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	09/11/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to maintain accurate advance directive information throughout the medical record (Resident #50) and failed to have a signed Medical Orders for Scope of Treatment (MOST) form (Resident #13, Resident #74, Resident #84). This deficient practice affected 4 of 8 residents reviewed for advance directives (Resident #50, Resident #13, Resident #74, Resident #84).The findings included: Resident #50 was admitted to the facility on [DATE]. Review of Resident #50’s quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #50 was cognitively intact. Review of the Code Book (a binder that contained paper copies of residents’ advanced directives and code status) revealed Resident #50’s paper medical record contained a signed MOST form that indicated Resident #50’s preference for a DNR (Do Not Resuscitate) status in the event she had no pulse and was not breathing. The form was signed by Resident #50’s Resident Representative and dated 8/25/2025, there was also a Goldenrod Form signed by the provider and dated 8/21/2025. Review of Resident #50’s active Physician’s orders revealed an active order for Full Code. Review of the profile page of Resident #50’s electronic health record on 9/8/2025 at 3:22 PM revealed both Do Not Resuscitate (DNR), and Full Code listed as Resident #50’s code status. During an interview on 9/9/2025 at 12:15 PM Resident #50 stated she wanted her code status to be a DNR. Resident #50 stated she and her family had discussed advanced directives, and Resident #50 made the decision to be a DNR. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/9/2025 at 10:39 AM Nurse #2 stated the code status for a resident was found in the Code Book and the profile page of the resident’s electronic medical record and the resident’s care plan. Nurse #2 verified Resident #50’s profile page contained both DNR and Full Code listed as the current Code status and had an active order for Full Code listed in physician’s orders. Nurse #2 Stated there should not be two code statuses listed on the profile page. Nurse #2 stated that having two on the profile page could have caused an issue and she would make sure the profile page was corrected after the orders were verified. Nurse #2 stated the nurses or unit managers are responsible for entering the updated code status into the electronic health record when the status is changed. Nurse #2 stated when Resident #50’s code status changed the old order should have been discontinued and the old code status removed from the profile page, but it appeared the new status was added to the profile page without the old status being removed. During an interview on 9/9/2025 at 10:50 AM the Unit Manager #2 stated a resident’s code status was found in the Code Book or on the resident’s profile page in the electronic health record and care plan. During an interview on 9/9/2025 at 11:20 AM the Unit Manager #1 stated a resident’s code status was found on the profile page of the resident’s electronic health record and each nurse’s station had a Code Book that contained MOST forms and DNR forms. The Unit Manager #1 stated Resident #50 changed her code status to DNR when she had the procedure in August, prior to the procedure Resident #50 had been a Full Code. The Unit Manager stated normally the old code status was removed from the resident’s profile page when the new code status was entered. Unit Manager #1 stated it was normally her responsibility to update the code status; it could also be updated by the nurses that work on the hall. During an interview on 9/11/2025 at 11:15 AM the Director of Nursing (DON) stated the Unit Managers or hall nurses were responsible to update the electronic health record when a resident’s code status was updated. The DON stated she expected a resident’s code status to be accurate and consistent throughout the resident medical record and that the profile page should not contain two different code statuses. During an interview on 9/11/2025 at 10:35 AM the Administrator stated his expected a resident’s code status to be correct, up to date and consistent through the entire medical record. 2. Resident #13 was admitted to the facility on [DATE] with diagnoses which included paraplegia (paralysis which affects the lower body) and chronic pain. Physician orders for Resident #13 dated 06/02/25 revealed an order for full code. A review of the active care plan revised on 06/02/25 revealed that Resident #13 had goals and interventions for advance directives and was a full code. