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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, record review, and interviews with resident and staff, the facility failed to ensure dependent residents could access the light switch located behind the bed for 1 of 1 residents reviewed for accommodation of needs (Resident #157). The findings included: Resident #157 was admitted to the facility on [DATE]. Review of Resident #157's medical records revealed she had resided in the current room since 04/09/25. The admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #157 with severely impaired cognition. The MDS indicated walking between locations inside the room for more than 10 feet was not attempted by Resident #157 during the assessment period due to medical condition or safety concerns. During an observation conducted on 04/21/25 at 11:19 AM, the switch for the light fixture that was located behind Resident #157's bed on the wall approximately 5 feet from the floor and 6 feet from the bed and was attached with a broken cord approximately 3 inches in length. Resident #157 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #157 on 04/21/25 at 11:20 AM. She stated she had a stroke recently and was bedbound. She could not recall when the switch cord was broken. She stated she did not have any control of the light fixture behind her bed as she could not stand up to reach the broken switch cord on the wall. She had to rely on nursing staff to control the light fixture and she was tired of asking for help repeatedly. She wanted the maintenance staff to fix the switch cord to accommodate her needs as soon as possible. During a joint observation conducted with the Maintenance Director and Nurse #1 on 04/21/25 at 12:50 PM, the switch cord for the light fixture behind Resident #157's bed remained inaccessible from her bed. Nurse #1 and the Maintenance Director acknowledged that the switch cord needed to be fixed immediately. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Maintenance Director on 04/21/25 at 12:54 PM. He stated he walked through the entire facility at least once per week to check for repair needs. He did not notice the switch cord for Resident #157's light fixture behind her bed was broken during his recent weekly walk through. In most cases, he depended on the staff to report repair needs via work orders electronically or verbal notifications. He checked the work order at least twice daily to ensure all repair needs were addressed in a timely manner. He could not explain why he missed the switch cord for Resident #157 and acknowledged that it had to be fixed immediately. During an interview conducted with Nurse #1 on 04/21/25 at 1:00 PM, she stated she provided care for Resident #157 in the morning, but she did not notice that her switch cord for the light fixture behind the bed was broken and inaccessible. She acknowledged that the broken switch cord needed to be fixed immediately to ensure Resident #157 had full control and accessibility to the light fixture behind the bed all the times. An interview was conducted with the Director of Nursing on 04/22/25 at 1:29 PM. She stated she expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs. It was her expectation for all the dependent residents to have full accessibility and control of the light fixture behind the bed all the times. During an interview conducted on 04/2325 at 5:10 PM with the Administrator, he expected nursing staff to pay attention to residents' homes and reported repair needs to the maintenance department in a timely manner.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36217 Based on record review and staff interviews, the facility failed to maintain accuracy and consistency of advance directive throughout the medical record for 1 of 1 resident (Resident #62) reviewed for advance directives. The findings included: Resident #62 was admitted to the facility on [DATE]. A review of Resident #62's care plan initiated on [DATE] indicated his advance directive was a full code. Interventions included receiving cardiopulmonary resuscitation (CPR) through the next review period. A review of Resident #62's electronic health records (EHR) indicated a physician's order dated [DATE] for Do Not Resuscitate (DNR). A review of the advance directive binder at the nurses' station dated [DATE] indicated Resident #62 was coded as DNR. During an interview conducted on [DATE] at 1:00 PM, Nurse #3, who was assigned to Resident #62, stated when a code was called, she would check the advanced directive in the EHR or the hard chart in the nurses' station to confirm whether the resident was a full code or a DNR. After reviewing Resident #62's care plan, Nurse #3 stated it could cause confusion as the care plan was inconsistent with the current code status. She acknowledged that the care plan for Resident #62 should be updated in a timely manner. An interview was conducted with MDS Coordinator #1 on [DATE] at 1:15 PM. She stated she was responsible for updating the code status for the care plan whenever it was changed. She explained she audited all residents' advanced directives routinely to ensure consistency with the care plan and did not know why Resident #62's care plan was missed. She attributed the error as an oversight and acknowledged Resident #62's care plan needed to be updated in a timely manner to avoid confusion. During an interview conducted on [DATE] at 1:29 PM, the Director of Nursing stated nursing staff would mainly check the code status in EHR instead of the care plan when a code was called. It was her expectation for the MDS Coordinator to update the care plan for advance directives in a timely manner whenever a change had been made. An interview was conducted with the Administrator on [DATE] at 5:10 PM. He expected the MDS coordinator to update the care plan in a timely manner when the code status had been changed to avoid confusion.