STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 unannounced Recertification survey and complaint investigation were conducted onsite 07/05/21 through 07/08/21. Additional inteviews were obtained offsite through 07/11/22; therefore, the exit date was changed to 07/11/22. A total of 27 allegations were investigated and 5 were substantiated: Intakes NC00190502, NC00189047, NC00185760, NC00186206, NC00190187, NC00188775, NC00185068, NC00184876, NC00186433, and NC00188830. Event ID# YLN811.	F 000		
F 636 SS=D	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.	F 636		8/19/22

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

Electronically Signed | 08/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 1 (x) Disease diagnosis and health conditions. (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 admission Minimum Data Set (MDS) assessments within 14 days of	F 636	1. Resident#38 admissions assessment's ARD 4/18/22 and was completed on 5/18/22 has since been transmitted and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 2 admission for 2 of 4 sampled residents reviewed for Resident Assessments (Residents #38 and #291). Findings included: 1. Resident #38 was admitted to the facility on 04/12/22. Review of Resident #38's electronic medical record revealed an admission MDS assessment with an ARD (Assessment Reference Date) of 04/18/22. The MDS assessment was noted as completed on 05/18/22. During an interview on 07/07/22 at 10:54 AM, the Regional MDS Consultant revealed the facility was currently without a full-time MDS Coordinator and he had been filling in until a permanent replacement was hired. The Regional MDS Consultant confirmed Resident #38's admission assessment dated 04/18/22 was not completed within 14 days of admission. During an interview on 07/08/22 at 3:45 PM, the Administrator stated she would expect for MDS assessments to be completed within the regulatory timeframe. 2. Resident #291 was admitted to the facility on 6/17/22. Review of Resident #291's medical record revealed an admission Minimum Data Set (MDS) with an ARD (Assessment Reference Date) of 6/21/22. The MDS was noted as completed on 7/2/22. In an interview on 7/8/22 at 3:16 PM the Regional	F 636	accepted. This cannot be modified. Resident#291 admission assessment's ARD 6/17/22 and was completed on 7/2/22 and has since been transmitted and accepted. This cannot be modified. 2. Newly admitted residents are at risk for being affected by this deficient practice. 100% audit of currently newly admitted residents was done by Regional Clinical Reimbursement Consultant on 8/2/22 with deficiencies noted but no modification is required. Audit completed 8/2/22. 3. Minimum Data Set Coordinator (MDS), Dietary Manager, Social Services Director, Director of Rehab, Business Office Manager and Administrator were educated on MDS' Comprehensive Admission Assessment timing and completion etc. Education will be completed by 8/19/22. Any new MDS staff, Dietary Manager, Social Services Director, Director of Rehab, Business Office Manager that were not educated by 8/19/22 will be educated upon hire or before next shift worked. 4. To ensure the facility has met substantial compliance the Administrator or designee will audit 5 resident assessments to ensure proper timing for 4 weeks, then 3 resident assessments to ensure proper timing for 4 weeks and 2 residents for 4 more weeks to ensure compliance with providing a comprehensive accurate standardized reproducing assessment of each resident's functional capacity. Data from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 3 MDS Coordinator indicated the admission MDS for Resident #291 was not completed within 14 days of admission. He stated the facility did not have a full time MDS coordinator and this MDS was "a few days late." During an interview with the Administrator on 7/08/22 at 3:45 PM she stated the MDS should be completed within the regulatory timeframe.	F 636	audits will be brought to Quality Assurance Performance Improvement committee meeting monthly times 3. 5. The date of compliance is 8/19/2022	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed within 14 days of a resident being admitted into Hospice care for 1 of 1 sampled resident reviewed for Hospice (Resident #36). Findings included: Resident #36 was admitted to the facility on 12/16/21 with multiple diagnoses that included	F 637	1. Resident #35 had a significant change of assessment ARD 2/14/22 and was completed on 3/4/22 and as been transmitted and accepted. This cannot be modified. 2. Residents that require significant change are at risk for being affected by this deficient proactive. 100% audit of current significant changes was completed by Regional Clinical	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 637	Continued From page 4 dementia without behavioral disturbances and age-related debility. The hospice certification plan of care, with an effective date of 02/04/22, noted Resident #36 was certified to receive hospice services for end-of-life care. Review of Resident #36's electronic medical record revealed a significant change MDS with an Assessment Reference Date (ARD) of 02/14/22. The MDS assessment was noted as completed on 03/04/22. During an interview on 07/07/22 at 10:54 AM, the Regional MDS Consultant revealed the facility was currently without a full-time MDS Coordinator and he had been filling in until a permanent replacement was hired. The Regional MDS Consultant confirmed Resident #36's significant change MDS assessment dated 02/14/22 was not completed within the regulatory time frame. During an interview on 07/08/22 at 3:45 PM, the Administrator stated she would expect for MDS assessments to be completed within the regulatory timeframe.	F 637	Reimbursement Consultant on 8/2/22 with no deficiencies noted. Audit completed on 8/2/22. 3. Minimum Data Set Coordinator (MDS), Dietary Manager, Social Service Director, Director of Rehab, Business Office Manager, and Administrator were educated on MDS' significant change, timing, and completion etc. Education completed by 8/2/22. Any new MDS, Dietary Manager, Social Service Director, Director of Rehab, Business Office Manager that were not educated by 8/19/22 will be educated upon hire or before next shift worked. 4. The Administrator or designee will audit 5 resident assessments to ensure proper timing for 4 weeks, 3 resident assessments for 4 weeks to ensure compliance with providing timing, and 2 resident assessments for 4 more weeks to ensure compliance with providing a comprehensive accurate standardized reproducing assessment of each resident's functional capacity once a significant change in condition has been identified. Data from audits will be brought to Quality Assurance Performance Improvement committee meeting monthly x 3. 5. The date of compliance is 8/19/22	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 640	Continued From page 5	F 640		

requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 640	Continued From page 6 initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit discharge Minimum Data Set (MDS) assessments within 14 days of the discharge date for 2 of 4 sampled residents (Resident #1 and #91). Findings included: 1. Resident #1 was admitted to the facility on 02/09/22 and discharged to the community on 03/18/22. Review of Resident #1's electronic medical record revealed the last completed MDS assessment was coded as an admission with an Assessment Reference Date (ARD) of 02/16/22. There was no discharge assessment completed or transmitted. During an interview on 07/07/22 at 10:54 AM, the Regional MDS Consultant revealed the facility was currently without a full-time MDS Coordinator and he had been filling in until a permanent replacement was hired. The Regional MDS Consultant confirmed a discharge MDS assessment was not initiated, completed, or transmitted for Resident #1 and explained it was an oversight.	F 640	1. Resident #1 had missed Discharge Assessment was scheduled for 3/18/22 and was completed and transmitted 7/7/22. No further corrective action required. Resident #91 had missed Discharge Assessment's ARD 4/29/22 and was completed on 5/20/22 and has since been transmitted and accepted. No further corrective action required. 2. All residents being discharged are at risk of being affected by this deficient practice affected by this deficient practice. 100% audit of newly discharged residents was done by Regional Clinical Reimbursement Consultant on 8/2/22 with deficiencies noted but no modification is required. All Discharge Assessments have been transmitted and had been accepted. The audit took place 8/2/22. 3. To ensure this deficient practice does not recur the following has been put in place: Minimum Data Set Coordinator (MDS), Dietary Manager, Social Service Director, Director of Rehab, Business Office Manager and Administrator were educated regarding discharge assessments by 8/19/22 by the Regional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 640	Continued From page 7 During an interview on 07/08/22 at 3:45 PM, the Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 2. Resident #91 was admitted to the facility on 04/19/22. Review of Resident #91's electronic medical record revealed a discharge return not anticipated MDS assessment dated 04/29/22 that was noted as completed on 05/20/22. During an interview on 07/07/22 at 10:54 AM, the Regional MDS Consultant revealed the facility was currently without a full-time MDS Coordinator and he had been filling in until a permanent replacement was hired. The Regional MDS Consultant confirmed Resident #91's discharge MDS assessment dated 04/29/22 was not completed or transmitted within the regulatory timeframe. During an interview on 07/08/22 at 3:45 PM, the Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.	F 640	Clinical Reimbursement Consultant. Any new MDS staff, Dietary Manager, Social Service Director, Director of Rehab, Business Office Manager that were not educated by 8/19/22 upon hire or before next shift worked. 4. The Administrator or designee will audit 5 resident assessments to ensure proper timing for 4 weeks, 3 resident assessments for 4 weeks to ensure proper timing, and 2 resident assessments for 4 ore weeks to ensure compliance with providing a timely discharge assessment and timely completion and transmission. Data from audits will be brought to Quality Assurance Performance Improvement Committee meeting monthly x 3. 5. The date of compliance is 8/19/2022	
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 and staff interviews the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of nutrition,	F 641	1. Resident#240 the 5/23/22 quarterly MDS assessment Section K0150C has been modified form K0150C2 = YES TO	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 641	Continued From page 8 hospice, and discharge location for 4 of 24 (Residents #240, #11, #90 and #91) sampled residents. Findings included: 1. Resident #240 was admitted to the facility 11/19/21 with diagnoses including stroke and diabetes. Review of the Care Area Assessment (CAA) for feeding tube dated 12/01/21 revealed Resident #240 received all nutrition via feeding tube. Review of Resident #240's Physician orders dated 04/12/22 revealed he was to receive jevity 1.5 (a nutrition supplement used for feeding tubes) at 85 milliliters (ml) an hour for 20 hours through his feeding tube and the feeding was to be off for 4 hours. The order also stated Resident #240's feeding tube was to be flushed with 100 ml of water every 4 hours. The quarterly Minimum Data Set (MDS) dated 05/23/22 revealed Resident #240 had a feeding tube, received a mechanically altered diet, received 51% or more calories through tube feeding during the assessment period, and received 501 cubic centimeters (CC) or more average fluid intake per day by tube feeding during the assessment period. Review of Resident #240's nutrition care plan last revised 07/05/22 revealed he was NPO (an abbreviation meaning nothing by mouth). An interview with the Regional MDS Coordinator on 07/08/22 at 03:39 PM revealed Resident #240 did not receive a mechanically altered diet	F 641	K0150C2 = no. The Modified Quarterly MDS assessment has since been completed, transmitted and accepted. Resident #11 4/28/22 quarterly MDS assessment Section K1050C has been modified form K0150C2 = yes to K0150C2 = no. The modified Quarterly MDS assessment has sine been completed, transmitted and accepted. Resident #90 12/7/21 Admission MDS assessment Section 00100K2 has been modified from 00100K2 = yes to 00100K2 = no. The modified Admission MDS assessment has since been completed, transmitted and accepted. Resident # 91 4/29/22 discharge Return Not Anticipated MDS assessment Section A2100 '03'= acute hospital to A2100 '01' = community. The modified Discharge Return Not Anticipated MDS assessment has since been completed, transmitted and accepted. 2. Residents with peg tubes that are also NPO are at risk of being affected by this deficient practice. 100% audit of residents with PEG tubes was done by the Regional Clinical Reimbursement Consultant on 7/28/22 with no deficiencies noted. Initial audit completed. Residents under Hospice Care are at risk of being affected by this deficient practice. 100% audit of residents receiving Hospice care was done by Regional Clinical Reimbursement Consultant with no deficiencies noted. Initial audit completed 7/28l22. Residents being discharged are at risk of being affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 641	Continued From page 9 because he was NPO. He stated Resident #240 received all his nutrition through his feeding tube and the MDS indicating Resident #240 received a mechanically altered diet was a coding error. An interview with the Interim Director of Nursing (DON) on 07/08/22 at 02:47 PM revealed she expected MDS to be coded correctly. An interview with the Administrator on 07/08/22 at 04:09 PM revealed the facility had not had a full-time MDS Coordinator since January 2022. She stated there had been a person helping with MDS coding on a part-time basis but they had not worked in a while. The Administrator explained the lack of having a full time MDS Coordinator contributed to coding errors, but she expected MDS assessments to be coded correctly. 2. Resident #11 was admitted to the facility 02/06/20 with diagnoses including stroke and diabetes. Review of Resident #11's Physician orders dated 01/04/21 revealed an order for her to be NPO. Resident #11 had a Physician order dated 12/02/21 to receive 100 milliliter (ml) of water flush through her feeding tube every 4 hours. Resident #11 had a Physician order dated 12/11/21 to receive jevity 1.5 at 65 ml per hour for 18 hours a day through her feeding tube. The quarterly MDS dated 04/08/22 revealed Resident #11 had a feeding tube, received a mechanically altered diet, received 51% or more calories through tube feeding during the assessment period, and received 501 cubic centimeters (CC) or more average fluid intake per	F 641	100% audit on 7/28/22 of newly discharged residents was done by Regional Clinical Reimbursement Consultant with no deficiencies noted. 3. To ensure this deficient practice does not recur the following has been put in place: Minimum Data Set Coordinator (MDS), Dietary Manager, Social Services Director, Director of Rehab, Business Office Manager were educated on accuracy of assessments and those that were not educated by 7/28/22 will be educated upon hire or before next shift worked by the Regional Clinical Reimbursement Consultant. 4. To ensure the facility has met substantial compliance the Administrator or designee will audit 5 resident assessments to ensure proper timing for 4 weeks, 3 resident assessments for 4 weeks to ensure proper timing, and 2 residents assessments for 4 more weeks to ensure compliance in encoding Section k0150C2 accurately for residents who are receiving PEG tube and are NPO. Data from audits will be brought to Quality Assurance Performance Committee meeting monthly x 3 by the Administrator for review. To ensure the facility has met substantial compliance the Administrator or designee will audit 5 resident assessments to ensure proper timing for 4 weeks, 3 resident assessments for 4 weeks to ensure proper timing, and 2 resident assessments for 4 more weeks to ensure compliance in encoding Section 00100K2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 641	Continued From page 10 day by tube feeding during the assessment period. An interview with the Regional MDS Coordinator on 07/08/22 at 03:39 PM revealed Resident #11 did not receive a mechanically altered diet because she was NPO. He stated Resident #11 received all her nutrition through her feeding tube and the MDS indicating Resident #11 received a mechanically altered diet was a coding error. An interview with the Interim Director of Nursing (DON) on 07/08/22 at 02:47 PM revealed she expected MDS to be coded correctly. An interview with the Administrator on 07/08/22 at 04:09 PM revealed the facility had not had a full-time MDS Coordinator since January 2022. She stated there had been a person helping with MDS coding on a part-time basis but they had not worked in a while. The Administrator explained the lack of having a full time MDS Coordinator contributed to coding errors, but she expected MDS assessments to be coded correctly. 3. Resident #90 was admitted to the facility 11/30/21. Review of the hospital discharge orders dated 11/30/21 indicated Resident #90 was discharged to a skilled nursing facility with hospice care. The physician's order dated 11/30/21 revealed Resident #90 was admitted for hospice level of care. Review of the baseline care plan dated 11/30/21 indicated Resident #90's admission goals were to receive hospice care.	F 641	accurately for residents who are under Hospice Care. Data from audits will be brought to Quality Assurance Performance Improvement committee meeting monthly x 3 by the Administrator of review. To ensure the facility has met substantial compliance the Administrator or designee will audit 5 resident assessments to ensure proper timing for 4 weeks, 3 residents for 4 weeks to ensure proper timing, and 2 residents for 4 more weeks to ensure compliance in encoding section A2100 accurately for residents who are being discharged. Data from audits will be brought to Quality Assurance Performance Improvement committee monthly x3 by the Administrator for review. 5. The date of compliance is 8/19/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 641	Continued From page 11	F 641		

