STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 12/12/22 through 12/16/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# L8F11.	E 000		
F 000	INITIAL COMMENTS An unannounced, onsite revisit along with a recertification and complaint investigation survey were conducted on 12/12/22 through 12/16/22. Tags F689, F755, and F760 were corrected as of 12/16/22. However, new tags were cited as a result of the recertification and complaint investigation survey that was conducted at the same time of the revisit. The facility is still out of compliance. Event ID# L8F11. The following intakes were investigated: NC00195018, NC00195042, NC00195443, NC00194950, NC00195307, and NC00195466. Five of the 17 allegations were substantiated, one without deficiency and 4 resulting in deficiencies (F684).	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		1/9/23

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

Electronically Signed | 01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the	F 580	1. The facility failed to notify the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 580	Continued From page 2 Medical Director and staff, the facility failed to notify the physician a resident's pain was not controlled after the administration of pain medication. The resident called emergency medical services and was evaluated for abdominal pain and diagnosed with acute cholecystitis (inflammation of the gallbladder) that required admission to the hospital for the surgical removal of the gallbladder for 1 of 2 residents reviewed for hospitalizations (Resident #270). The findings included: Resident #270 was admitted to the facility on 05/15/20 with diagnoses including a history of cervical spine trauma and quadriplegia. Resident #270 was discharged to the hospital on 11/22/22 and returned to the facility on 12/13/22. The quarterly Minimum Data Set dated 08/29/22 revealed Resident #270 was assessed as being cognitively intact. Routine and as needed pain medications were received during the lookback period and the resident reported his pain was moderate, frequent, and interfered with sleep and activities. Opioids (narcotic pain medications) were given all 7 days during the lookback period. Review of the Medication Administration Record revealed oxycodone-acetaminophen (a narcotic pain medication) 5-325 milligrams every 6 hours as needed for pain management was given twice on 11/22/22. The first dose at 3:56 PM for a pain level of 7 and the second dose at 10:06 PM for a pain level of 8. Both administrations were documented as being effective. Review of the nurse progress note dated 11/22/22, written by Nurse #4, revealed on	F 580	physician a resident's pain was not controlled after the administration of pain medication. The resident called emergency medical services and was evaluated for abdominal pain and diagnosed with acute cholecystitis (inflammation of the gallbladder) that required admission to the hospital for the surgical removal of the gallbladder for 1 of 2 residents reviewed for hospitalizations (Resident #270). Resident #270 had thorough pain evaluation completed by nurse practitioner (NP) on 12/15/2022 upon readmission from the hospital. NP continued current pain regimen due to resident stating the current regime treats pain adequately. 2. All residents have potential to be affected by this deficient practice. The Director of Nursing (DON) and unit managers completed a pain assessment on all current facility residents completed on 12/20/2022. The physician and NP were notified of results of assessments and medication adjustments and care plan revisions were made as needed for residents who reported insufficient pain control. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The DON educated current facility and agency licensed nurses on notifying the physician or NP in the event a resident is having inadequate pain control and the current facility and agency certified medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 580	Continued From page 3 11/22/22 at approximately 9:30 PM Resident #270 complained of bxxxhole pain and asked to be sent to the hospital. Nurse #4 obtained a set of vital signs and explained to the resident those were within normal limits and his pain medication was due soon and there was no clinical reason to send the resident to the hospital. The progress note indicated Resident #270 refused the pain medication stating it didn't work. The Director of Nursing (DON) was notified and agreed to not send the resident to the hospital for lack of a clinical reason however it was his right to call emergency medical service (EMS). Nurse #4 relayed the information to Resident #270 and EMS arrived at the facility at 10:56 PM to transfer the resident to the hospital. Review of the hospital discharge summary revealed Resident #270 was evaluated for abdominal pain using a computed tomography (diagnostic imaging of the inside of the body) and diagnosed with acute cholecystitis. General surgery was consulted and on 11/24/22 Resident #270's gallbladder was surgically removed. During a telephone interview on 12/14/22 at 9:56 AM Nurse #4 revealed after Resident #270 informed her of having anal pain she obtained a set of vital signs and those were within normal limits and gave the pain medication. Nurse #4 stated she didn't recall Resident #270 say the pain medication was ineffective, but her progress note documented what was done. Nurse #4 stated Resident #270 did not appear in distress, and everything had been normal for the resident that day. Nurse #4 stated she called the DON who agreed there was no clinical reason, but it was Resident #270's right to call EMS for transfer to hospital. Nurse #4 confirmed she did not notify	F 580	assistants (CMA) were educated to notify the licensed nurse if they have a resident reporting or exhibiting behaviors of inadequate pain control, so a pain assessment can be completed by the licensed nurse and follow-up notification to the physician or NP as necessary for new orders . Education was completed effective 01/06/2023. New facility and agency licensed nurses and CMA□s and staff unable to complete education by 1/6/2023 will be educated prior to working their next shift. 4. The DON or Unit Managers (UM) will audit five (5) residents twice weekly for 4 weeks, then weekly for 8 weeks to ensure physician and NP are notified if pain is not effectively managed with the resident□s current regimen. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 580	Continued From page 4 the MD for guidance. An interview was conducted on 12/14/22 at 4:21 PM with Resident #270. Resident #270 stated he told the nurse he was having a difficult time breathing and had stomach pain on 11/22/22 and called EMS because the nurse wouldn't. An interview was conducted on 12/16/22 at 4:46 PM with the DON. The DON revealed Nurse #4 called her about Resident #270 wanting to the hospital for anal pain and she didn't think that was a reason to send the resident out based on what the nurse told her. The DON revealed she didn't recall the being informed the pain medication was not effective and if she had her first response would be to call the physician. During an interview on 12/16/22 at 4:29 PM the Medical Director revealed would have expected to be notified Resident #270 was having pain and the medications were not relieving the pain so he could have evaluated the situation.	F 580		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 584	Continued From page 5 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to remove a black colored substance and repair caulking around the base of the toilet (Room #111, #116, #117, #118). Two of the rooms (Rooms #117 and #118) had a strong odor resembling the smell of urine. The facility failed to remove black colored corrosion and repair missing paint to the portion of a metal door frame in contact with the bathroom floor (Room #118); and failed to repair walls with linear	F 584	1. The facility failed to remove a black colored substance and repair caulking around the base of the toilet (Room #111, #116, #117, #118). Two of the rooms (Rooms #117 and #118) had a strong odor resembling the smell of urine. The facility failed to remove black colored corrosion and repair missing paint to the portion of a metal door frame in contact with the bathroom floor (Room #118); and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 584	Continued From page 6 gouges in the sheetrock (Rooms #117 and #118) and repair a hole in the sheetrock (Room #119) for 1 of 2 hallways reviewed for safe, clean, and homelike environment. The findings included: Review of the facility's estimates and billing for repairs made in 2022 revealed caulking the base of toilets, repair and paint gouges and holes to damage sheetrock, and removal of corrosion and paint a bathroom door were not included for the rooms observed with environment issues. 1a. An observation on 12/12/22 at 10:24 AM revealed the base of the toilet in the bathroom of Room #111 had black stains and missing caulk. b. An observation on 12/12/22 at 11:48 AM revealed the base of the toilet in the bathroom of Room #116 had black stains and missing caulk. c. An observation on 12/12/22 at 11:57 AM revealed the base of the toilet in the bathroom of Room #117 had black stains and missing caulk. A strong odor resembling the smell of urine was noted in the bathroom and the room. d. An observation on 12/12/22 at 2:12 PM revealed the base of the toilet in the bathroom of Room #118 had black stains and missing caulk. A strong odor resembling the smell of urine was noted in the bathroom and the room. 2. An observation on 12/12/22 at 2:12 PM revealed the metal frame of the bathroom door in Room #118 was corroded with a black substance and the paint had peeled off approximately 2 inches from where the frame was in contact with	F 584	failed to repair walls with linear gouges in the sheetrock (Rooms #117 and #118) and repair a hole in the sheetrock (Room #119) for 1 of 2 hallways reviewed for safe, clean, and homelike environment. All repairs were completed by the Maintenance Director effective 1/9/23. 2. Current facility residents have the potential to be affected by this deficient practice. The maintenance director and housekeeping staff completed environmental rounds to identify other areas needing repair and cleaning to the above cited issues. The surveillance rounds were completed on 12/26/2022 and a schedule initiated for ongoing cleaning and repairs to ensure a safe, clean, comfortable homelike environment for residents 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The administrator educated current housekeeping director and maintenance director, and current facility housekeeping staff on expectations of cleanliness, repairs, TELS (electronic maintenance reporting system), and the maintenance request logbook. Current facility and agency nursing staff received education on reporting needed repairs in the Maintenance Binder located at each nurses station. Education was completed by 1/9/2023. New facility maintenance and housekeeping staff and current nursing and agency staff unable to complete education by 1/9/2023 will be educated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 584	Continued From page 7 floor. The room had a strong odor that resembled the smell of urine. Subsequent observations of Room #118 on 12/13/22 at 9:00 AM and again on 12/13/22 at 4:30 PM revealed no repairs to the bathroom door. The room continued to have a strong odor resembling the smell of urine. 3a. An observation on 12/12/22 at 11:57 AM revealed the wall behind bed A and B in Room #117 had multiple linear gouges in the sheetrock. b. An observation on 12/12/22 at 2:12 PM revealed the wall behind the bed A and B in Room #118 had multiple linear gouges in the sheetrock. c. An observation on 12/12/22 at 3:30 PM revealed the wall underneath the window in Room #118 had a hole in the sheetrock approximately the size of small plate. A tour of the rooms identified with environment issues was conducted on 12/16/22 from 1:14 PM through 1:34 PM with the Maintenance Director, Administrator, and Regional Director of Operations. Rooms #111, #116, #117, #118, and #119 were observed to be in the same condition with no sign of repairs being made. The Maintenance Director stated he had worked at the facility for 11 months and was the only staff in the Maintenance Department. He walked through the building at least once a day and was aware of the repair issues shown but hadn't had a chance to address those because of higher priority repairs that were needed. The Maintenance Director stated usually, he identified repair needs by walking through the building or by work orders	F 584	prior to working their next scheduled shift. 4. The Administrator will monitor 5 resident rooms and all common areas twice weekly for 4 weeks and then weekly for 8 weeks to ensure facility is maintaining a homelike environment and completing worklist per log and maintenance reporting system. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 584	Continued From page 8 reported by the staff and it took different time frames to resolve the issues depending on the nature of the repair. The Maintenance Director and Administrator both agreed the odors in Room #117 and #118 resembled the smell of urine and could be caused by urine permeated between the flooring tiles and would require replacement to get rid of the smell. The Administrator and Maintenance Director revealed the new corporate office was aware of the current repair needs and planning to have something done soon.	F 584		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.	F 636		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 9 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD,	F 636	1. The facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, last	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 10 last day of the assessment period) for 8 of 9 residents reviewed for Resident Assessments (Residents #15, #38, #41, #45, #47, #60, #223, and #220). Findings included: 1. Resident #15 was admitted to the facility on 11/15/21. Review of Resident #15's medical record revealed an annual MDS assessment with an ARD of 11/06/22 that was marked as completed on 12/13/22. During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #15's annual MDS assessment dated 11/06/22 was not completed within the regulatory time frame. During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes. 2. Resident #38 was admitted to the facility on 10/27/21. Review of Resident #38's medical record revealed an annual MDS assessment with an ARD of 10/20/22 that was marked as completed on 11/30/22.	F 636	day of the assessment period) for 8 of 9 residents reviewed for Resident Assessments (Residents #15, #38, #41, #45, #47, #60, #223, and #220). Resident #15 had assessment dated 11/06/2022 completed on 12/13/2023. Resident #38 had assessment dated 10/20/2022 completed on 11/30/2022. Resident #41 had assessment dated 08/02/2022 completed on 09/14/2022. Resident #45 assessment dated 11/23/2022 was completed on 12/13/2022. Resident #47 assessment dated 08/02/2022 was completed on 09/24/2022. Resident #60 assessment dated 07/30/2022 was completed on 08/27/2022. Resident #223 assessment dated 08/24/2022 was completed on 09/14/2022. Resident #220 assessment dated 11/01/2022 was completed on 12/12/2022. 2. Current facility residents have the potential to be affected by this deficient practice. An audit was completed by the Minimum Data Set (MDS) coordinator on comprehensive MDS assessments with ARD dates between 11/20/2022 and 12/20/2022 to ensure all were completed, up to date, and submitted timely on 12/20/2022. Late assessments were completed and submitted by the MDS coordinator and Regional Clinical Reimbursement Specialist (RCRS) by 01/06/2023. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Effective 1/9/23,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 11 During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #38's annual MDS assessment dated 10/20/22 was not completed within the regulatory time frame. During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes. 3. Resident #41 was admitted to the facility on 08/31/21. Review of Resident #41's medical record revealed an annual MDS assessment with an ARD of 08/02/22 that was marked as completed on 09/11/22. During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #41's annual MDS assessment dated 08/02/22 was not completed within the regulatory time frame. During an interview on 12/16/22 at 5:24 PM, the	F 636	education was provided to the MDS coordinator and interdisciplinary team (IDT) by the RCRS on timely completion of comprehensive MDS□s within 14 days of ARD per the Resident Assessment Instrument (RAI) guidelines. 4. The IDT also implemented an update to their system of MDS completion by having a shared calendar of upcoming MDS□s and ARD dates to ensure collaboration and timely completion of comprehensive assessments. Education was completed by 01/06/2023. New facility MDS staff and current staff unable to complete education by 1/6/2023 will be educated prior to working their next scheduled shift. 5. The MDS coordinator and/or DON will monitor 5 random residents for timely completion of comprehensive assessments within 14 days of ARD. Monitoring will be completed twice weekly for 4 weeks, then weekly for 8 weeks. The facility will ensure deficient practice does not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing (DON) monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 6. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 12	F 636		

Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

4. Resident #45 was admitted to the facility on 12/09/20.

Review of Resident #45's medical record revealed an annual MDS assessment with an ARD of 11/23/22 that was marked as completed on 12/12/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #45's annual MDS assessment dated 11/23/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

5. Resident #47 was admitted to the facility on 07/27/22.

Review of Resident #47's medical record revealed an admission MDS assessment with an ARD of 08/02/22 that was marked as completed on 09/24/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 13	F 636		

starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #47's admission MDS assessment dated 08/02/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

6. Resident #60 was admitted to the facility on 07/18/22.

Review of Resident #60's medical record revealed an admission MDS assessment with an ARD of 07/30/22 that was marked as completed on 08/27/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #60's admission MDS assessment dated 07/30/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 14	F 636		

7. Resident #223 was admitted to the facility on 08/18/22.

Review of Resident #223's medical record revealed an admission MDS assessment with an ARD of 08/24/22 that was marked as completed on 09/14/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #223's admission MDS assessment dated 08/24/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

8. Resident #220 was admitted to facility on 10/25/22.

On 12/12/22, Resident 220's admission Minimum data set (MDS) with an assessment reference date (ARD) of 11/01/22 was observed as "in progress" and incomplete.

An interview was conducted on 12/12/22 at 3:40 PM with MDS nurse. She stated she started to work for the facility on 11/18/22. Another MDS nurse was filling in her position on "as needed" (PRN) basis prior to her employment. She did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 636	Continued From page 15 know that Resident #220's admission MDS was incomplete. During an interview conducted with the Regional MDS Coordinator on 12/12/22 at 3:42 PM, he acknowledged that Resident #220's admission MDS had been late. He explained the facility did not have a full time MDS nurse for more than 6 months in the past. The facility received assistance from a PRN MDS Nurse from another facility and he had to fill in the position most of the time in the past few months. An interview conducted on 12/16/22 at 10:49 AM with the Administrator revealed it was his expectation for all the MDS to be completed as scheduled according to the regulation in timely manner. During an interview with the Director of Nursing (DON) on 12/16/22 at 3:21 PM, she explained the facility did not have a full time MDS nurse in the past few months. It was her expectation for all the MDS to be completed as required by the regulation in timely manner.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the	F 638	1. The facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the	1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 638	Continued From page 16 Assessment Reference Date (ARD, the last day of the observation period) for 6 of 9 residents reviewed for Resident Assessments (Residents #41, #45, #46, #47, #56 and #60). Findings included: 1. Resident #41 was admitted to the facility on 08/31/21. Review of Resident #41's medical record revealed a quarterly MDS assessment with an ARD of 11/02/22 that was marked as completed on 12/13/22. During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #41's quarterly MDS assessment dated 11/02/22 was not completed within the regulatory time frame. During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes. 2. Resident #45 was admitted to the facility on 12/09/20. Review of Resident #45's medical record revealed a quarterly MDS assessment with an ARD of 10/10/22 that was marked as completed on 11/12/22.	F 638	Assessment Reference Date (ARD, the last day of the observation period) for 6 of 9 residents reviewed for Resident Assessments (Residents #41, #45, #46, #47, #56 and #60). Resident #41 quarterly assessment dated 11/02/2022 was completed on 12/13/2022. Resident #45 quarterly assessment dated 10/10/2022 was completed on 11/12/2022. Resident #46 quarterly assessment dated 08/05/2022 was completed 09/24/2022. Resident #47 quarterly assessment dated 10/27/2022 was marked completed on 12/04/2022. Resident #56 quarterly assessment dated 10/14/2022 was completed on 11/16/2022. Resident #60 quarterly assessment dated 10/30/2022 was completed on 12/12/2022. Assessments completed by the MDS Coordinator and submitted by the Regional Clinical Reimbursement Specialist (RCRS). 2. Current facility residents have the potential to be affected by this deficient practice. An audit was completed on 12/21/22 by the Minimum Data Set (MDS) coordinator on quarterly MDS assessments with ARD dates between 11/20/2022 and 12/20/2022 to ensure all were completed, audit completed on 12/20/2022. Late quarterly MDSs were completed and submitted as identified 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Education was provided to the MDS coordinator by the RCRS on timely completion of quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 638	Continued From page 17 During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #45's quarterly MDS assessment dated 10/10/22 was not completed within the regulatory time frame. During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes. 3. Resident #46 was admitted to the facility on 04/25/21. Review of Resident #46's medical record revealed a quarterly MDS assessment with an ARD of 08/05/22 that was marked as completed on 09/24/22. During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #46's quarterly MDS assessment dated 08/05/22 was not completed within the regulatory time frame. During an interview on 12/16/22 at 5:24 PM, the	F 638	MDS□s per Resident Assessment Instrument (RAI) guidelines. The IDT also implemented an update to their system of MDS completion by having a shared calendar of upcoming MDS□s and ARD dates. Education was completed by 01/06/2023. New facility MDS nurses and IDT members and current staff unable to complete education by 1/6/2023 will be educated prior to working their next scheduled shift. 4. The MDS coordinator and/or DON will monitor 5 random residents for timely completion of quarterly MDS assessments within 14 days of ARD. Monitoring will be completed twice weekly for 4 weeks, then weekly for 8 weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and does not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing (DON) monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 638	Continued From page 18	F 638		

Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

4. Resident #47 was admitted to the facility on 07/27/22.

Review of Resident #47's medical record revealed a quarterly MDS assessment with an ARD of 10/27/22 that was marked as completed on 12/04/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #47's quarterly MDS assessment dated 10/27/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

5. Resident #56 was admitted to the facility on 04/06/22.

Review of Resident #56's medical record revealed a quarterly MDS assessment with an ARD of 10/14/22 that was marked as completed on 11/16/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 638	Continued From page 19	F 638		

starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #56's quarterly MDS assessment dated 10/14/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

6. Resident #60 was admitted to the facility on 07/18/22.

Review of Resident #60's medical record revealed a quarterly MDS assessment with an ARD of 10/30/22 that was marked as completed on 12/12/22.

During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #60's quarterly MDS assessment dated 10/30/22 was not completed within the regulatory time frame.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated due to staffing shortages, they had been unable to complete MDS assessments within the regulatory timeframes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 655	Continued From page 21 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement a baseline care plan within 48 hours of admission to address the immediate needs for 1of 5 residents reviewed for new admissions (Resident #50). The findings included: Review of the hospital discharge summary dated 11/16/22 revealed Resident #50 had fallen at home, was sent to the hospital and diagnosed with a fractured right ankle. After an orthopedic consult, an open reduction and internal fixation surgical procedure was done on 10/26/22 to stabilize the right ankle. Resident #50 was discharged with instructions including to only bear 25% of weight to the right lower extremity, elevate the right leg for swelling, apply a controlled ankle motion (CAM) boot to the right ankle when out of bed, and to use fall precautions. Resident #50 was admitted to the facility on 11/16/22 with diagnoses including Alzheimer's, a fracture of the right ankle, and chronic respiratory failure with hypoxia (decreased oxygen levels). Review of the physician order dated 11/16/22 included administration of an inhaled albuterol (a medication to relax the airways of the lungs to improve breathing) to be given every 6 hours. Review of the physician order dated 11/17/22	F 655	1. The facility failed to develop and implement a baseline care plan within 48 hours of admission to address the immediate needs for 1of 5 residents reviewed for new admissions (Resident #50). Resident #50 comprehensive care plan was completed on 12/07/2022 and in place to help guide care of resident. 2. Newly admitted residents have the potential to be affected by the deficient practice. The Director of Nursing (DON) audited for dates between 11/20/2022 and 12/20/2022 to ensure there was a baseline care plan in place within forty-eight (48) hours of admission. Audit completed on 12/20/2022. No additional residents were affected. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Education was provided by the Regional Director of Clinical Services (RDCS) on timely completion of baseline care plans to current facility and agency licensed nurses, activities director, certified dietary manager, and MDS coordinator. Education was completed by 01/06/2023. New facility and agency MDS staff, licensed nurses, social services director, dietary manager, activities director and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 655	Continued From page 22 included administration of oxygen at 2 liters per minute for chronic obstructive pulmonary disease. Review of the physician order dated 11/18/22 instructed nursing staff to observe for pain every day and night shifts. Review of Resident #50's medical records revealed there was no baseline care plan in place within 48 hours of admission to include the immediate need for fall precautions and interventions in place for the fractured ankle, and the use of oxygen. An interview was conducted on 12/16/22 at 4:00 PM with the Director of Nursing and Administrator. The Administrator stated the admitting nurse was in charge of completing the baseline care plan for new admissions and the MDS Nurse was supposed to double check and ensure it was done.	F 655	current staff unable to complete education by 1/6/2023 will be educated prior to working their next scheduled shift. 4. The Director of Nursing (DON) will audit all new admissions three (3) times a week for four (4) weeks and then weekly for eight (8) weeks to ensure a baselines care plan is completed within 48 hours of admission. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing (DON) monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-	F 660		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 660	Continued From page 23	F 660		

(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 660	Continued From page 24 SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge plan that addressed the resident's discharge goals and post-discharge needs for a resident who wished to discharge to the community for 1 of 2 sampled residents (Resident #45). Findings included: Resident #45 was admitted to the facility on 12/09/20 with diagnoses that included chronic obstructive pulmonary disease (difficulty	F 660	1. The facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge plan that addressed the resident's discharge goals and post-discharge needs for a resident who wished to discharge to the community for 1 of 2 sampled residents (Resident #45). An updated discharge assessment was completed on 12/29/2022 by licensed nurse. 2. All current facility residents have the potential to be affected by this deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 660	Continued From page 25	F 660		

breathing), congestive heart failure and depression.

A social services progress note written by the Social Worker (SW) on 04/07/22 revealed Resident #45 was approved for a Medicaid program that helped individuals residing in nursing homes transition to their home in the community with support.

The quarterly Minimum Data Set (MDS) dated 10/10/22 indicated Resident #45 had moderate impairment in cognition. The MDS noted active discharge planning was in place and a referral was made to the local contact agency (organization responsible for providing counseling to nursing home residents regarding community support options).

A social services progress note written by the SW on 11/03/22 read in part, "SW sat with Resident #45 and explained housing."

Review of Resident #45's comprehensive care plan, last reviewed/revised 12/07/22, revealed no discharge care plan.

During interviews on 12/12/22 at 10:26 AM and 12/15/22 at 09:34 AM, Resident #45 stated his goal was to find an apartment and return to the community. Resident #45 explained he had planned on discharging to a family members home last year but it was cancelled due to concerns he wouldn't be able to climb the stairs to get to the bathroom that was located on the second floor of the apartment. Resident #45 stated he recently spoke with the facility's SW about wanting to return to the community and they had reviewed the paperwork for housing

practice. Current resident plans of care were audited by minimum data set (MDS) nurse and was completed on 01/06/2023 to ensure they had a person-centered discharge care plan in place. Residents identified that did not have a discharge care plan in place were interviewed by the mds coordinator and discharge assessments and care plan revisions were completed by the IDT 01/06/2023.

3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Education was provided by the Regional Clinical Reimbursement Specialist (RCRS) nurse on the process of ensuing person-centered discharge care plans are completed to current director of nursing, activities director, certified dietary manager, and MDS coordinator. Education was completed by 01/06/2023. New facility and agency MDS staff, social services director, dietary manager, activities director, and current staff unable to complete education by 1/6/2023 will be educated prior to working their next scheduled shift.