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #13 was cognitively intact. The Medical Orders for Scope of Treatment (MOST) form completed on 07/12/24 for Resident #13 was found in the advance directive's binder at the nurse's station but had not been signed by Resident #13 or her representative. Resident #13 was a full code per MOST form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Social Worker was conducted on 09/11/25 at 9:11 AM revealed the Social Worker was responsible for the completion of the advance directives. The Social Worker indicated she reviewed the residents’ wishes as part of the admission and then reviewed with the resident or their representative quarterly. The Social Worker stated that she thought the signature was optional since it said at the bottom of the MOST form “you are not required to sign this form to receive treatment”. The Social Worker stated that Resident #13 was alert and oriented and would be able to sign the form. An interview on 09/11/25 at 9:52 AM with the Director of Nursing (DON) indicated it was the responsibility of the Social Worker to obtain the resident's or representative's signature which was required on the MOST form. The DON stated that advance directive forms should be completed fully and accurately, and the signature indicated informed consent. An interview conducted on 09/11/25 at 11:07 AM with the Administrator revealed advance directive forms should be completed accurately. 3. Resident #74 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included Parkinson’s disease and chronic kidney disease. Physician orders for Resident #74 dated 05/28/25 revealed an order for full code. The MOST form completed on 06/05/25 for Resident #74 was found in the advance directive's binder at the nurse's station but had not been signed by Resident #74 or her representative. The Resident Representative name was written in, and it stated “via phone” but did not indicate a date or time that verbal consent was obtained or who obtained the verbal consent. Resident #74 was a full code per MOST form. A review of the active care plan revised 08/19/25 revealed that Resident #74 had goals and interventions for advance directives and was a full code. A review of the quarterly MDS dated [DATE] revealed Resident #74 was severely cognitively impaired. An interview with the Social Worker was conducted on 09/11/25 at 9:11 AM. The Social worker stated she was responsible for the completion of advance directives. The Social Worker indicated she reviewed the residents’ wishes as part of their admission and then reviewed with the resident or their representative quarterly. The Social Worker stated that she thought the signature was optional since it said at the bottom of the MOST form “you are not required to sign this form to receive treatment”. The Social Worker stated that when a verbal consent was obtained, she just writes “verbal” on the MOST form and had not included time, date or who witnessed verbal consent. The Social Worker stated that Resident #74 was severely cognitively impaired and would not be able to sign the MOST form. An interview on 09/11/25 at 9:52 AM with the DON indicated it was the responsibility of the Social Worker to obtain the resident or representative's signature as required on the MOST form. The DON stated that advance directive forms should be completed fully and accurately. The DON stated verbal consent should contain the name of who the consent was obtained from, the date, time, and who witnessed the verbal consent. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted on 09/11/25 at 11:07 AM with the Administrator revealed advance directive forms should be completed accurately. 4. Resident #84 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included end-stage renal disease and diabetes mellitus. A review of the admission MDS dated [DATE] revealed Resident #84 was cognitively intact. A review of the active care plan revised 08/04/25 revealed that Resident #84 had goals and interventions for advance directives and was a full code. The MOST form completed on 08/29/25 for Resident #84 was found in the advance directive's binder at the nurse's station but had not been signed by Resident #84 or her representative. Resident #84 was a full code per MOST form. An interview with the Social Worker was conducted on 09/11/25 at 9:11 AM and revealed the Social Worker was responsible for the completion of the advance directives. The Social Worker indicated she reviewed the residents’ wishes as part of the admission and then reviewed with the resident or their representative quarterly. The Social Worker stated that she thought the signature was optional since it said at the bottom of the MOST form “you are not required to sign this form to receive treatment”. She stated that Resident #84 was alert and oriented and would be able to sign the MOST form. An interview on 09/11/25 at 9:52 AM with the Director of Nursing (DON) indicated it was the responsibility of Social Worker to obtain the resident or representative's signature as required on the MOST form. Advance directive forms should be completed fully and accurately. An interview conducted on 09/11/25 at 11:07 AM with the Administrator revealed advance directive forms should be completed accurately.