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	345010	A. BUILDING _____ B. WING _____	C 05/05/2022

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 000	INITIAL COMMENTS An onsite, unannounced complaint investigation survey was conducted on 05/04/22 to 05/05/22. A total of 6 allegations were investigated and none were substantiated: NC00187854, NC00186363 and NC00185908. Event ID# S98X11.	F 000		
F 607 SS=B	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not reporting the results of investigations of alleged abuse to the Division of Health Service Regulation (DHSR) within 5 working days for 2 of 3 sampled residents reviewed for abuse (Residents #2 and #3). Findings included: The facility policy titled, "Abuse, Neglect, and Exploitation" revised 10/22/20, read in part: "Section VII. Reporting/Response, B. The Administrator will follow up with government	F 607	1. F607 (Develop/Implement Abuse/Neglect Polices) was cited. Based on the findings, resident #2's family reported to the facility staff on 3/30/22 that the resident was "jerked and pulled" by a staff member at the facility. The initial report was sent in to DHSR on 3/30/22 within the expected time frame. However, the 5-day investigative report was not sent in until 4/18/22. This date failed to meet the expected time frame required for reporting suspected abuse. -Resident #3 alleged that she was sexually abused on 2/06/22 while she was	5/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2022

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 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.

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F 607	Continued From page 1	F 607		

agencies, during business hours, to confirm the initial report was received and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies."

1. Review of the initial report submitted by the facility via fax transmission to DHSR noted an allegation type of staff to resident abuse that was reported by Resident #2's family member to the facility on 03/30/22 at 3:27 PM and the initial report was submitted from the facility to DHSR via fax transmission on 03/30/22 at 4:00 PM. Resident #2's family member alleged that Resident #2 was "jerked and pulled" by staff during her stay at the facility. The family member was unable to provide a date, description of the perpetrator or further specifics of when the incident allegedly occurred. Law enforcement was notified on 03/30/22 at 3:53 PM. Further review revealed the 5-day investigative report was submitted via fax transmission to DHSR on 04/18/22 at 3:22 PM and noted the allegation was unsubstantiated.

During a telephone interview on 05/05/22 at 2:55 PM, the Administrator confirmed the 5-day investigative report for the allegation of staff-to-resident abuse involving Resident #2 was submitted late. The Administrator explained he was waiting on additional information, such as interview with Resident #2, the police report and/or hospital records, and did not send anything to DHSR within 5 working days because the investigation was still ongoing.

2. Review of the initial report submitted by the facility via fax transmission to DHSR noted an allegation type of resident abuse that was a resident in the facility. The facility conducted an initial investigation, and no staff member matched the description given by the resident of the perpetrator. A 5-day report was sent in outside of the expected time frame required and was considered late.

2. For residents at risk of being affected by the alleged deficient practice, the following actions were taken:

- An audit of all reportable events occurring during the last 30 days was completed by the Regional Director of Operations on 5/06/22. No further late reports noted in the last 30 days.
- Education was provided to the Administrator on 5/06/22 by the Regional Director of Operations on the process of timely submission of reportable events.

3. Administrator will notify the Regional Director of Operations and Regional Director of Clinical Services of all reportable events for validation of timely submission of reporting.

4. The reporting process will be audited for all new reportables weekly for 12 weeks by the Regional Director of Operations.

5. Date of compliance 5/20/22.

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reported to the facility by law enforcement on 02/16/22 at 6:00 PM and the initial report was submitted from the facility via fax transmission to DHSR on 02/16/22 at 6:38 PM. Law enforcement reported Resident #3 alleged she was sexually assaulted on 02/06/22 while a resident at the facility. Review of the facility's investigation summary revealed the description given by Resident #3 of the alleged perpetrator did not match any staff member who had worked at the facility on 02/06/22 or prior. Further review revealed the 5-day investigative report was submitted via fax transmission to DHSR on 02/25/22 at 3:44 PM and noted the allegation was unsubstantiated.