4. The MDS coordinator will audit five (5) residents including planned discharges three (3) times a week for four (4) weeks and then weekly for eight (8) weeks to ensure the resident has a person-centered discharge care plan in place. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 660	Continued From page 26 options; however, the SW had since left employment and he had not heard anything further regarding the process. A telephone attempt on 12/15/22 at 9:21 AM for interview with the former SW was unsuccessful. During interviews on 12/15/22 at 3:54 PM and 12/16/22 at 4:05 PM, the Administrator revealed the SW was responsible for developing discharge care plans and updating them as discharge plans progressed. The Administrator explained the facility was currently without a SW and he was handling discharges until the position was filled. The Administrator stated Resident #45 spoke with him yesterday about wanting to discharge home and he had informed Resident #45 he would review the former SW's documentation to determine where she was in the process and proceed from there. The Administrator stated he would have expected the SW to develop a discharge care plan that addressed Resident #45's goal to return to the community.	F 660	during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the MDS coordinator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the	F 684	1. The facility failed to complete a	1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 684	Continued From page 27 Medical Director and staff the facility failed to complete a thorough assessment of a resident requesting to go to the emergency room due to increased pain. The resident called emergency medical services and was transported to the hospital and diagnosed with acute cholecystitis (inflammation of the gallbladder) that required surgical removal of the gallbladder for 1 of 2 residents reviewed for hospitalization (Resident #270). The findings included: Resident #270 was admitted to the facility on 05/15/20 with diagnoses including a history of cervical spine trauma and quadriplegia. Resident #270 was discharged to the hospital on 11/22/22. The quarterly Minimum Data Set dated 08/29/22 revealed Resident #270 was assessed as being cognitively intact. Routine and as needed pain medications were received during the lookback period and the resident reported his pain was moderate, frequent, and interfered with sleep and activities. Opioids (narcotic pain medications) were given all 7 days during the lookback period. Review of the Medication Administration Record (MAR) revealed a physician's order for oxycodone-acetaminophen (a narcotic pain medication) 5-325 milligrams every 6 hours as needed for pain management. The MAR revealed from 11/01/22 through 11/21/22 Resident #270 received 19 doses out of 84 available for his pain and doses received were considered effective. No pain medication was administered on 11/18/22 and 11/19/22. On 11/20/22 one dose was administered at 7:38 PM and consider effective. On 11/21/22 one dose was	F 684	thorough assessment of a resident requesting to go to the emergency room due to increased pain. The resident called emergency medical services and was transported to the hospital and diagnosed with acute cholecystitis (inflammation of the gallbladder) that required surgical removal of the gallbladder for 1 of 2 residents reviewed for hospitalization (Resident #270. Resident #270 had thorough pain assessment completed by nurse practitioner (NP) on 12/15/2022 upon readmission from the hospital. NP continued current pain regimen due to resident stating the current regime treats pain adequately. 2. All current facility residents have potential to be affected by this deficient practice. The Director of Nursing (DON) and unit managers (UMs) completed a pain assessment on all current facility residents on 12/20/2022. The physician and nurse practitioner were notified of results of assessments and medication adjustments and care plan revisions were made as needed for residents who reported insufficient pain control. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The DON educated current facility and agency licensed nurses on notifying the physician and NP in the event a resident is having inadequate pain control and the current facility and agency certified medication assistants (CMA) and certified nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 684	Continued From page 28 administered at 7:51 PM and considered effective. On 11/22/22 one dose was administered at 3:56 PM and considered effective and a second dose was given at 10:06 PM and considered effective. Review of the nurse progress note dated 11/22/22, written by Nurse #4, revealed on 11/22/22 at approximately 9:30 PM Resident #270 complained of bxxxhole pain and asked to be sent to the hospital. Nurse #4 obtained a set of vital signs and explained to the resident those were within normal limits and his pain medication was due soon and there was no clinical reason to send the resident to the hospital. The progress note indicated Resident #270 refused the pain medication stating it didn't work. The Director of Nursing (DON) was notified and agreed to not send the resident to the hospital for lack of a clinical reason however it was his right to call emergency medical service (EMS). Nurse #4 relayed the information to Resident #270 and EMS arrived at the facility at 10:56 PM to transfer the resident to the hospital. Review of the hospital discharge summary revealed Resident #270 was evaluated for abdominal pain using a computed tomography (diagnostic imaging of the inside of the body) and diagnosed with acute cholecystitis. General surgery was consulted and on 11/24/22 Resident #270's gallbladder was surgically removed. During a telephone interview on 12/14/22 at 9:56 AM Nurse #4 revealed after Resident #270 informed her of having anal pain she obtained a set of vital signs and those were within normal limits and gave the pain medication. Nurse #4 stated she didn't recall Resident #270 say the	F 684	aides (CNA) were educated to notify the nurse if a resident reports pain or is exhibiting behaviors indicative of inadequate pain control such as moaning, grimacing, tearfulness, etc. so that a pain assessment can be completed by the licensed nurse and follow-up notification to physician or NP made as necessary for new orders to manage resident pain. Education was completed on 01/09/2023. New facility and agency licensed nurses and CMA□s and staff unable to complete education by 1/09/2023 will be educated prior to working their next shift. 4. The DON or Unit Managers (UM) will audit five (5) residents twice weekly for 4 weeks, then weekly for 8 weeks to ensure a comprehensive pain assessment is completed, and physician/NP are notified if pain is not effectively managed with the residents current regimen. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 684	Continued From page 29 pain medication was ineffective, but she documented what she did in her progress note. Nurse #4 stated Resident #270 did not appear in distress, and everything had been normal for the resident that day. Nurse #4 stated she called the DON who agreed there was no clinical reason, but it was Resident #270's right to call EMS for transfer to hospital. Nurse #4 revealed Resident #270 did call EMS and was transferred to the hospital. An interview was conducted on 12/14/22 at 4:21 PM with Resident #270. Resident #270 stated he told the nurse he was having a difficult time breathing and had stomach pain on 11/22/22 and had to call EMS because the nurse wouldn't. During an interview on 12/16/22 at 4:46 PM the DON revealed Nurse #4 called her stating Resident #270 complained his bxxxhole was hurting and he needed to go to the hospital. The DON stated she didn't think that was a reason to send the resident out based on what the nurse was telling her and didn't recall the nurse saying the resident's pain medication was not effective. The DON revealed Resident #270 did call EMS that night and was transferred to the hospital. The DON revealed Resident #270 had called EMS the previous weekend and went to the hospital and wasn't admitted and was sent back to the facility the same day. During an interview on 12/16/22 at 4:29 PM the Medical Director revealed would have expected to be notified Resident #270 was having pain and the medications were not relieving the pain so he could have evaluated the situation.	F 684		
F 745 SS=E	Provision of Medically Related Social Service	F 745		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 745	Continued From page 30 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Doctor (MD) and staff interviews, the facility failed to refer residents for consultation appointments per MD order for 2 of 4 sampled residents (Resident #38 and #45). Findings included: 1. Resident #38 was admitted to the facility on 10/27/21. His diagnoses included occlusion and stenosis of unspecified carotid artery (narrowing or blockage of the large arteries on either side of the neck) and personal history of transient ischemic attack (mini-stroke caused by a temporary disruption in the blood supply to part of the brain). An active MD order dated 08/31/22 for Resident #38 read in part, "referral to Vascular MD (a doctor who specializes in the treatment of arteries and veins) for carotid stenosis." A MD progress note dated 12/07/22 for Resident #38 read in part, "referral to Vascular MD for carotid artery stenosis." Review of Resident #38's medical record revealed no documentation related to an appointment with a Vascular MD. During an interview on 12/15/22 at 2:54 PM, the	F 745	1. The facility failed to refer residents for consultation appointments per MD order for 2 of 4 sampled residents (Resident #38 and #45). Physician notified of missed referrals and Resident #38 referral was sent to consulting physician and appointment scheduled. Resident #45 was referral sent to consulting physician and appointment scheduled. 2. All current facility residents have potential to be affected by this deficient practice. Director of nursing (DON) and Unit Managers reviewed all current facility residents for referral orders to ensure all referrals had been placed. Audit completed on 01/06/2023. No additional concerns identified. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Regional Director of Clinical Services (RDCS) educated the DON and unit managers on process of reviewing orders daily during morning clinical meeting to validate that referral orders were successfully faxed to consulting physician and appointment made timely as appropriate. The DON and unit managers are responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 745	Continued From page 31 Assistant Business Office Manager (BOM) revealed she was responsible for scheduling resident appointments until October 2022 when the Transportation Aide started employment and took over. She added when the Transportation Aide quit in December 2022, she resumed the process of arranging resident appointments and tried to schedule them as soon as she was made aware of the referral. The Assistant BOM stated she was not informed of Resident #38's MD order dated 08/31/22 for a referral to a Vascular MD and confirmed an appointment had not been arranged. The Assistant BOM explained she didn't read the MD progress notes and was usually notified of the referral when staff brought her a copy of the MD order or she received an email from the MD but that didn't always happen. During a joint interview with the Director of Nursing (DON) and Regional Nurse Consultant on 12/15/22 at 4:17 PM, the DON explained her process was to review the 24-hour order listing report and confirm all new orders with the MD and/or Nurse Practitioner. She added once the order for a referral was confirmed, the information was faxed to the MD's office for them to call the facility to make the appointment and a printed copy of the MD order was given to the Assistant BOM, or Transportation Aide when hired, so they were aware and ensure the appointment was arranged. The DON stated when the MD mentioned to her today that Resident #38's referral dated 08/31/22 had not been made, she faxed all the information to the Vascular MD's office to arrange the appointment. The DON stated she was not employed in August 2022 when the initial referral for Resident #38 was ordered by the MD and was not sure what happened or why the appointment was not	F 745	faxing referrals and scheduling the appointment upon receipt of the referral order. Education was completed by 01/09/2023. New facility and agency DON and unit managers and staff unable to complete education by 1/9/2023 will be educated prior to working their next shift. 4. The DON will audit five (5) residents three (3) times a week for four (4) weeks and then weekly for eight (8) weeks to ensure all referrals appointments are made timely as ordered. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 745	Continued From page 32	F 745		

arranged. She further stated nursing staff should have given a printed copy of the MD order to the Assistant BOM for the appointment to be scheduled.

The joint interview with the Director of Nursing (DON) and Regional Nurse Consultant continued. The Regional Nurse Consultant explained their new process for referrals was for the MD to enter the order into the resident's medical record and each morning, the DON pulled the 24-hour order listing report to review during clinical meeting. The Regional Nurse Consultant stated the MD had mentioned having issues with referrals not being completed and she explained to the MD if they had been made aware when the issues were first identified, they could have addressed or fixed the process. The Regional Nurse Consultant stated she felt the lack of communication was one of the main reasons referrals were missed but felt confident the system they now had in place would be more efficient.

During an interview on 12/14/22 at 3:01 PM and follow-up telephone interview on 12/16/22 at 4:26 PM, the MD explained whenever he made a referral for resident, he typically entered the order into the resident's medical record, documented it in his progress notes and notified facility staff via email correspondence. The MD stated he was not sure why the appointment was not made when he initially ordered Resident #38's referral for a Vascular appointment on 08/31/22. The MD stated while there was no harm caused due to the delay in arranging the appointment for Resident #38, he wanted the appointment scheduled with the Vascular MD for medical management of Resident #38's carotid artery stenosis. The MD stated he expected for referral appointments to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 745	Continued From page 33	F 745		

be made as requested and per order.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated it was his expectation for appointments to be arranged per MD order.