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on observations, record reviews, resident and staff interviews, the facility failed to provide podiatry care for 1 of 7 residents (Resident #57) reviewed for activities of daily living. The findings included: Resident #57 was admitted to the facility on [DATE] with diagnoses which included type II diabetes mellitus, lymphedema, and peripheral vascular disease. Resident #57's care plan had a focus area for diabetes mellitus, type II dated last revised on 9/19/24 and revealed an intervention for a referral to podiatrist and/or foot care nurse to monitor and document foot care needs and to cut long nails. Resident #57's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and required substantial to maximal assistance with personal hygiene. There were no behaviors, and no rejection of care noted on the MDS. An observation of Resident #57 on 4/21/25 at 10:45 AM revealed Resident #57 was in her bed without a sheet or cover over her feet. Her toenails were jagged and pointed and the length varied with some nails around .5 to one inch in length on both feet. An interview with Resident #57 on 4/21/25 at 10:45 AM was conducted. She explained she was required to see the podiatrist due to her diabetes diagnosis and she was supposed to be seen by the podiatrist as her toenails were very long and painful. She indicated she had to keep her feet uncovered in bed as the pressure from the bed sheet made her toenails painful. Resident #57 explained she asked the nursing staff about seeing the podiatrist due to her long toenails and was told that she missed the podiatry clinic in March 2025 because she was in the hospital. Resident #57 indicated she was on the list for the next podiatry clinic, but did not know when that was supposed to occur. She could not recall which nursing staff member she discussed her toenails with. A review of the podiatry schedule was conducted. It revealed Resident #57 was seen on 5/15/24 and 11/13/24. The next podiatry clinic was to be held on 6/9/25 and 6/10/25. Resident #57 was on the list for the 6/9/25 podiatry clinic. Resident #57 was not seen by the podiatry clinic on 3/17/25 or 3/18/25 due to hospitalization . An interview on 4/23/25 at 1:49 PM with Nurse Aide #1 revealed she worked with Resident #57 earlier that morning. She stated Resident #57 reported to her that her toenails were very long and had been painful. Nurse Aide #1 stated she did not typically work with Resident #57 but reported her concerns regarding her painful toenails to Nurse #2. An interview with Nurse #2 was conducted on 4/23/25 at 1:55 PM. She stated she had been at the facility for about a year and a half. She explained Resident #57 was very alert and would communicate her needs to staff. Nurse #2 stated Resident #57 asked her on 4/22/25 when the podiatrist was coming to the facility, and she told her the schedule. She stated she was not made aware her toenails were painful and had not seen how long her toenails were. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 4/24/25 at 10:43 AM revealed Resident #57 was on the list for the podiatry clinic in June 2025. She stated she was not aware Resident #57 had indicated her nails were painful after she missed the March 2025 podiatry clinic due to hospitalization . The DON explained Resident #57 could be seen by an outside provider before the next onsite podiatry clinic and she would speak to her about that option. An interview with the Administrator on 4/24/25 at 12:34 PM was conducted. He expected Resident #57 to receive the podiatry care she needed whether onsite or at another provider.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, record review, and staff interviews, the facility failed to secure an opened bottle of antacid for 1 of 1 Resident (Resident #90) and failed to store 3 unopened eye drops at the proper temperature per manufacturer's instructions for 1 of 4 medication cart (100 halls medication cart) review for medication storage. The findings included: a. Resident #90 was admitted to the facility on [DATE]. A review of Resident #90's medication records revealed he had never been assessed nor approved for self-administration of medication since admission. A review of the physician's orders revealed Resident #90 did not have an order to receive liquid Pepto Bismol (an over-the-counter medication primarily used to relieve upset stomach symptoms such as nausea, heartburn, indigestion, and diarrhea). The significant change in status Minimum Data Set (MDS) dated [DATE] coded Resident #90 with moderately impaired cognition During a medication storage observation conducted on 04/21/25 at 11:33 AM, an opened bottle of liquid Pepto Bismol containing approximately 7 fluid ounces was seen left unattended on top of Resident #90's bedside table and ready to be used. An interview was conducted with Resident #90 on 04/21/25 at 11:35 AM. He stated his wife brought the Pepto Bismol for him about 3 days ago and left it in his room. He denied he had used this medication so far. He was unsure whether any staff were aware of this medication when providing care but so far none of