STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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	345179	A. Building B. Wing	07/11/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to provide notification of an accident that resulted in Resident #3 being hit in the eye area with the mechanical lift handle causing a skin tear with a small amount of bleeding that required a wound covering to the resident's family member or resident representative for 1 of 4 residents reviewed for notification of change (Resident #3).Resident #3 was admitted to the facility on [DATE] with diagnoses that included epilepsy, type II diabetes mellitus, atherosclerotic heart disease, and hypertension.Review of Resident #3's quarterly Minimum Data Set assessment dated [DATE] revealed him to be cognitively intact.Review of Resident #3's electronic health record revealed Family Member #1 as his resident representative.Review of facility incident accident logs revealed an incident with Resident #3 on 04/20/25. Per the facility's handwritten incident/accident report, Resident #3 suffered a skin tear to his left eye area after the top handle of the mechanical lift hit him. The report indicated that the hall nurse was alerted to the incident and when she entered the room, Resident #3 was still in the mechanical lift with a noted skin tear with scant bleeding to his left upper eyelid. Per the report, 2 nurse aides (NA #5 and NA #6) stated that Resident #3 was hit with the mechanical lift handle during a transfer. The incident report indicated that the physician was notified and Resident #3's skin tear was treated by cleaning the area with sterile water, was patted dry, and a steri-strip bandage was applied. The incident report indicated that the family or resident representative was not notified at the time of the incident. There was a place on the incident report for the nurse completing the report to write in which family member or resident representative was contacted, time and date of the contact, and the name of the staff member that contacted the family member or resident representative. These areas on the incident report were the only areas not completed and left blank. The report was completed by Nurse #5.An interview with Resident #3 on 06/25/25 at 11:01 AM revealed he was being transferred via mechanical lift from his bed into his chair on 04/20/25 when he was hit above his left eye. He stated there were 2 staff members in the room at the time, though he could not recall their names. He indicated he had a cut above his left eye from the incident. Resident #3 reported he did not know if his family was notified of the incident.An interview with Nurse Aide (NA) #5 on 06/25/25 at 2:49PM via telephone call revealed she was present when Resident #3 suffered a skin tear during a mechanical lift transfer. She stated she was operating the mechanical lift with NA #6 and they had lifted Resident #3 out of his bed and were lowering him into his chair. She reported as they got Resident #3 almost completely lowered, NA #6 reportedly tried to adjust Resident#3 into a better seated position and when she pulled on one of the mechanical lift pad straps, the mechanical lift tipped to the side and one of the handles grazed Resident #3 above his left eye causing a skin tear. She reported after the incident that the hall nurse, whom she could not recall, was immediately notified and the wound was treated. NA #5 stated as a nurse aide, she was only responsible for notifying the nurse of any injuries and did not know if Resident #3's family or resident representative was notified.An interview with NA #6 on 06/25/25 at 3:03 PM via telephone call revealed she was working with NA #5 on 04/20/25 to transfer Resident #3 from his bed to his chair via mechanical lift. She stated as they were lowering Resident #3 into the chair, she noticed that he needed to be adjusted further back into the chair and when she went to adjust him, the mechanical lift tipped to the side, and he was grazed above his left eye causing a small skin tear. She stated they immediately notified the nurse who came and assessed Resident #3, cleaned the wound and placed a bandage over the area. NA #6 reported she did not notify Resident #3's family or resident representative as she believed that it was the responsibility of the nurse to notify the physician and family know of incidents after the occurred.Multiple attempts to locate and interview Nurse #5 were unsuccessful.Multiple attempts to speak to Family Member #1 were made but unsuccessful.An interview with the Former Director of Nursing was conducted 06/26/25 at 11:21 AM via telephone call revealed she vaguely recalled the incident. She reported, if she remembered correctly, she was at home when the incident occurred and came into the building to complete an investigation. She reported that her staff were expected to complete the incident/accident report in its entirety and reported that although she could not state for certain whether or not Resident #3's family was notified, she stated she would have to assume they were not since the incident report did not have the required information on who was notified along with the date, time, and who notified the family or resident representative.Multiple attempts to reach the Former Administrator via telephone were unsuccessful