During a telephone interview on 05/05/22 at 2:55 PM, the Administrator confirmed the 5-day investigative report for the allegation of staff-to-resident abuse involving Resident #3 was submitted late. The Administrator explained he was waiting on additional information, such as interview with Resident #3, hospital records and the police report, and did not send anything to DHSR within 5 working days because the investigation was still ongoing.

F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/20/22

§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 and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of hospice and falls for 3 of 7 sampled residents reviewed

1. F641 (Accuracy of Assessments) cited. Based on the findings the facility failed to accurately code the MDS of 3 residents for Hospice services and falls.

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for MDS accuracy (Residents #4, #5, and #6).

Findings included:

1. Resident #4 was admitted to the facility on 10/02/16.

Review of the Hospice Plan of Care, with an effective date of 06/11/21, indicated Resident #4 was certified to receive Hospice services for end of life care.

The MDS assessment dated 03/21/22 noted Resident #4 had a life expectancy of 6 months or less; however, hospice care was not marked as received under special services and treatments.

During an interview on 05/05/22 at 2:33 PM, the MDS Coordinator confirmed Resident #4 currently received Hospice services and just overlooked marking hospice care was received on the MDS assessment dated 04/06/22.

During an interview on 05/05/22 at 4:45 PM, the Regional Director of Operations stated he would expect for MDS assessments to be completed accurately.

2. Resident #5 was admitted to the facility on 07/22/21.

Review of the nurse progress notes for Resident #5 revealed the following:
An entry written by Nurse #2 and dated 01/17/22 read in part, "as a staff member entered the room, Resident #5 fell forward out of her wheelchair and onto the floor hitting her forehead. Resident #5 was assessed and neurological checks were within normal limits except for pain."

Resident #4 was noted to have a diagnosis of 6 months or less to live and Hospice services were effective beginning 6/11/21 per the Hospice Care Plan however it was not coded on the MDS. Resident #5 was noted to have a fall on 3/12/22 sustaining a bruise to her forehead. On 4/6/22, a quarterly MDS was completed. Resident was coded for falls with no injury. Resident #6 was noted to have a fall on 3/5/22 sustaining a ST to the RFA and bruise to the R forehead. On 3/06/22 the MDS was coded that the resident had 1 fall without injury noted.
2. For residents at risk of being affected by the alleged deficient practice, the following actions were put into place: Residents receiving hospice services and residents sustaining a fall are at risk of being affected by this alleged deficient practice.
" An audit of all MDS□s was completed with issues corrected and Care Plans updated by the Regional MDS Nurse from 5/09/22-5/11/22.
" The MDS was corrected and resubmitted on 5/11/22 by the Regional MDS nurse.
" Education regarding accurate coding of the MDS regarding hospice services and falls with injury was provided to MDS coordinator on 5/5/22 by the Regional MDS nurse and the Regional Director of Operations.
3.
" Changes were made to the department staff on 5/9/22 by Regional Team.
" New MDS staff will be educated upon

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An entry written by Nurse #2 dated 01/19/22 read in part, "status post fall with no other injuries besides bruising to forehead. Purple bruising to forehead now draining into periorbital (tissues surrounding the eyes) areas."
An entry written by Nurse #3 and dated 03/12/22 read in part, "Resident #5 observed attempting to transfer from bed and slid down to the floor onto her buttocks. Resident #5 was assessed with no injuries noted."

Review of Resident #5's medical record revealed a quarterly MDS assessment dated 04/06/22 that noted she had 2 or more falls with no evidence of injury since the previous MDS assessment dated 01/04/22.

During an interview on 05/05/22 at 2:33 PM, the MDS Coordinator explained when falls were discussed during the morning clinical meetings, she asked if there were any injuries and then reviewed the progress note. The MDS Coordinator confirmed she had incorrectly coded Resident #5's MDS assessment dated 04/06/22 as having 2 falls with no evidence of injury. She stated the MDS assessment should have reflected Resident #5 had one fall with minor injury and one fall with no evidence of injury.

