STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CHARLOTTE	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted from 04/21/25 through 04/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # Q65011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 04/21/25 through 04/24/25. Event ID# Q65011. The following intakes were investigated: NC00227842, NC00227890, NC00228231, and NC00228757. 1 of 6 complaint allegations resulted in a deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to ensure dependent residents could access the light switch located behind the bed for 1 of 1 residents reviewed for accommodation of needs (Resident #157). The findings included: Resident #157 was admitted to the facility on	F 558	F-558 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #157's light cord was replaced by the Director of Maintenance on 4/21/2025. (2) How corrective action will be	5/16/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/15/2025

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F 558	Continued From page 1 04/09/25. Review of Resident #157's medical records revealed she had resided in the current room since 04/09/25. The admission Minimum Data Set (MDS) assessment dated 04/11/25 coded Resident #157 with severely impaired cognition. The MDS indicated walking between locations inside the room for more than 10 feet was not attempted by Resident #157 during the assessment period due to medical condition or safety concerns. During an observation conducted on 04/21/25 at 11:19 AM, the switch for the light fixture that was located behind Resident #157's bed on the wall approximately 5 feet from the floor and 6 feet from the bed and was attached with a broken cord approximately 3 inches in length. Resident #157 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #157 on 04/21/25 at 11:20 AM. She stated she had a stroke recently and was bedbound. She could not recall when the switch cord was broken. She stated she did not have any control of the light fixture behind her bed as she could not stand up to reach the broken switch cord on the wall. She had to rely on nursing staff to control the light fixture and she was tired of asking for help repeatedly. She wanted the maintenance staff to fix the switch cord to accommodate her needs as soon as possible. During a joint observation conducted with the Maintenance Director and Nurse #1 on 04/21/25 at 12:50 PM, the switch cord for the light fixture	F 558	accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 4/21/2025 the Director of Maintenance conducted an audit of all resident rooms to ensure that all light cords were working and accessible. Audit revealed that all resident light cords were working and accessible. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 4/22/2025, the Administrator re-educated the maintenance department to ensure that repair needs are fixed in a timely manner. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Observation monitoring will be done by the Administrator, Maintenance Director, or designee to monitor and ensure that all resident light cords are working and accessible. This monitoring process will take place weekly for 12 weeks by observing 10 residents per week. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 558	Continued From page 2 behind Resident #157's bed remained inaccessible from her bed. Nurse #1 and the Maintenance Director acknowledged that the switch cord needed to be fixed immediately. An interview was conducted with the Maintenance Director on 04/21/25 at 12:54 PM. He stated he walked through the entire facility at least once per week to check for repair needs. He did not notice the switch cord for Resident #157's light fixture behind her bed was broken during his recent weekly walk through. In most cases, he depended on the staff to report repair needs via work orders electronically or verbal notifications. He checked the work order at least twice daily to ensure all repair needs were addressed in a timely manner. He could not explain why he missed the switch cord for Resident #157 and acknowledged that it had to be fixed immediately. During an interview conducted with Nurse #1 on 04/21/25 at 1:00 PM, she stated she provided care for Resident #157 in the morning, but she did not notice that her switch cord for the light fixture behind the bed was broken and inaccessible. She acknowledged that the broken switch cord needed to be fixed immediately to ensure Resident #157 had full control and accessibility to the light fixture behind the bed all the times. An interview was conducted with the Director of Nursing on 04/22/25 at 1:29 PM. She stated she expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs. It was her expectation for all the dependent residents to have full accessibility and control of the light	F 558	The facility alleges compliance on 5/16/2025	

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F 558	Continued From page 3 fixture behind the bed all the times. During an interview conducted on 04/2325 at 5:10 PM with the Administrator, he expected nursing staff to pay attention to residents' homes and reported repair needs to the maintenance department in a timely manner. .	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		5/16/25

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F 578	Continued From page 4 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accuracy and consistency of advance directive throughout the medical record for 1 of 1 resident (Resident #62) reviewed for advance directives. The findings included: Resident #62 was admitted to the facility on 02/03/22. A review of Resident #62's care plan initiated on 03/24/22 indicated his advance directive was a full code. Interventions included receiving cardiopulmonary resuscitation (CPR) through the next review period. A review of Resident #62's electronic health records (EHR) indicated a physician's order dated 03/06/25 for Do Not Resuscitate (DNR). A review of the advance directive binder at the nurses' station dated 03/06/25 indicated Resident #62 was coded as DNR.	F 578	F-578 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 4/22/2025, Minimum Data Set Coordinator #1 updated resident #62s care plan to accurately reflect their code status. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 4/22/2025, an audit was completed by the Social Worker and Minimum Data Set Coordinator #1 to ensure that all residents care plans accurately reflected their code status. Audit verified by the Director of Nursing revealed that no other residents were affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in	

