

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Accordius Health at Concord		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Lake Concord Road NE Concord, NC 28025	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on observation, record review, and family, Lieutenant of Criminal Investigations and staff interviews, the facility failed to protect a resident's right to be free from abuse for 1 of 3 residents (Resident #2). Nurse aide (NA) # 1 and NA # 2 provided personal care to Resident # 2 while live streaming on a cell phone, the resident was naked from the waist up, the staff and the prison inmate watching the live stream spoke with profanity and vulgarity without any regard for the resident; the staff did not explain care as it was provided to the resident; the staff were physically aggressive during care; the staff allowed an inmate who was watching the live stream to view the resident and speak to the resident; the staff allowed this live streaming while other inmates were observed in the open area behind him. As Resident #2 was severely cognitively impaired, the reasonable person concept was applied. A reasonable person would have been traumatized by being abused by caregivers in their home environment making them feel worthless, angry, dehumanized and powerless.</p> <p>Immediate jeopardy began on 10/4/24 when Resident #2 was abused. Immediate jeopardy was removed on 12/5/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at the scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses which included anxiety, Alzheimer's disease, dementia, and mood disturbance.</p> <p>Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired and required extensive assistance with two-person for bed mobility and transfers. The MDS further revealed Resident #2 had adequate hearing and vision and was able to understand others. The MDS indicated no behaviors of rejection and care.</p> <p>Review of Resident #2's care plan dated 04/07/23 revealed the resident had an activities of daily living (ADL) self-care performance deficient due to Alzheimer's disease, impaired cognition, and muscle weakness. The goal was for Resident #2 to maintain its current level of function through the review date.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #2's care plan revised on 08/19/24 revealed the resident was resistive to care and refused to see the dentist and other medical directors at time due to dementia. The goal was for the resident to cooperate with care through the next review date. Interventions included for Resident #2 to make decisions about treatment regime and to give clear explanation of all care activities prior to an as they occur during each contact.</p> <p>Review of video footage provided by the Sheriff Department revealed the following events took place on 10/04/24 at 10:30 PM. The video revealed NA #1 and NA #2 located in a facility in the resident's room on live stream video through a cell phone with a prison inmate. The inmate was observed talking into a telephone receiver in an open area with several other inmates behind him. The inmate was looking at the live stream.</p> <p>The video was reviewed on 12/4/24 at 4:45 PM. The following was found and documented by the time mm:ss (minutes colon seconds) where mm represents minutes and ss represents seconds.</p> <p>-:01 Video starts with NA #1 walking down the facility hallway towards Resident #2's room. No residents were shown at this time.</p> <p>-:33 NA #1 entered Resident #2's room.</p> <p>-:45 NA #1 laid the cell phone down and shook her rear in the camera as the inmate states, that damn ass is fat. Look at that ass.</p> <p>That mother f . is fat. The video showed several inmates walking around the inmate while he was speaking to NA #1 and Resident #2 was visible sitting in the wheelchair with NA #1 and NA #2 present in the resident's room. NA #2 was observed undressing Resident #2 and taking off her shirt. It was observed that multiple inmates and a guard walked by the inmate during this time. Staff were not observed to be explaining their actions related to care to the resident.</p> <p>-:53 NA #2 was observed jerking the resident's shirt out of Resident #2's hands aggressively. Residents #2's bare shoulders were observed to be showing. NA #2 was not observed to explain care to the resident.</p> <p>-1:28 NA #1 picked up the cell phone and spoke to the inmate walking throughout the resident's room.</p> <p>-2:07 NA #2 was observed waving and smiling at the inmate through the cell phone acknowledging the inmate.</p> <p>-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 inmate in the open public area.</p> <p>-3:02 NA #1 was holding the cell phone and pointed it to NA #2 smiling and laughing into the camera. NA #2 acknowledged again she is on a live video stream call with the inmate.