The care plan initiated 11/30/21 by the hospice provider revealed Resident #90 started to receive hospice level of care since 11/30/21.

Review of the admission MDS dated 12/07/21 revealed Resident #90 was coded as not receiving hospice care while in the facility under the special treatments and programs in Section O.

An interview with the Regional MDS Coordinator on 07/07/22 at 10:53 AM revealed the MDS nurse who had coded Resident #90's assessment incorrectly was no longer working in the facility. He acknowledged that it was a coding error as Resident #90 admitted on 11/30/21 and was under hospice care since admission.

An interview with the Interim Director of Nursing (DON) on 07/07/22 at 01:34 PM revealed she expected all the MDS assessments to be completed accurately.

An interview with the Administrator on 07/08/22 at 04:09 PM revealed the facility had not had a full-time MDS Coordinator since January 2022. She stated there had been a person helping with MDS coding on a part-time basis but she had not worked in a while. The Administrator explained the lack of having a full time MDS Coordinator contributed to coding errors, but she expected MDS assessments to be coded correctly.

4. Resident #91 was admitted to the facility on 04/19/22.

A discharge summary of stay dated 04/29/22 revealed Resident #91 discharged home with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 641	Continued From page 12 home health services. The discharge Minimum Data Set (MDS) dated 04/29/22 indicated Resident #91 was discharged to an acute hospital. During an interview on 07/07/22 at 10:54 AM, the Regional MDS Consultant revealed the facility was currently without a full-time MDS Coordinator and he had been filling in until a permanent replacement was hired. The Regional MDS Consultant confirmed Resident #91's discharge MDS assessment dated 04/29/22 was coded in error as discharging to an acute hospital and a modification would be submitted to accurately reflect that she discharged to the community. During an interview on 07/08/22 at 3:45 PM, the Administrator stated she would expect for MDS assessments to be completed accurately.	F 641		
F 684 SS=E	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 staff interviews the facility failed to obtain labs per physician's order to monitor kidney function, liver function and a test for white blood cells (T-cells) which are an	F 684	1. Resident #14 had labs for CMP, CBS, and Ammonia Level drawn on 7/13/22. The results were reported to the MD on 7/13/22. Depakote level scheduled to be	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 13 indicator of immune function for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #14). Findings included: Resident #14 was admitted to the facility on 09/02/20 with diagnoses that included a virus that attacks the body's immune system, intracerebral hemorrhage (bleeding into the brain tissue), and seizure disorder. An active physician's order dated 03/23/21 for Resident #14 read in part, obtain kidney function, liver function and CD4 count (test that measures the white blood cells that fight infection) every 3 months in March, June, September, and December. Review of Resident #14's medical record revealed the last liver function lab test was obtained was on 12/30/21. There were no other lab tests obtained for kidney function, liver function or CD4 count. During an interview on 07/08/22 at 11:17 AM, the Interim Director of Nursing (IDON) revealed all orders for lab tests were placed in the lab communication book for them to be obtained when due. The Interim DON was not sure why the labs ordered for Resident #14 were not documented in the lab communication book and confirmed the labs were not obtained per physician order. During an interview on 07/08/22 at 3:45 PM, the Administrator stated she expected for labs to be completed per physician order. The Administrator was unaware Resident #14's labs were not	F 684	drawn on 8/3/22. Results reported to MD on 8/3/22. No new orders were received. 2. The Director of Nursing completed 100% audit of all residents for routine labs on 8/1/22. All residents routine labs were scheduled in PCC and ordered with American Health Associates lab. No additional labs were identified as missed. 3. The Director of Nursing /Staff Development Coordinator will re-educate all current nurses including agency staff on the correct process for transcribing lab orders by 8/19/22. All new nurses will receive education on the correct process for transcribing lab orders during orientation. All agency nurses will receive education on the correct process for transcribing lab orders during the first day of the assignment. A copy of the correct process for transcribing lab orders will be kept in a binder at each nurses station. A signed copy of the education for transcribing lab orders will be maintained for all nurses in the education folder maintained by the Staff Development Coordinator. The DON/designee is responsible for ensuring transcribed orders are completed when due and results are received. 4. The Director of Nursing/designee will review all new labs and verify that they are transcribed correctly including entry into PCC and the lab system during the morning clinical meeting M-F on-going effective 8/19/22. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 14 obtained as ordered and explained she felt the breakdown was due to not having a consistent DON to oversee the process. During a phone interview on 07/08/22 at 10:28 AM, the Medical Doctor (MD) revealed he would expect for labs to be obtained as ordered.	F 684	5. The date of compliance is 8/19/2022.	
F 756 SS=E	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	F 756		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 15 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 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 staff, Consultant Pharmacist (CP), and Medical Director (MD), the CP failed to identify drug irregularities and provide recommendations for 2 of 5 residents reviewed for unnecessary medications (Residents #26 and Resident #14). The findings included: 1. Review of manufacturer's package insert indicated patients on Depakote required lab monitoring of valproic acid level once every 2-3 months during the first 6 months of treatment. Subsequently, repeated labs must be conducted once every 6 to 12 months in stable patients and whenever the clinical status changed. Resident #26 was admitted to the facility 01/31/17 with diagnoses included Alzheimer's disease, dementia, anxiety disorder, and depression. Review of Resident #26's medical records revealed her last valproic acid level was completed on 02/17/21. No additional labs for valproic acid level had been documented since then. The physician's orders dated 02/18/21 revealed	F 756	1. Resident #26 was determined by the MD to need Valporic Acid level every 6 months on 7/8/22. The labs for Valporic Acid level was obtained on 7/8/22. The results were reported to the MD on 7/9/22. There were no new orders on 7/9/22. Resident #14 was determined by the MD to need Valporic Acid level every 6 months on 8/3/22. The labs for Valporic Acid Level was obtained on 8/3/22. The results were reported to the MD on 8/3/22. There were no new orders on 8/3/22. 2. The Director of Nursing gave the Medical Director on 7/20/22 the list of mediations that required lab monitoring. Through the audit it was determined that residents who needed monitoring needed to be scheduled for labs and the MD ordered and by 8/19/22 labs will be gotten and MD kept informed of results. 3. On 7/12/22 the Pharmacy Consultant was re-educated in the need to include recommendations for lab monitoring on required medications. The Staff Development Coordinator will re-educate all current nurses including agency staff on the correct process for transcribing lab orders by 8/19/22. All	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 16 Resident #26 had obtained an order to receive 2 capsules of Depakote 125 milligrams (mg) by mouth 2 times daily for mood stabilization. A review of medication administration records (MARs) indicated Resident #26 had received 2 capsules of Depakote 125 mg 2 times daily as ordered since it was in initiated on 02/18/21. Review of Resident #26's medical records revealed the CP had conducted medication regimen reviews (MRRs) monthly since February 2021. The last recommendation to the provider dated 03/31/21 was not related to Depakote. The quarterly Minimum Data Set (MDS) dated 04/08/22 assessed Resident #26 with severe impaired cognition. She received antidepressant and antianxiety daily during the 7-day assessment period. During a phone interview with the CP on 07/07/22 at 04:56 PM, he acknowledged that residents who were receiving Depakote required to check valproic acid level routinely according to the guidelines. He stated when he performed the monthly MRR, lab requirements were reviewed to ensure each resident would receive all the labs as indicated by the manufacturer's guidelines. He added he would never let any resident on Depakote without valproic acid level checked for over a year. When he identified irregularities and needed to make recommendations, he would notify the provider either verbally or in writing. He did not know why Resident #26's valproic acid level was not checked for so long as he could not access to the computer during the interview. A phone interview with the MD on 07/08/22 at	F 756	new nurses will receive education on the need to include routine monitoring lab orders for required medications during orientation. All agency nurses will receive education on the need to include routine lab orders for required medications during the first day of the assignment. A list of medications that require routine lab monitoring will be kept in a binder at each nurse's station. A signed copy of the education for obtaining routine labs for required medications requiring lab monitoring will be maintained for all nurses in the education folder maintained by the Staff Development Coordinator. 4 The Director of Nursing/designee will monitor all new orders for medications requiring routine lab monitoring during morning clinical meeting M-F effective 8/19/22. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee meeting monthly x3. 5. The date of compliance is 8/19/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 17	F 756		