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to implement care planned interventions by not placing a fall mat at the bedside of a resident with a history of falls. This occurred for 1 of 3 residents reviewed for care plan implementation (Resident #2). Findings Included: Resident #2 was admitted to the facility on [DATE] with Parkinson’s disease, epilepsy and dementia. A care plan revised on 5/7/25 indicated Resident #2 was at risk of falls related to cognitive impairment and impulsively attempting to get up without assistance at times. An intervention noted was to have a fall mat at the right side of the Resident’s bed. Review of the Quarterly MDS assessment dated [DATE] revealed Resident was cognitively intact. On observation of Resident #2 on 6/26/25 at 10:45 AM, Resident was asleep in the center of her bed, the bed was in the lowest position and the left side of bed was against the wall. The head of the bed was elevated approximately 30 degrees. There was no fall mat on the floor at right side of the bed. On observation of Resident #2 on 6/26/25 at 11:45 AM, Resident was asleep in center of her bed, the bed was in the lowest position and the left side of the bed was against the wall. The head of the bed was elevated approximately 30 degrees. There was no fall mat on the floor at right side of the bed. In an interview with Nurse Aide (NA) #3 on 6/26/25 at 12:00 PM, NA #3 informed that he did not know Resident #2 yet as it was his first day working at the facility. NA #3 stated that the nurse assistants look at the care guide to obtain needed information regarding Resident care and they also got needed information from their shift change report at the beginning of their shift. NA #3 informed that fall precaution information was obtained from the care guide. NA #3 stated that he had not seen the directive regarding the fall mat to be at the Resident’s right side of the bed but that he would inform the nurse and would place the fall mat down. On 6/26/25 at 12:10 PM an interview with Nurse #1was conducted. Nurse #1 informed that Resident #2 was usually cooperative but that she was impulsive and tried to get up sometimes without help. Nurse #1 stated that Resident #2 was confused sometimes and at other times was more alert, usually got up out of bed every day. Nurse #1 stated this morning Resident #2 was sleeping more because she had a seizure last night but her vitals have been stable and she was able to take her morning medications. Nurse #1 informed that NAs and Nurses obtained information regarding fall precautions from the care plan and the care guide. Nurse #1 could not remember if Resident #2’s fall mat was present this morning. Nurse #1 added that Resident#2 had a seizure last night it may have been moved but it should have been present. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview with the Director of Nursing (DON) and the Administrator on 6/26/25 at 2:00 PM, they both stated that NAs and Nurses obtained Resident care information from shift report as well as from care plans and the care guides. The Administrator and DON informed that a fall mat should have been present for Resident #2 with her history of falls and that it was the responsibility of all nursing staff to ensure that fall mats were on the floor beside the bed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, family, staff interviews and physician interviews, the facility failed to provide care in a safe manner when Resident #1 fell out of her bed during incontinent care. Resident #1 fell from an elevated bed position hitting her head and reported immediate pain in her right lower extremity upon falling. Resident #1 was subsequently transported to the Emergency Department via ambulance and was diagnosed with a right leg bone fracture. The facility also failed to provide a transfer in a safe manner when Resident #3's left eyebrow area was grazed with the mechanical lift during a transfer causing a skin tear. The deficient practice occurred for 2 of 3 residents reviewed for supervision to prevent accidents (Resident #1 and Resident #3). Findings included: 1.Resident #1 was admitted to the facility on [DATE] with diagnoses of cerebral vascular accident (a stroke) with left sided hemiparesis and hemiplegia (weakness and paralysis), left above the knee amputation, type II diabetes, hypertension, depression and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #1 was cognitively intact and was dependent requiring assistance with 2 or more staff for bed mobility and dependent for toileting/incontinent care. Resident #1’s revised Care Plan dated 4/1/25 noted focus areas for falls. Additionally, there was a care plan focus related to activities of daily living performance deficit with interventions revised on 5/7/25 that read; Bed mobility, toileting, hygiene, dressing, bathing: resident requires substantial to total dependance on 1-2 staff. Physician orders showed an active order dated 8/1/24 for Eliquis 5 mg (Eliquis is a blood thinning medication that helps prevent blood clots and mg is short for milligram and is a unit of measurement for certain medications) one tablet by mouth daily for blood clot prevention related to her history of stroke. Review of Resident #1’s Medication Administration Record (MAR) of May 2025 revealed that she had received all of her ordered doses of Eliquis up to and including her dose at 9:00 AM on 5/29/25. A Nursing Progress note dated 5/29/25 by Nurse #1 at 9:41AM read Resident #1 fell out of bed during a bed bath and hit her head on the floor and Nurse Aide (NA) #1 had called for help. Resident #1 was noted to be awake and complaining of pain to her right leg and she was being sent to the hospital by EMS (Emergency Medical Services) for evaluation. Resident #1’s responsible party was notified of event. (continued on next page)

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	345179	A. Building B. Wing	07/11/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of incident reports showed an incident report for falls was completed by Nurse #1 for 5/29/25 at 9:48 AM for Resident #1’s fall. The incident report indicated that NA #1 was giving Resident #1 a bed bath, the Resident was holding on to the privacy curtain and her right leg slipped off the bed. Resident #1 had a left leg amputation to her knee and was not able to balance herself which caused her to fall off the bed and hit her head on the floor. Resident #1 stated that she “told the aide that she was about to fall but the aid couldn’t catch her”. The incident report also indicated that neurological checks commenced, vital signs and limbs were assessed and that the Resident was stabilized in her position while they awaited EMS because she reported pain in her right leg. A phone interview was conducted on 6/25/25 at 11:09 AM with NA #1. NA #1 informed that she was Resident #1’s nurse assistant on 5/29/25 when the fall occurred. NA #1 stated she had worked at the facility for approximately 7 months and had the same assignment for the duration so she knew Resident #1 very well. NA #1 indicated that because she took care of Resident #1 so frequently they “had a very regular routine”. NA #1 informed that Resident #1 did not like to be in the lift for transfer and usually refused the lift. NA #1 stated that Resident #1 would ask for bed baths rather than be transferred by the lift to the shower/spa room for her bath. NA #1 said that she would roll Resident #1 over to her left side and Resident #1 would usually be able to assist by holding onto the bed or privacy curtain. NA #1 reported that the bed was elevated to waist height during the bed bath. While she was cleaning Resident #1’s back, the Resident had a bowel movement. NA #1 reported that she immediately proceeded to re-clean the Resident but that instead of Resident #1 holding on to the privacy curtain like she always did, the Resident was startled and “let go of everything including the curtain and rolled off the right side of the bed”. NA #1 reported that Resident hit her head when she fell. NA #1 stated that she asked the Resident if she was ok and “made sure she was alert and awake and breathing”, then she went to get help. NA #1 stated she got assistance from staff that were working at that time which included several nurses and another nursing assistant. Resident #1 was assessed by the nurses and the supervisor and provider were notified. In an interview on 6/25/25 at 12:05 PM with the Director of Nursing (DON), the DON informed that she was present at the facility when the fall occurred and was notified. The DON informed that the standard of care was for Resident #1 to have two-person assistance for bed baths. The DON informed that education was reinforced with NA #1 and other staff. The DON informed that Resident #1 was transferred to the hospital that same day and informed that she thought the Resident sustained a fracture but she was not sure about that. On 6/25/25 at 2:30 PM an interview with the Wound Care Nurse was obtained. The Wound Care Nurse informed that on 5/29/25 she responded to a request for assistance immediately following Resident #1’s fall. The wound care nurse said that Nurse #1 and the previous Nurse Manager (who no longer works for the organization) and several other nurses responded as well. The Wound Care Nurse stated that she did not remember the names of the other nurses as they were agency staff. Resident #1 was assessed and was awake throughout, but she reported pain in her leg. The Wound Care Nurse stated that staff deliberated on whether to get Resident back into the bed because Resident #1 was calling out to put her back in bed but the decision was made to await EMS and so that is what they did. (continued on next page)

