STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345162	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Gastonia	**416 N Highland Street , Gastonia, North Carolina, 28052**

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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/29/26 through 04/01/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 22C4CF-H1	E0000		04/15/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/29/26 through 04/01/26. Event ID# 22C4CF-H1. The following intakes were investigated 2742296, 2734965, 2800992, and 2806331. 5 of the 5 complaint allegations did not result in deficiency.	F0000		04/15/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications kept at bedside for 1 of 1 resident reviewed for self-administration (Resident #39). Findings included: Resident #39 was admitted to the facility on 2/19/26 with diagnoses that included chronic obstructive pulmonary disease, coronary heart disease, hypertension, and heart failure. Review of Resident #39's admission Minimum Data Set (MDS) assessment dated 03/04/26 revealed he was cognitively intact.	F0554	1. Medicine found at bedside was immediately removed from resident #39. Medication were removed from room on 3/31/2026. Self-administration assessment was completed on 3/31/26 which revealed that resident was capable of administering his medications. Resident no longer resides in the facility. 2. On 3/31/26 a 100% audit was completed on all residents to ensure no other medicines at bedside were identified/found. No other medications were noted at resident's bedside. Residents that are alert and oriented who expresses the desire to self-administer medications will have a self-administration assessment completed by the licensed nurse and review with the Medical Director. No residents voiced the desire to self-administer medications. Assistant Director of Nursing completed the audit. Current and new admissions will be assessed during the admission process, quarterly care plan meeting, and as voiced by residents for the desire to self-administer medications at which time a self-administration assessment will be completed by the licensed nurse. 3. All nursing staff were educated to ensure that any medicine found at the bedside is removed and reported to floor nurse and/or supervisor	04/24/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0554 SS = D	Continued from page 1 Review of Resident #39's active physician orders included albuterol sulfate (bronchodilator) aerosol 90 micrograms (mcg) inhale 2 puffs every 4 hours as needed for dyspnea (shortness of breath) dated 3/16/26. There was no active order for the oxymetazoline hydrochloride (antihistamine) nasal spray. Review of Resident #39's medical records revealed no documentation Resident #39 was assessed to safely self-administer medications. During an observation and interview with Resident #39 on 03/29/26 at 12:16 PM, two inhalers of albuterol sulfate 90 mcg and two bottles of oxymetazoline hydrochloride nasal spray were observed in a plastic basket on the overbed table beside the bed. Resident #39 was in bed, and both medications were within his reach. Resident #39 stated he used the inhalers probably twice a week when short of breath and took 2 puffs and he used the nasal spray for congestion. An observation on 03/30/26 at 12:57 PM revealed the two inhalers of albuterol and the two bottles of oxymetazoline hydrochloride nasal spray remained in the basket on the overbed table within the reach of Resident #39 while he rested in bed. An interview was conducted on 03/31/26 at 4:07 PM with Nurse #3, the assigned nurse for Resident #39. Nurse #3 revealed she had administered the day shift medications to Resident #39 on 3/31/26 but she did not notice the inhalers or nasal spray bottles in the basket on the bedside table. Nurse #3 stated if she had noticed the medications, she would have removed them from the room and stored them on the medication cart. Nurse #3 stated she was not aware of any resident that self-administered medications. During an interview on 03/31/26 at 3:13 PM, the Director of Nursing (DON) explained if Resident #39 wanted to self-administer his inhaler and nasal spray a self-administer assessment should have been done and the inhaler and nasal spray should be stored securely. An observation on 03/31/26 at 3:16 PM with the DON revealed the two albuterol inhalers and two bottles of oxymetazoline hydrochloride nasal spray remained in the basket placed on the overbed table beside Resident #39. Resident #39 refused to share where he got the inhalers and nasal spray when asked by the DON. The DON explained to Resident #39 if he wanted to self-administer the inhaler and	F0554	Continued from page 1 immediately. Education was completed by the Director of Nursing and Assistant Director of Nursing on 4/1/2026. New nursing and agency staff will be educated during the orientation process by the Director of Nursing, Assistant Director of Nursing, or designee. 4. An ad-hoc QAPI meeting was held with the interdisciplinary team on 4/17/2026 to discuss this plan. The Assistant Director of Nursing and nursing supervisors will conduct audits 3 times a week for 8 weeks and then twice a week for 4 weeks of all residents' rooms to ensure no medicine is found at bedside. Results of the audit will be discussed at the monthly Quality Assurance Improvement Meeting for 3 months to ensure substantial compliance is achieved by the Director of Nursing. 5. Date of Compliance: Date of Compliance _4/24/2026_.	04/24/2026