2. Resident #45 was admitted to the facility on 12/09/20. His diagnoses included mechanical loosening of internal prosthetic joint.

An active MD order dated 11/23/22 for Resident #45 read in part, "please ensure he has an Orthopedic appointment for loose, right hip hemiarthroplasty (surgical procedure where half of the hip is replaced).

Review of Resident #45's medical record revealed no documentation of an appointment with an Orthopedic MD in November 2022 or December 2022.

During an interview on 12/15/22 at 2:54 PM, the Assistant Business Office Manager (BOM) revealed she was responsible for scheduling outside appointments until October 2022 when the Transportation Aide started employment and took over. She added when the Transportation Aide quit in December 2022, she resumed the process of arranging resident appointments and was unaware of Resident #45's MD order for an Orthopedic appointment.

During a joint interview with the Director of Nursing (DON) and Regional Nurse Consultant on 12/15/22 at 4:17 PM, the DON explained her process was to review the 24-hour order listing report and confirm all new orders with the MD and/or Nurse Practitioner. She added once the order for a referral was confirmed, the information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 745	Continued From page 34	F 745		

was faxed to the MD's office for them to call the facility to make the appointment and a printed copy of the MD order was given to the Assistant BOM, or Transportation Aide when hired, so they were aware and ensure the appointment was arranged. The DON stated she was not sure how Resident #45's MD order for an Orthopedic appointment dated 11/23/22 was missed and it should have been scheduled.

The joint interview with the DON and Regional Nurse Consultant continued. The Regional Nurse Consultant explained their new process for referrals was for the MD to enter the order into the resident's medical record and each morning, the DON pulled the 24-hour order listing report to review during clinical meeting. The Regional Nurse Consultant stated the MD had mentioned having issues with referrals not being completed and she explained to the MD if they had been made aware when the issues were first identified, they could have addressed or fixed the process. The Regional Nurse Consultant stated she felt the lack of communication was one of the main reasons referrals were missed but felt confident the system they now had in place would be more efficient.

During an interview on 12/14/22 at 3:01 PM and follow-up telephone interview on 12/16/22 at 4:26 PM, the MD explained whenever he made a referral for resident, he typically entered the order into the resident's medical record, documented it in his progress notes and notified facility staff via email correspondence. The MD stated he expected for referral appointments to be made as requested and per order.

During an interview on 12/16/22 at 5:24 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 745	Continued From page 35 Administrator stated it was his expectation for appointments to be arranged per MD order.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not	F 756		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 756	Continued From page 36 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, Nurse Practitioner (NP), and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident #44). The findings included: Review of the lipid guidelines published in 2019 by the American College of Cardiology and American Heart Association indicated lipid panel should be conducted at baseline, then 4 to 12 weeks after statin therapy was started or when dosage was adjusted. Afterwards, lipid panel test should be repeated once every 3 to 12 months as needed. Resident #44 was admitted to the facility on 09/24/21 with diagnoses that included hyperlipidemia and high blood pressure. Review of physician's orders revealed Resident #44 had obtained orders to receive 1 tablet of atorvastatin 80 milligrams (mg) once daily at bedtime for high cholesterol since 09/24/21. On 06/03/22, dosage of atorvastatin was reduced to 40 mg once daily in the morning. Starting 10/07/22, the physician changed atorvastatin order to 40 mg once daily at bedtime. A review of medication administration records	F 756	1. The Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident #44). Pharmacy consultant reviewed medications for Resident #44 on 12/15/2022. Recommendation and lipid panel ordered and completed as appropriate. 2. All current facility residents taking medications to treat hyperlipidemia have potential to be affected by this deficient practice. Effective 1/9/23, current facility residents on hyperlipidemia were reviewed by the physician and nurse practitioner, lipid panels were ordered and obtained. Results were reviewed with physician, nurse practitioner, and pharmacy consultant. Lab monitoring orders were received and scheduled as appropriate for future monitoring of these medications. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Regional Director of Clinical Services (RDCS) educated the pharmacy consultant on drug regime review and recommendations for residents on hyperlipidemia treatment. Education was completed on 01/06/2023. The Director of Nursing (DON) will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 756	Continued From page 37 (MARs) indicated Resident #44 had received atorvastatin as ordered since statin therapy was initiated on 09/24/21. Review of all the labs for Resident #44 revealed a lipid panel test had never been done since her admission on 09/24/21. The annual Minimum Data Set (MDS) dated 10/05/22 assessed Resident #44 with intact cognition. Review of Resident #44's medical records revealed the Consultant Pharmacist had conducted medication regimen reviews monthly from 03/10/22 through 11/15/22. The Consultant Pharmacist had made one recommendation to the physician in the past 6 months on 06/09/22, but it was not related to cholesterol monitoring. Review of vital signs from 11/27/21 through 12/12/22 revealed Resident #44's BP and pulse were within the normal limits most of the time. During an interview conducted on 12/14/22 at 11:56 AM, Resident #44 could not recall having any lipid panel test since being admitted to the facility. An interview conducted with Nurse #3 on 12/14/22 at 4:33 PM revealed she had measured Resident #44's vital signs and indicated that they were within normal limits. She could not find any records of lipid panel tests and did not recall performing any lipid panel test for Resident #44. During an interview conducted with the NP on 12/15/22 at 9:00 AM, she stated Resident #44 should have a lipid panel test in place to monitor	F 756	pharmacy consultant report and recommendations monthly to ensure residents on hyperlipidemia treatment are reviewed by the consulting pharmacist with appropriate recommendations made for lab monitoring to identify drug irregularities. 4. The DON will monitor 5 residents taking medications to treat hyperlipidemia to ensure consulting pharmacist makes recommendations as necessary to identify drug irregularities. Monitoring will be completed twice weekly for 4 weeks then weekly for 8 weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 756	Continued From page 38	F 756		

her cholesterol level, especially after the dosage changes in June 2022. She expected the Consultant Pharmacist to recommend the provider to order a lipid panel test for cholesterol monitoring.

During a phone interview with the Consultant Pharmacist on 12/15/22 at 9:34 AM, he stated that he had conducted Resident #44's medication regimen reviews (MRRs) in the past 6 months. He was aware that Resident #44 had statin therapy since admission and the dosage had been decreased in June 2022. He had access to Resident #44's electronic health records including all the labs uploaded by the facility's staff. He did not notice lipid panel had not been completed for Resident #44 since her admission approximately 15 months ago. He explained when he did the recent monthly MRRs, he did not review Resident #44's statin therapy prior to 10/07/22 as shown in the MAR. Because of this, he did not recommend the provider to consider ordering lipid panel test for cholesterol level monitoring.

During an interview conducted with the Director of Nursing (DON) on 12/15/22 at 10:34 AM, she acknowledged that lipid panel test was not in place for Resident #44 since her admission. It was her expectation for the CP to recommend the provider in timely manner to consider lipid panel test for cholesterol monitoring per the guidelines.

Interview conducted with the Administrator on 12/16/22 at 10:49 AM revealed it was his expectation to monitor cholesterol level of all the residents who were receiving statin therapy per the guidelines.

During a phone interview with the MD on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 756	Continued From page 39 12/16/22 at 4:24 PM, he expected residents who were taking atorvastatin for cholesterol control and not under hospice care to have a lipid panel test in place to monitor the cholesterol level per the guidelines. Otherwise, he would expect the Consultant Pharmacist to remind the provider.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, Nurse Practitioner (NP), and Medical Director (MD), the facility failed to monitor cholesterol level for 1 of 5 residents reviewed for unnecessary medications	F 757	1. The facility failed to monitor cholesterol level for 1 of 5 residents reviewed for unnecessary medications (Resident #44). Lipid panel was ordered, collected, and results reviewed by	1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 757	Continued From page 40	F 757		

(Resident #44).

The findings included:

Review of the lipid guidelines published in 2019 by the American College of Cardiology and American Heart Association indicated lipid panel should be conducted at baseline, then 4 to 12 weeks after statin therapy was started or when dosage was adjusted. Afterwards, lipid panel test should be repeated once every 3 to 12 months as needed.

Resident #44 was admitted to the facility on 09/24/21 with diagnoses that included hyperlipidemia and high blood pressure.

Review of physician's orders revealed Resident #44 had obtained orders to receive 1 tablet of atorvastatin 80 milligrams (mg) once daily at bedtime for high cholesterol since 09/24/21. On 06/03/22, dosage of atorvastatin was reduced to 40 mg once daily in the morning. Starting 10/07/22, the physician changed atorvastatin order to 40 mg once daily at bedtime.

A review of medication administration records (MARs) indicated Resident #44 had received atorvastatin as ordered since statin therapy was initiated on 09/24/21.

Review of all the labs for Resident #44 revealed lipid panel test had never been done since her admission on 09/24/21.

The annual Minimum Data Set (MDS) dated 10/05/22 assessed Resident #44 with intact cognition.

physician on 12/16/2022.

