STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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E 000	Initial Comments An unannounced recertification and complaint investigation sruvey was conducted on 11/13/23 through 11/17/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 31B011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/13/23 through 11/17/23. Event ID# 31B011. The following intakes were investigated: NC00207903, NC00195411, NC00208086, NC00204516, NC00196910, NC00198254, NC00195362, NC00205675, NC00200964, NC00204162, NC00205627, and NC00204936. 7 of the 55 complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		12/15/23

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

Electronically Signed | 12/12/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 3 of 19 sampled residents reviewed for advanced directives (Residents #60, #63 and #71). Findings included: 1. Resident #60 was admitted to the facility on 03/14/23. Review of Resident #60's Electronic Health Record (EHR) revealed a physician's order dated 03/14/23 for a "Full Code" status. The profile section of Resident #60's EHR also indicated a "Full Code" status.	F 578	* Corrective Action(s): The Electronic Health Record (EHR) of residents #60, #63, and #71 were all corrected such that the advanced directive forms matched the order in the EHR. This was completed by the Social Worker (SW) on 11/13/23. * Current facility residents are at risk of being affected by the alleged deficient practice. The SW completed an audit of all current residents to ensure that the resident's advanced directive forms and the order in the EHR are accurate. No further issues were identified during this audit. The audit was completed on 11/17/23.	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 578	Continued From page 2 Review of the advanced directive care plan initiated on 03/27/23 revealed Resident #60 was a full code. The goal was to have his advanced directives followed by the staff. Interventions included performing cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. The care plan had never been revised since its initiation. The quarterly Minimum Data (MDS) assessment dated 10/19/23 coded Resident #60 with severely impaired cognition. Resident #60's hard copy advanced directive located at the nurse's station was reviewed on 11/13/23 at 4:05 PM. The front page of the advanced directive contained a doctor's order for a "Do not resuscitate" (DNR) status on a yellow form and was signed by the attending physician on 11/01/23. During interviews conducted on 11/13/23 at 4:37 PM and 11/14/23 at 4:41 PM, the Unit Manager (UM) explained when the Hospice provider updated the advanced directive for Resident #60, they must have placed the yellow form in the folder without notifying the nursing staff or the MDS nurse to update the EHR. The UM also explained when an advanced directive was changed, the provider was expected to notify the floor nurse and the floor nurse would notify the Social Worker (SW) or MDS Nurse to update the care plan. During an interview conducted on 11/15/23 at 3:00 PM, the SW stated that he was responsible for updating changes in advanced directives on the yellow hard copy form and putting it in the	F 578	* To ensure that this same alleged deficient practice does not recur, the facility has put the following in place: 1) current facility and agency licensed nurses and SW were educated on the advanced directive policy and procedure by the Director of Nursing (DON) by 12/15/23. Newly hired facility and agency licensed nurses and SW and any other staff not educated on this policy on or before 12/15/23 will receive the education upon hire and prior to working the next shift by the DON or Unit Manager (UM). Effective 12/15/23 the facility will ensure resident's advanced directive designation is reflected correctly throughout the resident's medical record including orders and care plan. * The Minimum Data Set (MDS) director will audit 5 random residents 3 times a week for a period of 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks to ensure that the advanced directives are accurate though out the EHR checking the order, MDS, and care plan. The MDS director will present the findings of the monitoring/audits to the Quality Assurance Process Improvement (QAPI) meetings monthly for a period of 3 months or longer if deemed necessary by the QAPI team. The plan will will be adjusted by the QAPI team as necessary in order to achieve compliance. The administrator is responsible for implementing and overseeing this plan of correction.	

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F 578	Continued From page 3	F 578	Date of Compliance: 12/15/23	

communication book for the attending physician to sign. Once it was signed, he placed the signed advanced directive hard copy in the folder located at the nurse's station. As he was not a nurse, he did not have the access in EHR to change the code status and required a nurse to change it for him every time; however, he was not notified by nursing staff or the Hospice provider when Resident #60's code status changed. The SW also explained he was responsible for updating the care plan when a resident's code status had changed. The SW acknowledged he was made aware of the change in Resident #60's advanced directive yesterday (11/14/23) but was overwhelmed with his workload over the past 2 days and did not have the time to update Resident #60's care plan.

