STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted 11/27/23-11/30/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # KI7911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted 11/27/23-11/30/23. Event ID# KI7911. The following intakes were investigated NC00206780, NC00209112, NC00206483, NC00207970, NC00207696, NC00208031, NC00206082, and NC00206181. 1 of the 18 complaint allegations resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		12/20/23

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

Electronically Signed | 12/18/2023

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F 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff the facility failed to provide a written response to ongoing grievances reported by the Resident Council in the resident council meetings for 7 of 12 months (2/23/2023, 4/20/2023, 5/25/2023, 7/27/2023, 8/28/2023, 10/27/2023 and 11/27/2023). Findings included: The Resident Council Meeting Minutes were reviewed 11/2022 to present and the following issues were identified that were also brought up during the Resident Council Meeting observed on 11/27/2023 at 2:25 pm: On 2/23/2023 residents complained of issues with food trays not being passed timely at all meals which causes food to be cold. On	F 565	1. On 11/30/2023, the Activity Director was educated by the Administrator regarding Resident Council concerns and the importance of grievance resolution each month or alternative actions need to be taken. 2. A quality review was conducted on 12/12/2023 by the Administrator for the last 6 months to identify any issues without resolution brought up by Resident Council during their monthly meetings. The administrator noted 3 reoccurring issues without resolution based on Resident Council Minutes. These issues will be addressed by the interdisciplinary team and presented for review at the next Resident Council Meeting on December 19, 2023. On 12/19/2023 the Activity Director and Administrator will hold a	

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F 565	Continued From page 2 4/20/2023 the resident council complained that food was not good and asked if someone could test the food. On 5/25/2023 the residents asked for dietary reform for menus and alternate meals. Again on 6/22/2023 Meal consistency and food not being stocked was a concern brought to the facility by resident council. On 7/27/2023 the resident council had concerns regarding the variety of foods being served. On 8/28/2023 dietary quality issues and food temperature issues were brought up in resident council. The resident council brought dietary request issues up in the resident council meeting, sweeteners were not being provided, and bread was not fresh. On 10/27/2023 the resident council brought up meal passing issues, variety of foods being served issues, and food quality issues again in the resident council meeting. A Resident Council Meeting was conducted on 11/27/2023 at 2:25 pm and residents in the meeting indicated there was an issue with the resolution of grievances. The residents who attended stated they had complained at previous meeting regarding issues with their food being burnt, too hard to chew, cold, and they did not get condiments with their meals. The residents that attended stated there was no resolution to the problems with the facility's food. During an interview with the Resident Council President on 11/28/2023 at 3:11 pm he stated he was not able to come to the resident council meeting on 11/27/2023 but he was not surprised there were complaints about the quality of food. The Resident Council President stated he knew that the issues had come up at resident council meetings in the past year.	F 565	Resident Council Meeting in conjunction with the Long Term Care Ombudsman to establish a new agenda for Resident Council meeting to ensure all previous month concerns have appropriate follow up as approved by the council. This new agenda will be created by and approved by the council. All Resident Council concerns will be signed off on by the Administrator after successful follow up has been made to ensure compliance and satisfaction. 3. On 12/12/2023, the Activity Director was educated regarding proper follow-up for issues brought up in Resident Council and the importance of ensuring each complaint is resolved in a timely manner. Any future activity director will be educated in orientation upon hire. 4. The Administrator or designee will complete quality monitoring starting on 12/19/2023 of all grievances reported in Resident Council each month for 3 months. The Administrator will report the results of the quality monitoring to the QAPI committee monthly for 3 months or until substantial compliance is met.	

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F 565	Continued From page 3 During an interview with the Activity Director on 11/27/2023 at 4:37 pm he stated the facility did not have a consistent Dietary Manager until recently and that may have been why food kept coming up, but the facility had a new Dietary Manager now. The Activity Director stated he sent out grievance forms to the department managers for each of the issues brought up in their resident council meetings, but he did not have the follow-up for each of the issues. The Administrator was interviewed on 11/30/2023 at 3:31 pm and she stated the intradisciplinary team had talked about the resident council meetings and plans were made to improve the monitoring of issues the residents brought up about the food during the Resident Council Meeting and the facility also planned to make improvements in how concerns are followed up on and are resolved.	F 565		
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 reviews, observations, resident	F 602	Past noncompliance: no plan of	

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and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of pain medication for 1 of 3 residents reviewed for abuse (Resident #11).

The findings included:

Resident #11 was admitted to the facility 11/29/2021 with diagnoses to included diabetes and lung disease. The annual Minimum Data Set (MDS) dated 9/28/2023 assessed Resident #11 to be cognitively intact. The MDS documented Resident #11 received as needed (PRN) pain medications for moderate pain.

A physician order (no date) for Resident #11 ordered oxycodone/acetaminophen 7.5/325 milligrams (mg) to be administered every 6 hours as needed for pain.