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A follow up phone interview with Lieutenant of Criminal Investigations on 12/05/24 at 9:20 AM explained the video occurred on 10/4/24 and the video call app used was Home WAV which is a video call that is recorded of both parties. The Lieutenant indicated when a video call occurred the inmate had a phone receiver to hear the conversation but had a computer size screen mounted on the wall to see who they are face calling. The Lieutenant stated other inmates were unable to hear the conversation but could visually see the video because the screen is in a non-private area with other inmates present.</p> <p>An interview conducted with NA #1 on 12/02/24 at 2:35 PM revealed she had worked in the facility for two years. NA #1 further revealed she had completed an in-service on abuse and neglect and was educated to report abuse or neglect to the administrator. NA #1 stated she had never taken any pictures or videos of any resident in the facility.</p> <p>A phone interview conducted with Nurse Aide (NA) #2 on 12/4/24 at 6:00 PM revealed she had been employed by the facility for approximately two years. NA #2 further revealed she had been educated on abuse upon hire, yearly, and randomly. NA #2 stated she had never observed any staff or had taken a video or picture of a resident. NA #2 indicated if she was to observe a staff member record a resident that she would report it to the Administrator. NA #2 denied any staff videoing Resident #2 while giving care.</p> <p>An interview conducted with the Director of Nursing (DON) and Administrator on 12/02/24 at 2:45 PM revealed they both had been recently employed at the facility. The interview revealed no staff had reported concerns about staff having their phones out in care areas and taking pictures or video footage of a resident. Both indicated nursing staff had been in-service at hire, annually, and anytime on resident privacy and person phones were not allowed to be out in resident rooms.</p> <p>The video was shared with facility staff on 12/4/24 at 5:45 PM. Those present were the Director of Nursing (DON), [NAME] President of Clinical Operations, and [NAME] President of Risk and QAPI (quality assurance and performance improvement). Facility staff were crying. After the video was reviewed, Resident #2, NA #1, and NA #2 were identified by the DON. It was further revealed NA #1 and NA #2 had been in-serviced on abuse and neglect and reporting upon hire, annually, and during any abuse investigations. It was indicated Resident #2 was not alert and oriented and could be combative and resistive to care. The DON revealed she expected staff to walk away and get help if the resident becomes frustrated or combative. It was further revealed nursing staff were not allowed to have personal cell phones in care areas and it was not permitted to record any audio or image of a resident. The DON stated NA #1 failed to protect the privacy of Resident #2 and NA #2 failed to report the exploitation and privacy of Resident #2.</p> <p>An interview conducted with Resident #2's Responsible Party (RP) on 12/5/24 at 3:15 PM revealed the facility had notified the family of the video on 12/04/24. The RP further revealed she was upset this had happened to Resident #2 but was glad it was being investigated and hoped justice would be served to NA #1 and NA #2.</p> <p>An interview conducted with the Administrator on 12/9/24 at 4:00 PM revealed she had been employed by the facility for a short period of time but assisted with the initial investigation. The Administrator further revealed NA #1 and NA #2 had denied being in any video or on a telephone call with a resident present. The Administrator further revealed she expected nursing staff to prevent abuse and neglect and report.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON), [NAME] President of Clinical Operations, and [NAME] President of Risk and QAPI were notified of immediate jeopardy on 12/5/24 at 12:35 PM. The Administrator was not present.</p> <p>The facility provided the following immediate jeopardy removal plan.</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.</p> <p>The facility failed to protect a resident's right to be free from mental and sexual abuse (Resident #2). On 10/4/24 Resident #2 was shown in compromised positions during an audiovisual phone call from Nursing Assistant (NA) #1 with a male individual who was witnessing the audiovisual through the use of a wall mounted screen in a common area of an incarceration center while other people in the prison were observed walking past the screen. During the audiovisual surveillance, NA #1 was observed to show Resident #2 to the male through her phone camera, the resident sitting in a wheelchair, naked, with no shirt or bra on, with her breasts exposed.</p> <p>There were two NAs witnessed in the video, NA #1 and NA #2. The NA's did not explain to the resident before each step of care was provided; NA # 1 shoved the resident to turn on her side aggressively; NA # 1 and the inmate talked inappropriately, using vulgar language including f**k and sh*t, about the resident and to the resident while NA # 1 and the inmate carried on their own private, foul mouthed (including discussion of NA #1's buttocks), conversation in the presence of the resident.