During interviews on 11/14/23 at 10:26 AM and 11/15/23 at 4:05 PM, the Director of Nursing (DON) stated he expected the code status in Resident #60's EHR to be consistent with the hard copy advanced directive. He further stated he expected the care plan for Resident #60 to be updated on a real time basis and also be consistent with the code status of the hard copy advanced directive. He explained the consistency was important to avoid any possible confusion among nursing staff or delay when a code was called.

An interview was conducted with the Administrator on 11/16/23 at 2:36 PM. She stated it was her expectation for the code status in the resident's EHR to be consistent with the hard copy advanced directive located at the nurse station. The Administrator explained the SW had multiple admissions and discharges the last couple of days and the MDS Nurse was on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 578	Continued From page 4	F 578		

vacation this week. She stated it was her expectation for the care plan to be updated on a real time basis and remain consistent with the code status of the advanced directive.

2. Resident #63 was admitted to the facility on 04/08/22.

Review of Resident #63's Electronic Health Record (EHR) revealed a physician's order dated 04/08/22 for a "Full Code" status. The profile section of Resident #63's EHR also indicated a code status of "Full Code."

The significant change in status MDS assessment dated 08/15/23 coded Resident #63 with moderately impaired cognition.

Resident #63's hard copy advanced directive located at the nurse's station was reviewed on 11/13/23 at 4:08 PM. The front page of the advanced directive contained a doctor's order for a "Do not resuscitate" status on a yellow form and was signed by the attending physician on 04/13/23.

During interviews conducted on 11/13/23 at 4:37 PM and 11/14/23 at 4:41 PM, the Unit Manager (UM) stated she did not know what had happened that resulted in inconsistency between the code status in Resident #63's EHR and the hard copy advanced directive. The UM also explained when an advanced directive was changed, the provider was expected to notify the floor nurse and the floor nurse would notify the Social Worker (SW) or MDS Nurse to update the care plan.

During an interview conducted on 11/15/23 at 3:00 PM, the SW stated that he was responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 578	Continued From page 5	F 578		

for updating changes in advanced directives on the yellow hard copy form and putting it in the communication book for the attending physician to sign. Once it was signed, he would place the signed advanced directive hard copy in the folder located at the nurse's station. As he was not a nurse, he did not have the access in EHR to change the code status and required a nurse to change it for him every time. The SW confirmed that he was the one who drafted the hard copy advanced directive for Resident #63. He acknowledged that it was an oversight for failure to update the code status in the EHR in a timely manner. The SW also explained he was responsible for updating the care plan when a resident's code status had changed. The SW acknowledged he was made aware of the change in Resident #63's advanced directive yesterday (11/14/23) but was overwhelmed with his workload over the past 2 days and did not have the time to update Resident #63's care plan.

During interviews on 11/14/23 at 10:26 AM and 11/15/23 at 4:05 PM, the Director of Nursing (DON) stated he expected the code status in Resident #63's EHR to be consistent with the hard copy advanced directive. He further stated he expected the care plan for Resident #63 to be updated on a real time basis and also be consistent with the code status of the hard copy advanced directive. He explained the consistency was important to avoid any possible confusion among nursing staff or delay when a code was called.

An interview was conducted with the Administrator on 11/16/23 at 2:36 PM. She stated it was her expectation for the code status in the resident's EHR to be consistent with the

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 578	Continued From page 6	F 578		

hard copy advanced directive located at the nurse station. The Administrator explained the SW had multiple admissions and discharges the last couple of days and the MDS Nurse was on vacation this week. She stated it was her expectation for the care plan to be updated on a real time basis and remain consistent with the code status of the advanced directive.
3. Resident #71 was admitted to the facility on 02/25/23.

The quarterly Minimum Data Set (MDS) dated 09/24/23 assessed Resident #71 with intact cognition.

Review of Resident #71's Electronic Health Record (EHR) revealed a physician's order dated 09/14/23 for a code status of Do Not Resuscitate (DNR). The profile section of Resident #71's EHR also indicated a code status of DNR.