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to post cautionary signage outside of resident rooms that indicated the use of oxygen for 4 of 5 residents reviewed for respiratory care (Resident #2, Resident #55, Resident #87, and Resident #88).Findings included: 1. Resident #2 was admitted on [DATE] with diagnoses that included heart failure, asthma, and dependence on supplemental oxygen. Resident #2’s physician orders revealed an order dated 09/11/24 for oxygen via nasal cannula as needed for shortness of breath at 3 liters per minute. A review of Resident #2’s care plan updated on 05/28/25 revealed a plan for oxygen therapy for respiratory disease. The stated goal was that Resident #2 would be free from respiratory complications. Interventions included oxygen via nasal cannula as ordered, monitor for signs of respiratory distress and notify provider if indicated, and administer medications as ordered. Resident #2’s admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #2 was severely cognitively impaired, dependent on staff for all activities of daily living, and coded for asthma, heart failure, and oxygen use. An observation of Resident #2 in her room on 09/08/25 at 9:50 AM revealed oxygen concentrator in use via nasal cannula at 3 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #2's room indicating oxygen was in use. A second observation of Resident #2 in her room on 09/08/2025 3:17 PM revealed oxygen concentrator in use via nasal cannula at 3 liters per minute. No cautionary oxygen in use signage outside of Resident #2's room indicating oxygen was in use. A third observation of Resident #2 in her room on 09/09/2025 11:08 AM revealed the oxygen concentrator in use via nasal cannula at 3 liters per minute. No cautionary oxygen in use signage outside of Resident #2's room indicating oxygen was in use. An interview with Nurse #1’s (agency staff) was conducted on 09/09/25 at 9:18 AM. Nurse #1 stated Resident #2 received oxygen continuously. Nurse #1 indicated she did not know who was responsible for applying the oxygen in use cautionary signs to resident rooms. Nurse #1 verbalized she had not noticed that Resident #2 did not have an oxygen in use sign on door. An interview was conducted with the Director of Nursing (DON) on 09/11/2025 9:52 AM. The DON stated that oxygen in use cautionary signage should be posted outside the doors of all residents’ rooms that used continuous or as needed oxygen. The DON verbalized that the facility had to order more oxygen signs because they were out of them. 2. Resident #55 was admitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #55’s physician orders revealed an order dated 2/19/2025 for oxygen continuous at 2 to 3 Liters Per Minute (LPM) via nasal canula every 24 hours as needed. A review of Resident #55’s care plan updated 5/22/2025 revealed a plan for respiratory complications with interventions that included administer medications as ordered, administer oxygen as ordered, head of bed elevated to prevent shortness of breath as tolerated. Resident #55’s quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #55 had moderately impaired cognition, was independent with most activities of daily living, required set up assistance with lower body dressing and personal hygiene and supervisory/touching assistance with toileting hygiene, and coded for chronic obstructive pulmonary disease. An observation of Resident #55 in her room on 9/8/2025 at 1:51 PM revealed oxygen concentrator in use via nasal cannula at 3 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #55's room indicating oxygen was in use. A second observation 9/9/2025 at 10:05 AM revealed oxygen concentrator in use via nasal cannula at 3 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #55's room indicating oxygen was in use. A third observation 9/10/2025 at 9:49 AM revealed oxygen concentrator in use via nasal cannula at 3 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #55's room indicating oxygen was in use. During an interview on 9/10/2025 at 9:59 AM Nurse #2 stated that when a resident is admitted with an order for oxygen, the Unit Manager received the paperwork, entered the order into the electronic health record, the nurse was responsible to have the concentrator and nasal cannula ready, to administer when the resident arrived and to place the oxygen in use sign on the door. Nurse #2 stated that the Unit Managers also help make sure the equipment and signs were on the door. During an interview on 9/10/2025 at 11:27 AM the Unit Manager #1 stated when a resident was admitted with an order for oxygen the nurse on the hall was supposed to put the oxygen in use sign on the resident’s door. The Unit Manager #1 stated she normally tried to double check that the oxygen use signs were in place. The Unit Manager #1 stated they had recently ordered and received more oxygen use signs to make sure they had enough. The Unit Manager placed an oxygen use sign on Resident #55’s door after the interview. During an interview on 09/11/2025 at 9:52 AM the Director of Nursing (DON) stated that oxygen in use cautionary signage should be posted outside the doors of all residents’ rooms that used continuous or as needed oxygen. The DON verbalized that the facility had to order more oxygen signs because they were out of them. During an interview on 9/11/2025 at 10:35 AM the Administrator stated residents that used oxygen should have a sign posted at the door. 3. Resident #87 was admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), pneumonia, and other nonspecific abnormal findings of lung field. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #87’s physician orders revealed an order dated 9/4/2025 for oxygen 2 liters per minute via nasal canula continuous. A review of Resident #87’s care plan initiated 9/3/2025 revealed Resident #87 was care planned at risk for respiratory complications secondary to chronic obstructive pulmonary disease, pneumonia and respiratory failure with interventions that include administer medication as orders, administer oxygen as ordered, head of bed elevated to prevent shortness of breath as tolerated, observe for signs symptoms of respiratory complications An observation of Resident #87 on 9/8/2025 at 11:50 AM in her room revealed oxygen concentrator in use via nasal cannula at 2 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #87's room indicating oxygen was in use. A second observation on 9/9/2025 at 10:05 AM revealed Resident #87 in her room, oxygen concentrator in use via nasal cannula at 2 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #87's room indicating oxygen was in use. A third observation on 9/10/2025 at 9:50 AM revealed Resident #87 in her room, oxygen concentrator in use via nasal cannula at 2 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #87's room indicating oxygen was in use. During an interview on 9/10/2025 at 9:59 AM Nurse #2 stated that when a resident was admitted with an order for oxygen, the Unit Manager received the paperwork, entered the order into the electronic health record, the nurse was responsible to have the concentrator and nasal cannula ready, to administer when the resident arrived and to place the oxygen in use sign on the door. Nurse #2 stated that the Unit Managers also help make sure the equipment and signs were on the door. During an interview on 9/10/2025 at 11:27 AM the Unit Manager #1 stated when a resident was admitted with an order for oxygen the nurse on the hall is supposed to put the oxygen in use sign on the resident’s door. The Unit Manager #1 stated she normally tried to double-check that the oxygen use signs were in place. The Unit Manager #1 stated they had recently ordered and received more oxygen use signs to make sure they had enough. The Unit Manager placed an oxygen use sign on Resident #87’s door after the interview. During an interview on 09/11/2025 at 9:52 AM the Director of Nursing (DON) stated that oxygen in use cautionary signage should be posted outside the doors of all residents’ rooms that used continuous or as needed oxygen. The DON verbalized that the facility had to order more oxygen signs because they were out of them. During an interview on 9/11/2025 at 10:35 AM the Administrator stated residents that used oxygen should have a sign posted at the door. 4. Resident #88 was admitted on [DATE] with diagnoses that included pneumonia, acute respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD). Resident #88’s physician orders revealed an order dated 9/5/2025 for oxygen 10 liters via nasal canula continuous one time a day for COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #88’s care plan updated on 9/8/2025 revealed a care plan for risk of respiratory complications secondary to COPD, respiratory failure, supplementary oxygen requirement with interventions that included administer medications as ordered, administer oxygen as ordered, head of bed elevated to prevent shortness of breath as tolerated, observe for signs and symptoms of respiratory complications. An observation of Resident #88 on 9/08/2025 at 11:36 AM in his room revealed oxygen concentrator in use via nasal cannula at 10 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #88's room indicating oxygen was in use. A second observation on 9/8/2025 at 3:16 PM revealed oxygen concentrator in use via nasal cannula at 10 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #88's room indicating oxygen was in use. A third observation 9/9/2025 at 10:27 AM revealed oxygen concentrator in use via nasal cannula at 10 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #88's room indicating oxygen was in use. During an interview on 9/10/2025 at 9:59 AM Nurse #2 stated that when a resident was admitted with an order for oxygen, the Unit Manager received the paperwork, entered the order into the electronic health record, the nurse was responsible to have the concentrator and nasal cannula ready, to administer when the resident arrived and to place the oxygen in use sign on the door. Nurse #2 stated that the Unit Managers also help make sure the equipment and signs were on the door. During an interview on 9/10/2025 at 11:27 AM the Unit Manager #1 stated when a resident was admitted with an order for oxygen the nurse on the hall was supposed to put the oxygen in use sign on the resident’s door. The Unit Manager #1 stated she normally tried to double-check that the oxygen use signs were in place. The Unit Manager #1 stated they had recently ordered and received more oxygen use signs to make sure they had enough. The Unit manager stated a sign had been placed on Resident #88’s door. During an interview on 09/11/2025 at 9:52 AM the Director of Nursing (DON) stated that oxygen in use cautionary signage should be posted outside the doors of all residents’ rooms that used continuous or as needed oxygen. The DON verbalized that the facility had to order more oxygen signs because they were out of them. During an interview on 9/11/2025 at 10:35 AM the Administrator stated residents that used oxygen should have a sign posted at the door.