During an interview on 05/05/22 at 4:45 PM, the Regional Director of Operations (RDO) stated he would expect for MDS assessments to be completed accurately.

3. Resident #6 was admitted to the facility on 12/17/21.

A nurse progress note written by Nurse #2 and dated 03/05/22 read in part, Resident #6 came

hire by the Regional MDS nurse to ensure accuracy of coding and monitored by Regional MDS nurse.
" DON will alert Regional MDS nurse of any clinical concerns of changes to update as needed during am clinical meeting until MDS replacement is hired.
4. MDS□s will be audited by Regional MDS nurse 3x/weekly and PRN x12 weeks.
5. Date of compliance 5/20/22.

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F 641	Continued From page 5 from his room stating he fell but was unable to explain how. Upon nurse assessment, Resident #6 was observed to have a "1.5 inch skin tear to the right forearm that was bleeding and a contusion to the right forehead, reddish-purple in color and approximately 1 inch round." Review of Resident #6's medical record revealed a quarterly MDS assessment dated 03/26/22 that noted he had one fall with no evidence of injury since the previous MDS assessment dated 12/24/21. During an interview on 05/05/22 at 2:33 PM, the MDS Coordinator explained when falls were discussed during the morning clinical meetings, she asked if there were any injuries and then reviewed the progress note. The MDS Coordinator confirmed she had incorrectly coded Resident #6's MDS assessment dated 03/26/22 as having one fall with no evidence of injury. She stated the MDS should have reflected Resident #4 had one fall with minor injury. During an interview on 05/05/22 at 4:45 PM, the Regional Director of Operations (RDO) stated he would expect for MDS assessments to be completed accurately.	F 641		
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.	F 761		5/20/22

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§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 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 observations and staff interviews the facility failed to remove expired medications in accordance with the manufacturer's expiration date for 3 of 4 medication carts (West #1 and #2, East #1) reviewed for medication storage.

The findings included:

a. An observation was made on 05/05/22 at 9:27 AM, the following expired medications were found in medication cart #1 for the West Hall and available for use:
1 zip lock bag of 10 Bisacodyl rectal suppositories 10 milligram (mg) expired in December 2021.
2 used blister cards which contained 63 tablets of metoclopramide 5 mg expired on 04/18/22.

b. An observation was made on 05/05/22 at 9:59 AM, the following expired medications were found

1. F761 (Label/Store Drugs and Biological) cited. Based on the findings, the facility failed to accurately remove expired medications from 3 of the 4 medication carts within the facility. The Director of Nursing and Nurse Managers discarded all expired medications identified on 5/6/22.
2. For residents at risk of being affected by the alleged deficient practice the following actions were taken:
" The Director of Nursing conducted an audit of expired medications for all medication carts and medication room beginning on Friday 5/6/22 and was completed on 5/9/22.
" All Licensed Nurses and Medication Aides completed medication storage education given by the Director of Nursing

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in medication cart #2 for the West Hall and available for use:
1 used blister card contained 29 tablets of Levetiracetam 500 mg expired on 12/03/21.
1 unused blister card contained 30 tablets of Levetiracetam 500 mg expired on 12/05/21.
1 used blister card contained 20 tablets of Baclofen 10 mg expired on 08/31/21.
1 used blister card contained 27 tablets of Baclofen 10 mg expired on 12/31/21.
1 unused blister card contained 30 tablets of Baclofen 5 mg expired on 02/02/22.
2 unused blister cards contained 60 tablets of Baclofen 5 mg expired on 04/08/22.
1 used blister card contained 23 tablets of Buspirone 5 mg expired on 02/24/22.
1 unused blister card contained 30 tablets of Buspirone 5 mg expired on 02/28/22.

During an interview with the Medication Aide #1 working in West Hall on 05/05/22 at 10:12 AM she stated she was an agency staff who had been working in the facility for 4 days. She did not know why the expired medications were stored in the medication carts in the West Hall. She added she normally would check the medication before administration to avoid administering expired medication to the residents.

c. An observation was made on 05/05/22 at 10:54 AM, an opened bottle contained approximately 800 tablets of sodium bicarbonate 650 mg expired on 09/30/21 was found in medication cart #1 for East Hall and available for use.