Review of the Code Status book for residents kept at the nurses' station revealed Resident #71 had a DNR form signed by the physician with an effective date of 09/14/23 and no expiration.

Review of Resident #71's comprehensive care plans, last revised on 10/25/23, revealed an advanced directive care plan indicating Resident #71 was a Full Code. Interventions included to review advanced directives with Resident #71 quarterly and as needed.

During an interview on 11/14/23 at 4:41 PM, the Unit Manager explained when a resident's advanced directive was changed, the provider was expected to notify the floor nurse and the floor nurse would notify the Social Worker (SW) or MDS Nurse to update the care plan.

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 578	Continued From page 7 During an interview on 11/15/23 at 3:00 PM, the SW explained he reviewed advanced directives with the resident and/or their Responsible Party quarterly and as needed. He stated either he or the MDS Nurse were responsible for updating the advanced directive care plan when a resident's code status had changed. The SW stated it was an oversight that Resident #71's care plan was not updated to accurately reflect her code status. During an interview on 11/15/23 at 4:05 PM, the Director of Nursing (DON) stated he expected the care plan for Resident #71 to be updated and remain consistent with the code status of the hard copy advanced directive. He explained the consistency was important to avoid any possible confusion among nursing staff or delay when a code was called. During an interview on 11/17/23 at 12:40 PM, the Administrator stated it was her expectation for a resident's care plan to be updated and remain consistent with the code status of the hard copy advanced directive.	F 578		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		12/15/23

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 622	Continued From page 8	F 622		

sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is

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F 622	Continued From page 9 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, Medical Director and staff interviews, the facility failed to provide written documentation which stated the reason	F 622	* The Facility allegedly failed to provide written documentation which stated the reason the Facility could not meet the	

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 622	Continued From page 10	F 622		

the facility could not meet the residents' needs for 2 of 4 residents reviewed for transfer and discharge (Residents #87 and #184).

The findings included:

1. Resident #87 was admitted to the facility on 06/09/23 with multiple diagnoses that included dementia without behavioral disturbance and adjustment disorder with anxiety.

The admission Minimum Data Set (MDS) dated 06/15/23 revealed Resident #87 had severe impairment in cognition. He wandered 4 to 6 days and displayed no behaviors such as physical or verbal aggression and no hallucinations or delusions during the MDS assessment period.

A physician's order dated 07/31/23 read, transfer to ER (Emergency Room) for evaluation.

A Social Worker (SW) progress note dated 07/31/23 at 10:03 AM read in part, SW was informed that Resident #87 hit another resident. SW completed immediate discharge notice due to being a danger to other residents in the facility. SW proceeded to file Involuntary Commitment (IVC) with the Magistrate and returned to the facility.

Review of Resident #87's medical record revealed no documentation of a physician's statement describing the specific needs and behaviors that could not be managed or met at the facility, facility efforts to meet those needs and specific services the receiving facility would provide to meet the needs of Resident #87.

During interviews on 11/15/23 at 3:28 PM and

residents' need for 2 of 4 residents reviewed for transfer and discharge. The residents identified (#87 and #184) are no longer residents of this Facility therefore this cited issue cannot be resolved for these specific residents.

* Current Facility residents receiving a 30 day notice are at risk of being affected by this same alleged deficient practice. The Regional Director of Clinical Services (RDCS) reviewed all current transfer and discharge notices that are in effect at the facility to ensure that the facility could no longer meet the resident's needs was stated accurately on the discharge notice form. No other issues were identified. This was completed on 12/4/23.