10:51 AM revealed he depended on the CP to report any irregularities to ensure all the required labs were in place according to the guidelines. The potential harm for residents receiving Depakote without monitoring of valproic acid levels could be increased behaviors, seizures, or mood fluctuations. It was his expectation for the CP to alert him when Resident #26's lab for valproic acid was due.

An interview with the Interim Director of Nursing (DON) on 07/08/22 at 02:55 PM revealed she expected the CP to report all drug irregularities identified during the MRR to the provider to ensure all the labs required by the guidelines were completed in timely manner.

An interview with the Administrator on 07/08/22 at 03:46 PM revealed she expected the CP to identify all the drug irregularities and alert the provider to ensure all the labs required by the guidelines were completed in timely manner.

2. Review of the manufacturer's package insert indicated patients on Depakote required lab monitoring of valproic acid level once every 2 to 3 months during the first 6 months of treatment. Subsequently, repeated labs must be conducted once every 6 to 12 months in stable patients and whenever the clinical status changed.

Resident #14 was admitted to the facility on 09/02/20 with diagnoses that included a virus that attacks the body's immune system, intracerebral hemorrhage (bleeding into the brain tissue), and seizure disorder.

An active physician's order for Resident #14 dated 10/19/21 read, Depakote (anticonvulsant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 18	F 756		

medication used to treat seizure disorders) 375 milligrams (mg) by mouth twice daily for epilepsy (seizure disorder).

The quarterly Minimum Data Set (MDS) dated 04/14/22 assessed Resident #14 with moderate impairment in cognition.

The Medication Administration Records (MARs) for May 2022, June 2022 and July 2022 revealed Resident #14 received Depakote 375 mg twice daily as ordered.

A Psych progress note dated 05/16/22 read in part, "Depakote level ASAP (as soon as possible)."

Review of Resident #14's medical records revealed there were no lab results for valproic acid level for the months of May 2022, June 2022 or July 2022.

Review of Resident #14's medical record revealed monthly Medication Regimen Reviews (MMRs) were completed by the Consultant Pharmacist (CP) with the last review completed on 06/05/22. There were no recommendations from the CP related to obtaining a Depakote level.

During a phone interview on 07/07/22 at 4:56 PM, the CP acknowledged that according to manufacturer guidelines, valproic acids were required to be checked routinely for residents who received Depakote medication. He explained when completing the monthly MRR, lab results were reviewed to ensure each resident received all the labs as indicated by the guidelines. The CP further explained when he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 19 identified irregularities and needed to make recommendations, he notified the provider either verbally or in writing. The CP could not explain why Resident #14's valproic acid level was not checked as he did not have access to the computer during the interview. During a phone interview on 07/08/22 at 10:51 AM, the Medical Doctor (MD) revealed he depended on the CP to report any irregularities to ensure all the required labs were obtained according to the guidelines. The MD stated the potential harm for residents receiving Depakote medication, without monitoring valproic acid levels, could be increased behaviors, seizures, or mood fluctuations. The MD stated it was his expectation for the CP to alert him when Resident #14's lab for valproic acid was due. During an interview on 07/08/22 at 02:55 PM, the Interim Director of Nursing (DON) stated she expected the CP to report all drug irregularities identified during the MRR to the provider to ensure labs were completed as required by the guidelines and/or physician's order. During an interview on 07/08/22 at 03:46 PM, the Administrator stated she expected the CP to identify all the drug irregularities and alert the provider to ensure all the labs were obtained as required by the guidelines and/or physician's order.	F 756		
F 757 SS=E	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	F 757		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 20 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 staff, Consultant Pharmacist (CP), and Medical Director (MD), the facility failed to ensure each resident's medication regimen was free from unnecessary medication for failure to provide adequate lab monitoring for 2 of 5 residents reviewed for unnecessary medications (Residents #26 and Resident #14). The findings included: 1. Review of manufacturer's package insert indicated patients on Depakote required lab monitoring of valproic acid level once every 2-3 months during the first 6 months of treatment. Subsequently, repeated labs must be conducted once every 6 to 12 months in stable patients and whenever the clinical status changed.	F 757	1. Resident #14 had orders for Valporic Acid Level obtained on 8/3/22. Lab obtained 8/3/22 and reported to MD on 8/3/22. Results were within normal levels and no new orders made. Resident #26 had orders for Valporic Acid level obtained 7/8/2022. The labs for Valporic Acid level was obtained 7/8/2022 and reported to MD on 7/9/2022 and no new orders made. 2. The Director of Nursing and Nursing Leadership Team completed 100% audit on all lab orders since 6/1/22 to 8/1/22 and no additional missed lab orders identified. 3. We will be continuing to look at Pharmacy lab recommendations and see that there is follow through through the MD. The DON/designee is responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 21 Resident #26 was admitted to the facility 01/31/17 with diagnoses included Alzheimer's disease, dementia, anxiety disorder, and depression. Review of care plan for psychosocial well-being initiated 12/04/20 revealed Resident #26's family requested mental health services with the goal to reduce psychiatric medication whenever possible without risk to compromise her mental health. Interventions included providing psychotropic medications and labs as ordered. Review of Resident #26's medical records revealed her last valproic acid level was completed on 02/17/21. No additional labs for valproic acid level had been documented since then. The physician's orders dated 02/18/21 revealed Resident #26 had obtained an order to receive 2 capsules of Depakote 125 milligrams (mg) by mouth 2 times daily for mood stabilization. A review of medication administration records (MARs) indicated Resident #26 had received 2 capsules of Depakote 125 mg 2 times daily as ordered since it was in initiated on 02/18/21. The quarterly Minimum Data Set (MDS) dated 04/08/22 assessed Resident #26 with severe impaired cognition. She received antidepressant and antianxiety daily during the 7-day assessment period. During a phone interview with the CP on 07/07/22 at 04:56 PM, he acknowledged that residents who were receiving Depakote required to check valproic acid level routinely according to the	F 757	ensuring transcribed orders for routine labs are completed when due and results are received. The Staff development Coordinator will re-educate all current nurses including agency staff on the correct process for transcribing lab orders by 8/19/22. All new nurses will receive education on the need to include routine monitoring lab orders for required medications during orientation of new employees. All agency nurses will receive education on the need to include routine lab orders for required medications during the first day of the assignment. A list of medications that require routine lab monitoring will be kept in a binder at each nurse's station. A signed copy of the education for obtaining routine labs for required medications requiring lab monitoring will be maintained for all nurses in the education folder maintained by the Staff Development Coordinator. 4. The Director of Nursing/designee will monitor all new orders for medications requiring routine lab monitoring during morning clinical meeting M-F effective 8/19/22. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee monthly x3. 5. The date of compliance is 8/19/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 22	F 757		