</p> <p>On 12/2/2024 at 1:30pm, the Director of Nursing (DON), [NAME] President of Clinical Operations (VPCO) and [NAME] President of Risk and Quality Assurance (VPRQA) were notified by a surveyor during a recertification and complaint survey that a complaint was received from the community alleging an inappropriate photo or video of an unknown elderly female, partially unclothed and a female identified as NA #1 was witnessed.</p> <p>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 this time and the presence of a witness was unknown, the facility was unable to make notifications to Resident #2's resident representative or initiate immediate suspension of NA #2.</p> <p>On 12/2/24 at 2:15pm, the Social Worker (SW) notified the local police department and adult protective services (APS). A police report number was obtained.</p> <p>On 12/2/24 at 3:30pm, the Administrator submitted the initial allegation report to North Carolina Department of Health Human Services (NCDHHS).</p> <p>On 12/2/24 at 4:00pm, the Administrator completed an observational round of facility residents and staff to ensure that resident rights to privacy and freedom from abuse is maintained. Observations included 1) care being provided only by authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas and 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space and 5) observations to ensure residents have no physical signs or behaviors indicative of potential abuse. No additional concerns identified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Effective 12/2/2024, the Administrator, DON or designee will complete ongoing daily observational rounds of facility residents and staff to ensure that residents are free from abuse and resident rights to privacy is maintained, including strict prohibition of staff cellular phone use or any type of audio or video device use in resident care areas. Observations to include 1) care being provided only be authorized staff, 2) use of privacy curtains, closed doors during personal care and covering/draping to prevent exposure of body parts, 3) no cellular or other video devices used by staff in resident care areas, 4) any other violation of resident right to personal privacy not only of a residents' own physical body, but of his or her personal space, 5) observations of any form of physical, sexual or emotional abuse which include but are not limited to; a. ensuring residents are not harmed physically or handled roughly during care but are provided with care that is gentle, kind, dignified; b. residents are free from offensive comments, profanities or other form of verbal abuse and c. observations to ensure residents are not exhibiting signs of mental anguish such as tearfulness, withdrawal, fear, guarding, aggressiveness and other unusual changes in resident behaviors. On 2/2/24, licensed nurses were educated and notified by the VPCO of their responsibility to complete observational rounds each shift for his/her unit and observe resident and staff interactions as above.</p> <p>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 platforms. With the guidance of our legal counsel, 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.</p> <p>Effective 12/2/2024, the Administrator is ultimately responsible for the implementation and completion of this removal plan.</p> <p>Alleged Date of IJ Removal: 12/5/2024</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Accordius Health at Concord		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Lake Concord Road NE Concord, NC 28025	

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/10/2024, the facility's credible allegation for immediate jeopardy was validated. Resident #2 was observed in the dining room pleasant and smiling with other residents in the table. During the tour of the facility residents were observed to 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 evidence of daily Quality Assurance auditing of all residents divided on cognitively intact residents for interview and cognitively impaired 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.</p> <p>The immediate jeopardy removal date of 12/5/24 was validated.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129</p> <p>Based on record review, and interviews with staff, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 3 residents reviewed for misappropriation of a resident's property (Resident #6). The resident received her pain medication as scheduled.</p> <p>Findings included:</p> <p>The facility's Abuse, Neglect, and Exploitation Policy, last updated on 10/22/24, was reviewed and it included misappropriation in part was the protection of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.</p> <p>Resident #6 was admitted to the facility on [DATE] with a diagnosis of chronic pain.