* To ensure that this same alleged deficient practice dose not recur, the RDCS educated the Interdisciplinary Team (IDT) and the facility Medical Director on the Transfer and Discharge policy and the 30-day notice requirements. Facility Transfer Discharge Notices state the resident need that the facility can not meet and that this is also documented in the Electronic Health Record (EHR) by the Medical Director (MD). The documentation by the MD must also contain the reason the resident's needs cannot be met at the Facility, what the receiving Facility can provide that current Facility cannot, and the current Facility's efforts to meet the needs of the affected resident. This was completed on 11/21/23. Newly hired IDT members or Medical Directors or IDT members and

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 622	Continued From page 11 11/17/23 at 12:40 PM, the Administrator confirmed Resident #87 was discharged to the hospital on 07/31/23 and explained the facility was not equipped to handle residents with psych-related behaviors. The Administrator revealed she was not that familiar with the regulation and was not aware of a written physician statement in Resident #87's medical record summarizing the specific needs that could not be met, facility efforts to meet those needs or specific services provided by the receiving facility that would meet his needs. During a telephone interview on 11/17/23 at 3:24 PM, the Medical Director confirmed Resident #87 was discharged to the hospital on 07/31/23 due to increased behaviors. The Medical Director explained Resident #87 displayed unpredictable, aggressive behaviors that would have likely continued despite psychiatric medication adjustments. The Medical Director stated Resident #87 resided on the Memory Support Unit at the facility and would become upset when others wandered into his room/space which was what usually happened on a dementia unit. The Medical Director stated he felt Resident #87 needed a less stimulating environment. The Medical Director revealed he was unaware of the regulation that required documentation by the resident's physician which indicated the specific needs of Resident #87 the facility could not meet, facility efforts to meet those needs or specific services the receiving facility would provide to meet his needs and confirmed he had not documented a statement in Resident #87's medical record. 2. Resident #184 was admitted to the facility on 05/23/23 with multiple diagnoses that included	F 622	Medical Director not educated by 12/15/23 will be educated upon hire or prior to working their next shift. This will be done by the Administrator. Potential discharge/transfer notices will be discussed in the morning meeting with IDT members prior to being issued. * The administrator will review the medical record of all discharge/transfer notices issued for 12 weeks to ensure that the issued Facility Transfer Discharge Notices state the resident need that the facility can not meet and that this is also documented in the Electronic Health Record (EHR) by the Medical Director (MD). The documentation by the MD must also contain the reason the resident's needs cannot be met at the Facility, what the receiving Facility can provide that current Facility cannot, and the current Facility's efforts to meet the needs of the affected resident. The administrator will present the findings of the audits to the Quality Assurance Performance Improvement (QAPI) team in the monthly meeting. Any findings that are not in compliance with this requirement will be corrected immediately by the Medical Director, Director of Nursing and/or Administrator. This will continue for a period of 3 months or longer if deemed necessary by the QAPI team. The plan will be adjusted as needed by the QAPI team in order to achieve compliance. Date of Compliance: 12/15/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 622	Continued From page 12	F 622		

dementia with behavioral disturbance and bipolar disorder.

The admission Minimum Data Set (MDS) dated 05/30/23 revealed Resident #184 had moderate impairment in cognition. She wandered and displayed verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others 1 to 3 days during the MDS assessment period.

The quarterly MDS assessment dated 06/07/23 revealed Resident #184 had moderate impairment in cognition. She wandered and displayed other behavioral symptoms not directed toward others 1 to 3 days during the MDS assessment period.

A physician's order dated 06/13/23 read, send to ER (Emergency Room) for psychiatric behavior management.

A Social Worker (SW) progress note dated 06/13/23 at 11:07 AM read in part, SW was informed that Resident #184 was hitting other residents and staff unprovoked today. It was recommended by administration to initiate Involuntary Commitment (IVC) to send her to the ER due to these behaviors. SW went to the Magistrate and initiated IVC.

Review of Resident #184's medical record revealed she was not readmitted to the facility upon her discharge from the hospital. Further review revealed no documentation of a physician's statement describing the specific needs and behaviors that could not be managed or met at the facility, facility efforts to meet those needs and specific services the receiving facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 622	Continued From page 13	F 622		

would provide to meet the needs of Resident #184.

During interviews on 11/15/23 at 3:28 PM and 11/17/23 at 12:40 PM, the Administrator confirmed Resident #184 was discharged to the hospital on 06/13/23. The Administrator revealed she had not yet started at the facility when Resident #184 was discharged to the hospital but was told there was a lot of discussion about what kind of facility/treatment would be best for Resident #184 upon her discharge from the hospital. She explained the hospital felt her behaviors were more psych-related rather than due to dementia and the facility was not equipped to handle residents with psych-related behaviors. The Administrator revealed she was not that familiar with the regulation and was not aware of a written physician statement in Resident #184's medical record summarizing the specific needs that could not be met, facility efforts to meet those needs or specific services provided by the receiving facility that would meet her needs.

