| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345130 | A. Building<br>B. Wing | 02/27/2026 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident, staff, Psychiatric Nurse Practitioner, and Medical Director, the facility failed to ensure residents were free from abuse when Resident #6, who had a known history of aggressive behaviors toward others, physically abused 2 of 5 residents (Resident #10 and Resident #117) reviewed for abuse. On 11/24/25 Resident #6 hit Resident #10, a resident with severe cognitive impairment, in the face resulting in a bruised, swollen, and busted open and bleeding lip. On 1/10/26 Resident #6 spat on and punched Resident #10 in the face resulting in swelling to the right eyebrow and swelling, bruising, and a gash on her upper lip. Resident #10 did not have the cognitive capacity to express an adverse psychosocial outcome. A reasonable person would have experienced feelings such as fear, anxiety, isolation, and withdrawal. On 2/13/26 Resident #6 struck Resident #117 multiple times in the head and upper body. Resident #117 had no physical injuries but reported that he felt victimized, did not feel safe, and had to sleep with one eye open.Findings included:Resident #6 was admitted to the facility on [DATE] with diagnoses that included anxiety, violent behavior, bipolar disorder, paranoid schizophrenia, dementia with mood disturbance, and insomnia.Physician orders for Resident #6 dated 1/26/24 included: haloperidol (antipsychotic medication) 10 milligrams (mg) tablet twice daily for schizophrenia, buspirone HCl (antianxiety medication) 5 mg three times a day for agitation related to anxiety, and trazodone (antidepressant medication) 50 mg once daily at bedtime for insomnia.The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #6 was cognitively intact and had no behavioral issues within the review period. He was able to ambulate with a walker 150 feet once standing. Resident #6 was on antipsychotic, antianxiety, and antidepressant medications. Resident #6's care plan dated 10/30/25 revealed a care area with interventions initiated on 7/22/25 related to a history of verbal aggression towards his peers, poor impulse control, and threatening statements towards his peers. The goal for Resident #6 was to be less distressed by his own behaviors. The interventions included one to one (1:1) activity as needed; monitor behavior episodes and attempt to determine the underlying cause, consider location, time of day, persons involved and situations; staff to explain all procedures to Resident #6 before starting and allow him time to adjust to changes; and psychiatric and behavioral services as needed with medication reviews.a. Resident #10 was readmitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia, wandering, and cognitive communication deficit.The quarterly MDS assessment dated [DATE] for Resident #10 revealed she rarely/never understood others, was rarely/never understood, had short-term and long-term memory problems, and cognitive skills for daily decision-making was coded as severely-impaired-never/rarely made decisions. Resident #10 had no behavioral issues and no wandering. She was coded as fully dependent on staff for all activities of daily living with the exception of eating and she used a manual wheelchair. She was not on any blood thinning medication. Resident #10's Care Plan dated 9/10/25 revealed a care area with<br><br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | interventions initiated on 7/6/25 related to the risk for elopement. She was noted to seek out exits and bump into doorways and furniture. The interventions included checking placement of her wanderguard each shift; staff to guide her away from doors; offer pleasant distractions; observe for purposeful or aimless wandering; and intervene with distractions for the resident.An Initial Report dated 11/24/25 at 6:40 PM completed by the Administrator for an allegation of resident?to?resident abuse stated Resident #6 hit Resident #10 in the face at 6:00 PM when she self?propelled her wheelchair into his room. The report stated the incident was not witnessed by staff. Resident #124 (Resident #6's roommate) reported seeing Resident #10 with a bloody lip. Resident #10's lip cut was treated, and she resumed her usual routine with no noted behavior changes.A Nurse 's note completed by Unit Manager #1 dated 11/24/25 at 7:20 PM stated Resident #6 hit another resident who wandered into his room. After hitting the other resident, he climbed into his bed. The on-call provider was notified and advised that Resident #6 be monitored. Resident #6 was placed on 1:1 supervision for close monitoring.An interview with Unit Manager #1 was conducted on 2/18/26 at 8:45 AM. She reported that on 11/24/25 she responded to a call for assistance from a nursing assistant (unable to recall which nursing assistant) and when she arrived at Resident #6's door she