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 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 interviews, the facility failed to assess a resident for the use of side rails prior to installation of bed rails on the resident's bed for 1 of 1 resident reviewed for side rails (Resident #4).The findings included:Resident #4 was most recently readmitted to the facility on [DATE] with diagnoses that included dementia with behaviors, bipolar disorder, polyneuropathy, and anxiety disorder.Review of Resident #4's annual Minimum Data Set assessment dated [DATE] revealed he was cognitively intact with no delusions, behaviors, rejection of care, or instances of wandering. He was coded as requiring limited assistance with bed mobility and was not using any restraints or alarms.Review of Resident #4's physician orders revealed an order dated 04/07/25 for 1/4 side rails to be up while in bed to promote independence. Review of Resident #4's treatment administration record indicated Resident #4 had side rails installed on his bed on 07/12/25. The treatment administration record for Resident #4's use of side rails was signed off by Nurse #5.Multiple attempts to reach Nurse #5 were unsuccessful.Review of Resident #4's care plans last updated on 07/28/25 revealed a care plan for an activity of daily living, self-care performance deficit related to decreased mobility. The interventions within the care plan included 1/4 side rails while in bed to promote independence.Review of Resident #4's electronic medical health record revealed an assessment titled Side Rail & Entrapment Risk Assessment dated 08/19/25 that showed in progress. Additional review of the assessment revealed that it was a quarterly assessment and side rails would be used for the assistance of turning and positioning.Additional review of Resident #4's electronic medical health record revealed no additional documented side rail assessments, including no initial assessment prior to the installation of Resident #4's side rails on 07/12/25.An observation of Resident #4 completed on 09/09/25 at 9:05 AM revealed he had 1/4 side rails installed and in operation on his bed.Attempts to interview Resident #4 on 09/09/25 at 9:06 AM and 09/11/25 at 10:27 AM were unsuccessful.An interview with the Maintenance Director on 09/10/25 at 4:25 PM revealed he was responsible for the installation and removal of all side rails in the facility. He stated he was typically notified through the electronic maintenance request program utilized by the facility to place maintenance requests. He continued, reporting that he had nothing to do with the completion of side rail assessments prior to the installation of the side rails and that he does not verify the completion of an initial side rail assessment prior to installation of side rails. The Maintenance Director reported he believed Unit Manager #1 would be the staff member responsible for ensuring that an initial side rail assessment was completed prior to the installation of side rails.An interview with Unit Manger #1 on 09/11/25 at 10:36 AM revealed there were multiple staff members who could be responsible for completing an initial side rail assessment including the nurse assigned to the resident upon their admission, herself, or the Director of Nursing. She stated once they receive a physician's order for the placement of side rails, an initial side rail assessment was completed before the Maintenance Director installed side rails onto a resident's bed. The Unit Manager indicated that she did not complete the initial side rail assessment for Resident #4 and that she did not know if anyone had completed his initial side rail assessment prior to the side rails being installed on his bed.An interview with the Director of Nursing on 09/11/25 at 11:39 AM revealed that the facility's unit managers were typically assigned to ensure that initial side rail assessments were completed prior to the installation of side rails. She stated if the unit managers were unavailable or busy, the responsibility would be hers to ensure the side rail assessment was completed. She reported it appeared as though Resident #4 did not have an initial side rail assessment prior to the installation of side rails to his bed. She reported if she had to surmise the reason it was not completed, she would assume it had to do with the amount of agency staff in the building and they probably just did not do the work.An interview with the Administrator on 09/11/25 at 11:51 AM revealed he was very new to the facility and was not familiar with the facility's side rail policy and procedures but stated he expected that an initial side rail assessment be completed prior to the installation of side rails on a resident's bed.