An interview conducted with Nurse #1 on 05/05/22 at 11:02 AM revealed she was an agency nurse who had been working in the facility for about one month. She checked the

beginning on 5/6/22 and ended on 5/13/22. They were not allowed to work until education complete.
" Pharmacy representative performed audit of all med carts and med room on 5/11/22.
" All expired medications identified during this audit were discarded by the Director of Nursing and Nurse Managers on 5/11/22.
3. The DON or SDC will ensure that new nursing staff to include agency have been educated on proper medication storage during orientation.
4. Medication cart and medication room audits will continue 2x/weekly for 12 weeks by the DON or Nurse Managers for continued compliance.
5. Date of compliance 5/20/22.

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F 761	Continued From page 8 medications for expiration before administering and would check the medication cart for expired medication and proper storage when she had down times. She explained the bottle of expired sodium bicarbonate was missed as it was rarely used. During an interview with the Director of Nursing (DON) on 05/05/22 at 11:26 AM, she stated the consultant pharmacist had checked all the medication carts and medication storage rooms on 04/18/22. She explained she was in her position for the third week and she would like to investigate in order to identify the root cause before making a statement. During an interview with the Regional Director of Operations on 05/05/22 at 4:45 PM, he stated medications for discharged or expired residents should be pulled from the med carts immediately. It was his expectation for the facility to remain free of expired medication.	F 761		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	F 888		5/13/22

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§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19

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vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the

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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 888	Continued From page 11	F 888		

contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to implement the facility's process for tracking COVID-19 vaccination status for 1 of 10 contracted dietary staff reviewed for vaccinations (Dietary Aide #1). The facility was not currently in outbreak status.

Findings included:

" F888 (COVID Vaccination of Facility Staff) cited. Based on the findings, Dietary Aide #1 had not received the 2nd dose of the 2-part COVID 19 series to be considered fully vaccination by the Federal Guidelines related to staff working in Long-term Care. She had received her 1st dose on 12/31/21 of the 2-part series

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 05/05/2022

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The facility's "Employee COVID-19 Vaccination Mandate Policy" with a reviewed/revised date of 04/05/22, read in part: "it is the policy of this facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State, and local guidelines. Compliance Guideline #2: Employees who provide any care, treatment or other services for the facility and/or its residents regardless of clinical responsibility or resident contact are required to be fully vaccinated against COVID-19 and include the following: facility employees, licensed practitioners, students, trainees, volunteers, and individuals under contract or by any other arrangement. Compliance Guideline #5: The facility will ensure that all staff (except for staff who have been granted exemptions to the vaccination requirements, or those staff for whom COVID-19 must be temporarily delayed, as recommended by the CDC (Centers for Disease Control and Prevention), due to clinical precautions and considerations, are fully vaccinated or up-to-date for COVID-19."

A review of the National Healthcare Safety Network (NHSN) data for the week ending 04/17/22 revealed the following: Recent Percentage of Staff who are Fully Vaccinated = 100%.

Review of the COVID-19 Vaccination Reports and Record Cards for facility and contracted staff revealed no employee was listed as having an exemption.

Review of the COVID-19 Vaccination Record Card for Dietary Aide (DA) #1 provided by the facility revealed she received the first dose of a

as evidenced by the card on file in the facility vaccination records. Dietary Aide #1 was educated on 5/5/22 by Dietary Manager and sent home. She scheduled her 2nd vaccine and will wait 14 days prior to returning to work. She will then begin testing per the CDC guidelines for non-boosted staff members who work in Long-term care

2. For residents and staff that were at risk of being affected by the alleged deficient practice, the following actions were taken:
" Dietary Manager and Next Level Corporate staff educated by Regional Director of Operations verbally by phone on CDC vaccination mandate requirements on 5/5/22 and 5/6/22.
" An audit was completed by the Business Office Manager (BOM) and the Director of Nursing (DON) of all staff and departments beginning on 5/9/22 and was completed on 5/13/22. No further concerns noted.
3.
" All department heads were educated on the CDC vaccine mandate by Regional Director of Clinical Services on 5/9/22.
" On 5/10/22, all new hires will need to be reviewed by (BOM) for accuracy of vaccination status and ensure card is filed in the binder and DON will then be notified to complete a 2nd check of the process.
1. Audits will be completed by all department heads and reviewed by BOM and DON 3x/week for 12 weeks.
2. Date of compliance 5/13/22.