2. All current facility residents receiving statin medication therapy to treat high cholesterol have the potential to be affected by this deficient practice. Effective 1/9/23, the Director of Nursing (DON) completed an audit to identify current residents receiving statin medication therapy to treat high cholesterol and to identify if lab monitoring has been completed as required. Findings were reported to the physician and nurse practitioner and orders were obtained and completed for residents identified. Results were reported by the licensed nurse to the physician and/or NP with follow-up as indicated with lab monitoring orders received and scheduled as appropriate.

3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Director of Nursing (DON) educated the physician and nurse practitioner (NP) on ensuring proper lab monitoring for residents receiving statin medication therapy to treat high cholesterol to ensure residents drug regime is free from unnecessary drugs. Education was completed on 01/09/2023. Newly hired physicians and NPs will receive education upon hire. A list of medications with recommended lab monitoring was provided to the medical providers and posted at nurses station for quick reference.

4. The DON will audit five (5) residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 757	Continued From page 41 During an interview conducted on 12/14/22 at 11:56 AM, Resident #44 could not recall having any lipid panel test since being admitted to the facility. An interview conducted with Nurse #3 on 12/14/22 at 4:33 PM revealed she could not find any records of lipid panel tests and did not recall performing any lipid panel test for Resident #44. During an interview conducted with the NP on 12/15/22 at 9:00 AM, she stated Resident #44 should have a lipid panel test in place to monitor her cholesterol level, especially after the dosage changes in June 2022. During a phone interview with the Consultant Pharmacist on 12/15/22 at 9:34 AM, he stated that he had conducted Resident #44's medication regimen reviews (MRRs) in the past 6 months. He was aware that Resident #44 had statin therapy since admission and the dosage had been decreased in June 2022. He had access to Resident #44's electronic health records including all the labs uploaded by the facility staff. He did not notice lipid panel was not in place for Resident #44 since her admission approximately 15 months ago. During an interview conducted with the Director of Nursing (DON) on 12/15/22 at 10:34 AM, she acknowledged that lipid panel test was not in place for Resident #44 since her admission. It was her expectation for the Consultant Pharmacist to recommend the provider in timely manner to consider lipid panel test for cholesterol monitoring per the guidelines. Interview conducted with the Administrator on	F 757	receiving statin medication therapy to treat high cholesterol twice weekly for four (4) weeks then weekly for eight (8) weeks for appropriate lab monitoring. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 757	Continued From page 42 12/16/22 at 10:49 AM revealed it was his expectation to monitor cholesterol level of all the residents who were receiving statin therapy in timely manner per the guidelines. During a phone interview with the MD on 12/16/22 at 4:24 PM, he expected residents who were taking atorvastatin for cholesterol control and not under hospice care to have a lipid panel test in place to monitor the cholesterol level per the guidelines. Otherwise, he would expect the Consultant Pharmacist to recommend the provider.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 758	Continued From page 43 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacist in Charge and the Medical Director the facility failed to ensure an as needed psychotropic medication was used for a limited duration of time of 14 days or provide a rational to continue the use for 1 of 5 residents reviewed for unnecessary medications (Resident #50). The findings included: Review of the hospital discharge summary dated 11/16/22 listed the medications Resident #50 was to continue taking and included instructions to	F 758	1. The facility failed to ensure an as needed psychotropic medication was used for a limited duration of time of 14 days or provide a rational to continue the use for 1 of 5 residents reviewed for unnecessary medications (Resident #50). Resident #50 as needed psychotropic medication was discontinued on 12/14/2022. 2. Current facility residents on as needed psychotropic medications have potential to be affected by this deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 758	Continued From page 44 give trazodone (an antidepressant medication) 50 milligrams (mg) every night at bedtime as needed for insomnia. Resident #50 was admitted to the facility on 11/16/22 with diagnoses including Alzheimer's, diabetes mellitus, chronic respiratory failure with hypoxia (decreased oxygen levels), and chronic kidney disease. Resident #50 was discharge to the hospital on 12/13/22. Review of the physician orders revealed trazodone 50 mg give 1 tablet as needed for insomnia was started on 11/16/22. Review of the admission Minimum Data Set dated 11/23/22 revealed Resident #50's cognition was assessed as being severely impaired and antidepressant medications were received for 7 days during the lookback period. A care plan for the use of psychotropic medications related to disease process, depression, and insomnia was initiated on 12/05/22. Interventions included to administer psychotropic medications as ordered by the physician and consult with pharmacy and the Medical Doctor to consider dosage reduction when clinically appropriate and at least quarterly. Review of the Medication Administration Records (MAR) for November and December 2022 revealed the physician's order for trazodone 50 mg give 1 tablet as needed for insomnia and was started on 11/16/22 and discontinued on 12/14/22. The MAR revealed Resident #50 received one dose of trazodone on 11/22/22 for insomnia that was considered effective.	F 758	practice. All current facility residents as needed psychotropic medications were audited by the Director of Nursing (DON) on 12/21/2022 to ensure each had appropriate stop dates per Centers for Medicare and Medicaid Services (CMS) regulation. No further residents identified during audit. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Effective 1/9/23, the DON educated current facility and agency licensed nurses and physician and nurse practitioner (NP) on guidelines for unnecessary as needed psychotropic medications and ensuring appropriate stop dates are in place with physician rationale for continued use if extending beyond 14 days. Education also included that as needed antipsychotic medications are excluded from extending beyond 14 days. Newly hired facility and agency licensed nurses not receiving education by 01/09/23 will receive education prior to next worked shift. 4. The DON will audit five (5) residents on as needed psychotropic medications twice weekly for four (4) weeks and then weekly for eight (8) weeks to ensure appropriate stop dates and physician rationale for any use beyond 14 days (excluding antipsychotics) are in place per guidelines. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 758	Continued From page 45 During an interview on 12/16/22 at 11:40 AM the Pharmacist in Charge revealed the consultant reviewed the medications when a resident was admitted to the facility. The Pharmacist in Charge stated trazodone was a psychotropic medication and if used as needed a 14 day stop dated should be in place and reevaluated by the prescriber for use of the medication. An interview was conducted on 12/16/22 at 4:29 PM with the Medical Director. The Medical Director stated trazodone was a psychotropic medication and if ordered to be used as needed, he would expect a 14 day stop date.	F 758	during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 761	Continued From page 46 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to store unopened medications in the temperatures specified by manufacturer's guidelines for 2 or 4 medications carts observed (East Front and East Back medication carts) during medication storage checks. The findings included: 1. Review of manufacturer's package insert for insulin Aspart indicated unused insulin Aspart should be stored in a refrigerator between 36° to 46° Fahrenheit (F). Once opened, the insulin pen may be stored at room temperature up to 86 F for up to 28 days. Review of manufacturer's package insert for Latanoprost eye drops reveled unopened bottle should be stored under refrigeration between 36° to 46°F and protected from light. Once opened, Latanoprost may be stored at room temperature up to 77F for up to six weeks. An observation was conducted on 12/13/22 at 3:58 PM for the East Front medication cart in the presence of Nurse #1. The observation revealed one unopened bottle of Latanoprost eye drop still in the plastic seal, and 1 unopened pen of insulin aspart also wrapped in the plastic seal. Both unopened medications were stored in the room temperature and prescribed for Resident #44.	F 761	1. The facility failed to store unopened medications at the temperatures specified by manufacturer's guidelines for 2 or 4 medications carts observed (East Front and East Back medication carts) during medication storage checks. The Director of Nursing (DON) disposed of medications that were not stored correctly as identified on 12/16/2022. 2. All current facility residents have potential to be affected by this deficient practice. The DON and unit managers audited all medication carts and medication storage rooms to ensure all medication requiring refrigeration are properly stored and properly dated and labeled when removed from refrigeration and placed on the medication cart for resident use. Audit completed on 12/23/2022. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The DON educated current facility and agency licensed nurses and certified medication aides (CMAs) on proper medication storage and placed reference tools at nursing station. Licensed nurses and CMA□s are responsible for immediately dating and labeling medications upon	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 761	Continued From page 47 Review of physician's orders and medication administration records (MARs) revealed Resident #44 had a current order to receive the mentioned insulin and eye drops. An interview was conducted with Nurse #1 on 12/13/22 at 4:09 PM. She stated the hall nurses were instructed to check their respective medication cart at least once weekly for expired medication and proper storage. She added this medication cart was indeed checked by the Unit Manager (UM) this morning. She did not know why the unopened insulin and eye drops were stored in room temperature in the medication cart. During an interview with the UM on 12/13/22 at 4:17 PM, she stated the Director of Nursing (DON) had set up routine medication cart checks at least once weekly to ensure proper storage and free of expired medications. In addition, the consultant pharmacist would conduct random medication cart checks once monthly. She explained she put the new insulin pen in the medication cart this morning as the old insulin pen was almost depleted. She acknowledged that both the insulin pen and the eye drops should be stored in the refrigerator until they were ready to be used. 2. An observation was conducted on 12/13/22 at 5:25 PM for the East Back medication cart in the presence of Nurse #2. The observation revealed one unopened bottle of Latanoprost eye drop wrapped in the plastic seal for Resident #43 stored in the room temperature. Review of physician's orders and MARs revealed Resident #43 had a current order to receive the	F 761	removal from refrigeration and placement on medication cart for resident use Education completed by 01/09/2023. New facility and agency licensed nurses and CMA□s and staff unable to complete education by 01/09/2023 will be educated prior to working their next shift. 4. The DON and unit managers will audit all medication carts and medication rooms twice weekly for four (4) weeks and then weekly for eight (8) weeks for proper medication storage and proper dating/labeling of refrigerated medications upon placement onto the medication cart for resident use. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 761	Continued From page 48 mentioned Latanoprost. During an interview with Nurse #2 on 12/13/22 at 5:27 PM, he explained he was not sure why the unopened Latanoprost was stored in the medication under room temperature as he had not been working with East Back medication cart for a while. He acknowledged that Latanoprost should be stored in the refrigerator until it was ready to be used. An interview was conducted with the DON on 12/13/22 at 5:33 PM. She did not know why the staff missed the insulin and Latanoprost despite routine medication cart checks were conducted. It was her expectation for all the medications to be stored in the temperature as specified by the manufacturer's guidelines. Interview with the Administrator on 12/16/22 at 10:49 AM revealed it was his expectation for the nursing staff to follow drug manufacturer's storage guidelines.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 812	Continued From page 49 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and manufacturer recommendations, the facility failed to date, remove, or discard potentially hazardous foods stored for use with signs of spoilage, store foods in sealed containers and store nonperishable foods off the floor. This failure occurred in 1 of 3 refrigeration units, 1 of 1 freezer and 1 of 1 dry storage rooms with the potential to affect 65 of 67 residents. The findings included: 1. An observation of reach-in refrigerator #2 on 12/12/22 at 9:53 AM with the Food Service Manager (FSM) revealed the following: a. A sixteen-ounce bag of red grapes, open to air, with white/black, hair-like growth; no date of opening/use by date. b. A sixteen-ounce bag of green grapes, open to air; no date of opening/use by date. c. Six stalks of celery with a manufacturer pack date of 11/7/22, stored in a box open to air, brown discoloration, wilted, and wrinkled without date of opening/use by. d. One unopened clear plastic bag of coleslaw mix (shredded cabbage and shredded carrots) with a received date of 11/10/22 and manufacturer use by date of 11/19/22, observed with brown discoloration in a milky cloudy liquid. e. A box that contained 12, 8-ounce containers of	F 812	1. The facility failed to date, remove, or discard potentially hazardous foods stored for use with signs of spoilage, store foods in sealed containers and store nonperishable foods off the floor. This failure occurred in 1 of 3 refrigeration units, 1 of 1 freezer and 1 of 1 dry storage rooms with the potential to affect 65 of 67 residents. All identified items were discarded by the dietary manager on 12/12/2022. 2. Current facility residents have the potential to be affected by this deficient practice. The dietary manager completed a 100% audit of food storage including refrigerators, freezers, dry storage, and nourishment rooms to ensure all food was within usage dates, properly stored, labeled, and items properly disposed of as identified. Audit completed on 12/29/2022. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Regional Dietary Manager completed education with all current and agency dietary staff on proper food procurement, storage, preparation, labeling and sanitary service.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 812	Continued From page 50 yogurt with a manufacturer expiration date of 11/30/22. 2. An observation of reach-in refrigerator #3 on 12/12/22 at 10:05 AM with the FSM revealed the following: a. Four clear plastic bags of 12 preboiled eggs per bag, with a manufacturer use by date of 12/9/22 and 2 bags left open to air. b. One gallon container of whole fat milk with a manufacturer use by date of 12/9/22. c. Four containers of commercially prepared tuna salad, with a manufacturer use by date of 11/27/22. All containers were inflated and odorous and the tuna salad was brown, soupy, and lumpy. 3. An observation of the walk-in freezer on 12/12/22 at 10:11 AM with the FSM revealed the following: a. Two white fish fillets stored in a clear plastic bag, open to air, not labeled with a date of storage, opening or use by date. b. One case of rib shaped pork patties stored open to air. 4. An observation of dry storage on 12/12/22 at 10:12 AM with the FSM revealed one case of sodas stored on the floor with 3 cases of sodas stacked on top. During an interview with the FSM on 12/12/22 at 10:13 AM, he stated that cold and dry storage should be checked daily for expired foods, foods stored in sealed containers, labeled with a date of storage and a use by date. He stated that he started 10 days ago and had not had a chance to check food storage since he arrived. He further stated that he received commercial deliveries	F 812	Dietary staff are responsible for maintaining this practice throughout their shift while handling food products. Education was completed on 01/09/2023. New facility dietary staff unable to complete education by 01/09/2023 will be educated prior to working their next shift. 4. The dietary manager or designee will audit refrigerators, freezers, dry storage, and nourishment rooms to ensure all food was within usage dates, properly stored, and labeled three (3) times a week for four (4) weeks and weekly for eight (8) weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 812	Continued From page 51 once weekly on Thursdays, he was responsible for putting stock away and that nonperishable foods should not be stored on the floor. He discarded the expired foods and confirmed that the expired foods had not been served to residents. An interview with the Regional Dietary Manager (RDM) on 12/14/22 at 12:52 PM revealed that when the previous FSM left, some daily dietary practices were dropped. The RDM stated that he expected daily monitoring of cold storage and all foods to be labeled/dated, used first in, first out and all expired foods to be discarded per manufacturer recommendations. During an interview with the Administrator on 12/15/22 at 12:35 PM, he stated that he was made aware of the food storage concerns identified in the dietary department and expected the dietary staff to maintain food storage per manufacturer recommendations.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such	F 867		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 52	F 867		

