

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/31/2025
NAME OF PROVIDER OR SUPPLIER  Accordius Health at Monroe		STREET ADDRESS, CITY, STATE, ZIP CODE  204 Old Highway 74 East Monroe, NC 28112	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</b></p> <p>Based on record review, resident, and staff interviews, the facility failed to protect a resident from misappropriation when his debit card was used while he was hospitalized . This was for 1 of 3 residents reviewed for misappropriation (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility [DATE] with diagnoses including lung disease and heart failure.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #3 to be severely cognitively impaired. Resident #3 did not have any behaviors noted on the MDS assessment.</p> <p>A nursing note dated [DATE] documented Resident #3 was sent to the hospital for evaluation after a change in status.</p> <p>A note dated [DATE] documented Resident #3 died at the hospital on [DATE].</p> <p>Resident #3's bank statement dated [DATE] documented debit card used from [DATE] to [DATE] totaling \$157.92. The bank statement indicated 70 transactions had been completed from ,d+[DATE] to [DATE] and all but one transaction had been conducted at a vending machine. A transaction dated [DATE] was for a pizza delivery.</p> <p>Resident #3's guardian was interviewed by phone on [DATE] at 11:21 AM. The guardian reported upon Resident #3's death, she ran a bank statement report to review his account. The guardian reported she discovered the debit card had been used multiple times per day during his hospitalization and on the day he died . The guardian reported she and the facility searched Resident #3's room and they were unable to find the missing debit card. The guardian reported the facility would not reimburse the debit card charges and told her to talk to the bank. The guardian explained she had Power of Attorney for Resident #3 until his death and then the responsibility of the finances was to be turned over to his Next of Kin, but she felt it was important to have the money reimbursed to the debit card.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) was interviewed on [DATE] at 11:16 AM. The DON explained that on [DATE] Resident #3's guardian came to the facility to notify the facility Resident #3 had died at the hospital and that she had discovered activity on his debit card during his hospitalization . The DON explained Resident #3's room was searched, and the debit card could not be located. The guardian reported \$157.92 was used on the debit card, and she brought in the bank statements to review with the facility. The DON reported they did not know who ordered the pizza delivery, but pizza was delivered from the business on the bank statement to the facility on [DATE]. The DON described completing the report and conducting the investigation by reviewing the camera footage from the living room with the vending machines as well as interviewing staff and residents, including Resident #2. The DON reported they were unable to identify any staff or residents using Resident #3's debit card from the camera footage. The DON said that the police were called, and the officer conducted interviews with Resident #2 and staff and was unable to determine if the debit card was taken. The DON reported the facility had not reimbursed Resident #3's guardian for the debit card charges and reported that would be the bank's responsibility.</p> <p>Resident #2 was interviewed on [DATE] at 11:00 AM. Resident #2 reported he was Resident #3's roommate and he was not aware of the missing debit card until he was interviewed by police. Resident #2 was not certain which date the police interviewed him, but reported it was in [DATE]. Resident #2 reported he had not used Resident #3's debit card to obtain snacks from the vending machine or order pizza.</p> <p>The Administrator was interviewed on [DATE] at 2:32 PM and she reported Resident #3 had a lock box in his room and his wallet was in the lock box, but the debit card was not found. The Administrator explained that Resident #2 was interviewed, and he denied knowing the debit card was missing, and denied using the debit card. The Administrator reported the police were notified and they interviewed Resident #2 and staff members, and the police told the facility there was nothing else that could be done. The police could not prove the debit card was stolen.</p> <p>A follow-up interview was conducted with the Administrator on [DATE] at 1:45 PM. The Administrator explained that the bank did reimburse the debit card for the charges and the facility did not reimburse the charges. The Administrator explained the guardian did not want to press charges against Resident #2. The Administrator reported she expected there was no misappropriation of resident property, but if it did happen, it was reported according to the regulations.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37281</p> <p>Based on record review, observation, and Wound Physician Assistant, Physician, and staff interviews, the facility failed to change a pressure ulcer dressing according to physician orders for 1 of 3 residents reviewed for pressure ulcer care (Resident #6).</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnoses including pressure ulcer and hypertension.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] documented Resident #6 was severely cognitively impaired, and she had one Stage 4 pressure ulcer on admission.</p> <p>Wound care orders for Resident #6 were reviewed and an order dated 1/24/25 specified wound care was to be provided daily: cleanse with normal saline or wound cleanser, pack with packing strip wet with sodium hypochlorite (an antiseptic wound treatment), cover with absorbent dressing.</p> <p>Review of Resident #6's Treatment Administration Record revealed no nurse initials for 1/28/25 that indicated the wound care had been completed that date for the Stage 4 pressure ulcer.</p> <p>An observation of wound care was conducted on 1/29/25 at 12:17 PM with the Wound Care Nurse and the Wound Care Physician Assistant. The pressure ulcer dressing in place on Resident #6 was noted to be dated 1/27/25. During the observation, Resident #6 was asked if the wound care was provided the previous day on 1/28/25 and Resident #6 reported it was not completed.</p> <p>The Wound Care Nurse was interviewed during the observation, and she revealed she had left work early on 1/28/25 and did not complete the wound care for Resident #6. The Wound Care Nurse explained that when she was not working, the nurse assigned to the hall was responsible for wound care dressing.</p> <p>The Wound Care Physician Assistant was interviewed on 1/29/25 at 12:28 PM and he reported Resident #6's wound measurements had decreased, and the wound was improving. The Wound Care Physician Assistant reported the one missed dressing change had not negatively affected Resident #6.</p> <p>The Unit Manager was interviewed on 1/29/25 at 12:33 PM. The Unit Manager explained the Wound Care Nurse had left early on 1/28/25 and the nurse assigned to the hall should have completed the wound care. The Unit Manager reported she was not aware Resident #6's wound care had not been provided on 1/28/25.</p> <p>Nurse #1 was interviewed by phone on 1/30/25 at 9:08 AM. Nurse #1 explained she was an agency nurse, and she had been to the facility a few times before 1/28/25. Nurse #1 reported she was assigned to Resident #6 on 1/28/25. Nurse #6 reported she had been told the Wound Care Nurse would complete all wound care for the residents on her assigned hall, and she was not aware the wound care nurse had left early on 1/28/25. Nurse #1 explained if she had been aware, she would have provided the wound care to Resident #6.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Wound Care Nurse was interviewed again on 1/30/25 at 10:51 AM and she reported she had left early on 1/28/25 and the Unit Manager and Director of Nursing were aware she was leaving early. The Wound Care Nurse reported she was not aware the wound care for Resident #6 had not been completed until it was observed during wound care on 1/29/25.</p> <p>The Physician was interviewed by phone on 1/31/25 at 10:22 AM. The Physician reported he had been notified of the missed wound care for Resident #6 when the facility discovered it and he was in agreement with the Wound Care Physician Assistant that the missed wound care had not adversely affected Resident #6.</p> <p>The Director of Nursing was interviewed by phone on 1/31/25 at 11:59 AM and she reported she was aware the Wound Care Nurse left early on 1/28/25 and Nurse #1 should have been notified she was expected to complete wound care. The Director of Nursing explained wound care was expected to be completed according to physician orders.</p> <p>The Administrator was interviewed by phone on 1/31/25 at 1:45 PM and she reported the Wound Care Nurse left early on 1/28/25 and Nurse #1 should have been told she needed to complete wound care. The Administrator explained there was a lot of activity on that date and Nurse #1 may not have been told she needed to complete wound care. The Administrator reported she expected wound care to be completed according to physician orders.</p>