During a telephone interview on 11/17/23 at 3:24 PM, the Medical Director confirmed Resident #184 was discharged to the hospital on 06/13/23 due to increased behaviors. The Medical Director explained Resident #184's cognition was not that bad and her behaviors were primarily psych-related. He recalled she would just hit someone and remember doing it but was not able to explain why. The Medical Director revealed he was unaware of the regulation that required documentation by the resident's physician which indicated the specific needs of Resident #184 the facility could not meet, facility efforts to meet those needs or specific services the receiving facility would provide to meet her needs and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 622	Continued From page 14 confirmed he had not documented a statement in Resident #184's medical record.	F 622		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, Responsible Party and staff interviews, the facility failed to provide written notification to the Responsible Party	F 625	* The Facility allegedly failed to provide written notification to the Responsible Party (RP) regarding bed hold upon a	12/15/23

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 625	Continued From page 15 regarding bed hold upon a resident's transfer to the hospital for 3 of 4 residents reviewed for hospitalization (Residents #87, #184, and #80). Findings included: 1. Resident #87 was admitted to the facility on 06/09/23. The admission Minimum Data Set (MDS) assessment dated 06/15/23 revealed Resident #87 had severe impairment in cognition. A physician's order for Resident #87 dated 07/24/23 read, recommend involuntary commitment (IVC) due to physical altercations and increased behaviors. Review of Resident #87's medical record revealed he was discharged to the hospital on 07/24/23 for evaluation and was readmitted to the facility on 07/25/23. Further review of the medical record revealed no staff progress notes or scanned documents indicating Resident #87's Responsible Party (RP) was provided written notification of the facility's bed hold policy upon his transfer to the hospital. During a telephone interview on 11/15/23 at 12:42 PM, Resident #87's RP stated she was notified by the Social Worker (SW) when Resident #87 was sent out to the hospital on 07/24/23 but did not receive any information regarding a bed hold. During an interview on 11/15/23 at 2:16 PM, the SW revealed he did not provide resident's or their RPs with written notification of the facility's bed hold policy when a resident was transferred to the hospital. He only obtained the IVC paperwork if	F 625	resident's transfer to the hospital for 3 out of 4 residents reviewed for hospitalization. Residents affected included Residents #87, #184, and #80, none of these residents currently reside in the Facility therefore corrective action for these affected residents cannot be achieved. * Current Facility residents being sent to the hospital for evaluation and treatment are at risk of being affected by this same alleged deficient practice. The Regional Director of Clinical Services (RDCS) audited hospital discharges over the past 7 days to ensure that the bed hold policy has been sent with the resident to the hospital and reviewed with the RP. This audit was completed on 12/4/23 and no additional issues/concerns were identified. * To ensure that this alleged deficient practice doesn't recur, the facility has put the following in place: 1) the RDCS educated the Interdisciplinary Team (IDT) on the Facility's Bed Hold policy on 11/21/23. 2) The Director of Nursing (DON) and Administrator then educated the current facility and agency licenses nurses on the bed hold policy and how the information about this policy must be sent out with the resident when the resident is transferred to the hospital. This education will be completed for current licensed nurses by 12/15/23. Newly hired facility or agency licensed nurses or new hired IDT members or staff who are unable to complete the education by 12/15/23, will be educated by the DON or administrator prior to their next worked shift. 3)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 625	Continued From page 16 needed. The SW stated nursing staff provided the bed hold policy to the resident when they were transferred to the hospital. During an interview on 11/17/23 at 12:07 PM, the Director of Nursing stated the facility's bed hold policy was not included in the packet of the paperwork nursing staff sent with the resident when they were transferred to the hospital; however, the resident's bed was held for their return. A telephone interview was conducted on 11/17/23 at 1:42 PM with Nurse #4 who was Resident #87's assigned nurse on 07/24/23 when he was discharged to the hospital. Nurse #4 explained when a resident was sent out to the hospital, nursing staff prepared a packet of information to send with the resident which included a SBAR (Situation Background Assessment and Recommendation) form, medication administration record and pertinent lab results if available. Nurse #4 stated nurses did not provide a resident with the facility's bed hold policy or include it in with the paperwork. She indicated administration handled any paperwork relating to a bed hold. During interviews on 11/15/23 at 3:28 PM and 11/17/23 at 12:40 PM, the Administrator explained the facility's bed hold policy was reviewed with the resident and/or their RP upon admission and one was usually sent with the resident when they were sent to the hospital but they didn't always receive it back. She stated the facility did not require a resident to sign the bed hold policy upon their transfer to the hospital nor had they ever charged a resident for a bed hold because they automatically held the bed for them to return.	F 625	Effective 12/15/23 The licensed nursing staff responsible for sending a resident to the hospital will ensure bed hold policy information is sent with the resident and complete discharge check off form and turn in to DON. The Business Office Manager (BOM) or Social Worker (SW) will follow up with the responsible party (RP) of any resident transferred to the hospital (and admitted) to discuss the Bed Hold process. This will occur on or before the next business day following the resident's transfer and documented in the Electronic Health Record. * The administrator will audit 5 residents who have been transferred to the hospital, 3 times a week for 4 weeks, then 5 residents who have been transferred to the hospital, 2 times a week for 4 weeks, and then 5 residents who have been transferred to the hospital, weekly for 4 weeks. Any findings that are not compliant will be corrected immediately. The results of the audits will be presented to the Quality Assurance Performance Improvement (QAPI) team monthly by the administrator for a period of 3 months or longer as deemed necessary by the QAPI team. Adjustments to this plan may be made by the QAPI team to achieve and maintain compliance. Date of Compliance: 12/15/23	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 625	Continued From page 17	F 625		

