted. abel/Store Drugs and Biologicals FR(s): 483.45(g)(h)(1)(2) 483.45(g) Labeling of Drugs and Biologicals rugs and biologicals used in the facility must be beled in accordance with currently accepted ofessional principles, and include the propriate accessory and cautionary structions, and the expiration date when		X (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI			12/20/24

Event ID: ITBP11

Facility ID: 953050

If continuation sheet Page 63 of 65

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED	
		B. WING	1:	C 12/11/2024			
NAME OF F	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP CODE	DE .		
ACCORD	IUS HEALTH AT CONCO	RD		515 LAKE CONCORD ROAD NE CONCORD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 761	Federal laws, the fac biologicals in locked of temperature controls personnel to have ac §483.45(h)(2) The fac locked, permanently storage of controlled the Comprehensive E Control Act of 1976 at abuse, except when a package drug distribut quantity stored is min- be readily detected. This REQUIREMENT by: Based on manufactur observations, and sta failed to date three of tears stored for use in reviewed for medicat medication cart). Findings included: A review of the manu- for artificial tears stat opened it should hav days. On 12/3/2024 at 11:0 B-hall medication car bottles of artificial tear open date. Nurse #5 the boxes and the da previous evening. Nu	ility must store all drugs and compartments under proper , and permit only authorized	F 76	1 #1 On 12/3/24, the licensed nur disposed of three bottles on artific that were opened without a labele #2 On 12/13/24, the Director of (DON) and Unit Managers (UMs) completed an audit of medication and medication rooms for proper and labeling of drugs and biologic Items improperly stored without p labeling were disposed of accord #3 On 12/20/24, the DON and L completed education with license on labeling of drugs and biologica and biologicals. The licensed nur responsible for labeling in accord with manufacturer recommendati will not administer medications th improperly labeled, stored or exp will properly dispose of drug or bi accordingly. Newly hired licensed and those not receiving education 12/20/24 will receive education d orientation or prior to next worked	cial tears ed date. Nursing carts storage cals. roper ingly. JMs d nurses als Drugs se will be ance ons and at are ired and ological I nurses n by uring		

Event ID: ITBP11

Facility ID: 953050

If continuation sheet Page 64 of 65

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	0: 01/14/2025 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345130		B. WING _		12/	C 11/2024	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT CONCOR	RD		515 LAKE CONCORD ROAD NE		
				CONCORD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 On 12/9/2024 at 11:06 am the Director of Nursing was interviewed by phone, and she sated the bottles of artificial tears that were opened in the B-hall medication cart should have been dated when they were opened. The Administrator was present during the interview and stated either the box or the bottle of the artificial tears should have been dated when the bottle was opened.		F 7	761 #4 The DON or UMs will complete of assurance monitoring of medication of and rooms for proper labeling and sto of drugs and biologicals. Monitoring of completed three (3) times weekly for (4) weeks, two (2) times weekly for for (4) weeks, weekly for four (4) weeks as necessary thereafter. The DON were report findings of the monitoring to the during QAPI meetings monthly and vere maintain compliance with the labeling storage of drugs and biologicals. Compliance Date: 12/20/24	carts brage vill be four bur and ill e IDT <i>i</i> ll ary to	

Facility ID: 953050

If continuation sheet Page 65 of 65