guidelines.

A phone interview with the MD on 07/08/22 at 10:51 AM revealed the potential harm for residents receiving Depakote without monitoring of valproic acid levels could be increased behaviors, seizures, or mood fluctuations.

An interview with the Interim Director of Nursing (DON) on 07/08/22 at 02:55 PM revealed she expected all the labs required by the manufacturer's guidelines to be carried up, followed-up, and completed accurately in timely manner.

An interview with the Administrator on 07/08/22 at 03:46 PM revealed she expected all the labs required by the manufacturer's guidelines to be completed in timely manner.

2. Review of the manufacturer's package insert revealed patients on Depakote medication required lab monitoring of valproic acid level once every 2 to 3 months during the first 6 months of treatment. Subsequently, repeated labs must be conducted once every 6 to 12 months in stable patients and whenever the clinical status changed.

Resident #14 was admitted to the facility on 09/02/20 with diagnoses that included a virus that attacks the body's immune system, intracerebral hemorrhage (bleeding into the brain tissue), and seizure disorder.

An active physician's order for Resident #14 dated 10/19/21 read, Depakote (anticonvulsant medication used to treat seizure disorders) 375 milligrams (mg) by mouth twice daily for epilepsy (seizure disorder).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 23	F 757		

The quarterly Minimum Data Set (MDS) dated 04/14/22 assessed Resident #14 with moderate impairment in cognition.

Review of Resident #14's psychosocial well-being care plan, last reviewed/revised on 05/22/22, revealed his Guardian requested mental health services with a goal to reduce psychiatric medication whenever possible without risk to his mental health. Interventions included providing medications and obtaining labs as ordered.

The Medication Administration Records (MAR) for May 2022, June 2022 and July 2022 revealed Resident #14 received Depakote 375 mg twice daily as ordered.

A Psych progress note dated 05/16/22 read in part, "Depakote level ASAP (as soon as possible)."

Review of Resident #14's medical records revealed there were no lab results for valproic acid level for the months of May 2022, June 2022 or July 2022.

During a phone interview on 07/07/22 at 4:56 PM, the Consultant Pharmacist (CP) revealed that according to manufacturer guidelines, valproic acids were required to be checked routinely for residents who received Depakote medication.

During a phone interview on 07/08/22 at 10:51 AM, the Medical Doctor (MD) revealed the potential harm for residents receiving Depakote medication, without monitoring valproic acid levels, could be increased behaviors, seizures, or mood fluctuations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 24 During an interview on 07/08/22 at 02:55 PM, the Interim Director of Nursing (DON) stated she expected for all labs to be obtained, followed-up on, and completed per the manufacturer's guidelines. During an interview on 07/08/22 at 03:46 PM, the Administrator stated she expected labs to be completed as required per the manufacturer's guidelines.	F 757		
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 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 and staff interviews the facility failed to change oil used in a deep fryer that appeared burnt and black in color, failed to	F 812	1. The oil in the deep fryer was emptied and the fryer was cleaned thoroughly inside and out on 7/5/22. Fresh oil was	8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 25 remove a buildup of dark colored oil splatter marks from the inside and outside of the fryer and from the shelves of metal table located beside the fryer, failed to remove crumbs and dust debris from the lower shelf of a metal prep table, failed to remove a buildup of a black colored substance from two ceiling vents located above the steam table to prevent possible cross contamination of food, and failed to ensure staff covered facial hair during food service and meal tray setup. These failures had the potential to affect the food being served to residents. Findings included: 1. A tour of the kitchen on 07/05/22 at 10:00 AM with the Dietary Manager (DM) revealed oil in the deep fryer was black in color. The top and sides of the deep fryer had a large amount of buildup of dark colored oil splattered on the inside and outside of the fryer. A metal table located beside the deep fryer had multiple areas of dark colored oil splattered on the top and lower shelf of the table. During an interview on 07/05/22 at 10:01 AM the DM confirmed the oil in the deep fryer was black in color indicating it needed to be changed. He also acknowledged oil had splattered on the inside and outside of the deep fryer and the table beside it and both needed to be cleaned to remove the buildup. The DM revealed he didn't have a schedule to show how often the oil in the deep fryer was changed or when it was last cleaned. The DM stated it was the responsibility of kitchen staff to ensure the oil in the deep fryer was changed when needed and the kitchen equipment was kept clean.	F 812	added to the fryer on 7/5/22. The oil splatter was cleaned from the shelves and metal table beside the fryer on 7/5/22. The crumbs and dust were immediately cleaned from the lower shelf of the metal prep table on 7/5/22.The ceiling vents above the steam table were cleaned on 7/5/22. On 7/5/22 DA#1 was re-educated on wearing a beard guard. DA#1 donned beard guard on 7/5/22. 2. All residents receiving meals from the dietary department at the center have the potential to be affected. All areas of the kitchen were inspected and cleaned as needed on 7/5/22. On 7/25/22 a cleaning schedule was set up for all equipment in the kitchen including the fryer, shelves, tables, vents and other kitchen equipment and surfaces. All kitchen staff were re-educated on kitchen cleanliness, kitchen cleaning schedule on 7/25/22. All staff were re-educated on the importance of wearing hair nets and beard guars on 8/3/22. 4. The Dietary Manager will preform audits for kitchen cleanliness including staff compliance with hair nets and beard guards 5 staff for 4 weeks, 3 staff for 4 weeks and 2 staff for 4 more weeks. He will also be looking to see that cleaning schedule is being followed weekly for 4 weeks, twice a week for 4 weeks and once a week for 4 more weeks. The results of the kitchen audits will be reported to the Quality Assurance Performance Improvement Committee monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 26 An interview was conducted on 07/08/22 at 3:45 with the Administrator. The Administrator revealed it was her expectation dietary staff kept kitchen equipment clean. The Administrator revealed it was her expectation dietary staff followed a schedule to clean the equipment used in the kitchen. 2. Observations during the initial tour of the kitchen on 07/05/22 at 10:00 AM revealed a metal food prep table with crumbs and dust debris scattered along the lower shelf. During an interview on 07/05/22 at 10:00 AM the DM revealed the lower shelf on the prep table had crumbs and dust debris and needed to be cleaned. The DM revealed the prep table should be wiped off daily but was unable to confirm when it was last done. The DM stated it was the responsibility of kitchen staff to ensure kitchen equipment was kept clean. An interview was conducted on 07/08/22 at 3:45 with the Administrator. The Administrator revealed it was her expectation dietary staff kept kitchen equipment clean. The Administrator revealed it was her expectation dietary staff followed a schedule to clean the equipment used in the kitchen. 3. An observation of meal tray service on 07/05/22 at 11:35 AM revealed two air vents in the ceiling with a buildup of a black colored substance. Both had developed several condensation droplets of water along each vent. The vents were located above the steam table where food was being plated and ready to serve to residents. No air was felt coming from the vents.	F 812	5. The date of compliance is 8/19/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 27	F 812		