saw Resident #10 in her wheelchair outside of the room. She observed Resident #10 with a bruised, swollen lip and a cut that had stopped bleeding. The nursing assistant reported that Resident #6's roommate, Resident #124, stated he saw Resident #6 strike Resident #10. Unit Manager #1 reported that Resident #124 was alert and oriented and able to communicate what he witnessed. She indicated that Resident #124 had passed away and was not available for an interview. She reported that Resident #10 was calm and had a confused look on her face. She stated she had nursing staff move Resident #10 to her room, placed Resident #6 on 1:1 supervision, and brought Resident #6 to the Nurse s Station to sit with staff. Unit Manager #1 indicated a stop sign was placed on Resident #6's doorway as a visual cue for Resident #10. Unit Manager #1 reported she was aware of Resident #6's past aggressive behaviors towards other residents and staff.The nurse's note completed by Nurse #9 dated 11/24/25 at 7:37 PM stated Resident #10 was struck in the mouth by another resident (Resident #6) for entering his room and caused injury. The Police were called and the supervisor and Administrator were notified. The on-call provider service was notified and made aware with instructions to notify the provider of any changes and keep separation between the two residents. Resident #10 was given medication for pain.A telephone interview with Nurse #9 was conducted on 2/27/26 at 7:30 AM. Nurse #9 reported that on 11/24/25 she responded to Resident #6's room when she heard his roommate hollering Stop, don't you hit her like that. When she arrived at Resident #6's room she saw Resident #10 sitting in her wheelchair outside the room with Resident #6 standing inside his doorway. Nurse #9 reported she escorted Resident #6 to the nurse's station and observed her top lip was busted open and bleeding. She washed the blood off of Resident #10's lips and cleansed the cut to her top lip and applied ointment. Nurse #9 reported she applied a cold compress because Resident #10 kept touching her lip and it would start to bleed again. She reported that Resident #10 stayed with her at the nurse's station for an extended period of time and remained calm. She reported the police arrived and completed their interviews. Nurse #9 stated she assisted during the exam of Resident #10 for the on-call provider's video visit. Nurse #9 reported she interviewed Resident #6 and he told her that he hit Resident #10 because he did not want her in his room. Nurse #9 indicated she was aware Resident #6 had a past history of aggressive behaviors. The provider's note for Resident #6 completed by Physician #2 dated 11/24/25 at 9:16 PM stated Resident #6 was evaluated via telehealth with the DON present and assisting with the exam. Resident #6 reportedly hit another resident, returned to bed, and had no further contact. Resident #6 was negative for acute symptoms and<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | was to remain in the facility and be monitored for mood and behaviors. The provider's note for Resident #10 completed by Advanced Practice Nurse #3 dated 11/24/25 at 8:19 PM stated Resident #10 had swelling and bruising of the upper lip and a small cut to the upper right side of her lip. She was calm and made no complaints of pain. The provider's note stated the injuries were consistent with being struck in the mouth with a closed fist. The resident's vital signs were normal. No new orders were issued, and she was to remain at the facility under observation. The facility's investigation report dated 11/27/25 completed by the Administrator stated Resident #10 required no further treatment. Resident #6 denied hitting Resident #10 and stated he only told her to get out. Corrective actions included placing Resident #6 on 1:1 observation for 24 hours, then reducing to checks every four hours for 48 hours and a STOP sign was placed on the doorway of Resident #6's room.A Psychiatric Nurse Practitioner's note for Resident #6 completed by Psychiatric Nurse Practitioner #2 dated 11/27/25 at 8:00 AM stated Resident #6 denied hitting Resident #10 and smiled during the interaction. The Psychiatric Nurse Practitioner educated him that physical aggression was not permitted. No changes to the plan of care were recommended.An Initial Report dated 1/8/26 at 9:00 PM completed by the Administrator for an allegation of resident-to-resident abuse stated Resident #6 spat on, cursed at, and punched Resident #10 when she wandered into his room. The incident was witnessed by Resident #6's roommate, Resident #124. Resident #10's lip cut was treated with topical ointment and she resumed usual activities. Resident #6 was moved to another hall, encouraged to engage in activities, and placed on 1:1 supervision immediately. The report stated Resident #6 told staff he didn't mean to hurt her and just wanted her out of his room.A telehealth