information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 53	F 867		

impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 54 (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a focused infection control survey completed on 01/04/21, a recertification and complaint investigation survey completed on 01/28/22, and a follow-up revisit and complaint investigation survey completed on 05/05/22. This was for one repeat deficiency in the area of COVID-19 testing of residents and staff that was originally cited on 01/04/21 during a focused infection control survey and eight repeat deficiencies in the areas of safe, clean and homelike environment, comprehensive assessments and timing, quarterly assessments at least every three months, baseline care plan, develop/implement comprehensive care plans,	F 867	1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a focused infection control survey completed on 01/04/21, a recertification and complaint investigation survey completed on 01/28/22, and a follow-up revisit and complaint investigation survey completed on 05/05/22. This was for one repeat deficiency in the area of COVID-19 testing of residents and staff that was originally cited on 01/04/21 during a focused infection control survey and eight repeat deficiencies in the areas of safe, clean and homelike environment, comprehensive assessments and timing, quarterly assessments at least every three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 55 provision of medically related social services, medication storage, and prepare/store/serve food under sanitary conditions that were originally cited on 01/28/22 during a recertification and complaint investigation survey and/or revisit survey and complaint investigation on 05/05/22. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F584: During the recertification and complaint investigation survey of 12/16/22, the facility failed to remove a black colored substance and repair caulking around the base of the toilet (Room #111, #116, #117, #118). Two of the rooms (Rooms #117 and #118) had a strong odor resembling the smell of urine. The facility failed to remove black colored corrosion and repair missing paint to the portion of a metal door frame in contact with the bathroom floor (Room #118); and failed to repair walls with linear gouges in the sheetrock (Rooms #117 and #118) and repair a hole in the sheetrock (Room #119) for 1 of 2 hallways reviewed for safe, clean, and homelike environment. During the recertification and complaint investigation survey of 01/28/22, the facility failed to ensure residents' overbed tables, rooms, closets, bathrooms and walls were clean and in good repair and personal care equipment was labeled and covered. The facility also failed to ensure missing baseboard in the nourishment room was repaired and the resident shower room	F 867	months, baseline care plan, develop/implement comprehensive care plans, provision of medically related social services, medication storage, and prepare/store/serve food under sanitary conditions that were originally cited on 01/28/22 during a recertification and complaint investigation survey and/or revisit survey and complaint investigation on 05/05/22. The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. Facility had an Ad Hoc QAPI meeting on 01/06/2023 to review repeat citations and plans put in place to prevent future citations and have a successful and productive Quality Assurance and Performance Improvement (QAPI) Committee. 2. All residents have the potential to be affected by this deficient practice. The facility initiated a weekly QAPI risk meeting to review the results of the ongoing audits per the plan of correction and its continued effectiveness on 1/6/2023. Changes will be made to the plan as necessary to maintain compliance and to ensure and effective QAPI program to prevent repeat citations. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Vice President of Quality Assurance (VPQA) educated QAPI committee members on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 56 was clean and sanitary. F636: During the recertification and complaint investigation survey of 12/16/22, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, last day of the assessment period) for 8 of 9 residents reviewed for Resident Assessments (Residents #15, #38, #41, #45, #47, #60, #223, and #220). During the recertification and complaint investigation survey of 01/28/22, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the ARD. F638: During the recertification and complaint investigation survey of 12/16/22, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, the last day of the observation period) for 6 of 9 residents reviewed for Resident Assessments (Residents #41, #45, #46, #47, #56 and #60). During the recertification and complaint investigation survey of 01/28/22, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the ARD. F655: During the recertification and complaint investigation survey of 12/16/22, the facility failed to develop and implement a baseline care plan within 48 hours of admission to address the immediate needs for 1of 5 residents reviewed for new admissions (Resident #50). During the recertification and complaint investigation survey of 01/28/22, the facility failed	F 867	maintaining an effective QAPI program and monitoring system to prevent repeat citations on 01/03/2023. QAPI meetings to be held weekly, monthly, and as needed by the facility QAPI committee with oversight by the regional team. 4. The Regional Director of Clinical Services (RDCS) or VPQA will monitor weekly for 4 weeks then, monthly for 2 months for compliance with daily/weekly/monthly/PRN Ad Hoc QAPI risk review of audits of repeat tags for proper monitoring of effectiveness by QAPI committee to maintain an effective QAPI program that prevents repeat citations by effective monitoring. Results of monitoring will be presented to the Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee and RDCS or VPQA will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 57	F 867		

to complete baseline care plans in conjunction with resident and/or responsible party and failed to provide the resident or their responsible party with a written summary of the baseline care plan.