During an interview on 07/05/22 at 11:35 AM The DM revealed maintenance oversaw the cleaning of the air vents in the kitchen. The DM indicated maintenance was aware the vents needed to be cleaned but due to an unexpected event the previous maintenance person was recently replaced. The DM was unsure if the new Maintenance Director was aware he was responsible for cleaning the air vents in the kitchen.

During an interview on 07/11/22 at 9:55 AM the Maintenance Director revealed he started his position on 06/27/22. The Maintenance Director explained staff communicate with him using a paper form or verbally tell him of issues that need to be addressed. The Maintenance Director revealed he wasn't aware of being responsible for cleaning the ceiling vents in the kitchen and since he started his position hadn't receive a request from kitchen staff related to cleaning ceiling vents. The Maintenance Director revealed he would need to follow up with the DM to address issues with cleaning ceiling vents and would make it his top priority.

An interview was conducted on 07/08/22 at 3:45 with the Administrator. The Administrator revealed it was her expectation dietary staff kept kitchen equipment clean. The Administrator revealed it was her expectation dietary staff followed a schedule to clean the equipment used in the kitchen.

4. During an observation on 07/05/22 at 11:26 AM the DM and Dietary Aide (DA) #1 wore a surgical mask over their nose and mouth during the plating of food ready to serve to residents. Their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 28 beard hair was long and extended from the outside of the surgical mask pass the chin and face. DA #1 stood in front of the steam table where food was being plated ready to serve to the residents. During an interview on 07/05/22 at 11:26 AM DA #1 revealed he had his beard guard on earlier but took it off and forgot to replace it. DA #1 explained he was trained when hired if you had a beard, you must wear a guard. An interview was conducted with the DM on 07/05/22 at 11:28 AM. The DM revealed dietary staff with a beard should wear a guard. The DM stated he and DA #1 should have worn their beard guards for as long as their beards were. An interview was conducted on 07/08/22 at 3:45 with the Administrator. The Administrator revealed it was her expectation dietary staff keep hair, including facial hair, covered when prepping, cooking, and plating meals being served to residents.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (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(i) Medical records.	F 842		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 842	Continued From page 29	F 842		

§483.70(i)(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(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 842	Continued From page 30 legal age under State law. §483.70(i)(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 maintain complete and accurate medical records for 2 of 2 residents with missing documentation in their medical records (Resident #74 and #49). Findings included: 1. Resident #74 was admitted to the facility 05/18/22 with diagnoses including hypertension (high blood pressure) and arthritis. A nurse's note dated 06/27/22 at 02:48 PM revealed Resident #74 had an episode of not being able to complete sentences and not being able to move his hands and was sent to the hospital for evaluation. Review of the nurse progress notes for Resident #74 revealed no there was no documentation of the resident's return to the facility. An interview with Nurse #1 on 07/08/22 at 12:06	F 842	1. Resident #74 was seen in the emergency department on 6/27/22. A copy of the ED note was obtained and file in the electronic medical record on 7/12/22. Nurse #1 was educated on the requirement to complete a progress note including the date/time the resident returns from the hospital, vital signs and the resident's general condition. Resident #49 was seen for an orthopedic consult on 6/24//22. A copy of the consultation report was filed in the electronic medical record on 8/3/22. 2. On 8/3/22 the Medical Records Coordinator completed 100% audit of all residents who have had a medical appointment, emergency room visit or inpatient hospitalization form 6/1/22 to current to verify that a copy of the consultation or progress report is filed in the electronic medical record. 10 additional residents were noted with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 842	Continued From page 31	F 842		

PM revealed she cared for Resident #74 on 06/27/22 on the 03:00 PM to 11:00 PM shift. She stated Resident #74 returned to the facility from the hospital at some point on her shift on 06/27/22. Nurse #1 stated she received report from the hospital and thought Resident #74 had been diagnosed with a urinary tract infection (UTI). She stated she usually wrote a nurse's note when a resident returned from the hospital that included the date and time they returned to the facility and their general condition. Nurse #1 stated it was an oversight that she did not write a note when Resident #74 returned to the facility on 06/27/22.

An interview with the Interim Director of Nursing (DON on 07/08/22 at 11:38 AM revealed she expected a nurse's note to be written any time a resident returned from the hospital and it should include the date and time the resident returned, their vital signs, and their general condition.

An interview with the Administrator on 07/08/22 at 04:09 PM revealed she expected a nurse's note to be written any time a resident returned to the facility from being in the hospital.

2. Resident #49 was admitted to the facility 04/29/21 with diagnoses including arthritis and diabetes.

Review of Resident #49's Physician orders revealed an order dated 05/13/22 for a spine and neurosurgery consult for pain.

Review of Resident #49's medical record revealed no consultation note for being evaluated by a spine and neurosurgery provider.

missing consults or progress notes and contact with the doctors or hospitals was made on 8/3/2022 to get records.

3. On 7/25/22 the Administrator educated the Medical Records Coordinator on the requirement that all residents who leave the center for a medical appointment, emergency room visit or inpatient hospital admission have a copy of the consultation or progress report filed in the electronic medical record.
By 8/19/22 the Staff Development Coordinator will have educated all nurses and agency on the requirement that all residents who return to the center from the emergency room or doctors appointment make a progress note in the medical record vital signs resident condition and orders received. That that paperwork given to Medical Records to upload in the electronic medical record. This will be part of the orientation of new staff and new agency will also be educated on the importance of documenting when residents leave and return to the building. A signed copy of the education on documenting residents leaving and returning to the facility will be kept in a folder by the Staff Development coordinator.