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	345179	A. Building B. Wing	07/11/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a phone interview with NA #2 on 6/25/25 at 3:05 PM NA #2 confirmed that he responded to NA #1’s call for assistance following Resident #1’s fall out of bed on 05/29/25. NA #2 informed that the Resident was awake and alert but did report pain in her leg. NA #2 reported that Resident #1 was repeatedly asking to be put back in her bed but that he told her he had to wait until she was assessed by the nurse or by EMS. NA #2 reported that EMS arrived approximately 20 minutes later and the Resident was transported to the hospital. NA #2 reported he had taken care of Resident #1 before and that she was total care for getting up and for activities but that she could roll herself in bed with one person assisting and when he took care of her, he was usually able to perform her care by himself. A 6/25/25 phone interview at 3:30 PM with former Unit Manager revealed that on the morning of 5/29/25 the Wound Care nurse told her that a Resident had fallen, and the NA was asking for help. The former Unit Manager reported that upon entering the room, she saw Resident #1 lying on the floor, her bed was elevated. She asked NA #1 what happened. NA #1 told her Resident #1 “turned and rolled and she couldn’t catch her”. The former Unit Manager confirmed that Nurse #1 immediately began assessing her. The former Unit Manager reported that she observed the bed was in the highest position. She reported that Resident #1’s vital signs were stable and that her right leg hurt. The former Unit Manager informed that the providers were notified of the fall and that she requested to have the Resident evaluated at the hospital which the provider agreed to. The former Unit Manager informed that Resident #1 was usually a one person assist, sometimes two and the Resident was able to roll herself with help. The former Unit Manager stated that at the morning meeting the next day, the new Administrator (Admin) informed her that the Resident had a fracture. On 6/26/25 at 1:30 PM an interview with Nurse #1 was conducted. Nurse #1 confirmed she was Resident #1’s primary nurse on 5/29/25 when Resident #1 fell out of bed. Nurse #1 reported that she was called into the Resident’s room on the day of the incident by staff saying NA #1 needed help because the Resident had fallen out of bed. Nurse #1 reported that upon entry into the room, Resident #1 was on the floor. Nurse #1 reported that she began assessing the Resident “with neuro checks, the Resident was awake and alert throughout and vitals were stable”. Nurse #1 confirmed that Resident #1 said she hit her head when she fell. Nurse #1 stated that she assessed Resident #1 and she reported pain in her leg. Nurse #1 reported that they did not move her, they put a new brief on her and covered her and put blankets underneath her so she could be as comfortable as could be while they waited for EMS. Nurse #1 reported that EMS arrived about 20-25 minutes later and took Resident #1 to the hospital. Review of the EMS report from 5/29/25 revealed that on they received a call at 10:33 AM, dispatched at 10:37 AM and arrived at the patient at 10:43 AM. Resident #1 was found lying on the floor upon arrival, with pillows under head and that she was covered with blankets. Resident #1 was alert and oriented and she reported severe pain to her right lower extremity. EMS noted shortening and rotation of right leg upon arrival. EMS notes indicated that EMS staff lifted Resident #1 to the transfer stretcher with a draw sheet once spinal precautions and hip immobilization was achieved. Transfer to hospital then followed. (continued on next page)

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	345179	A. Building B. Wing	07/11/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A history and physical obtained in the emergency room on 5/29/25 indicated Resident #1’s report of rolling and falling out of a raised bed at her nursing home and that she complained of right knee pain. The physical exam showed right upper knee tenderness and swelling. Further review of the 5/29/25 hospital records revealed an x-ray of the right knee showed distal femoral diaphyseal fracture and that bone demineralization present (the femur bone had a fracture in it and the bone itself was weak and brittle). A Computed Tomography scan, or CT scan (a type of x-ray scan) of the head on 5/29/25 showed no head trauma or bleeding, no intraparenchymal hemorrhage, no extra-axial fluid collection, no mass, mass effect or midline shift (no bleeding had occurred). A chest x-ray on 5/29/25 showed cardiomegaly and pulmonary vascular congestion (enlargement of the heart muscle and lung