STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345130	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CONCORD	515 LAKE CONCORD ROAD NE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite revisit and complaint investigation was conducted 9/13/2023 to 9/14/2023. Event ID #K14G11. The following intakes were investigated NC00206540 and NC00206168. 1 of the 2 complaint allegations resulted in a deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect the residents right to be free of misappropriation of narcotic pain medication for 1 of 1 resident (Resident #1) reviewed for misappropriation of resident property. Findings included: A review of the facility's Abuse, Neglect and Exploitation policy dated 11/1/2020 indicated the facility would prohibit and prevent misappropriation of resident property. Resident #1 was admitted for a short stay for rehabilitation to the facility on 7/14/2023 after a hospitalization for encephalopathy and weakness.	F 602	F602 Resident #1 was discharged from the facility. Resident #1 was called by the Director of Nursing on 10/3/23 related to the facility reimbursement for the missing medication. Resident #1 in agreement with reimbursement and check requested. Check received by facility on 10/3/23. Check mailed to Resident #1 via certified mail on 10/4/23. The current residents have the potential to be affected by this deficient practice. An audit will be completed by 10/5/23 by the Director of Nursing/Unit Manager for the	10/6/23

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

Electronically Signed | 10/04/2023

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F 602	Continued From page 1 A review of Resident #1's Physician's Orders revealed he did not have an order for hydromorphone. An admission Minimum Data Set assessment dated 7/31/2023 indicated Resident #1 was cognitively intact and required extensive assistance with bed mobility and transfers, and he did not require pain medication. Attempted to call Resident #1 during the survey and there was no answer at the number the facility had for him, and the phone did not receive messages. Nurse #13 was interviewed by phone on 9/13/2023 at 3:32 pm and she stated she had gone into Resident #1's room shortly after he admitted to the facility on 7/14/2023 and found a medication bottle with 58 hydromorphone, a narcotic pain medication, sitting on his bedside table and had explained to him it would need to be locked in the medication cart and he agreed. Nurse #13 stated she put the bottle in the medication cart and counted the medications with another nurse and put a medication count form in the narcotic book to ensure the medication was counted each shift. Nurse #13 stated she notified the Director of Nursing (DON) the medication was in the locked narcotic drawer on the medication cart. Nurse #13 stated she worked on 8/1/2023 on the 7:00 am to 3:00 pm shift and counted the hydromorphone with Nurse #14 when she arrived for the 3:00 pm to 11:00 pm shift on 8/1/2023. Nurse #13 stated when she arrived for her shift on 8/2/2023 on the 7:00 am to 3:00 pm shift the bottle of hydromorphone was missing from the medication cart. Nurse #13 stated there were	F 602	last 60 days to ensure residents are free from misappropriation of resident property to include narcotic pain medication. The facility staff to include the licensed nurses, certified nursing assistants, certified medication aides, housekeeping, dietary, agency staff and therapy staff will be educated by the Staff Development Coordinator (SDC), Unit Managers, and/or Nursing Supervisors by 10/5/23 related to ensuring that residents are free from misappropriation of resident property to include narcotic pain medication. The nursing staff to include the licensed nurses, certified medication aides, and the certified nursing assistants were educated by 10/5/2023 on ensuring narcotics are being counted and narcotic medications residents bring from home are being handled according to facility policy by the SDC, Unit Managers, and/or Nursing Supervisors. The new hire facility staff to include licensed nurses, certified nursing assistants, certified medication aides, housekeeping, dietary, agency staff and therapy staff will not be allowed to work until the education is completed. The Director of Nursing/Unit Managers will complete audits of at least 8 residents weekly for 4 weeks and monthly for 2 months to ensure that residents continue to be free from misappropriation of resident property to include narcotic pain medication.	

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F 602	Continued From page 2 fifty-eight pills in the medication bottle when she left the facility on 8/1/2023 at 3:00 pm. On 9/13/2023 at 3:46 pm Nurse #14 stated she worked the 3:00 pm to 11:00 pm shift on 8/1/2023 and an agency nurse, Nurse #15, was the nurse that came in on the 11:00 pm to 7:00 am shift, and he had counted the narcotic medications with her when she was leaving at 11:00 pm and there were 58 hydromorphone tablets in Resident #1's medication bottle. Nurse #4 was interviewed on 9/13/2023 at 4:11 pm and she stated she was the supervisor on the 3:00 pm to 11:00 pm shift on 8/1/2023. Nurse #4 stated Nurse #15 became erratic and was cussing and taking his clothes off in the courtyard of the facility during the 3:00 pm to 11:00 pm shift on 8/1/2023 and she stated she questioned him about his behavior he said he was sleep deprived and she sent him home. Attempted to contact Nurse #15 during the survey and there was no answer on his phone and the phone did not accept messages. On 8/2/2023 at 12:15 pm Nurse #13's Nurse's Progress Note stated Resident #1 was discharged home with his family without pain or discomfort. The note further stated Resident #1 was informed his personal medication was missing and he was not happy. The Director of Nursing was interviewed on 9/13/2023 at 4:35 pm and she stated Resident #1 brought in a bottle of medication that was a narcotic pain medication, hydromorphone, when he was admitted to the facility. She stated the day he was discharged the hydromorphone were no longer in the medication cart but they were the	F 602	The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement committee meeting monthly for 3 months for review to ensure the facilities continued compliance.	

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F 602	Continued From page 3 evening before he was discharged. The DON stated the facility does not drug test nurses unless there is a reasonable suspicion of them being under the influence. The DON stated Nurse #15 was sent home due to erratic behavior and when the narcotic medication was discovered missing, he would not come back to the facility for a drug test. The DON stated the facility had reported the missing narcotic medication to the police department and the Drug Enforcement Agency (DEA). The Director of Nursing stated she did notify the staffing agency of the incident and told them she did not want Nurse #15 to return to the facility. The Administrator stated on 9/14/2023 at 3:36 pm he was not the administrator when the drug Resident #1's home medications were misplaced 8/1/2023.	F 602		