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	09/11/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to remove expired milk from 1 of 1 walk-in refrigerator and 1 of 1 reach-in refrigerator. This failure had the potential to affect all resident who eat food items prepared with milk and all residents who may ingest milk as fluid.The findings included:An observation of the facility's kitchen on 09/08/25 at 10:23 AM revealed one gallon of whole milk with a use by date of 09/02/25 was found in the reach-in refrigerator. The gallon of milk was opened, with approximately 1/5 of it remained and was available for use. Additionally, one unopened gallon of whole milk and one opened gallon of whole milk with expiration dates of 09/02/25 were located in the facility's walk-in refrigerator along with one individual carton of 2% milk with an expiration date of 09/03/25 observed in the same walk-in refrigerator.An interview with the Dietary Manager on 09/11/25 at 10:34 AM revealed the dietary aides were typically responsible for checking the kitchen areas daily for foods that were expired or were approaching their expiration date. The Dietary Manager reported he also goes behind the dietary aides to ensure that they did not overlook any food items that had expired. He stated the failure to remove the expired milk from the reach-in and walk-in refrigerators ultimately fell to him and that he must have overlooked the expired milk when he had checked the kitchen for expired food items last on 09/05/25.An interview with the Administrator on 09/11/25 at 11:51 AM revealed he expected the kitchen should be checked daily for expired food. He reported to prevent excessive food waste he expected the dietary staff to use food on a first arrival, first used approach. The Administrator reported the gallons of milk with expiration dates of 09/02/25 and the individual carton of milk with an expiration date of 09/03/25 should have been removed on their expiration date.

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interviews, the facility failed to implement their infection control policy for Enhanced Barrier Precautions (EPB) when the Wound Nurse did not don (put on) a gown when performing wound care for Resident #44. The Wound Nurse also failed to perform change gloves and perform hand hygiene between wound sites. This occurred for 1 of 3 staff members observed for infection control practices (Wound Nurse).Findings included:Review of the facility's Enhanced Barrier Precautions (EBP) dated 03/28/24 revealed it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident activities such as wound care.A review of the facility's Infection Prevention and Control Policy revised 06/01/23 revealed hand hygiene should be completed after contact with non-intact resident's skin, wound dressings, or contaminated items.A continuous observation of wound care for Resident #44 was completed on 09/10/25 from 9:36 AM through 10:04 AM. Resident #44 had a sign for EBP over the bed which instructed staff to don gloves and a gown for high contact resident care activities which included wound care. Personal protective equipment (PPE) was observed on Resident #44's door. The Wound Nurse performed hand hygiene and donned gloves. The Wound Nurse did not don a gown per the EBP policy. Resident #44 was positioned for wound care and the Wound Nurse cleaned Resident #44's wound to left ischium (lower buttock area above thigh) with gauze. The gauze was noted to have large amount of brown colored drainage on the gauze after cleaning. The Wound Nurse removed the glove from her right hand and discarded it along with gauze but did not remove the glove from her left hand. The Wound Nurse entered the bathroom and performed hand hygiene on right hand only. The Wound Nurse then applied a new glove to her right hand but failed to change the left-hand glove. The Wound Nurse then cleaned Resident #44's sacral wound with gauze. The Wound Nurse cleaned the left ischium wound for a second time with a cotton tipped swab without changing gloves and performing hand hygiene directly after cleaning the sacral wound. The Wound Nurse removed her gloves, then reapplied new gloves without performing hand hygiene. The Wound Nurse then cleaned right ischium wound with gauze and removed her gloves and performed hand hygiene. The Wound Nurse donned new gloves and placed gauze to right ischium wound and applied new bordered dressing. The Wound Nurse removed gloves and performed hand hygiene. The Wound Nurse applied new gloves, placed gauze on sacral wound, applied a new bordered dressing to wound, removed her gloves and performed hand hygiene. The Wound Nurse donned clean gloves, applied gauze and a bordered dressing to Resident #44's left ischium wound. The Wound Nurse removed gloves, discarded trash, and performed hand hygiene to complete wound care. An interview with Wound Nurse was conducted on 09/10/25 at 11:42 AM. The Wound Nurse verbalized understanding that a gown should have been applied as required by the facility EBP policy for wound care. The Wound Nurse stated that she had been educated on EBP when hired and she would normally apply a gown and follow EBP policy for wound care. The Wound Nurse reported that due to nervousness, she had forgotten to apply a gown prior to wound care on Resident #44. The Wound Nurse further stated she was nervous and didn't notice she had not performed hand hygiene between wounds. An interview with the Director of Nursing (DON) (the facility's Infection Preventionist) was conducted on 09/11/25 at 9:52 AM. The DON stated that Resident #44 required EBP due to chronic wounds. The DON verbalized that staff were expected to follow EBP when performing care that required EBP per facility's EBP policy. The DON stated that staff should perform hand hygiene between wounds and changing gloves during wound care per the hand hygiene policy.