</p> <p>Resident #6 had an order for oxycodone 10 milligrams (mg) every 6 hours for chronic pain dated 2/13/24.</p> <p>A pharmacy packing slip dated 3/25/24 documented dispense date of 3/25/24 of 4 cards of oxycodone 10 mg and each card had 10 tablets for a total of 40 tablets.</p> <p>A review of the medication monitoring/control record received by Nurse #4 documented between 3/25/24 through 3/27/24 there were 10 oxycodone 10 mg administered every 6 hours as ordered, signed with correct descending amount. The remaining amount was 0 for card number one. There were three remaining oxycodone 10 mg cards with 10 tablets each with a medication monitoring/control record.</p> <p>The daily nursing schedule dated 3/27/24 had Nurse #2 scheduled on B-Hall assigned to Resident #6 on day shift, and she was responsible for this hall's medication cart.</p> <p>The shift change narcotic count verification for total number of narcotic sheets for all residents on Hall B medication cart ending date 3/26/24 was documented by Nurse #3 total number 32 sheets. Four sheets were added for a total of 36. A 6 was written with a 4 for the column sheets added and the total column was written as 38. The 8 appeared to be written on with another number that was not legible. The comments column documented Resident #6 had 4 oxycodone cards on 3/26/24. All rows were filled on this sheet.</p> <p>A new shift change narcotic count verification sheet was started dated 3/27/24 3 pm shift oncoming nurse signature Nurse #2 and off going nurse was blank. Number 36 was in the narcotic sheets column. A new row on the narcotic count verification sheet was started dated 3/27/24 11 pm shift oncoming nurse and off going nurse columns were both signed with a signature of Nurse #3's name. There was no number in the narcotic sheets column. The handwriting of the signatures on this sheet appeared to be the same for both names, all 3 signatures.</p> <p>The Director of Nursing (DON) provided a folder with Resident #6's narcotic misappropriation investigation dated 3/27/24 documentation:</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/24 the 2nd shift nurse reported that Resident #6 was missing 1 of 4 cards of oxycodone 10 mg that were delivered on 3/25/24. The DON completed a review of the shift verification count sheet and noted that the sheet count number had been altered. Further investigation revealed 1 medication monitoring control record and 1 card of 10 oxycodone 10 mg tablets were missing. The pharmacy and police were notified. All other facility medication carts of narcotic counts were audited, and no other concerns were noted. Nurse #2 was suspended pending investigation. The pharmacy confirmed that 4 cards of oxycodone 10 mg were delivered on 3/25/24. The pharmacy packing slip indicated that 4 cards of oxycodone 10 milligrams with 10 tablets on each card were delivered. Nurse #2 was contacted by phone and refused to provide a statement related to oxycodone. Nurse #2 was reported to the North Carolina Board of Nursing on 4/3/24. Education was initiated with licensed nurses regarding the narcotic count and correcting errors in the medication record properly. Corrective actions: The pharmacy was contacted by the DON on 3/28/24 and a replacement refill card of oxycodone 10 mg 10 tablets was obtained at the expense of the facility. The police were contacted, and they informed the facility they were unable to reach Nurse #1 by phone or the address on file by the agency. Nurse #2 will not be allowed to work in the facility.</p> <p>On 4/8/24 a urine specimen was obtained from Nurse #3. The test was negative for all drugs including opiate.</p> <p>Nurse #2 was left messages on 3/27/24 and 3/28/24 twice. A return call was received from her on 3/29/24 at 10:40 am. She stated that she wanted her pay approved. Nurse #2 was asked to come to the facility and provide a statement. A statement was not provided.</p> <p>All residents that had narcotic orders were reviewed for accuracy of administration and count. All medication control records were reviewed and medication audited, and no other misappropriation of medication was identified.</p> <p>Audits were completed for weeks 4/3/24 through 5/1/24 weekly for 4 weeks or longer if concerns were identified. Goal: Residents' controlled drugs will be properly handled and the facility will have correct records/documentation on the narcotic count sheets. The audits were completed, and counts were correct.</p> <p>An in-service roster of nurses signed for education about the policy controlled substance administration and accountability revision November 2017 had 32 staff signatures. Additional information to correct mistakes appropriately was included.