congestion). There was notation of Resident #1’s past history of hypoxic respiratory failure related to a diagnosis of pneumonia in 2024. Resident #1 was admitted to the hospital to ensure stable cardiopulmonary condition, pain control and to obtain an orthopedic consult. Review of an Orthopedic progress note on 6/3/25 indicated that Resident #1 had just finished eating, was wearing a right knee immobilizer, her pain was controlled with medication. The Orthopedic physical exam showed that Resident #1 had easily palpable pulses in her right foot, she was able to flex and extend her right foot fully, which indicated her right leg and foot were neurologically intact and she had intact sensation. The noted plan was non-operative and for Resident #1 to continue to be non-weight bearing to her right lower extremity, to continue wearing the knee immobilizer at all times, to ice the knee and to continue medical management and treatment per the hospitalist service. The progress note indicated that the orthopedic team had signed off. A repeat head CT on 6/11/25 was negative for bleeding. A repeat right knee x-ray on 6/15/25 showed the distal femur fracture, same as prior. A follow up Orthopedic progress note dated 6/16/25 was reviewed and indicated that a follow up visit was per Resident #1’s request. Orthopedic physician reiterated the plan for non-operative treatment secondary to Resident #1 being notably high risk for surgery and that surgery would not benefit her at this time. The plan was for Resident #1 to follow up with orthopedic team as an outpatient, to continue treatment per the hospitalist service and to continue to be non-weight bearing to the right lower extremity and to wear the right knee immobilizer as able. A hospital progress noted dated 6/26/25 noted that Resident #1 was being planned for discharge but the discharge was cancelled per the Resident #1 and her family’s request that they did not want to return to the same facility. A hospital progress note 7/2/25 noted that Resident #1 was stable for discharge due to non-operative treatment for fracture, stable and chronic cardiopulmonary condition and that case management was working on placement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a phone interview with Resident #1 on 7/2/25 at 2:00 PM, she recalled the events that occurred on 05/29/25. Resident #1 stated she had a bowel movement and NA #1 was changing her “diaper. ” She stated that she has always had 2 people assist her with care even when changing her “diaper” but NA #1 did it by herself on that day. Resident #1 stated NA #1 was on the left side of the bed and she was holding on to the side rail and fell out of the bed on the right side. She stated when she hit the floor she screamed in pain in her right leg. Resident #1 also stated she hit her head when she rolled out of bed and the nurse came in but she was unable to recall the nurse’s name. Resident #1 stated that generally they use the lift to transfer her but this day they did not and they did not use a draw sheet, they just picked her up and put her back to bed. She stated it took EMS about 20 minutes to get to the facility, and she went to the hospital where she had a broken hip bone but the doctor and her family told her she was too weak to have surgery. Resident #1 stated her pain was better, but she had a lot of healing to do. Resident #1 stated she had been waiting on a facility and she hoped to be out of the hospital this weekend. On 6/26/25 at 1:40 PM a joint interview with the DON and Administrator as conducted. The Administrator and DON both confirmed that Resident #1 should have had assistance from two staff members for her bed bath care. The DON stated that NA #1 was educated that she should have had another staff member assisting her based on Resident #1’s care plan and care guide. On 7/7/25 at 1:07 PM a phone interview was conducted with the facility Medical Director. The Medical Director informed that the clinical picture for Resident #1 from what he could remember was that Resident #1 was pleasantly confused at times, but no significant altered mental status, she was overweight, she had impaired mobility. The Medical Director reported that he was not in the facility at the time of the fall but that the DON did call him to inform him that Resident had fallen. The Medical Director informed that when DON called him with the update, the Resident’s family had already decided not to return Resident #1 to the facility, thus he did not receive any report or update from any of the hospital physicians as to her condition after she left the facility. At 11:30 AM on 7/10/25, a phone interview was conducted with the hospital Physician overseeing Resident #1’s hospital care. The Physician informed that Resident #1 was still in the hospital. He reported her femur fracture was consistent with her report of falling from an elevated bed position. The Physician confirmed Resident #1 sustained one fracture to her right distal femur on 5/29/25 and that repeat x-rays were performed on 5/16/25 and 7/8/25 and showed the same right femur fracture. He said she had no other fractures. The Physician confirmed Resident #1’s head CTs on 5/29/25 and 6/11/25 were negative for bleeding. The Physician informed that Resident #1’s chest x-rays which showed pulmonary congestion were chronic and stable. Her pain has been controlled throughout her hospital course, that she was clinically improved and was stable for discharge and awaiting placement at this time. The facility provided the following corrective action plan with a completion date of 5/31/25. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. (continued on next page)

