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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Charlotte	5939 Reddman Road Charlotte, NC 28212

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51936 Based on record review, resident and staff interviews, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 1 of 1 resident reviewed for safe, clean, comfortable, homelike environment (Resident #71). The findings included: Resident #71 was admitted to the facility on [DATE] with diagnoses which included history of a right above the knee amputation (R AKA) and neoplasm of the brain. The significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #71 was cognitively intact. An interview with Resident #71 on 4/22/2025 at 10:43 AM revealed he was sent to the hospital from the facility on 1/21/2025. When he returned to the facility on [DATE], he found out his belongings had been packed up and removed from his room during his hospital stay. Resident #71 recalled the housekeeping manager brought 2 boxes to his room on 2/6/2025. The boxes were sealed with tape. After unpacking the boxes that evening, Resident #71 stated his Apple iPad Pro, a new bag of white sleeveless t-shirts, a few pairs of pants and his right leg prosthesis were not in either of the 2 boxes. Resident #71 stated it was concerning that his property was gone. Resident #71 indicated he was mostly upset about the loss of the iPad Pro. He stated he no longer used the right leg prothesis and the clothes were already replaced. Resident #71 stated that if the belongings had been packed up by the facility, then the facility should have returned the same items to him. Resident #71 reported the missing items to nursing staff on 2/6/2025 as soon as he realized the items were not in the boxes. He stated he spoke directly to the previous Administrator on 2/11/2025 to follow up on the missing items. Resident #71 filed a grievance with the facility on 3/26/2025 regarding the missing iPad Pro. Resident #71 stated the facility had recently placed a lock on his closet door. A review of the facility grievance report dated 3/26/2025 revealed that Social Worker #1 had met with Resident #71 to discuss the grievance regarding his lost property. Social Worker #1 documented that Resident #71 was unaware of the location of the iPad Pro and unsure when it was exactly misplaced. Social Worker #1 reminded Resident #71 that the matter regarding the iPad Pro had been previously discussed. Social Worker #1 re-educated Resident #71 regarding having pricey items in the facility. Social Worker #1 documented the grievance resolved on 3/28/2025. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/22/2025 at 3:35 PM with NA #2 revealed she cared for Resident #71 routinely. She stated she had never seen Resident #71 with an iPad Pro and had signed statement regarding this for the previous Administrator. She stated she could obtain an empty iPad Pro box like the one Resident #71 had in his room. She reported she had never seen a right leg prothesis. NA #2 stated she was working the day Resident #71 was transferred to the hospital and she requested his family take his personal items with them. NA #2 stated housekeeping is responsible for packing up resident belongings. An interview on 4/22/2025 at 3:40 PM with Unit Manager B/Assistant Director of Nursing (ADON) revealed he knew Resident #71 very well. Resident #71 told him about the items missing from the 2 boxes. He did not know what had happened to Resident #71's property. An interview on 4/22/2025 at 3:51 PM with the Housekeeping Manager revealed he had packed up Resident #71's belongings on 2/6/2025 at approximately 2:00 PM. He stated he remembered this clearly because he had just taken the 2 boxes to his office when he received a text that Resident #71 was returning later that afternoon. The 2 boxes were never taken to the main storage area. The Housekeeping manager stated he packed Resident #71's clothes, a tablet, and a prosthetic leg. He stated he used very strong biohazard tape to seal the boxes and there is no way anyone could have tampered with the boxes. He stated he took the 2 boxes back to the room around 5:00 PM and asked Resident #71 if he would like him to unpack for him. He stated Resident #71 had family/visitors in the room and stated he would unpack himself. He stated he spoke with Resident #71 later regarding the missing items but did not know what had happened as the 2 boxes were sealed when he returned them. An interview on 4/22/2025 at 4:05 PM with Social Worker #1 revealed she assisted Resident #71 in filing a grievance with the facility regarding the missing property. She stated the matter had been handled by the previous Administrator. An interview on 4/23/2025 at 10:37 AM with the Administrator revealed that when residents go to the hospital, they should either take their valuables with them or leave them with the social worker. The Administrator stated he had been working at the facility 3 weeks and spoke with Resident #71 on his second working day regarding the missing items. The Administrator stated Resident #71 told him he may have lost the iPad between the hospital and the facility. The Administrator stated he felt the situation is resolved as Resident #71 lost the item and there was nothing the facility could do about it.