4. The DON/designee will monitor during clinical meetings M-F to see that documentation of appointments, emergency room visits and hospitalization are being done and seeing that Medical Records is requesting records from appointments, ER visits and seeing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 842	Continued From page 32 During an interview with the Medical Records Coordinator on 07/08/22 at 09:20 AM she confirmed no spine and neurosurgery consult note was in Resident #49's medical record. She stated Resident #49 had received her spine and neurosurgery consult because she was wearing a specialized back brace that would have come from a specialist, but she was not sure when Resident #49 saw the specialist. The Medical Records Coordinator stated residents usually returned from consults with a progress note but she was not sure why there was not one in Resident #49's medical record. An interview with the Interim Director of Nursing (DON) on 07/08/22 at 02:47 PM revealed she expected a resident's medical record to contain any type of consultation report and she was not sure why Resident #49 did not have a spine and neurosurgery consult note on her chart. An interview with the Administrator on 07/08/22 at 04:09 PM revealed she expected resident medical records to be as complete and accurate as possible and any consult notes should be included in the resident's medical record.	F 842	Medical Records reports problems getting the information. The results will be reported to the Quality Assurance Performance Improvement committee monthly x 3. 5. The date of compliance is 8/19/2022.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 880	Continued From page 33	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 880	Continued From page 34 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and implement infection control policies and procedures to reduce the risk of growth and spread of Legionella in the building water systems which could affect 89 of 89 residents. In addition, the facility failed to implement their infection control policies and Center for Diseases Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 1 housekeeper (Housekeeper #1) failed to wear an N-95 mask, a gown, and gloves when entering a resident room to remove the trash and perform hand hygiene after exiting the resident's room for 1 of 1 resident (Resident #240) reviewed for infection control practices. Findings included: 1. Review of the facility's Emergency Preparedness plan revealed no information	F 880	1. Housekeeper #1 will be educated by the Infection Control Preventionist, Regional Environmental Manager and interpreter will re-educate on infection control practices including PPE use and handwashing procedures on 8/8/22 prior to her return to work. Legionella Test Kit was ordered on 7/15/22 on Amazon.com. On 7/19/22, the Maintenance Director completed the onsite Legionella test using water collected for Shower room A and shower room B heads and the dish room spray head in the kitchen All samples were negative. He developed the Water Safety Management Plan on 7/19/2022. 2. All residents have the potential to be affected by this deficient act. 3. On 8/1/22 the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 880	Continued From page 35 related to a facility water safety management program to minimize the risk of transmission of Legionella Disease to the residents, staff, and visitors by testing the water. In an interview on 07/08/22 at 05:25 PM the Administrator stated she was unaware of the requirement to develop a program to minimize the risk of transmission of Legionella through the facility's water system. She stated she spoke with the facility Maintenance Director and he was also unaware of the requirement. The Administrator further stated the facility water was supplied by the city and no water testing had been done. 2. Review of the facility policy titled, "Infection Control Guidelines for all Nursing Procedures" revised 08/2012 read in part: "Transmission-Based Precautions will be used whenever measures more stringent then Standard Precautions are needed to prevent the spread of infection." The facility's policy for PPE-Using Face Masks revised 09/2010, under the section When to Use a Mask, read in part, "When providing services to a patient and the use of a mask is indicated." The facility's policy for PPE-Using Gowns revised 09/2010, under the section When to Use a Gown, read in part, "When indicated or as instructed." The facility's policy for PPE-Using Gloves revised 09/2010, read in part, "Use gloves when cleaning contaminated surfaces." An observation of the open door of Room #1 on 07/07/22 at 02:06 PM revealed a sign stating	F 880	Performance Improvement Committee along with the Infection Preventionist, Administrator and Housekeeping Director completed a Root Cause Analysis of Housekeeper #1 to properly use PPE and handwashing. The Root Cause Analysis indicated that the Housekeeper #1 has a language barrier. The education for housekeeper #1 will be 8/8/22. On 8/1/22 the Quality Assurance Performance Improvement Committee along with the Infection Control Preventionist, Administrator, and Maintenance Director completed a Root Cause Analysis for failure to have Legionella testing. The Root Cause Analysis indicated that the Maintenance Director was not aware of the needs for the facility to conduct Legionella test. On 7/11/22, the Administrator educated the Maintenance Director on the need to have a Water Management Plan including the Legionella Testing. On 7/19/22, the Maintenance Director prepared the facility Water Management Plan including the Legionella Testing. The Infection Control Preventionist will educated all staff on the facility Water Management Plan including information on Legionella by 8/19/22. By 8/19/2022 the Infection Preventionist will educate all staff including agency on infection control practices including use of proper PPE and handwashing practices. All newly hired staff and new agency staff will receive education on infection control and proper use of PPE and handwashing practices before the first shift worked. The Infection Control Preventionist will monitor 10 staff including agency weekly for 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 880	Continued From page 36 Resident #240 was on Special Droplet Contact Precautions and all healthcare personnel entering the room must clean hands before entering and when leaving the room, wear a gown when entering and remove before leaving, wear N-95 or higher level respirator before entering the room and remove after exiting, wear protective eyewear, and wear gloves when entering room and remove before leaving. The sign was written in English and Spanish. A cart containing N-95 masks, gowns, and gloves was positioned outside Room #1. A continuous observation of Housekeeper #1 on 07/05/22 from 02:06 PM to 02:08 PM revealed she removed the trash from the trashcan of Room #1, walked into the hall and placed the trash on her cart, and continued down the hall with her cart. Housekeeper #1 did not wear an N-95 mask, a gown or gloves while in Room #1. Housekeeper #1 did not perform hand hygiene after exiting Room #1. An interview was attempted with Housekeeper #1 on 07/05/22 at 02:08 PM but Housekeeper #1 indicated she did not speak English and walked down the hall. An interview with the Regional Housekeeping Manager on 07/05/22 at 02:45 PM revealed there was a language barrier with Housekeeper #1, but she did weekly in-services with housekeeping staff on PPE use in isolation rooms and hand hygiene and another housekeeping staff member acted as a translator during the in-services. The Regional Housekeeping Manager stated she expected housekeeping staff to completely gown up and wear gloves while in an isolation room and remove them before leaving an isolation room.	F 880	weeks, 5 weekly for 4 weeks and 2 weekly for 4 more weeks. 4. The housekeeping director will perform audits of all Housekeeping staff for Infection Control practices monitoring Housekeeper #1 closely. The audit will be looking at using PPE and handwashing practices and infection control practices all housekeeping staff weekly for 4 weeks, 2 staff weekly for 4 weeks and 1 staff weekly for 4 more weeks. The results of the housekeeping audit will be reported to the Quality Assurance Performance Improvement committee monthly x3. The Maintenance Director will perform audits for Legionella testing annually on-going. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee annually. The Water Safety Management Plan will also go to Quality Assurance Performance Improvement committee annually as well for continued approval. 5. The date of compliance is 8/19/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 880	Continued From page 37 She also stated the trash should have been placed in a red container in the resident's room and not put in with the regular trash. The Regional Housekeeping Manager stated she expected housekeeping staff to perform hand hygiene when exiting an isolation room and alcohol-based hand rub (ABHR) was available in the hallway and on housekeeping carts. An interview with the Interim Director of Nursing (DON) on 07/08/22 at 11:38 AM revealed she expected any staff member who entered a resident's room that was on Special Droplet Contact Precautions to wear an N-95 mask, a gown, and gloves when in the room. She also stated she expected any staff member to perform hand hygiene when exiting a resident room. An interview with the Administrator on 07/08/22 at 04:09 PM revealed she expected housekeeping staff to follow signage when entering an isolation room and housekeeping staff had repeated in-services on wearing PPE while in isolation rooms. She stated she expected housekeeping staff to perform hand hygiene when exiting resident rooms.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		8/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 883	Continued From page 38	F 883		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 883	Continued From page 39 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include in the resident's medical record documentation of education or immunization status for the influenza vaccine for 3 of 5 sampled residents (Residents #15, #42, and #75). Findings included: The facility's policy titled "Influenza Vaccination" reviewed/revised 10/27/20 read in part, "It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from influenza by offering our residents, staff members and volunteer workers annual immunization against influenza ...2) Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized, or refuses the vaccine ...8) The resident's medical record will include documentation that the resident and/or their representative was provided education regarding the benefits and potential side effects of the immunization and that the resident received or did not receive the immunization due to contraindication or refusal." 1. Resident #15 was admitted to the facility on 02/20/20.	F 883	1. For residents #15, 342, #75 with the responsible party or the resident will be given information on the influenza and pneumococcal shots available and that they can chose to have the shots or decline and this paperwork will be uploaded in the electronic medical record by 8/19/22. 2. The Director of Nursing /Designee completed 100% audit that showed that most all residents lacked the documentation about the choice of influenza and pneumococcal vaccination. All residents/or responsible parties will be asked and get to sign the necessary paperwork and have it uploaded in the electronic medical record by 8/10/22. 3. The Infection Preventionist educated the Social Worker and Nurses on the updated process for giving residents information on influenza and pneumococcal vaccinations 8/4/22. For any new hires or agency nurses that have not had the training, they will be trained before the first shift worked. The Social Worker will review the influenza/pneumococcal consent/declination with the resident or responsible party during the 72 hour care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 883	Continued From page 40 The quarterly Minimum Data Set (MDS) dated 04/08/22 assessed Resident #15 with severe impairment in cognition. Review of Resident #15's medical record revealed he received an influenza vaccine on 01/06/21. There was no documentation to indicate he was offered, received, or declined the influenza vaccine in or after October 2021. During an interview on 07/08/22 at 2:49 PM, the Interim Director of Nursing (IDON) revealed she had only been in the position for a little over a week and was not sure what the facility's process was for keeping track of immunization status for the residents. The Interim DON confirmed Resident #15's medical record did not contain documentation to indicate he was educated on the influenza vaccine and received or declined the influenza vaccine in or after October 2021. During an interview on 07/08/22 at 5:10 PM, the Administrator revealed she was responsible for obtaining consents for the COVID-19 vaccination and the Director of Nursing (DON) was responsible for obtaining consents for the influenza and pneumococcal vaccines. The Administrator stated she knew they had provided residents with the influenza vaccine last year if they consented and indicated all information to support the influenza vaccine was offered, received, or refused should have been documented in each resident's medical record. The Administrator could not explain why Resident #15's medical record did not contain documentation to indicate he was provided education regarding the influenza vaccine or the influenza vaccine was received or refused. The Administrator explained she felt the breakdown	F 883	conference. The Social Worker will forward the completed consent/declination form to the Infection Control Preventionist. The Infection Preventionist will review the Influenza/Pneumococcal consent/declination form and enter the information into the resident's electronic medical record in PCC in the immunization tab if declined. If resident consents, then the Infection Preventionist will enter the order to the administer the vaccination in PCC. The Infection Preventionist will then forward the consent/declination form to the Medical Records for uploading in the resident's electronic medical record. The Nurse will administer the vaccination as indicated and document on the MAR in PCC. The Nurse will also enter the vaccination information into the vaccination tab in PCC. 4. The Director of Nursing/designee will audit all new admissions in morning clinical meeting M-F on-going to verify Influenza/Pneumococcal consent/declinations are obtained, Influenza/Pneumococcal Vaccinations are administered and documented in the resident's electronic medical record as indicated. The results of the Influenza/Pneumococcal audit will be reported to the Quality Assurance Performance Improvement Committee monthly x3. 5. The date of compliance is 8/19/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 883	Continued From page 41	F 883		