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	345179	A. Building B. Wing	07/11/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/29/2025 at 9:48 am, Resident #1 sustained a fall from the bed while turning and repositioning during a bed bath by Certified Nursing Assistant (CNA #1). According to CNA # 1 the resident lifted her right leg and crossed it over to assist in turning to her side. Additionally, it was noted Resident #1 removed her hand from the bed enabler and grabbed the privacy curtain while in motion. CNA #1 did not instruct resident to continue to use the enabler bar and allowed the resident to continue to hold the privacy curtain. Resident #1 was care planned to be a 1-2 assist with care. CNA #1 was unable to stabilize Resident #1 in time and as a result Resident #1 rolled out of bed and onto the floor. Resident #1 assessed by Unit Manager and Nurse Practitioner. Resident #1 complained of pain; an order was issued to send to the hospital for evaluation. Resident #1 was diagnosed at the hospital with a fracture of the right femur. On 5/29/2025 Certified Nursing Assistant #1 was re-educated by Director of Nursing (DON) to review all residents’ Kardex (Resident Care Guide) for level of assist required prior to providing care. If Kardex does not reflect the level of care status, alert the nurse before providing care to ensure appropriate assistance is provided for all residents. On 5/29/2025 the DON educated CNA #1 to direct residents to utilize bed rails during care. On 05/30/25 Resident #1’s bed mobility status was updated to populate to resident care guide (Kardex) by the Minimum Data Set (MDS) nurse to reflect 2-person assist with ADL care. · Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Root Cause Analysis identified that Resident #1 required extensive assistance of 1-2 staff with bed mobility per care plan, however, this was not populating to the Kardex for staff to see. On 05/30/2025, the MDS Coordinator and DON audited and corrected all resident care plans to ensure the level of activities of daily living (ADL) assistance was accurate and appropriately populated to the Kardex. The MDS Coordinator/designee will ensure that all residents’ Activities of Daily Living (ADL) status and level of assistance are appropriately reflected on the Kardex. This duty began 5/30/25. The facility Administrator instructed the MDS Coordinator on 5/30/25 to update ADL status as needed following each quarterly, annual, and significant changes. · Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 05/30/2025, Education began with all nurses and CNAs, including agency staff on the requirement to review resident's Kardex for level of assist required prior to providing care. If Kardex does not reflect the level of care status, alert the nurse before providing care to ensure appropriate assistance is provided. Any staff not educated in person on 05/30/2025 were educated via phone by the Assistant Director of Nursing. Education for all nurses and CNAs was completed on 5/30/25. · Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. (continued on next page)

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	345179	A. Building B. Wing	07/11/2025

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Accordius Health at Mooresville	752 E Center Avenue Mooresville, NC 28115

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ongoing audits will be conducted once a week for 8 weeks of all new admissions and 5 random residents Kardex’s to ensure that the level of ADL assistance is accurately reflected. DON/designee will conduct 3 random observations of ADL care. Random ADL observation audits are performed to ensure care plans and Kardex are being followed. Observation of appropriate ADL level during care to be done by DON/designee 3 times a week for 8 weeks. On 5/29/25 a plan of correction was completed. On 5/29/25 the facility Administrator made the decision to complete a corrective action plan and present the monitoring tools and review of incidents during QAPI (Quality Assurance Performance Improvement). An Ad Hoc QAPI meeting was held on 05/30/25 with the Interdisciplinary team. The Director of Nursing will review the ADL observations of care audits and any further incidents