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F 578	Continued From page 5 During an interview conducted on 04/22/25 at 1:00 PM, Nurse #3, who was assigned to Resident #62, stated when a code was called, she would check the advanced directive in the EHR or the hard chart in the nurses' station to confirm whether the resident was a full code or a DNR. After reviewing Resident #62's care plan, Nurse #3 stated it could cause confusion as the care plan was inconsistent with the current code status. She acknowledged that the care plan for Resident #62 should be updated in a timely manner. An interview was conducted with MDS Coordinator #1 on 04/22/25 at 1:15 PM. She stated she was responsible for updating the code status for the care plan whenever it was changed. She explained she audited all residents' advanced directives routinely to ensure consistency with the care plan and did not know why Resident #62's care plan was missed. She attributed the error as an oversight and acknowledged Resident #62's care plan needed to be updated in a timely manner to avoid confusion. During an interview conducted on 04/22/25 at 1:29 PM, the Director of Nursing stated nursing staff would mainly check the code status in EHR instead of the care plan when a code was called. It was her expectation for the MDS Coordinator to update the care plan for advance directives in a timely manner whenever a change had been made. An interview was conducted with the Administrator on 04/23/25 at 5:10 PM. He expected the MDS coordinator to update the care plan in a timely manner when the code status had	F 578	the future: On 4/22/2025, the Director of Nursing re-educated the Social Worker and the Minimum Data Set Coordinators regarding the requirement that all resident care plans should accurately reflect their code status. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to ensure that by reviewing on admission with the clinical team the code status is accurately coded in the care plan and during care plan meetings that any changes in code status are updated in the care plan. This monitoring process will take place weekly for 4 weeks and then monthly for 2 months. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/16/2025	

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F 578	Continued From page 6 been changed to avoid confusion.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		5/16/25

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F 584	Continued From page 7 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 1 of 1 resident reviewed for safe, clean, comfortable, homelike environment (Resident #71). The findings included: Resident #71 was admitted to the facility on 7/4/2024 with diagnoses which included history of a right above the knee amputation (R AKA) and neoplasm of the brain. The significant change Minimum Data Set (MDS) dated 2/11/2025 revealed Resident #71 was cognitively intact. An interview with Resident #71 on 4/22/2025 at 10:43 AM revealed he was sent to the hospital from the facility on 1/21/2025. When he returned to the facility on 2/6/2025, he found out his belongings had been packed up and removed from his room during his hospital stay. Resident #71 recalled the housekeeping manager brought 2 boxes to his room on 2/6/2025. The boxes were sealed with tape. After unpacking the boxes that evening, Resident #71 stated his Apple iPad Pro, a new bag of white sleeveless t-shirts, a few pairs of pants and his right leg prosthesis were not in either of the 2 boxes. Resident #71 stated it was concerning that his property was gone. Resident	F 584	F-584 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 3/3/2025 the Maintenance Director placed a hasp for a padlock on Resident #71s closet door. On 3/28/2025 the Social Worker re-educated resident #71 to lock up in his closet any valuable items that he may have. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 4/24/2025 the Administrator and the Director of Nursing initiated staff and resident interviews to determine if any other residents have been affected. Interviews revealed that no other residents have been affected. 3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 5/7/2025 the Administrator and the Director of Nursing initiated re-education to all facility staff that all residents have the right to a safe/clean/comfortable/homelike	