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 05/05/2022

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two dose vaccination series on 12/31/21. There was no other date listed to indicate the second dose was received.

Review of the Time Clock Report for DA #1 revealed she worked on the following dates: 04/27/22 7:02 AM to 2:22 PM, 04/28/22 7:00 AM to 2:03 PM, 04/29/22 6:45 AM to 1:45 PM, 05/01/22 6:41 AM to 2:05 PM, and 05/02/22 7:02 AM to 2:03 PM.

Telephone attempt on 05/05/22 at 01:16 PM for interview with Dietary Aide (DA) #1 was unsuccessful.

During an interview on 05/05/22 at 1:02 PM, the Dietary Manager (DM) confirmed he was responsible for keeping track of the vaccination status for contracted dietary staff, including DA #1. The DM explained DA #1 had been employed at the facility for several years prior to him starting his employment and he did not think to check her vaccination status. The DM confirmed DA #1 had worked in dietary during the past week and stated he was informed on 05/05/22 that DA #1 had only received the first dose of the COVID-19 vaccination series. The DM added DA #1 was scheduled to receive the second dose today.

During an interview on 05/05/22 4:45 PM, the Regional Director of Operations (RDO) stated he would expect for all facility and contracted staff to have received all doses of the primary COVID-19 vaccination series. The RDO revealed it was the responsibility of the Administrator to follow-up and ensure all facility and contracted staff were up to date with their COVID-19 vaccinations.

The Administrator was not available for an

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345010	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/5/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff the facility failed to develop a comprehensive care plan for 1 of 1 resident reviewed for respiratory care (Resident #1) The findings included: Resident #1 was admitted to the facility on 02/14/22 with multiple diagnoses included acute and chronic respiratory failure with hypercapnia. Review of physician's order dated 02/14/22 revealed Resident #1 was ordered to receive Albuterol Sulfate hydrofluoroalkane (HFA) aerosol solution 108 microgram per actuation 2 puff by mouth 4 times daily as needed for wheezing or short of breath. On 02/16/22, the physician ordered to administer oxygen continuously for Resident #1 at 3 liters per minutes via nasal cannula every shift. Review of medication administration records indicated Resident #1's vital signs included oxygen saturation level was monitored 3 times daily since 02/15/22. Review of Resident #1's comprehensive care plans on 05/05/22 at 12:17 PM revealed no care plan was

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 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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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developed for respiratory care.

During an interview on 05/05/22 at 12:58 PM the MDS Coordinator confirmed she was responsible for developing care plans for Resident #1 as indicated. She explained she was overloaded with her workload in February 2022 due to staffing shortages and she had been pulled to help on the floor when needed. She stated Resident #1 should have a care plan for her respiratory care as she was diagnosed with respiratory failure, receiving oxygen continuously, and being monitored for oxygen saturation levels 3 times daily. The MDS Coordinator added she had failed to develop a comprehensive care plan for Resident #1's respiratory care and it was her oversight.

Interview with the Director of Nursing (DON) on 05/05/22 at 1:10 PM revealed it was her expectation for all the residents who received respiratory care in the facility to have a comprehensive care plan in place.

During an interview on 05/05/22 at 4:45 PM, the Regional Director of Operations (RDO) stated Resident #1 was diagnosed with respiratory failure and receiving oxygen therapy. It was his expectation for the facility to develop a comprehensive care plan to address Resident #1's respiratory needs.