note completed by On-Call Provider #3 dated 1/9/26 at 12:35 AM stated Resident #10 had swelling and bleeding of the lip and jaw. Vital signs were normal. Resident #10 was alert but confused. The plan was to order a jaw x?ray and have staff notify a clinician if there were any changes in condition.A medical provider's note for Resident #10 completed by Nurse Practitioner #1 dated 1/9/26 at 10:30 AM stated Resident #10 was seen for follow?up related to injuries from the assault, noting she was assaulted by the same resident (Resident #6) two months prior. Medication changes included scheduling acetaminophen for pain, as she was unable to communicate pain reliably. Cold compresses were ordered, and additional safety measures were recommended, including consideration for placement in a locked Alzheimer's Unit.A nurse's note dated 1/9/26 at 6:47 AM completed by the Director of Nursing indicated Resident #10 showed no signs of distress. Swelling, bruising, and a gash were present on her upper lip, and swelling was noted to the right eyebrow.An interview with the Director of Nursing (DON) was conducted on 2/16/26 at 10:45 AM. The DON reported she previously served as the Evening/Nights Supervisor and recently assumed the DON role. She stated she was present and working on the unit during the incident on 1/8/26. The DON reported that on 1/8/26, she responded to Resident #6's room when Resident #124 (Resident #6's roommate) put his call light on to report that Resident #6 had hit Resident #10 in the face. The DON assessed Resident #10 and noted she had facial injuries with a swollen lip. She reported that she ensured the residents were safe, separated, and notified the on?call provider. The DON reported she moved Resident #10 to a room on the opposite side of the facility during the night shift on 1/8/26 to reduce the risk of Resident #10 re?entering Resident #6's room. She stated the on?call provider was notified of Resident #6's behaviors, and Resident #6 was sent to the emergency room for evaluation on 1/9/26. She reported Resident #6's roommate, Resident #124, witnessed the incident. Emergency Department documentation for Resident #6 dated 1/9/2026 stated the resident was seen for evaluation of agitation and aggressive behavior. He was awake and alert but uncooperative and spat at staff. He received 10 mg olanzapine (antipsychotic medication). Labs, an electrocardiogram, and vital signs were normal.A provider's note<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | for Resident #6 completed by Nurse Practitioner (NP) #1 dated 1/12/26 at 9:30 AM stated Resident #6 was medically cleared in the local emergency department, evaluated by psychiatry, had his haloperidol increased and returned to the facility on 1/11/26. Resident #6 continued to be combative following hospital return. He would not cooperate with the exam, was agitated, and was noted to be a danger to other residents, staff, and possibly himself. He remained on 1:1 supervision.A Psychiatric Nurse Practitioner's note for Resident #6 completed by Psychiatric NP #2 dated 1/13/26 at 12:22 AM indicated Resident #6 was sent to the emergency room for evaluation and remained hospitalized from [DATE] through 1/11/26. During his hospitalization, his medications were adjusted, and he was discharged . Resident #6 stated, If she comes here again, I will do it again, and I don't care. He remained on 1:1. Resident #10 had been moved to another unit. Psychiatric NP #2 initiated divalproex sodium (anticonvulsant used as a mood stabilizer) 250 mg twice daily to help stabilize his mood swings and recommended 1 to 1 supervision for one more day; hourly safety checks for three days; safety checks each shift for two weeks; maintaining relocation of the other resident; early de?escalation techniques; and minimizing overstimulation.An x-ray report for Resident #10 indicated it was completed by a mobile radiology service on 1/13/26 at 7:33 AM. The report findings signed by the radiologist on 1/13/26 at 7:54 AM revealed no fractures. A Computed Tomography (CT) scan was recommended if clinically indicated. No further imaging was ordered. b. Resident #117 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease. A provider's admission history and physical note completed by NP #1 on 2/13/26 at 7:40 AM stated Resident #117 was in no distress and was seen while resting in bed. Resident #117 had intact skin and no bruising or lesions were observed. Resident #117 had normal cognition, orientation, insight and judgement, and memory.The Initial Report completed by the Administrator dated 2/13/26 for an allegation of resident-to-resident abuse stated Resident #6 was the aggressor and struck Resident #117. Resident #117 was moved to another room, had no injuries, and went to sleep without issue. Resident #6 was placed on 1:1.An interview and observation were conducted with Resident #117 on 2/18/26 at 4:30 PM. He