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F 584	Continued From page 8 #71 indicated he was mostly upset about the loss of the iPad Pro. He stated he no longer used the right leg prothesis and the clothes were already replaced. Resident #71 stated that if the belongings had been packed up by the facility, then the facility should have returned the same items to him. Resident #71 reported the missing items to nursing staff on 2/6/2025 as soon as he realized the items were not in the boxes. He stated he spoke directly to the previous Administrator on 2/11/2025 to follow up on the missing items. Resident #71 filed a grievance with the facility on 3/26/2025 regarding the missing iPad Pro. Resident #71 stated the facility had recently placed a lock on his closet door. A review of the facility grievance report dated 3/26/2025 revealed that Social Worker #1 had met with Resident #71 to discuss the grievance regarding his lost property. Social Worker #1 documented that Resident #71 was unaware of the location of the iPad Pro and unsure when it was exactly misplaced. Social Worker #1 reminded Resident #71 that the matter regarding the iPad Pro had been previously discussed. Social Worker #1 re-educated Resident #71 regarding having pricey items in the facility. Social Worker #1 documented the grievance resolved on 3/28/2025. An interview on 4/22/2025 at 3:35 PM with NA #2 revealed she cared for Resident #71 routinely. She stated she had never seen Resident #71 with an iPad Pro and had signed statement regarding this for the previous Administrator. She stated she could obtain an empty iPad Pro box like the one Resident #71 had in his room. She reported she had never seen a right leg prothesis. NA #2 stated she was working the day Resident #71	F 584	environment that includes reasonable care for the protection of the resident's property from loss or theft. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that through the grievance process and resident interviews, no additional occurrences of loss of property take place. This monitoring process will consist of 5 resident interviews weekly for 4 weeks and then 10 resident interviews monthly for 2 months. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/16/2025	

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F 584	Continued From page 9	F 584		

was transferred to the hospital and she requested his family take his personal items with them. NA #2 stated housekeeping is responsible for packing up resident belongings.

An interview on 4/22/2025 at 3:40 PM with Unit Manager B/Assistant Director of Nursing (ADON) revealed he knew Resident #71 very well. Resident #71 told him about the items missing from the 2 boxes. He did not know what had happened to Resident #71's property.

An interview on 4/22/2025 at 3:51 PM with the Housekeeping Manager revealed he had packed up Resident #71's belongings on 2/6/2025 at approximately 2:00 PM. He stated he remembered this clearly because he had just taken the 2 boxes to his office when he received a text that Resident #71 was returning later that afternoon. The 2 boxes were never taken to the main storage area. The Housekeeping manager stated he packed Resident #71's clothes, a tablet, and a prosthetic leg. He stated he used very strong biohazard tape to seal the boxes and there is no way anyone could have tampered with the boxes. He stated he took the 2 boxes back to the room around 5:00 PM and asked Resident #71 if he would like him to unpack for him. He stated Resident #71 had family/visitors in the room and stated he would unpack himself. He stated he spoke with Resident #71 later regarding the missing items but did not know what had happened as the 2 boxes were sealed when he returned them.

An interview on 4/22/2025 at 4:05 PM with Social Worker #1 revealed she assisted Resident #71 in filing a grievance with the facility regarding the missing property. She stated the matter had been

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F 584	Continued From page 10 handled by the previous Administrator. An interview on 4/23/2025 at 10:37 AM with the Administrator revealed that when residents go to the hospital, they should either take their valuables with them or leave them with the social worker. The Administrator stated he had been working at the facility 3 weeks and spoke with Resident #71 on his second working day regarding the missing items. The Administrator stated Resident #71 told him he may have lost the iPad between the hospital and the facility. The Administrator stated he felt the situation is resolved as Resident #71 lost the item and there was nothing the facility could do about it.	F 584		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide podiatry care for 1 of 7 residents (Resident #57) reviewed for activities of daily living.	F 687	F-687 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #57 is scheduled to be seen by	5/16/25

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F 687	Continued From page 11 The findings included: Resident #57 was admitted to the facility on 5/25/23 with diagnoses which included type II diabetes mellitus, lymphedema, and peripheral vascular disease. Resident #57's care plan had a focus area for diabetes mellitus, type II dated last revised on 9/19/24 and revealed an intervention for a referral to podiatrist and/or foot care nurse to monitor and document foot care needs and to cut long nails. Resident #57's annual Minimum Data Set (MDS) assessment dated 3/31/25 revealed she was cognitively intact and required substantial to maximal assistance with personal hygiene. There were no behaviors, and no rejection of care noted on the MDS. An observation of Resident #57 on 4/21/25 at 10:45 AM revealed Resident #57 was in her bed without a sheet or cover over her feet. Her toenails were jagged and pointed and the length varied with some nails around .5 to one inch in length on both feet. An interview with Resident #57 on 4/21/25 at 10:45 AM was conducted. She explained she was required to see the podiatrist due to her diabetes diagnosis and she was supposed to be seen by the podiatrist as her toenails were very long and painful. She indicated she had to keep her feet uncovered in bed as the pressure from	F 687	the podiatrist on 6/9/2025. Resident #57 was offered to be seen by an outside service before this date and has refused. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: An audit was done on 4/22/2025 by the Director of Nursing to determine if any other residents were not seen by podiatry. Audit revealed that all residents on the list were seen. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 4/24/2025, the Administrator re-educated the Social Worker regarding the need to provide alternative, outside podiatry services if unable to be seen during the facility visit. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator, Director of Nursing, or designee to ensure that by reviewing the podiatry list, all residents were seen and if unable to be seen, alternative accommodations were offered. This monitoring process will take place weekly for 12 weeks. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the	