The Administrator stated she couldn't speak to the process before she started at the facility but indicated there were a stack of bed hold notices located at the nurses' station that should be included as part of the hospital transfer packet.

2. Resident #184 was admitted to the facility on 05/23/23.

The admission Minimum Data Set (MDS) assessment dated 05/30/23 revealed Resident #184 had moderate impairment in cognition.

A physician's order for Resident #184 dated 06/13/23 read, send to ER (Emergency Room) for psychiatric behavior management.

Review of Resident #184's medical record revealed she was discharged to the hospital on 06/13/23 for evaluation of behavioral symptoms. Further review of the medical record revealed no staff progress notes or scanned documents indicating Resident #184's Responsible Party (RP) was provided written notification of the facility's bed hold policy upon her transfer to the hospital.

During a telephone interview on 11/15/23 at 12:42 PM, Resident #184's RP revealed she did not receive any information regarding a bed hold when Resident #184 was transferred to the hospital.

During an interview on 11/15/23 at 2:16 PM, the SW revealed he did not provide resident's or their RPs with written notification of the facility's bed hold policy when a resident was transferred to the hospital. He only obtained the IVC paperwork if needed. The SW stated nursing staff provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 625	Continued From page 18	F 625		

the bed hold policy to the resident when they were transferred to the hospital.

During an interview on 11/17/23 at 12:07 PM, the Director of Nursing stated the facility's bed hold policy was not included in the packet of the paperwork nursing staff sent with the resident when they were transferred to the hospital; however, the resident's bed was held for their return.

A telephone interview was conducted with Nurse #4 on 11/17/23 at 1:42 PM who was Resident #184's assigned nurse on 06/13/23 when she was discharged to the hospital. Nurse #4 explained when a resident was sent out to the hospital, nursing staff prepared a packet of information to send with the resident which included a SBAR (Situation Background Assessment and Recommendation) form, medication administration record and pertinent lab results if available. Nurse #4 stated nurses did not provide a resident with the facility's bed hold policy or include it in with the paperwork. She indicated administration handled any paperwork relating to a bed hold.