them had said anything. During an interview conducted on 04/21/25 at 11:42 AM, Nurse #1 stated when she did medication pass for Resident #90 in the morning of 04/21/25, she did not notice the bottle of liquid Pepto Bismol left unattended in his room. She acknowledged that none of the medications should be left unattended in the resident's room. An interview was conducted with Nurse Aide #1 (NA) on 04/21/25 at 12:14 PM. She stated that she provided care for Resident #90 in the morning of 04/21/25, but she did not notice he had an opened bottle of Pepto Bismol left unattended in his room. Otherwise, she would report the incident to the nurse. b. Review of the manufacturer's package insert for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between 36 to 46 Fahrenheit (F) and protected from light. Once opened, Latanoprost may be stored at room temperature up to 77 F for up to six weeks. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication storage audit conducted on 04/22/25 at 2:21 PM for the 100 hall medication cart in the presence of Nurse #2, three unopened bottles of Latanoprost 0.005% eye drop (medication used to treat glaucoma) were found in the medication cart at room temperature and ready to be used. Each bottle had a hand-written opening date of 04/20/25 but the plastic seal for all three bottles remained intact. An interview was conducted with Nurse #2 on 04/22/25 at 2:25 PM. She confirmed all three bottles of Latanoprost eye drops in 100 hall medication cart were unopened. She explained she had been off for the last 2 days and did not know who had placed the Latanoprost eye drops in the medication cart. She acknowledged that unopened Latanoprost eye drops should be stored in the refrigerator until they were ready to be used. During an interview conducted on 04/22/25 at 2:48 PM, the Director of Nursing (DON) expected all the nursing staff to be more attentive to resident's living environment to ensure the facility free of unattended medications. It was her expectation for all the nursing staff to store the medications according to the manufacturer's guidelines. An interview was conducted with the Administrator on 04/23/25 at 5:10 PM. He expected all the nursing staff to follow manufacturer's guidelines in medication storage and keep the facility free of unattended medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51936 Based on observation and staff interviews, the facility failed to cover facial hair during food service for 1 of 4 dietary staff observed (Dietary Manager #1). This deficient practice had the potential to affect food served to residents. The findings included: During a follow up tour of the kitchen on 4/22/2025 at 7:30 AM, Dietary Manager #1 was observed in the kitchen area with a short, neatly trimmed beard with no facial hair covering. As the tray line for breakfast began, Dietary Manager #1 was observed at the steam table and began to assist with plating food. This surveyor called Dietary Manager #1 away from the steam table and asked if he used facial hair covering. He immediately obtained one and put it on. He stated he usually wore a facial hair covering. Dietary Manager #1 stated he was from a different facility, had come to pick up chemicals from the kitchen and had not planned to stay at the facility. He reported he had spoken to the Culinary Director by telephone, and she had requested he stay until she arrived at work. An interview on 4/24/2025 at 10:45 AM with the Culinary Director revealed that facial hair coverings were always required in the kitchen for staff with facial hair. She did not know why Dietary Manager #1 was not wearing a facial hair covering. An interview on 4/24/2025 at 11:45 AM with the Administrator indicated Dietary Manager #1 should have used a facial hair covering while in the kitchen.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on record reviews and staff interviews, the facility failed to maintain an accurate and consistent electronic medication administration record (eMAR) for 1 of 1 resident review for documentation accuracy (Resident #152). The findings included: Resident #152 was admitted to the facility on [DATE] with diagnoses including opioid dependence. A review of physician order dated 04/17/25 revealed Resident #152 had an order to receive 1 tablet of oxycodone-acetaminophen (Percocet) 5/325 milligrams (mg) by mouth once every 4 hours as needed (PRN) for pain at his right hip. Review of the eMAR dated 04/21/25 revealed Resident #152 had received 1 tablet of Percocet 5/325 mg at 8:15 AM and 4:24 PM. On 04/22/25, the eMAR indicated Resident #152 had received 1 tablet of Percocet 5/325 mg at 7:45 AM and 2:25 PM. Review of the nurse's progress notes dated 04/21/25 and 04/22/25 revealed none of the nursing staff had documented any notes related to Resident #152's need for PRN Percocet. Review of the controlled substance declining sheet indicated Resident #152 had received 1 tablet of Percocet 5/325 mg 3 times respectively on 04/21/25 at 8:00 AM, 4:15 PM, and 10:00 PM. On 04/22/25, the controlled substance declining sheet revealed Resident #152 had received 1 tablet of Percocet 5/325 mg 3 times respectively at 7:45 AM, 2:25 PM, and 10:00 PM. The Percocet signed out for Resident #152 on 04/21/25 at 10:00 PM and 04/22/25 at 10:00 PM by Nurse #4 were not charted in the eMAR. An interview was conducted with Resident #152 on 04/23/25 at 12:59 PM. He confirmed he had received his PRN Percocet on 04/21/25 and 04/22/25 around 10 PM and stated the medication was