A review of the medication administration record for 9/5/2023 revealed Resident #11 had received oxycodone/acetaminophen 7.5/325 mg at 1:00 PM.

The facility investigative report dated 9/13/2023 documented on 9/5/2023, Nurse #3 was sent home after poor performance. The report documented the oncoming nurse (Nurse #1) counted narcotics with Nurse #3 prior to Nurse #3 leaving and no issues were noted by Nurse #1, however Nurse #1 reported to the Director of Nursing (DON) that Nurse #3 was acting odd and flipping the narcotic count sheets while the narcotics were being counted. The report documented that the DON and Nurse #1 recounted the narcotics and determined that 7 tablets were missing from Resident #11's card of oxycodone/acetaminophen 7.5/325 mg. The

correction required.

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report documented Resident #11 had a pain assessment completed and she denied pain, and no concerns were identified with Resident #11's pain control. The facility notified the police department, staffing agency and the Board of Nursing was notified of the drug diversion. Nurse #3 was listed as "Do Not Return" to the facility.

A facility investigation report dated 9/13/2023 documented further on the incident, including a noted behavioral change of Nurse #3 during her 7:00 AM to 7:00 PM shift. The report documented that the DON asked Nurse #3 to leave and requested Nurse #1 count narcotics with her prior to leaving the facility. The report documented Nurse #3 was acting suspiciously during the narcotic count, including opening all the drawers, and flipping pages in the narcotic count book. The count was completed, and Nurse #3 left the facility and did not speak to the DON or the Administrator. The report documented Nurse #1 discovered a card of narcotic medications belonging to Resident #11 was missing from the narcotic drawer and it was discovered in the unlocked medications. Nurse #1 requested the DON count the narcotics with her and they found that 7 tablets of oxycodone/acetaminophen were missing from Resident #11's narcotic card. Resident #11 was interviewed at the time of the discovery and pain assessment was completed. Resident #11 reported she had received a dose of oxycodone/acetaminophen about 1:00 PM and her pain was relieved.

Resident #11 was interviewed on 11/27/2023 at 2:59 PM and she reported she received her pain medications when she requested them. Resident #11 was unable to recall the incident on 9/5/2023.

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Nurse #1 was interviewed on 11/29/2023 at 3:10 PM. Nurse #1 recalled 9/5/2023 when she was asked by the DON to count narcotics with Nurse #3 and take over her medication cart. Nurse #1 explained that Nurse #3 was acting odd, flipping the pages of the narcotic book, fidgeting, and acting strangely. Nurse #1 described discovering Resident #11's narcotic medication card in the drawer with regular medications, and that she immediately got the DON to recount the narcotic medications.

The Administrator was interviewed on 11/30/2023 at 1:40 PM and she reported that the facility had a daily meeting to discuss staffing and to review the nurses who were coming from the staffing agency. The Administrator explained that prior to the drug diversion on 9/5/2023, the facility only checked nursing licenses. The Administrator reported after the incident occurred, they reviewed Nurse #3's record and discovered that she had not taken the annual abuse, neglect, and misappropriation in-service. The Administrator explained that Nurse #3 had no action against her when she worked at the facility. The Administrator explained the new process of reviewing agency nurses who were scheduled to work at the facility included reviewing their license, checking the Board of Nursing for any actions against them, and reviewing their in-service record.

An interview was conducted on 11/30/2023 with Nurse #2 and she reported she was the charge nurse for the facility. Nurse #2 explained that Nurse #3 was unable to complete her morning medication pass on 9/5/2023 and she went to talk to Nurse #3 to see if she needed help. Nurse #2 described how Nurse #3 had medications spread all over the top of the medication cart and she

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had said she was "working on" the medication pass. Nurse #2 reported to the DON that Nurse #3 was running very behind and when Nurse #3 took a break before her medication pass was completed, the DON decided to send Nurse #3 home.

The Assistant Director of Nursing (ADON) was interviewed on 11/30/2023 at 2:39 PM. The ADON explained she had stepped down from the DON position on 11/27/2023, but she was the DON on 9/5/2023. The ADON described approaching Nurse #3 on 9/5/2023 to inform her she was being sent home, after multiple residents reported they had not received their morning medications and it was after 12:00 PM. The ADON explained she got Nurse #1 to count narcotics with Nurse #3 and after Nurse #3 left the building, Nurse #1 came to her and the Administrator to report she had found a card of narcotic pain medications in the unlocked medication drawers of the medication cart. The ADON reported that she and the Administrator accompanied Nurse #1 to the medication cart and she and Nurse #1 recounted the narcotics, and they found that 7 tablets were missing from the oxycodone/acetaminophen card for Resident #11. The ADON explained multiple attempts were made to contact Nurse #3, but she did not return the calls or text messages. The ADON described interviewing and assessing Resident #11 and finding she had received an oxycodone/acetaminophen tablet prior to Nurse #3 leaving the building and Resident #11 denied having untreated pain. The ADON explained that she and the Administrator checked all three medication carts for missing narcotics and no issues were identified in the other 2 medication carts. The ADON reported she provided

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education to all the nurses on 9/5/2023 through 9/13/2023 regarding narcotic counting, receiving narcotics from the pharmacy, and misappropriation of resident property. The ADON reported she conducted audits 5 times a week for 1 month, then 2 times a week for another month, and then weekly for another month, concluding the audits on 11/27/2023.