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 2:54 pm an interview was conducted with Nurse #2. She stated on 3/25/27 four oxycodone cards with 10 tabs each were received for Resident #6 and Nurse #3 and #4 observed, documented, and counted that this was added to the shift change narcotic count verification sheet and there was a medication monitoring control record for each oxycodone card. Both nurses signed for the received oxycodone. The new cards were added to the shift change narcotic count verification sheet, and we used the last row of that sheet with a date of 3/26/24. A new shift change narcotic count verification sheet was started and signed by Nurse #3 and #4. Nurse #2 was on day shift 3/27/24 responsible for the narcotics and counted with Nurse #3 at shift change 3:00 pm. The Medication monitoring control record that was being used was accurate. There were the correct number of shift change narcotic count verification sheets numbered. Nurse #3 stated she went to administer an oxycodone at the beginning of her evening shift and checked the paperwork. She noticed that the new shift change narcotic count verification sheet was not the sheet she and Nurse #4 had started and signed on 3/26/24. The signatures were not theirs and both appeared to be signed by the same person. A check of the previous shift change narcotic count verification sheet ending date 3/26/24 that Nurse #3 and #4 had completed to the last row of the sheet had the number of narcotic sheets added and total number of narcotic sheets on the cart were changed. The numbers were written over and were not the correct numbers, the numbers written by Nurse #3 the evening before 3/26/24. Nurse #3 noticed that one of the oxycodone cards was missing. There should have been 3 cards remaining and now there were only 2. Nurse #2 had left immediately after report at shift change and narcotic count and was unable to be reached by telephone.</p> <p>On 12/5/24 at 2:40 pm an interview was conducted with the [NAME] President of Quality. She stated the Administrator was not present and the DON employed March 2024 was no longer working at this facility. She also stated she would look for additional nursing education roster sheets, QAPI (Quality Assurance/Performance Improvement) minutes, and Drug Enforcement Administration notification.</p> <p>On 12/5/24 at 4:20 pm the [NAME] President of Quality provided a QAPI minute meeting dated 3/27/24 with the topic drug diversion and the team roster.</p> <p>Nurse # 4 was interviewed on 12/10/24 at 12:25 pm. Nurse #4 stated 4 cards of oxycodone 10 mg were received for Resident #6 on 3/25/24. Nurse #3 and Nurse #4 counted, documented, and signed for the receipt of the Oxycodone 3/25/24 at 7:00 am. One card of the Oxycodone 10 mg was used and counted down to 0 on 3/27/24. The count was correct when Nurse #4 left after night shift 3/27/24 7:00 am and counted with Nurse #2. Nurse #4 started a new shift change narcotic count sheet with Nurse #3 and signed and dated 3/26/24. Nurse #4 counted with Nurse #2 at the beginning of her day shift 3/27/24 at 7:00 am and the narcotic count was correct. The sheet Nurse #4 started was present and there were 3 full cards of oxycodone 10 mg remaining. On 3/27/24 at 3:00 pm the shift change narcotic count sheet that Nurse #3 and Nurse #4 started was missing. Another sheet was started by an agency nurse (Nurse #2). Nurse #4's name was not on this new sheet. Nurse #3 and Nurse #2's name were on the new sheet and the handwriting looked the same.</p> <p>On 12/10/14 the [NAME] President of Quality provided the remaining nurse education roster and a statement that the Drug Enforcement Administration was notified under the facility's previous name and identification number and the document was not obtainable.</p> <p>The facility provided the following corrective action plan with a completion date of 4/7/24:</p> <p>F602</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Corrective action for resident(s) affected by the alleged deficient practice:</p> <p>Resident #6 was affected by misappropriation of her schedule oxycodone pain medication. The resident received her medication as scheduled. The medication was replaced by the facility.</p> <p>2. Corrective action for residents with the potential to be affected by the alleged deficient practice:</p> <p>All residents with a narcotic order for pain had potential to be affected. The Director of Nursing completed an audit of all medication carts with narcotics to verify that all narcotics and narcotic sheets were accounted for with no other concerns identified. The audit was completed on 3/27/24.</p> <p>3. Measures/Systemic changes to prevent recurrence of alleged deficient practice:</p> <p>On 3/27/24 through 4/7/24 training on the following topics for all licensed nurses and medication aids regarding misappropriation of personal property that focused on shift-to-shift count, verifying medications on hand, misappropriation, and documentation. The Director of Nursing and/or designee would continue to maintain and monitor controlled medication records to ensure consistency and accountability. Education was completed by 4/7/24 for all nursing staff, including agency staff. Monitoring of the medication carts began on 3/27/24 with the initial audit after the misappropriation. The monitoring continued weekly for 4 weeks. The QA members were notified on 3/27/24.