was observed with no visible injuries to his face, neck, or arms. Resident #117 reported he arrived at the facility on 2/12/26 shortly before lunch. He stated that when he was wheeled into his new room, his roommate, Resident #6, was present lying in bed with his eyes closed. He indicated Resident #6 briefly opened his eyes, waved slightly, and said hello. He stated this was their only interaction prior to going to sleep. Resident #117 reported that around midnight he activated his call light to request that staff lower the room temperature. While waiting, he stated that Resident #6 approached the foot of his bed and began yelling, cursing, and spitting at him. He reported that Resident #6 then moved to the side of the bed and struck him multiple times on the head and upper body. He stated he did not recall whether Resident #6's hand was open or closed when striking him. Resident #117 reported that a female staff member entered the room, instructed Resident #6 to stop, and escorted him into the hallway. He reported he had just arrived at the facility so he did not know any of the staff by voice and could not see clearly to provide a description of which staff came in the doorway and told Resident #6 to stop. Staff then moved Resident #117, in his bed, to another room. When asked whether he felt safe at the facility, Resident #117 responded, No! I do not feel safe here, and I feel like I have to sleep with one eye open. I have no peace here. He stated that, although difficult for him to say, as a man this age, I feel victimized. He reported that because it was sudden and unprovoked, he believed Resident #6 would repeat the behavior if they encountered one another without staff present. During this portion of the interview, Resident #6's voice trembled, he appeared visibly distressed, and his facial expression was downturned.During the telephone interview with Nurse #10 on 2/20/2026 at 11:06 AM she reported that on<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2/13/26 staff came down the hall and stated that Resident #117 put his call light on and when it was responded to the indicated that Resident #6 had hit and spit on him. She did not recall which of the staff members it was. She reported that she had staff immediately remove Resident #6 from the doorway of the room and placed on 1:1 supervision. She indicated that she completed an assessment of Resident #117 and he remained calm and laid in bed during her assessment. She found no injuries and the resident did not report pain. She reported that she had staff move Resident #117 while in his bed to another unit across the facility. Nurse #10 notified the DON and Administrator and reported to the police what Resident #6 told her. She reported Resident #6 claimed he struck Resident #117 because he believed he was going to be kicked. She was unaware of prior incidents involving Resident #6 due to previously being on extended leave. Nurse #10 reported Resident #6 remained on 1:1 observation as of her last scheduled workday, 2/17/26.On 2/16/26 at 1:12 PM Resident #6 was observed lying in bed with staff at bedside providing 1:1 observation. Resident #6 acknowledged the surveyor but would not engage or respond when asked for an interview and turned over in bed and closed his eyes.A provider's note for Resident #6 completed by Nurse Practitioner #1 dated 2/13/26 at 8:15 AM stated Resident #6 was sitting in a wheelchair during exam with a staff member monitoring him. He reported his roommate tried to kick him when he adjusted the thermostat, so he (Resident #6) spit on and punched him. No visible injuries were noted.A provider's note for Resident #117 completed by Nurse Practitioner #1 dated 2/13/26 at 8:30 AM stated Resident #117 reported he was spat on and struck three times in the right cheek. No injuries or marks were observed. No new orders.An interview with the Psychiatric Nurse Practitioner (NP) was conducted on 2/18/26 at 3:48 PM. The Psychiatric NP reported Resident #6 had diagnoses of bipolar disorder and schizophrenia and his mood swings were related to bipolar disorder. She reported Resident #6 was aware and cognizant of his actions during the incidents (11/24/25, 1/8/26, and 2/13/26) and would likely respond the same way again if someone entered his environment and he was not redirected by staff. The Psychiatric NP reported she adjusted Resident #6's mood stabilizer on 2/13/26 in response to his continued aggressive behaviors. She stated that his earlier behaviors had appeared to be reactions to Resident #10, but she now believed the aggression was triggered by anyone altering or stressing his environment. The Psychiatric NP reported Resident #6 refused to discuss the 2/13/26 incident with her or other staff.An interview with the Medical Director was conducted on 2/19/26 at 10:10 AM. The Medical Director reported he was aware of the incidents on 11/24/25, 1/8/26, and 2/13/26 involving