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 11/01/2019

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

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E 000	Initial Comments An unannounced Recertification and Complaint Investigation Survey was conducted on 10/29/19 through 11/01/19. The facility was found in compliance with the requirement CFR 483..73, Emergency Preparedness. Event ID# 9ZSQ11.	E 000		
F 000	INITIAL COMMENTS An unannounced Recertification and Complaint Investigation Survey was conducted from 10/28/19 through 11/01/19. There were 27 complaint allegations investigated and one was substantiated without deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to accurately code the discharge Minimum Data Set (MDS) assessment dated 10/16/19 for discharge status on 1 of 3 sampled closed records (Resident #62). The findings included: Resident #62 was admitted to the facility on 9/25/19 and discharged to home on 10/16/19. Review of the Discharge MDS dated 10/16/19 revealed Resident #62 was coded as having been discharged to acute hospital. The MDS further indicated Resident #62 was cognitively intact. Review of a progress note by Nurse #1 on	F 641	F641 Correction has been completed and submitted for the alleged deficient practice: Resident #62 minimum data set coordinator modified the assessment on 11/21/2019. Discharged, return not anticipated., Current residents have a potential to be effected by the alleged deficient practice. MDS coordinator completed and audit for section A2100 on November 21, 2019 from 1/1/2019 tp 11/21/2019 to validate accurate coding. Audit showed no coding errors. Measures put in place to ensure the	11/26/19

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

Electronically Signed | 11/26/2019

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F 641	Continued From page 1 10/16/19 at 2:13 PM in Resident #62's electronic medical record indicated Resident #62 was discharged to home. A phone interview with Resident #62 on 10/29/19 at 11:05 AM revealed he was discharged to home on 10/16/19. An interview with Nurse #1 on 10/31/19 at 2:04 PM revealed Resident #62 was discharged to home on 10/16/19. An interview with the MDS Nurse on 11/1/19 at 2:36 PM revealed she was sure Resident #62 was discharged to home on 10/16/19. After reviewing the Discharge MDS dated 10/16/19 with the MDS Nurse, she stated that she just missed it and that she should have coded him as going to community. She stated she would make a correction on the MDS. An interview was conducted with the Director of Nursing (DON) on 11/1/19 at 4:06 PM. The DON stated she wasn't familiar with Resident #62 but agreed that the discharge status for his discharge MDS dated 10/16/19 should have been coded as going to community. The DON stated she expected that the MDS should be coded accurately. An interview was conducted with the Administrator on 11/1/19 at 4:56 PM. The Administrator stated that the discharge status on Resident #62's discharge MDS dated 10/16/19 was definitely an error and that the MDS nurse should pay more attention when completing the MDS assessments.	F 641	alleged deficient practice does not reoccur: MDS coordinator was in-serviced by Regional Clinical Re-imbursement Specialist on 11/15/19, regarding accuracy of assessments to ensure correct discharge status was coded correctly. Director of Nursing/Regional Clinical Specialist will review weekly for 4 weeks and bi-weekly for 12 weeks, starting 11/24/19 for all discharge assessments prior to submissions to validate assessments for accuracy of coding. Adminstrator will analyze audits for patterns and trends and report results to QAPI monthly meeting for 3 months. Plan will be adjusted based on data. Completion date was 11/26/2019.	
F 838	Facility Assessment	F 838		11/26/19

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F 838 SS=C	Continued From page 2 CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to,	F 838		

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F 838	Continued From page 3 (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and annually update the facility assessment. The findings included: A review of the facility assessment revealed facility census information from April 2018. It further indicated that the facility did not use agency staffing. The facility assessment also failed to document the current Administrator, Director of Nursing and the rest of the Administrative staff. An interview conducted with the Administrator on	F 838	F.838 1. Facility Assessment was completed by the Accordius Health at Asheville interdisciplinary team on November 18, 2019. The assessment includes: Facility capacity and physical characteristics. Average number of admits and discharges Diseases/conditions, physical and cognitive disabilities. Acuity level and special treatments and resident care needs. Resident support/care needs Facility Resources, staff type and	

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F 838	Continued From page 4 11/1/19 at 3:56 PM revealed he was not sure when the facility assessment was last updated but he agreed some of the statements in it were not current. He stated the facility used agency staffing and the Administrative list did not reflect the current Administrative staff. The Administrator further stated it was his job to make sure the facility assessment was updated and usually did it after 11 months. He has been the Administrator at the facility for a week and he thought the previous Administrator had updated it this year.	F 838	positions, and staffing plan. Staff training/education and competencies. Physical environment and building/plant needs. Health information technology resources. Infection prevention and control program. Facility and community risk assessment. 2. The facility assessment plan was reviewed and agreed upon in our monthly QAPI meeting held on November 26, 2019. 3. The facility Assessment Plan will be reviewed at the monthly QAPI meeting. All necessary changes will be made at that time. The quarterly review will continue for 4 quarters and then reduce to semi-annual there after. 4. The completion date was 11/26/2019.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the	F 867	F.867 1. The deficient practice could have had a negative effect but in this situation no negative effect occurred.	11/26/19

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F 867	Continued From page 5 recertification survey of 1/25/19. This was for one deficiency that was originally cited in January 2019 and subsequently recited on the current recertification survey of 11/01/19. The repeated deficiency was in the area of accuracy of assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Findings included: This tag is cross referenced to: F 641: Based on record review, resident and staff interviews, the facility failed to accurately code the discharge Minimum Data Set (MDS) assessment dated 10/16/19 for discharge status on 1 of 3 sampled closed records (Resident #62). During the annual recertification survey of 01/25/19 the facility failed to accurately code the MDS (Minimum Data Set) assessments in the areas of Hospice , Level II Preadmission Screening and Resident Review, Diagnoses, and Activities of Daily Living for 5 of 22 residents reviewed for MDS accuracy. During an interview on 11/01/19 at 5:27 PM the Administrator stated systems were put into place to correct the deficiencies cited following the recertification survey of 01/25/19. He felt the breakdown was a result of the multiple transitions in Administrative staff. He stated going forward he was committed to putting processes into place to address the repeated areas of concern and the QA committee would review and monitor the systems to ensure the facility maintained ongoing compliance.	F 867	2. MDS coordinator completed an audit on all resident charts from 1/1/2019 to 11/21/2019. No other issues were found. 3. Weekly MDS audit on all newly discharged resident will be completed by Director of Nursing and Administrator for 4 weeks. The bi-weekly audits for 12 weeks. The MDS audit started on 11/24/19 4. Administrator will analyze audit for patterns and trends and discuss during Monthly QAPI meeting for 3 months. The administrator will adjust plan as data indicates. 5. Completion date is 11/26/2019.	

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