</p> <p>4. Monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p> <p>The Director of Nursing audited all medication carts weekly for 4 weeks. There were no adverse findings. The misappropriation was reported to the QAPI (Quality Assurance/Performance Improvement) Committee on 3/27/24.</p> <p>Compliance Date: 4/8/24</p> <p>Validation of the corrective action plan was completed on 12/11/24.</p> <p>Review of documentation/staff roster of education that was completed with 33 nurses and medication aides who had responsibility to administer narcotic medication and had access to controlled substances covered drug loss or theft, administration, and shift-to-shift drug count was completed. The education took place between 3/27/24 through 4/7/24.</p> <p>On 12/5/24 interviews were conducted individually with Nurse #1 and #3 and on 12/10/24 with Nurse #4. The Nurses stated they participated in education for narcotic misappropriation, storage, reporting, count, and documentation.</p> <p>The compliance date of 4/8/24 was validated.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129</p> <p>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.</p> <p>Findings included:</p> <p>Resident #65 was admitted to the facility on [DATE] with the diagnosis of limited range of motion.</p> <p>Resident #65's Minimum Data Set, dated dated dated [DATE] documented her cognition was intact. The resident required assistance from one staff member for bathing and personal grooming.</p> <p>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.</p> <p>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 uneven, long, and had black matter underneath the nails, especially the right hand. The resident stated she usually had a bed bath and had no offer from the Nursing Assistant (NA) to provide nail care. The resident stated she would like nail care, and she had not refused care. The resident also stated she had asked an NA to cut her nails, but the NA had not returned to provide care a couple of days earlier.</p> <p>On 12/5/24 at 1:50 pm an observation and interview was completed with Resident #65. The Resident's nails remained long, uneven but had less black matter. The right hand had two nails that remained with black matter underneath. The Resident stated she was taken to the dining room by the Activity Director yesterday for an activity. The Resident was informed she was going to receive a manicure including nail polish. The Resident stated she had not gotten her nails done and was taken back to her room and had not known why. The resident stated she had a bed bath yesterday and the NA assigned had not provided nail care and she did not know why. The Resident had not asked for nail care. The Resident stated she required assistance with all bathing and nail care. She could not cut her own nails and had no access to wash her hands/nails without staff assistance.</p> <p>An interview was conducted with NA #4 on 12/5/24 at 1:55 pm. NA #4 stated he was assigned on day shift to Resident #65 on 12/4/24 and 12/5/24. NA #4 stated he provided a bed bath on 12/4/24 but had not provided nail care. NA #4 had not provided nail care because his assignment was heavy. NA #4 stated he ran out of time. NA #4 had not offered or provided nail care today (12/5/24) but would provide care now. NA #4 stated he was aware and had observed the resident place her hand inside her brief to scratch and had not provided hand hygiene before meals. The resident had itchy skin all over her body. NA #4 further stated he had not informed the nurse about the scratching.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 1:45 pm an interview was conducted with NA #3. NA #3 stated she was assigned to Resident #65 on 12/5/24, day shift. The NA stated she provided morning care for the resident and her bath was yesterday. The NA stated on rounds this morning the resident was observed to have her hands in her brief scratching what appeared to be her private area. The resident told the NA that she was scratching her leg. The NA stated she had not offered to clean the resident's hands after the scratching and before lunch. The NA had not known why the resident's nails were long, uneven, and dirty underneath. The NA stated she would provide nail care following the interview.</p> <p>On 12/5/24 at 1:55 pm an interview was conducted with the Activity Assistant. She stated there was an activity yesterday for manicures. She stated the activity ran out of time and the dining room was needed for lunch. Resident #65 was not able to have her manicure due to a lack of time. The Activity Director was also an NA and would clean/cut a resident's nails if needed. The Activity Assistant stated she was going to have another manicure activity on Saturday but could not cut the resident's nails, she was not an NA. She further stated Resident #65 would be added to the list for manicure this Saturday (12/7/24).