A phone interview was conducted with Nurse #3 on 11/30/2023 at 3:27 PM. Nurse #3 reported she was asked to leave the facility on 9/5/2023 and she counted narcotics with Nurse #1 and the narcotic count was correct when she left the building. Nurse #3 reported she had not received any call or text messages from the facility, but 10 days later she received a phone call from the Board of Nursing notifying her they were investigating an allegation of drug diversion.

The facility plan of correction dated 9/5/2023 was reviewed. The plan of correction included a summary of the incident and immediate actions taken, including a pain assessment of Resident #11, a review of Resident #11's medication administration, narcotic counts, and initial audits of all medication carts. The plan of correction detailed the education provided to the nurses. The plan of correction noted that a report was filed on 9/5/2023 to the Division of Health Service Regulation, the local police were notified, and the Board of Nursing was notified of the allegation of narcotic diversion. The facility conducted an ad-hoc Quality Assurance Performance Improvement (QAPI) meeting on 9/7/2023 to discuss the incident and the initiation of audits, as well as reporting potential misappropriation or diversion. The facility was to discuss the results of the audits at the monthly QAPI meeting for 3

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F 602	Continued From page 9 months. An attachment dated 9/13/2023 included the education provided and nursing signatures of attendance. Nurses and medication aides were interviewed and each one had received education related to counting narcotics at shift change, reporting narcotic discrepancies, receiving narcotic medications from the pharmacy, and documenting narcotic administration. Narcotic administration was observed during the survey and no issues were identified. Audits were reviewed and no issues were identified by the facility relating to misappropriation or drug diversion during the audits. These results were discussed during the QAPI meeting in October 2023 and November 2023. The facility date of completion of 9/7/2023 was validated.	F 602		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff.	F 851		12/20/23

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Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing

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F 851	Continued From page 11 information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to submit accurate payroll data, regarding 24-hour licenses nurse coverage, for 4 of 4 days reviewed (7/10/2022, 7/17/2022, 8/7/2022, and 8/20/2022) of the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) for the 4th quarter in fiscal year 2022. Findings included: The CMS submission report, PBJ Final File Validation Report for Fiscal Year 2022 (July 1 to September 30) showed the facility failed to have Licensed Nursing Coverage, 24 hours out of 24 hours, for the days of 7/10/2022, 7/17/2022, 8/7/2022 and 8/20/2022. Posted Nurse Staffing, nurse schedules, and the nursing staff's timecards for 7/10/2022, 7/17/2022, 8/7/2022, and 8/20/2022 were reviewed and revealed multiple licensed nurses were not accurately coded and omitted on the PBJ report for the 4th quarter of Fiscal Year 2022. During an interview with the Administrator on 11/30/2023 at 11:32 am she stated the Nurse Scheduler and Payroll Manager that were employed during the 4th quarter of Fiscal Year 2022 no longer worked at the facility. She stated	F 851	1. On 11/30/2023, the Scheduler was educated by the Administrator on the importance of ensuring all agency hours are recorded in the facility time keeping application to ensure accurate reporting each quarter. 2. A quality review was conducted on 12/12/2023 by the Administrator of the last 30 days of the schedule to ensure all agency hours were properly accounted for in HostedTime. No further issues identified. 3. On 12/13/2023, the Nurse scheduler was educated on the importance of ensuring all agency hours are recorded in the facility time keeping application to ensure accurate reporting each quarter. Any future newly hired nurse scheduler will be educated in orientation upon hire. 4. The Administrator or designee will complete quality monitoring starting on 12/19/2023 of the nurse schedule to ensure all hours worked the previous day (or weekend as appropriate) were properly transcribed into the facility's timekeeping application. Each quarter the facility Administrator in partnership with the Vice President of Human Resources will complete an audit to ensure there are no days without nursing hours reported.	

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ACCORDIUS HEALTH AT MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

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F 851	Continued From page 12 the facility had changed ownership six months ago, prior to her employment with the facility, and she did not have the contact information for the former employees. The Administrator stated the facility had accurately coded and submitted the PBJ report since she came to the facility. She stated she believed the previous ownership had not put a process in place to capture agency licensed nurses, and their hours, to ensure the PBJ reported data was correct.	F 851	The Administrator will report the results of the quality monitoring to the QAPI committee monthly for 3 months or until substantial compliance is met.	