to ensure continued compliance. Results will be reported in QAPI monthly until substantial compliance is met. The Kardex and the observation of care audits will be included in QAPI and reviewed by the Director of Nursing to ensure compliance. Alleged date of compliance: 5/31/2025 The facility's corrective action plan with a completion date of 5/31/25 was validated on 7/11/25. Review of in-service sign in sheets and interviews revealed staff had received training as specified in the corrective action plan. Observations of the provision of care during the survey yielded no concerns for resident safety. Audits of the care plans, kardex and observations/audits of the provisions of care were reviewed and were completed as specified in the corrective action plan. The corrective action plan completion date of 5/31/25 was validated. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included epilepsy, type II diabetes mellitus, atherosclerotic heart disease, and hypertension. Review of Resident #3’s quarterly Minimum Data Set assessment dated [DATE] revealed him to be cognitively intact with no delusions, behaviors, rejection of care, or instances of wandering. He was coded with an impairment to one side of his upper extremity and impairments to both sides of his lower extremities. Resident #3 was dependent on others for transfers. Review of Resident #3’s care plan, last updated on 01/23/25 revealed a care plan area for “[Resident #3] has an [activities of daily living] self-care performance deficit related to weakness”. Interventions included “extensive assistance with dressing, hygiene, bathing, toileting with one staff assist, and [mechanical lift] with 2 staff assist for transfers”. Review of facility incident accident logs revealed an incident with Resident #3 on 04/20/25. Per the facility’s handwritten incident/accident report, Resident #3 suffered a skin tear to his left eye area after the top handle of the mechanical lift hit him. The report indicated that the hall nurse was alerted to the incident and when she entered the room, Resident #3 was still in the mechanical lift with a noted skin tear with scant bleeding to his left upper eyelid. Per the report, 2 nurse aides (NA #5 and NA #6) stated that Resident #3 was hit with the mechanical lift handle during a transfer. The incident report indicated that the physician was notified and Resident #3’s skin tear was treated by cleaning the area with sterile water, was pat dry, and a steri-strip bandage was applied. The incident report was completed by Nurse #5. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An observation and interview with Resident #3 on 06/25/25 at 11:01 AM revealed he was being transferred via mechanical lift from his bed into his chair on 04/20/25 when he was hit above his left eye. He stated there were 2 staff members in the room at the time, though he could not recall their names. He indicated he had a cut above his left eye from the incident. Resident #3’s left eye area was noted to be healed with no lasting issues. An interview with NA #5 on 06/25/25 at 2:49PM via telephone call revealed she was present when Resident #3 suffered a skin tear during a mechanical lift transfer. She stated she was operating the mechanical lift with NA #6, and they had lifted Resident #3 out of his bed and were lowering him into his chair. She reported as they got Resident #3 almost completely lowered, NA #6 reportedly tried to adjust Resident#3 into a better seated position and when she pulled on one of the mechanical lift pad straps, the mechanical lift tipped to the side and one of the handles grazed Resident #3 above his left eye causing a skin tear. She reported the mechanical lift tipped and then immediately settled back into an upright position. She reported she did not know what caused the mechanical lift to tip to the side as she reported all parts of the mechanical lift were in the correct operating positions with the legs opened. She reported after the incident, the hall nurse, whom she could not recall, was immediately notified and the wound was treated. An interview with NA #6 on 06/25/25 at 3:03 PM via telephone call revealed she was working with NA #5 on 04/20/25 to transfer Resident #3 from his bed to his chair via mechanical lift. She stated as they were lowering Resident #3 into the chair she noticed that he needed to be adjusted further back into the chair and when she went to adjust him, the mechanical lift tipped to the side, and he was grazed above his left eye causing a small skin tear. She reported the mechanical lift leaned to one side and then almost immediately settled back into an upright position. She stated they immediately notified the nurse who came and assessed Resident #3, cleaned the wound and placed a bandage over the area. NA #5 stated she kept an eye on Resident #3 the rest of her shift and did not notice any other injuries or swelling to the area. Multiple attempts to locate and interview