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	345243	A. BUILDING _____ B. WING _____	C 04/24/2025

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F 687	Continued From page 12 the bed sheet made her toenails painful. Resident #57 explained she asked the nursing staff about seeing the podiatrist due to her long toenails and was told that she missed the podiatry clinic in March 2025 because she was in the hospital. Resident #57 indicated she was on the list for the next podiatry clinic, but did not know when that was supposed to occur. She could not recall which nursing staff member she discussed her toenails with. A review of the podiatry schedule was conducted. It revealed Resident #57 was seen on 5/15/24 and 11/13/24. The next podiatry clinic was to be held on 6/9/25 and 6/10/25. Resident #57 was on the list for the 6/9/25 podiatry clinic. Resident #57 was not seen by the podiatry clinic on 3/17/25 or 3/18/25 due to hospitalization. An interview on 4/23/25 at 1:49 PM with Nurse Aide #1 revealed she worked with Resident #57 earlier that morning. She stated Resident #57 reported to her that her toenails were very long and had been painful. Nurse Aide #1 stated she did not typically work with Resident #57 but reported her concerns regarding her painful toenails to Nurse #2. An interview with Nurse #2 was conducted on 4/23/25 at 1:55 PM. She stated she had been at the facility for about a year and a half. She explained Resident #57 was very alert and would communicate her needs to staff. Nurse #2 stated Resident #57 asked her on 4/22/25 when the podiatrist was coming to the facility, and she told her the schedule. She stated she was not made	F 687	facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/16/2025	

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F 687	Continued From page 13 aware her toenails were painful and had not seen how long her toenails were. An interview with the Director of Nursing (DON) on 4/24/25 at 10:43 AM revealed Resident #57 was on the list for the podiatry clinic in June 2025. She stated she was not aware Resident #57 had indicated her nails were painful after she missed the March 2025 podiatry clinic due to hospitalization. The DON explained Resident #57 could be seen by an outside provider before the next onsite podiatry clinic and she would speak to her about that option. An interview with the Administrator on 4/24/25 at 12:34 PM was conducted. He expected Resident #57 to receive the podiatry care she needed whether onsite or at another provider.	F 687		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		5/16/25

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F 761	Continued From page 14 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to secure an opened bottle of antacid for 1 of 1 Resident (Resident #90) and failed to store 3 unopened eye drops at the proper temperature per manufacturer's instructions for 1 of 4 medication cart (100 halls medication cart) review for medication storage. The findings included: a. Resident #90 was admitted to the facility on 03/03/25. A review of Resident #90's medication records revealed he had never been assessed nor approved for self-administration of medication since admission. A review of the physician's orders revealed Resident #90 did not have an order to receive liquid Pepto Bismol (an over-the-counter medication primarily used to relieve upset stomach symptoms such as nausea, heartburn, indigestion, and diarrhea). The significant change in status Minimum Data Set (MDS) dated 03/30/25 coded Resident #90	F 761	F-761 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 4/21/2025, Nurse #1 removed the opened bottle of antacid from Resident #90's bedside table. On 4/22/2025 Nurse #2 removed the 3 unopened eye drops from 100 halls med cart. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 4/22/2025, the Director of Nursing audited 200, 300, and 400 hall nursing carts to ensure all medications were properly stored. All medications were noted to be stored properly. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 4/24/2025, the Director of Nursing and designee(s) initiated re-education to all	