Resident #6 and other residents. He reported he was not aware of any severe injuries to Resident #10 or Resident #117 but stated his collaborating NP would notify him of any serious injury and he would conduct an on?site evaluation. He stated Resident #6 was followed by psychiatry and that he and the Psychiatric NP collaborated on care management. He reported Resident #6 was cognitively intact and had the ability to refrain from violent behavior but had developed a pattern of striking out when he did not get his way. He stated he did not believe Resident #6 felt threatened during the incidents but did not want other residents to enter his room. The Medical Director stated that close observation and monitoring were the most effective interventions to protect other residents. He stated redirection and reducing the risk of wanderers entering Resident #6's environment were preferred strategies over increasing medications to avoid overmedicating Resident #6. He explained that the facility attempted to avoid over-medication to prevent cumulative side effects. He reported he had no concerns about Resident #6's safety in the facility and that the NP would continue to see Resident #6 as needed. The Medical Director reported that the facility attempted to keep all residents safe from abuse.An interview with the Administrator was conducted on 2/17/26 at 2:30 PM. She reported she was not present for the incidents on 11/24/25, 1/8/26, or 2/13/26.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | She stated she was aware of Resident #6's aggressive behaviors before and since the incidents on 11/24/25, 1/8/26, and 2/13/26. She reported that the facility implemented 1:1 observation and later close supervision for several weeks following the 11/24/25 incident. She stated that after the 1/8/26 incident, 1:1 observation was put in place and remained in place for a few days after her returned from the hospital. She reported Resident #6 was placed on 1:1 observation after the 2/13/26 incident and remained on 1:1 at present. She reported Resident #6 would be more appropriate for an assisted living setting or small group home with fewer environmental stressors and that they had been referring the resident to other facilities but none of the referrals had been accepted.A follow?up interview with the Administrator was conducted on 2/19/26 at 2:30 PM. The Administrator reported that Resident #6 would remain on 1:1 observation and close supervision as long as he posed a safety risk to other residents, himself, or staff. She reported the facility worked to keep all residents at the facility safe and free from abuse. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident, staff, and Nurse Practitioner (NP), the facility failed to administer oxygen as ordered by the physician for 1 of 3 residents reviewed for respiratory care (Resident #59). The findings included:Resident #59 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure.Review of physician orders dated 10/02/2025 revealed an order for oxygen at 3 liters per minute via nasal cannula continuously for shortness of breath.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #59 was cognitively intact, received oxygen therapy and utilized a non-invasive mechanical ventilator.Observations of Resident #59's oxygen via nasal cannula connected to the bedside oxygen flowmeter revealed the oxygen was set at 2 liters per minute on 02/16/2026 at 11:00 AM, 02/17/2026 at 10:00 AM, and 02/18/2026 at 10:00 AM.An interview with Resident #59 was conducted on 02/16/2026 at 10:30 AM. Resident #59 stated her oxygen was supposed to be set at 3 liters per minute. She reported she was unsure how long she had not received 3 liters Resident #59 stated that when she was placed in her wheelchair, nursing staff sometimes set the oxygen at 2 liters instead of the prescribed 3 liters. Resident #59 stated staff informed her of the oxygen setting and the amount remaining in the tank, as the equipment is positioned behind her wheelchairReview of Resident #59's electronic Medication Administration Record (eMAR) revealed that Nurse #6 documented that the resident received oxygen at 3 liters per minute in accordance with the physician's order on 2/16/2026, 2/17/2026 and 2/18/2026 for first shift and Nurse #7 documented that the resident received oxygen at 3 liters per minute in accordance with the physician's order on 2/17/2026 and 2/18/2026 for the night shift. Review of the nurse assignment sheets reflected Nurse #6 was assigned to Resident #59 on first shift and Nurse #7 was assigned on third shift on 02/16/2026, 02/17/2026, and 02/18/2026.An interview conducted with Nurse #6 on 02/18/2026 at 11:15 AM revealed she was assigned to and responsible for the care of Resident #59 on 02/16/2026, 02/17/2026, and 02/18/2026 during first shift. Nurse #6 verified that Resident #59's oxygen was observed set at 2 liters per minute via nasal cannula