F656: During the recertification and complaint investigation survey of 12/16/22, the facility failed to develop a dialysis care plan to include individualized interventions related to dialysis treatment for 1 of 1 sampled resident (Resident #15).

During the recertification and complaint investigation survey of 01/28/22, the facility failed to implement a resident's care plan interventions for falls and develop a care plan for a resident who smoked.

During the revisit and complaint investigation survey of 05/05/22, the facility failed to develop a care plan for a resident related to respiratory care.

F745: During the recertification and complaint investigation survey of 12/16/22, the facility failed to refer residents for consultation appointments per physician order for 2 of 4 sampled residents (Resident #38 and #45).

During the recertification and complaint investigation survey of 01/28/22, the failed to schedule two surgical referrals as ordered by the physician.

F761: During the recertification and complaint investigation survey of 12/16/22, the facility failed to store unopened medications in the temperatures specified by manufacturer's guidelines for 2 or 4 medications carts observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 58	F 867		

(East Front and East Back medication carts) during medication storage checks.

During the recertification and complaint investigation survey of 01/28/22, the failed to discard expired intravenous fluids in accordance with the manufacturer's expiration date.

During the revisit and complain investigation survey of 05/05/22, the failed to remove expired medications from medication carts in accordance with the manufacturer's expiration date.

F812: During the recertification and complaint investigation survey of 12/16/22, the facility failed to date, remove, or discard potentially hazardous foods stored for use with signs of spoilage, store foods in sealed containers and store nonperishable foods off the floor. This failure occurred in 1 of 3 refrigeration units, 1 of 1 freezer and 1 of 1 dry storage rooms with the potential to affect 65 of 67 residents.

During the recertification and complaint investigation survey of 01/28/22, the facility failed to discard bags of shredded lettuce with visible signs of spoilage and ensure dietary staff had all hair covered during 2 separate meal services which had the potential for cross-contamination of food served to residents.

F886: During the recertification and complaint investigation survey of 12/16/22, the facility failed to maintain COVID-19 test results in the residents' medical record for 5 of 5 sampled residents reviewed (Resident #6, Resident #21, Resident #43, Resident #52, and Resident #56).

During the focused infection control survey of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 59 01/04/22, the facility failed to conduct COVID-19 testing of staff and residents per the Centers for Disease Control and Prevention (CDC) guidelines upon identification of a positive staff member. During an interview on 12/16/22 at 5:26 PM, the Administrator revealed they had continued to review the systems put into place to correct the issues identified during monthly QAPI meetings; however, due to ongoing staffing issues they did not always have the management staff needed to ensure the systems were consistently executed. The Administrator stated with the new management and interdisciplinary team the facility now had in place along with new ownership who provided much more support, he felt they were headed in the right direction and going forward, he felt the issues would be resolved quickly.	F 867		
F 886 SS=B	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		1/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 886	Continued From page 60	F 886		

(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 886	Continued From page 61 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain COVID-19 test results in the residents' medical record for 5 of 5 sampled residents reviewed (Resident #6, Resident #21, Resident #43, Resident #52, and Resident #56). Findings included: The facility's COVID-19 test results binders revealed COVID-19 rapid antigen tests were completed on residents during the following dates/weeks: 06/03/22 to 06/04/22, 06/05/22 to 06/11/22, 06/12/22 to 06/18/22, 06/26/22 to 06/27/22, 11/21/22 to 11/26/22, 11/27/22 to 12/03/22, and 12/04/22 to 12/10/22. 1. Resident #6 was admitted to the facility on 07/06/20. Review of Resident #6's medical record revealed a nurse progress note dated 11/30/22 at 4:23 PM that noted Resident #6 tested positive for COVID-19. Further review revealed no additional documentation of COVID-19 test results since December 2021. A joint interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 12/14/22 at 4:04 PM. The DON explained each resident's COVID-19 rapid antigen test result was documented individually on a facility form and stored in a monthly binder by the date	F 886	1. The facility failed to maintain COVID-19 test results in the residents' medical record for 5 of 5 sampled residents reviewed (Resident #6, Resident #21, Resident #43, Resident #52, and Resident #56). Resident # 21, Resident #6, Resident #43, Resident #52, and Resident #56□s COVID test results were uploaded into the electronic health record (EHR) effective 1/6/23 by the medical records clerk. 2. All residents have the potential to be affected by this deficient practice. All current residents COVID testing records completed after 11/21/2022 were uploaded into their EHR by 1/6/23 by the medical records clerk. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Director of Nursing (DON) educated the medical records clerk on ensuring residents covid test records have been uploaded into the EHR in a timely manner and on the policy of maintaining residents completed medical records. The medical record clerk is responsible for uploading resident COVID testing in the EHR. Education was completed by 01/09/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 886	Continued From page 62 the test was completed. The DON stated positive test results were typically documented in the resident's medical record via staff progress notes and was unaware all COVID-19 test results should be maintained in the resident's medical record. During an interview on 12/16/22 at 5:24 PM, the Administrator stated he was aware of the regulation and was unable to explain why COVID-19 test results had not been maintained in the resident's medical record. The Administrator stated he would expect for resident's medical records to contain documentation of all COVID-19 test results. 2. Resident #21 was admitted to the facility on 05/16/18. Review of Resident #21's medical record revealed no documentation of COVID-19 test results since March 2021. A joint interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 12/14/22 at 4:04 PM. The DON explained each resident's COVID-19 rapid antigen test result was documented individually on a facility form and stored in a monthly binder by the date the test was completed. The DON stated positive test results were typically documented in the resident's medical record via staff progress notes and was unaware all COVID-19 test results should be maintained in the resident's medical record. During an interview on 12/16/22 at 5:24 PM, the Administrator stated he was aware of the regulation and was unable to explain why	F 886	4. The DON will audit five (5) residents twice weekly for four (4) weeks, then weekly for eight (8) weeks for proper record keeping of COVID test results. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 886	Continued From page 63	F 886		

COVID-19 test results had not been maintained in the resident's medical record. The Administrator stated he would expect for resident's medical records to contain documentation of all COVID-19 test results.

3. Resident #43 was admitted to the facility on 07/27/22.

Review of Resident #43's medical record revealed a Nurse Practitioner progress note dated 11/29/22 that noted Resident #43 tested positive for COVID-19 on 11/28/22. Further review revealed no additional documentation of COVID-19 test results.

A joint interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 12/14/22 at 4:04 PM. The DON explained each resident's COVID-19 rapid antigen test result was documented individually on a facility form and stored in a monthly binder by the date the test was completed. The DON stated positive test results were typically documented in the resident's medical record via staff progress notes and was unaware all COVID-19 test results should be maintained in the resident's medical record.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated he was aware of the regulation and was unable to explain why COVID-19 test results had not been maintained in the resident's medical record. The Administrator stated he would expect for resident's medical records to contain documentation of all COVID-19 test results.

4. Resident #52 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 886	Continued From page 64	F 886		

10/12/21.

Review of Resident #52's medical record revealed no documentation of COVID-19 test results since December 2021.
A joint interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 12/14/22 at 4:04 PM. The DON explained each resident's COVID-19 rapid antigen test result was documented individually on a facility form and stored in a monthly binder by the date the test was completed. The DON stated positive test results were typically documented in the resident's medical record via staff progress notes and was unaware all COVID-19 test results should be maintained in the resident's medical record.

During an interview on 12/16/22 at 5:24 PM, the Administrator stated he was aware of the regulation and was unable to explain why COVID-19 test results had not been maintained in the resident's medical record. The Administrator stated he would expect for resident's medical records to contain documentation of all COVID-19 test results.

5. Resident #56 was admitted to the facility on 04/06/22.

Review of Resident #56's medical record revealed a no documentation of COVID-19 test results.

A joint interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 12/14/22 at 4:04 PM. The DON explained each resident's COVID-19 rapid antigen test result was documented individually on a facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 886	Continued From page 65 form and stored in a monthly binder by the date the test was completed. The DON stated positive test results were typically documented in the resident's medical record via staff progress notes and was unaware all COVID-19 test results should be maintained in the resident's medical record. During an interview on 12/16/22 at 5:24 PM, the Administrator stated he was aware of the regulation and was unable to explain why COVID-19 test results had not been maintained in the resident's medical record. The Administrator stated he would expect for resident's medical records to contain documentation of all COVID-19 test results.	F 886		