</p> <p>On 12/4/24 at 3:39 pm an interview was conducted with Nurse #1. She stated the NAs were responsible to provide the residents with nail care during the shower or bed bath unless refused and the nurse would need to be notified. She stated the NAs had not notified her Resident #65 had refused care, including nail care. Nurse #1 was not aware that the resident's nails required care and would let the NA scheduled know.</p> <p>An interview was conducted with Nurse #1 on 12/5/24 at 2:05 pm. She was not aware that the resident's nails were not cared for yesterday with the bath (12/4/24). The resident sometimes preferred a bath over a shower but had not refused care. She was not aware that the resident was observed by NA #3 and NA #4 putting her hand into her brief and scratching. She could not remember which NA provided the bed bath yesterday.</p> <p>On 12/5/24 at 3:45 pm an interview was conducted with the Director of Nursing (DON). The DON was not aware Resident #65 had not received nail care and was scratching her skin, including inside her undergarment. The DON would want staff to provide hand hygiene before meals if a resident was scratching inside an undergarment.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643</p> <p>Based on record review and staff interviews, the facility failed to complete a quarterly smoking assessments for 2 of 3 residents reviewed for smoking (Resident #31 and Resident #72).</p> <p>The findings included:</p> <p>1a. Resident #31 was admitted to the facility on [DATE] with diagnoses which included hypertension, muscle weakness, dementia, and blindness in one eye.</p> <p>Review of Resident #31's annual MDS dated [DATE] revealed the resident was coded for smoking.</p> <p>Review of Resident #31's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was severely cognitively impaired and was totally dependent on staff for most activities of daily living (ADL). Resident #31 was coded for moderate visual impairment. The MDS indicated Resident #31's mobility device was a wheelchair use.</p> <p>Review of Resident #31's care plan revised on 12/4/24 revealed the resident was a smoker and was supervised because he was once non-compliant with smoking policy and witnessed smoking in his room. The goal was for Resident #31s smoking related injuries to be minimized with intervention through next review. Interventions included smoking assessment to be completed per facility policy.</p> <p>Review of Resident #31's smoking assessments revealed the only smoking assessment completed since the last recertification dated 07/08/23 was on 09/17/24. The smoking assessment dated [DATE] concluded Resident #3 was a supervised smoker because he was unable to demonstrate and understand the smoking policy, times, and place to smoke.</p> <p>1b. Resident #72 was originally admitted to the facility on [DATE] with diagnoses which included hypertension and unsteadiness of feet.</p> <p>Review of Resident #72's annual MDS dated [DATE] revealed the resident was not coded for smoking.</p> <p>Review of Resident #72's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident's cognition was moderately impaired and required supervision for most ADL. The MDS further revealed Resident #72 had adequate vision. Resident #72 was coded for wheelchair and walking cane use.</p> <p>Resident #72's had a smoking assessment completed on 12/02/23 and the next smoking assessment was not conducted until 06/02/24 which assessed Resident #72 as an independent smoker.</p> <p>Review of Resident #72's care plan revised on 07/24/24 revealed the resident was an independent smoker. The goal was for Resident #72 to not suffer injury from unsafe smoking practices.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The interview conducted with Nurse #6 on 12/05/24 at 12:55 PM revealed Resident #31 was a supervised smoker and Resident #72 was an unsupervised smoker. Nurse #6 further revealed nurses assigned to residents were expected to complete smoking assessment quarterly. The Nurse indicated the computer system notified staff when a residents' assessment needs to be completed. Nurse #6 revealed she does not know why they were not completed on time but should have been.</p> <p>Interview conducted with Unit Manager (UM) #1 on 12/05/24 at 1:20 PM revealed smoking assessments were expected to be completed quarterly. UM #1 indicated nurses were notified by the computer what assessments were pending and needed to be completed during their shift, and they were expected to do so. UM #1 indicated she was not aware Resident #31 and Resident #72's smoking assessments had not been completed quarterly.</p> <p>Interview conducted with the Director of Nursing on 12/05/24 at 3:10 PM revealed she had not been employed with the facility for long but expected quarterly smoking assessments to be completed. The DON further revealed she was not aware Resident #31 and Resident #72 went several months without a smoking assessment being conducted.</p>