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F 761	Continued From page 15 with moderately impaired cognition During a medication storage observation conducted on 04/21/25 at 11:33 AM, an opened bottle of liquid Pepto Bismol containing approximately 7 fluid ounces was seen left unattended on top of Resident #90's bedside table and ready to be used. An interview was conducted with Resident #90 on 04/21/25 at 11:35 AM. He stated his wife brought the Pepto Bismol for him about 3 days ago and left it in his room. He denied he had used this medication so far. He was unsure whether any staff were aware of this medication when providing care but so far none of them had said anything. During an interview conducted on 04/21/25 at 11:42 AM, Nurse #1 stated when she did medication pass for Resident #90 in the morning of 04/21/25, she did not notice the bottle of liquid Pepto Bismol left unattended in his room. She acknowledged that none of the medications should be left unattended in the resident's room. An interview was conducted with Nurse Aide #1 (NA) on 04/21/25 at 12:14 PM. She stated that she provided care for Resident #90 in the morning of 04/21/25, but she did not notice he had an opened bottle of Pepto Bismol left unattended in his room. Otherwise, she would report the incident to the nurse. b. Review of the manufacturer's package insert for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between 36° to 46° Fahrenheit (F) and protected	F 761	licensed nursing staff including med-aides and agency staff regarding the requirements for storing unopened eye drops and that no medications are to be left at a resident's bedside. Any newly hired med-aides or licensed nurses will be educated during orientation upon hire. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Observation monitoring will be done by the Director of Nursing or designee to ensure that all eye drops are stored properly and that no medications have been left at a resident's bedside. This monitoring will take place 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/16/2025	

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F 761	Continued From page 16	F 761		

from light. Once opened, Latanoprost may be stored at room temperature up to 77° F for up to six weeks.

During a medication storage audit conducted on 04/22/25 at 2:21 PM for the 100 hall medication cart in the presence of Nurse #2, three unopened bottles of Latanoprost 0.005% eye drop (medication used to treat glaucoma) were found in the medication cart at room temperature and ready to be used. Each bottle had a hand-written opening date of 04/20/25 but the plastic seal for all three bottles remained intact.

An interview was conducted with Nurse #2 on 04/22/25 at 2:25 PM. She confirmed all three bottles of Latanoprost eye drops in 100 hall medication cart were unopened. She explained she had been off for the last 2 days and did not know who had placed the Latanoprost eye drops in the medication cart. She acknowledged that unopened Latanoprost eye drops should be stored in the refrigerator until they were ready to be used.

During an interview conducted on 04/22/25 at 2:48 PM, the Director of Nursing (DON) expected all the nursing staff to be more attentive to resident's living environment to ensure the facility free of unattended medications. It was her expectation for all the nursing staff to store the medications according to the manufacturer's guidelines.

An interview was conducted with the Administrator on 04/23/25 at 5:10 PM. He expected all the nursing staff to follow manufacturer's guidelines in medication storage and keep the facility free of unattended

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F 761	Continued From page 17 medications.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to cover facial hair during food service for 1 of 4 dietary staff observed (Dietary Manager #1). This deficient practice had the potential to affect food served to residents. The findings included: During a follow up tour of the kitchen on 4/22/2025 at 7:30 AM, Dietary Manager #1 was observed in the kitchen area with a short, neatly trimmed beard with no facial hair covering. As the tray line for breakfast began, Dietary Manager #1	F 812	F-812 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly identified as being affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be	5/16/25

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F 812	Continued From page 18 was observed at the steam table and began to assist with plating food. This surveyor called Dietary Manager #1 away from the steam table and asked if he used facial hair covering. He immediately obtained one and put it on. He stated he usually wore a facial hair covering. Dietary Manager #1 stated he was from a different facility, had come to pick up chemicals from the kitchen and had not planned to stay at the facility. He reported he had spoken to the Culinary Director by telephone, and she had requested he stay until she arrived at work. An interview on 4/24/2025 at 10:45 AM with the Culinary Director revealed that facial hair coverings were always required in the kitchen for staff with facial hair. She did not know why Dietary Manager #1 was not wearing a facial hair covering. An interview on 4/24/2025 at 11:45 AM with the Administrator indicated Dietary Manager #1 should have used a facial hair covering while in the kitchen.	F 812	affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 4/24/2025, the Administrator re-educated the Dietary Director regarding the requirements of covering facial hair during food service. On 4/24/2025, the Dietary Director re-educated the dietary staff regarding the requirements of covering facial hair during food service. Any newly hired dietary employee will be educated during new hire orientation. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Observation monitoring will be done by the Administrator, Dietary Director or designee to ensure that facial hair is covered during food service. This monitoring will take place 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 812	Continued From page 19	F 812	The facility alleges compliance on 5/16/2025	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		5/16/25