Nurse #5 were unsuccessful. A telephone interview with the Former Director of Nursing was conducted on 06/26/25 at 11:21 AM, who was present at the time of the incident on 04/20/25 revealed she vaguely recalled the incident. She reported, if she remembered correctly, she was at home when the incident occurred and came into the building to complete an investigation. She stated she reviewed the mechanical lift for mechanical failure with no issues found and reviewed the straps of the lift pad Resident #3 used with no concerns noted. She reported she believed the nurse involved was an agency nurse and did not have her contact information. She reported after the incident; the facility held in-service training on mechanical lifts and reviewed the competencies of the nurse aides involved. She reported she ultimately could not determine the root cause of the failure which resulted in Resident #3 being hit with the mechanical lift. She did indicate that a resident should not be injured during transfers. Multiple attempts to reach the Former Administrator via telephone were unsuccessful. The facility provided the following corrective action plan with a completion date of 4/23/25. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/20/25 Resident #3 was being transferred to his chair with a mechanical lift by a 2-person assist. While Resident #3 was being transferred with the mechanical lift, Resident #3 obtained a skin tear above his left eye. Nurse Aide (NA) 6 attempted to adjust the sling straps in an attempt to better position Resident #3 when the skin tear occurred. Resident #3 was assessed immediately by Nurse #5 post incident. Nurse #5 observed a skin tear to the left eye of Resident #3 and treatment and monitoring were initiated by protocol by Nurse #5. The facility Wound Nurse monitored area above left eye until resolved. A safety and incident report were completed by the Unit Manager on 5/7/25. Resident #3’s representative was notified by the Unit Manager on 4/21/2025. On 04/20/2025 NA #5 and NA #6 were removed from transfer duties and immediately reeducated on transfer duties on the total mechanical lift use and transfer safety by the Director of Nursing (DON). How will the facility identify other residents having the potential to be affected by the same deficient practice? Root cause analysis determined (NA) # 6 did not remove the sling from the lift prior to repositioning Resident #3 in the wheelchair resulting in the lift bar striking the resident above the left eye. A cross-check of all resident care plans and physician orders and assistive device needs was completed by the MDS coordinator on 4/21/25. No concerns were noted. On 4/21/25 through 4/23/25 observations of transfers were completed on all shifts to identify additional risks the by Director on Nursing. All residents requiring a total mechanical lift were assessed. No other residents were identified to have received unsafe transfers. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? On 4/21/2025 through 4/23/2025 All staff received mandatory in-person retraining on total mechanical lift procedures, 2-person transfers protocol and education not to pull on lift straps per manufacturer’s instructions. Education was completed by the Director of Nursing and Unit Manager. All new staff, agency staff, or staff not educated on 4/21/25 were educated prior to starting the shift by the DON/designee. All facility total lift equipment was inspected by the Maintenance Director to ensure the equipment was functioning correctly. The facility Environmental Services Director inspected all slings to ensure the facility slings were free from damage. All lifts were functioning properly, and all slings were free from damage. Audits were completed 4/21/25. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? The DON/designee will conduct 3 random total lift audits 3 times a week for one month and then one audit once a week for one month. The observation audit tools include 2-person transfer, communication between staff and residents, and equipment safety check. Audit findings will be reviewed during monthly QAPI (Quality Assurance and Performance Improvement). Noncompliance will result in immediate reeducation and disciplinary review if necessary. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/21/25 QAPI meeting was held with the interdisciplinary team to discuss the incident, education and audit tools implemented. Completion date: 4/23/25 The facility's corrective action plan with a completion date of 4/23/25 was validated on 7/11/25. Review of in-service sign in sheets and interviews revealed staff had received training as specified in the corrective action plan. Observations of the provision of care during the survey yielded no concerns for resident safety. Audits of lift transfers were reviewed and were completed as specified in the corrective action plan. The corrective action plan completion date of 4/23/25 was validated.