was due to not having a consistent DON to oversee the process.

2. Resident #42 was admitted to the facility on 01/13/18.

The quarterly Minimum Data Set (MDS) dated 05/04/22 assessed Resident #42 with moderate impairment in cognition.

Review of Resident #42's medical record revealed no documentation to indicate he was educated on the influenza vaccine and received or declined the influenza vaccine.

During an interview on 07/08/22 at 2:49 PM, the Interim Director of Nursing (IDON) revealed she had only been in the position for a little over a week and was not sure what the facility's process was for keeping track of immunization status for the residents. The Interim DON confirmed Resident #42's medical record did not contain documentation to indicate he was educated on the influenza vaccine and received or declined the influenza vaccine in or after October 2021.

During an interview on 07/08/22 at 5:10 PM, the Administrator revealed she was responsible for obtaining consents for the COVID-19 vaccination and the Director of Nursing (DON) was responsible for obtaining consents for the influenza and pneumococcal vaccines. The Administrator stated she knew they had provided residents with the influenza vaccine last year if they consented and indicated all information to support the influenza vaccine was offered, received, or refused should have been documented in each resident's medical record. The Administrator could not explain why Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 883	Continued From page 42	F 883		

#42's medical record did not contain documentation to indicate he was provided education regarding the influenza vaccine or the influenza vaccine was received or refused. The Administrator explained she felt the breakdown was due to not having a consistent DON to oversee the process.

3. Resident #76 was admitted to the facility on 12/27/19.

The quarterly Minimum Data Set (MDS) dated 05/30/22 assessed Resident #76 with intact cognition.

Review of Resident #76's medical record revealed no documentation to indicate he was educated on the influenza vaccine and received or declined the influenza vaccine.

During an interview on 07/08/22 at 2:49 PM, the Interim Director of Nursing (IDON) revealed she had only been in the position for a little over a week and was not sure what the facility's process was for keeping track of immunization status for the residents. The Interim DON confirmed Resident #76's medical record did not contain documentation to indicate he was educated on the influenza vaccine and received or declined the influenza vaccine in or after October 2021.

During an interview on 07/08/22 at 5:10 PM, the Administrator revealed she was responsible for obtaining consents for the COVID-19 vaccination and the Director of Nursing (DON) was responsible for obtaining consents for the influenza and pneumococcal vaccines. The Administrator stated she knew they had provided residents with the influenza vaccine last year if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(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 883	Continued From page 43 they consented and indicated all information to support the influenza vaccine was offered, received, or refused should have been documented in each resident's medical record. The Administrator could not explain why Resident #76's medical record did not contain documentation to indicate he was provided education regarding the influenza vaccine or the influenza vaccine was received or refused. The Administrator explained she felt the breakdown was due to not having a consistent DON to oversee the process.	F 883		