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F0554 SS = D	Continued from page 2 nasal spray she would need to ensure there was a physician's order for the medications and a self-administration assessment was needed to ensure he could safely administer the medication. Resident #39 confirmed he wanted to self-administer his albuterol inhaler and nasal spray. The DON removed both inhalers and nasal spray bottles from the room. During an interview on 04/01/26 at 2:09 PM, the Administrator stated Resident #39's ability to safely administer would need to be assessed if he wanted to self-administer the albuterol inhaler and nasal spray. The Administrator revealed the medications would need to be stored securely and not be left within reach of other residents.	F0554		04/24/2026
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews with staff and Nurse Practitioner, the facility failed to follow a Nurse Practitioner order for the care of an intravenous (IV) access site for 1 of 1 resident who had a Peripherally Inserted Central Catheter (PICC) (Resident #85). Findings included: Hospital discharge summary dated 03/20/26 revealed orders for Resident #85 to continue IV antibiotics for 38 days. A Nurse Practitioner order dated 03/20/26 revealed to change of the PICC line dressing every 7 days on Fridays. The Care Plan dated 03/21/26 revealed Resident #85 had a PICC line with an intervention of dressing change per order. The comprehensive Minimum Data Set (MDS) assessment dated 03/22/26 revealed Resident #85 is cognitively intact, received IV medication and had IV access in the form of a PICC.	F0694	1. Resident #85 PICC line dressing was immediately assessed and changed using sterile technique per facility policy on 3/30/26. The insertion site was evaluated for signs and symptoms of infection, with no adverse findings noted. 2. A 100% audit was conducted on all residents with PICC lines to ensure dressing were changed per the Nurse Practitioners order. Any identified issues were immediately corrected. Assistant Director of Nursing completed the audit on 4/1/2026. 3. All Licensed Nursing staff were re-educated on the facility policy regarding central line care and ensuring all Nurse Practitioner orders are followed to ensure PICC line dressing are changed in appropriate time frame. Education was completed by the Director of Nursing and Assistant Director of Nursing on 4/1/2026. New nursing and agency staff will be educated during the orientation process by the Director of Nursing, Assistant Director of Nursing or designee. 4. An ad-hoc QAPI meeting was held with the interdisciplinary team on 4/17/2026 to discuss this plan. The Assistant Director of Nursing will conduct Weekly audits of all PICC/central line dressings weekly for 12 weeks. Results of the audit will be discussed at the monthly Quality Assurance Improvement Meeting for 3 months to ensure substantial compliance is achieved by the Director of Nursing. 5. Date of Compliance: Date of Compliance _4/24/2026_.	04/24/2026

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F0694 SS = D	Continued from page 3 The medication administration record (MAR) revealed to change the PICC line dressing every Friday during dayshift with a start date of 03/27/26; it was left blank and not signed off as completed on 3/27/26. Review of progress notes dated 03/27/26 revealed no documentation as to why the dressing change did not occur. During an interview and observation on 03/29/26 at 2:19 PM of Resident #85 it was revealed that Resident #85 had a PICC line for IV antibiotic therapy. Observation of the IV access site revealed an intact dressing with corners curled up, no redness or drainage at the insertion site and a date of 03/18/26. During an interview conducted on 03/30/26 at 2:09 PM, Nurse #1 stated he had been assigned as the nurse for Resident #85 on 03/27/26. Nurse #1 revealed he was supposed to change the dressing on the PICC line as per the order, but he did not complete the task. During an interview conducted on 03/30/26 at 2:54 PM, the Assistant Director of Nursing (ADON) indicated that she had completed the PICC dressing change on 03/30/26. The ADON revealed the old dressing was dated 03/18/26. The ADON stated she expected the dressing to be changed on 03/27/26 and it was not changed. The ADON stated the dressing change was not completed as ordered. During an interview on 04/01/26 at 10:07 AM the Director of Nursing (DON) stated that dressing changes for IV access sites must be completed at least every seven days, with daily flushes ordered and the site monitored daily for signs of infection. The DON explained she would expect the nurse assigned to Resident #85 to assess the site and recognize that the dressing change was overdue. She emphasized that PICC line dressings must be changed every seven days to prevent infection. During an interview conducted with the Nurse Practitioner on 04/01/2026 at 9:32 AM, she indicated that she expected dressing changes to be performed every seven days. She explained that exceeding this timeframe increases the risk of infection.	F0694		04/24/2026
F0842 SS = A	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F0842		04/15/2026

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F0842 SS = A	Continued from page 4 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F0842		04/15/2026

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F0842 SS = A	Continued from page 5 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure medications were accurately documented on the medication administration record (MAR) for 1 of 1 resident reviewed for accurate medical records (Resident #102). Findings included: Review of Resident #102's active physician's orders included aluminum/magnesium hydroxide (antacid) 200 milligrams (mg)/5 milliliters (ml) give 20 ml one time only for nausea and vomiting dated 1/23/26. Review of Resident #102's MAR revealed Nurse #2 initialed aluminum/magnesium hydroxide to indicate the medication was administered on 1/23/26 at 5:05 AM. During an interview on 03/31/26 at 2:23 PM, Nurse #2 stated Resident #102 refused the aluminum/magnesium hydroxide, and she did not administer the medication. Nurse #2 stated she mistakenly initialed the MAR on 1/23/26 at 5:05 AM	F0842		04/15/2026

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F0842 SS = A	Continued from page 6 to indicate it was given. During an interview on 04/01/26 at 2:09 PM, the Administrator stated Nurse #2 was responsible for accurately documenting medication administration on the MAR. She further stated that if Nurse #2 did not administer aluminum/magnesium hydroxide to Resident #102 on 1/23/26, Nurse #2 should not have initialed the MAR to indicate it was given.	F0842		04/15/2026