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F 842	Continued From page 20 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain an accurate and consistent electronic medication administration record (eMAR) for 1 of 1 resident review for documentation accuracy (Resident #152).	F 842	F-842 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 4/23/2025, nurse #4 was re-educated	

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F 842	Continued From page 21 The findings included: Resident #152 was admitted to the facility on 03/11/25 with diagnoses including opioid dependence. A review of physician order dated 04/17/25 revealed Resident #152 had an order to receive 1 tablet of oxycodone-acetaminophen (Percocet) 5/325 milligrams (mg) by mouth once every 4 hours as needed (PRN) for pain at his right hip. Review of the eMAR dated 04/21/25 revealed Resident #152 had received 1 tablet of Percocet 5/325 mg at 8:15 AM and 4:24 PM. On 04/22/25, the eMAR indicated Resident #152 had received 1 tablet of Percocet 5/325 mg at 7:45 AM and 2:25 PM. Review of the nurse's progress notes dated 04/21/25 and 04/22/25 revealed none of the nursing staff had documented any notes related to Resident #152's need for PRN Percocet. Review of the controlled substance declining sheet indicated Resident #152 had received 1 tablet of Percocet 5/325 mg 3 times respectively on 04/21/25 at 8:00 AM, 4:15 PM, and 10:00 PM. On 04/22/25, the controlled substance declining sheet revealed Resident #152 had received 1 tablet of Percocet 5/325 mg 3 times respectively at 7:45 AM, 2:25 PM, and 10:00 PM. The Percocet signed out for Resident #152 on 04/21/25 at 10:00 PM and 04/22/25 at 10:00 PM by Nurse #4 were not charted in the eMAR. An interview was conducted with Resident #152 on 04/23/25 at 12:59 PM. He confirmed he had received his PRN Percocet on 04/21/25 and	F 842	by the Director of Nursing regarding the requirement of not only charting in the controlled substance declining sheet, but the electronic medication administration record as well when administering Percocet. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 4/23/2025 the Director of Nursing audited all residents receiving Percocet in the last 30 days to determine if any other residents were affected. The audit revealed that no other residents were noted to be affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 4/24/2025, the Director of Nursing and designee(s) initiated re-education to all licensed nursing staff including med-aides and agency staff regarding the requirement that the administration of Percocet is to not only be charted in the controlled substance declining sheet, but in the electronic administration record as well. Any newly hired med-aides or licensed nurses will be educated during orientation upon hire. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Observation monitoring will be done by the Director of Nursing or designee to	

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F 842	Continued From page 22 04/22/25 around 10 PM and stated the medication was administered by Nurse #4. During a phone interview conducted on 04/24/25 at 9:50 AM, Nurse #4 stated he worked second shift on 04/21/25 and 4/22/25. He recalled Resident #152 had asked for his PRN Percocet and confirmed he had administered the pain medication to Resident #152 around 10 PM both night. Typically, he would sign out narcotic in the controlled substance declining sheet first. After it was administered, he would chart it in the eMAR. He was surprised to learn that he did not chart both entries in the eMAR and attributed it to distractions. He acknowledged that all medication administration that involved controlled substance should be documented in the controlled substance declining sheet and eMAR. During an interview conducted with the Director of Nursing on 04/23/25 at 1:28 AM, she acknowledged that Resident #152's Percocet that were administered by Nurse #4 should be charted in the controlled substance declining sheet and eMAR as well. It was her expectation for all the controlled substances to be accounted for and documented accurately in a timely manner. An interview was conducted with the Administrator on 04/23/25 at 5:10 PM. He expected nursing staff to document all the controlled substances accurately and consistently in the controlled substances declining sheet and eMAR.	F 842	ensure that all residents receiving Percocet had charting in both the controlled substance declining sheet and the electronic medication administration record as well. This monitoring will take place 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/16/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/16/25

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	345243	A. BUILDING _____ B. WING _____	C 04/24/2025

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F 880	Continued From page 23	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 24 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to implement Transmission-Based Precautions (TBP) when two Nurse Aides provided incontinence care for Resident #55 and did not wear a gown for 2 of 5 staff members observed for infection control practices (Nurse Aide #3, Nurse Aide #4). The findings included: Review of the facility's policy for Transmission-Based Precautions (TBP) dated 10/27/20 revealed the TBP will be implemented for the	F 880	F-880 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 4/24/2025, the Director of Nursing put a sign on resident #55s door to alert staff to take transmission-based precautions before entering the room. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue	