administered by Nurse #4. During a phone interview conducted on 04/24/25 at 9:50 AM, Nurse #4 stated he worked second shift on 04/21/25 and 4/22/25. He recalled Resident #152 had asked for his PRN Percocet and confirmed he had administered the pain medication to Resident #152 around 10 PM both night. Typically, he would sign out narcotic in the controlled substance declining sheet first. After it was administered, he would chart it in the eMAR. He was surprised to learn that he did not chart both entries in the eMAR and attributed it to distractions. He acknowledged that all medication administration that involved controlled substance should be documented in the controlled substance declining sheet and eMAR. During an interview conducted with the Director of Nursing on 04/23/25 at 1:28 AM, she acknowledged that Resident #152's Percocet that were administered by Nurse #4 should be charted in the controlled substance declining sheet and eMAR as well. It was her expectation for all the controlled substances to be accounted for and documented accurately in a timely manner. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 04/23/25 at 5:10 PM. He expected nursing staff to document all the controlled substances accurately and consistently in the controlled substances declining sheet and eMAR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40476 Based on observation, record review and staff interview, the facility failed to implement Transmission-Based Precautions (TBP) when two Nurse Aides provided incontinence care for Resident #55 and did not wear a gown for 2 of 5 staff members observed for infection control practices (Nurse Aide #3, Nurse Aide #4). The findings included: Review of the facility's policy for Transmission- Based Precautions (TBP) dated 10/27/20 revealed the TBP will be implemented for the prevention of transmission of multidrug-resistant organisms. Three categories of precautions were listed on the policy including Contact Precautions, Droplet Precautions and Airborne Precautions. Contact precautions included the following: 1. Personal Protective Equipment (PPE) a. Staff and visitors will wear gloves when entering the room for all interactions that may involve contact with the resident and/or the residents' environment. b. Staff and visitors will remove gloves and perform hand hygiene prior to leaving the resident's room. c. Staff and visitors will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves were removed. d. Staff and visitors will wear a gown when entering the room for all interactions that may involve contact with the resident and/or the residents' environment. e. Staff and visitors will remove the gown and perform hand hygiene prior to leaving the resident's room. f. Staff and visitors will avoid touching potentially contaminated surfaces with clothing after the gown is removed. A physician order dated 04/22/25 for Resident #55 revealed an order for contact precautions due to Enterobacter cloacae complex (a group of closely related bacterial species known for causing various infections) in her urine. An observation was conducted on 04/23/25 at 3:00 PM of Resident #55's room. The observation revealed signage posted on Resident #55's door for Enhanced Barrier Precautions (EBP). A three-compartment container was observed on the outside of the resident's door with gown, gloves and mask in the compartments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of incontinence care conducted on 04/23/25 at 3:36 PM revealed Enhanced Barrier Precaution (EBP) signage on Resident #55's door. Nurse Aide (NA) #3 and NA #4 entered Resident #55's room and provided incontinence care wearing only gloves for the duration of the task. NA #3 and NA #4 were observed changing Resident #55's bed sheet, incontinence brief and bottom sheet. The staff members had a wash basin and were observed washing Resident #55's peri area. An interview was conducted with NA #3 on 04/23/25 at 3:45 PM. During the interview she stated she was unaware Resident #55 was on Transmission Based Precautions (TBP). An interview was conducted with NA #4 on 04/24/25 at 9:16 AM. During the interview she stated she did not wear a gown while providing care for Resident #55 because she didn't know the resident was on TBP. On 04/23/25 at 4:04 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she was also in charge of Infection Prevention in the facility. She stated there should have been signage on Resident #55's door indicating for staff to wear a gown and gloves while performing incontinence care. The interview revealed the physician order was placed into the electronic system by the Assistant Director of Nursing (ADON), and he should have placed a sign on the door at the time the order was put in. The DON stated the staff should have worn gown and gloves while providing care for Resident #55. On 04/24/25 at 12:00 PM an interview was conducted with the ADON. He stated there was already an Enhanced Barrier Precaution sign on Resident #55's door for her roommate so he thought he did not have to put another sign on the door. He stated he did not realize that staff wouldn't know Resident #55 was on contact precaution isolation. After realizing the issue, the ADON stated he should have put a contact precaution sign on Resident #55's door. On 04/24/25 at 12:32 PM an interview was conducted with the Administrator. During the interview she stated a contact precaution sign should have been on Resident #55's door if she had a physician order stating those precautions were required.