connected to the bedside oxygen flowmeter at the time of observation. Nurse #6 confirmed the physician order indicated oxygen was to be administered at 3 liters per minute continuously. Nurse #6 stated Resident #59 told her a few months ago to set the oxygen at 2 liters, reporting that the resident was familiar with that setting from home use. Nurse #6 stated Resident #59 had been receiving 2 liters previously and she was unaware of the updated order requiring 3 liters per minute. Nurse #6 stated Resident #59 had not complained of pain or shortness of breath. Nurse #6 further stated the electronic Medication Administration Record (eMAR) allows staff to document oxygen administration by selecting yes if oxygen was administered or no if it was not administered in accordance with physician orders. Nurse #6 indicated oxygen had been documented as yes (administered), as she believed the resident was receiving 3 liters per minute as ordered.On 02/18/2026 at 11:45 AM, Nurse #6 stated Resident #59's bedside oxygen equipment was not functioning properly. Nurse #6 reported the oxygen regulator was turned to the highest setting however, it was only delivering 2 liters per minute instead of the physician orders of 3 liters per minute. Nurse #6 stated she replaced the oxygen tank with a new tank, which functioned properly. Nurse #6 further stated she documented her concerns regarding the resident not receiving the prescribed amount of oxygen in the facility's medical provider communication binder to notify the Nurse Practitioner (NP) of the non-emergent issue.An interview with Nurse #7 was conducted on 02/19/2026 at 12:33 PM and revealed she was assigned to and responsible for the care of Resident #59 on third shift of 02/17/2026 and 02/18/2026. Nurse #7 stated she documented oxygen as<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Accordius Health at Concord | 515 Lake Concord Road NE<br>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) |
|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | administered because she believed Resident #59 was receiving 3 liters per minute as ordered.An interview with Unit Manager #1 was conducted on 02/19/2026 at 12:55 AM. Unit Manager #1 stated if oxygen was set at the wrong liter flow, it was to be fixed immediately, and nursing staff should follow up by routinely checking the oxygen settings and verify the correct liter flow during rounds. Unit Manager #1 stated she also checked oxygen settings when completing her rounds and had not previously noticed an incorrect liter setting for Resident #59. An interview with the Nurse Practitioner (NP) was conducted on 02/19/2026 at 1:35 PM. The NP stated she reviewed the patient communication binder on 02/19/2026 located at the nurses' station for non-emergent concerns. The NP reported she observed documentation in the communication binder regarding Resident #59's oxygen being set at the incorrect liter flow. The NP stated she reviewed Resident #59's oxygen saturation levels, which appeared stable and above 92%. The NP further stated she asked Resident #59 whether she had adjusted the oxygen setting herself, and the resident stated she had not. The NP stated that because Resident #59 has Chronic Obstructive Pulmonary Disease (COPD), the oxygen must be maintained at the prescribed liter flow to support breathing.An interview with the Director of Nursing (DON) was conducted on 02/18/2026 at 2:00 PM. The DON stated she had not been made aware that Resident #59's oxygen was set at an incorrect liter flow. She stated nursing staff should notify the on-call physician or Nurse Practitioner if oxygen was found to be administered at an incorrect setting.An interview with the Administrator was conducted on 02/18/2026 at 2:15 PM. The Administrator stated she was unaware that Resident #59's oxygen was not being administered at the prescribed liter flow. The Administrator stated it was the expectation that all staff follow physician orders. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345130 | A. Building<br>B. Wing | 02/27/2026 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to follow the planned menu for residents prescribed a mechanically altered diet during 2 of 2 lunch meal observations. This deficient practice affected 1 of 5 residents observed on mechanically altered diets (Resident #78) and 23 other residents who were prescribed a mechanically altered diet. Findings included: Resident #78 was admitted to the facility on [DATE] with diagnoses including protein calorie malnutrition, lipoprotein deficiency (inherited metabolic disorder where a defective gene prevents the body from producing the enzyme needed to break down dietary fat), and dysphagia (difficulty swallowing). The significant change Minimum Data Set (MDS) dated [DATE] indicated Resident #78 was severely cognitively impaired. The MDS was coded for Resident #78 receiving a mechanically altered