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F 880	Continued From page 25 prevention of transmission of multidrug-resistant organisms. Three categories of precautions were listed on the policy including Contact Precautions, Droplet Precautions and Airborne Precautions. Contact precautions included the following: 1. Personal Protective Equipment (PPE) a. Staff and visitors will wear gloves when entering the room for all interactions that may involve contact with the resident and/or the residents' environment. b. Staff and visitors will remove gloves and perform hand hygiene prior to leaving the resident's room. c. Staff and visitors will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves were removed. d. Staff and visitors will wear a gown when entering the room for all interactions that may involve contact with the resident and/or the residents' environment. e. Staff and visitors will remove the gown and perform hand hygiene prior to leaving the resident's room. f. Staff and visitors will avoid touching potentially contaminated surfaces with clothing after the gown is removed. A physician order dated 04/22/25 for Resident #55 revealed an order for contact precautions due to Enterobacter cloacae complex (a group of closely related bacterial species known for causing various infections) in her urine. An observation was conducted on 04/23/25 at 3:00 PM of Resident #55's room. The observation revealed signage posted on Resident #55's door for Enhanced Barrier Precautions (EBP). A	F 880	needing to be addressed: On 4/24/25, an audit was completed by the Director of Nursing for all residents that require transmission-based precautions to ensure appropriate signage and personal protective equipment is in place and visible to staff. The audit revealed that no other residents were noted to be affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 4/24/2025, The Administrator re-educated the Director of Nursing (Infection Preventionist) and the Assistant Director of Nursing that any time an order is given for a resident to be on transmission-based precautions, signage needs to be posted on the resident’s door indicating the resident is on transmission-based precautions and the appropriate personal protective equipment needs to be available as well. On 4/24/2025, The Director of Nursing re-educated the nurse management team that any time an order is given for a resident to be on transmission-based precautions, signage needs to be posted on the resident’s door indicating the resident is on transmission-based precautions and the appropriate personal protective equipment needs to be available as well. (4) Indicate how the facility plans to monitor its performance to make sure that	

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F 880	Continued From page 26 three-compartment container was observed on the outside of the resident's door with gown, gloves and mask in the compartments. An observation of incontinence care conducted on 04/23/25 at 3:36 PM revealed Enhanced Barrier Precaution (EBP) signage on Resident #55's door. Nurse Aide (NA) #3 and NA #4 entered Resident #55's room and provided incontinence care wearing only gloves for the duration of the task. NA #3 and NA #4 were observed changing Resident #55's bed sheet, incontinence brief and bottom sheet. The staff members had a wash basin and were observed washing Resident #55's peri area. An interview was conducted with NA #3 on 04/23/25 at 3:45 PM. During the interview she stated she was unaware Resident #55 was on Transmission Based Precautions (TBP). An interview was conducted with NA #4 on 04/24/25 at 9:16 AM. During the interview she stated she did not wear a gown while providing care for Resident #55 because she didn't know the resident was on TBP. On 04/23/25 at 4:04 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she was also in charge of Infection Prevention in the facility. She stated there should have been signage on Resident #55's door indicating for staff to wear a gown and gloves while performing incontinence care. The interview revealed the physician order was placed into the electronic system by the Assistant Director of Nursing (ADON), and he should have placed a sign on the door at the time the order was put in. The DON stated the staff	F 880	the solutions are achieved and sustained: Observation monitoring will be done by the Administrator, Director of Nursing, or designee to ensure that through order review, any resident placed on transmission-based precautions have the appropriate signage posted on their door along with the necessary personal protective equipment available. This monitoring process will take place 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 5/16/2025	

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F 880	Continued From page 27 should have worn gown and gloves while providing care for Resident #55. On 04/24/25 at 12:00 PM an interview was conducted with the ADON. He stated there was already an Enhanced Barrier Precaution sign on Resident #55's door for her roommate so he thought he did not have to put another sign on the door. He stated he did not realize that staff wouldn't know Resident #55 was on contact precaution isolation. After realizing the issue, the ADON stated he should have put a contact precaution sign on Resident #55's door. On 04/24/25 at 12:32 PM an interview was conducted with the Administrator. During the interview she stated a contact precaution sign should have been on Resident #55's door if she had a physician order stating those precautions were required.	F 880		