diet. Review of the physician order dated 1/7/2026 indicated Resident #78 required a mechanically altered diet with thin liquids for diagnosis of dysphagia. The diet spread sheet for therapeutic diets for the lunch meal on 2/16/2026 revealed mechanically altered diets were to receive seasoned sauteed zucchini (soft, cooked and fork mashable) as their vegetable and apple sauce for dessert for their lunch meal. The Diet Type Report revealed there were 24 residents on mechanically altered diets.Resident #78 was observed in the main dining room on 2/16/2026 at 11:57 AM. Resident #78's tray ticket indicated she was on a regular, mechanically altered diet with thin liquids. Her lunch meal consisted of herb roasted pork chopped, pasta alfredo, broccoli with mixed vegetables, and tropical fruit. There was no evidence of seasoned zucchini or apple sauce on Resident #78's meal tray. Resident #78 was observed in the main dining room on 2/17/2026 at 12:00 PM. The diet spread sheet for the lunch meal indicated mechanically altered diets and Resident #78 should receive turkey cutlet ground with gravy, mashed potatoes, cut green beans (soft, cooked and fork mashable) and cherry cobbler for dessert. Resident #78's meal tray was observed with turkey cutlet with gravy chopped, red whole sliced potatoes, broccoli, and a cookie for dessert. During an interview with the Dietary Manager on 2/18/2026 at 2:34 PM, she indicated she was aware of Resident #78's mechanically altered diet. She stated Resident #78 had received the wrong vegetables and wrong dessert. The Dietary Manager confirmed that all residents who were prescribed a mechanically altered diet, 24 total residents, received the wrong vegetables and wrong dessert on 2/16/2026 and 2/17/2026. The Dietary Manager stated the expectation was to serve what is on the menu. The Dietary Manager added that when items were not in supply, they must adjust the menu. During an interview on 2/17/2026 at 12:25 PM, the Regional Dietary Manager indicated the facility had run out of food and this was why there were changes made in the menu. The Regional Dietary Manager confirmed 24 total residents prescribed mechanically altered diets did not receive the correct vegetable or dessert for their lunch meal. During an interview with the Administrator on 2/18/2026 at 2:49 PM she stated her expectation was the facility dietary staff follow the menu as planned. She further revealed that if there are changes to the menu the facility dietary staff should log those changes and notify the residents. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations and staff interviews, the facility failed to label and date leftover food stored for use, discard food past its use-by-date and discard food showing signs of spoilage in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents. The findings included:a. During an initial observation of the facility's kitchen with the Regional Dietary Manager and the Dietary Manager on 2/16/2026 at 9:52 AM, the walk-in freezer was noted to have the following concerns: - An opened unsealed package of chicken tenderloins with signs of frost bite spots and discolored grayish brown patches; - An opened, unlabeled, and unsealed package of chicken breasts with signs of frost bite spots and discolored grayish brown patches; - One opened, unlabeled, unsealed box of chocolate chip cookies with signs of frost bite spots and discolored grayish brown patches and; - One opened, unlabeled, unsealed package of biscuit dough with ice crystal formation. b. During an initial observation of the facility's kitchen with the Regional Dietary Manager and the Dietary Manager on 2/16/2026 at 10:00 AM the walk-in refrigerator was noted to have the following concerns: - An opened and unlabeled 5-pound (lb.) bag of parmesan fancy shredded cheese; -An opened, unlabeled, and unsealed box of herb thyme with signs of spoilage (brownish/ blackish in color) and; -An open, 1-quart size of pimento cheese spread with use by date of 2/2/2026. An interview was conducted with the Dietary Manager on 2/18/2026 at 2:34 PM. The Dietary Manager stated that labels and dates on open food items should be checked weekly. The Dietary Manager further stated the items in the walk-in freezer should not have been opened and needed to be discarded. The Dietary Manager stated items in the walk-in cooler and in the walk-in refrigerator should have an open date, be closed and sealed in both areas. She further indicated whenever a staff member used an item they were to label when opened and the item should be closed. An interview with the Administrator on 2/18/2026 at 2:49 PM revealed all food and beverage items should be dated when they were opened, food with signs of spoilage should be discarded, and food items should be used or discarded according to use-by policies. She further stated the dietary department was responsible for food storage and safety daily. |