During interviews on 11/15/23 at 3:28 PM and 11/17/23 at 12:40 PM, the Administrator explained the facility's bed hold policy was reviewed with the resident and/or their RP upon admission and one was usually sent with the resident when they were sent to the hospital but they didn't always receive it back. She stated the facility did not require a resident to sign the bed hold policy upon their transfer to the hospital nor had they ever charged a resident for a bed hold because they automatically held the bed for them to return. The Administrator stated she couldn't speak to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 625	Continued From page 19	F 625		

the process before she started at the facility but indicated there were a stack of bed hold notices located at the nurses' station that should be included as part of the hospital transfer packet.

3. Resident #80 was admitted to the facility 05/03/22.

The quarterly Minimum Data Set (MDS) assessment dated 09/20/23 revealed Resident #80 was cognitively intact.

A nurse's note dated 10/16/23 and written by Nurse #7 revealed Resident #80 was discharged with police due to aggressive behavior.

Review of Resident #80's medical record revealed he was discharged to the hospital 10/16/23 for evaluation of behavioral symptoms.

Further review of the medical record revealed no staff progress notes or scanned documents indicating Resident #80's Responsible Party (RP) was provided written notification of the facility's bed hold policy upon his transfer to the hospital.

During a telephone interview on 11/17/23 at 10:10 AM Resident #80's RP revealed he did not receive any information regarding a bed hold when Resident #80 was transferred to the hospital.

During an interview on 11/17/23 at 12:07 PM the Director of Nursing (DON) stated the facility's bed hold policy was not included in the packet of the paperwork nursing staff sent with the resident when they were transferred to the hospital; however, the resident's bed was held for their return.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 625	Continued From page 20 Nurse #7 was unavailable for interview during the survey. During interviews on 11/15/23 at 3:28 PM and 11/17/23 at 12:40 PM, the Administrator explained the facility's bed hold policy was reviewed with the resident and/or their RP upon admission and one was usually sent with the resident when they were sent to the hospital but they didn't always receive it back. She stated the facility did not require a resident to sign the bed hold policy upon their transfer to the hospital nor had they ever charged a resident for a bed hold because they automatically held the bed for them to return. The Administrator stated she couldn't speak to the process before she started at the facility but indicated there were a stack of bed hold notices located at the nurses' station that should be included as part of the hospital transfer packet.	F 625		
F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and	F 626		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 21 (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party, Hospital Case Manager, Medical Director and staff interviews, the facility failed to allow residents to return to the facility after being sent to the hospital for a psychiatric evaluation using the residents' behaviors prior to discharge as a basis for their decision for 2 of 4 residents reviewed for transfer and discharge (Residents #87 and #184). The findings included: 1. Resident #87 was admitted to the facility on 06/09/23 with multiple diagnoses that included dementia without behavioral disturbance, psychotic disturbance and adjustment disorder with anxiety.	F 626	* The facility failed to allow residents to return to the facility after being sent to the hospital for a psychiatric evaluation using the residents' behaviors prior to discharge as a basis for their decision for 2 of 4 residents reviewed for transfer and discharge (Resident #87 and #184). Residents #87 and #184 were admitted to other facilities and no longer resident at this facility. * Current facility residents being sent to the hospital are at risk of being affected by this same practice. The Regional Director of Clinical Services (RDCS) reviewed all current residents who were receiving care at the hospital within the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 626	Continued From page 22 The admission Minimum Data Set (MDS) dated 06/15/23 revealed Resident #87 had severe impairment in cognition. He wandered 4 to 6 days and displayed no behaviors such as physical or verbal aggression and no hallucinations or delusions during the MDS assessment period. A behavioral care plan initiated on 07/26/23 revealed Resident #87 had the potential to be physically aggressive related to dementia. Interventions included one-to-one monitoring by staff and document/report as needed any signs or symptoms of him posing a danger to self and others. A Social Worker (SW) progress note dated 07/31/23 at 10:03 AM read in part, SW was informed that Resident #87 hit another resident. SW completed immediate discharge notice due to being a danger to other residents in the facility. SW proceeded to file Involuntary Commitment (IVC) paperwork with the Magistrate. Review of a Nursing Home Notice of Transfer/Discharge document revealed on page 1 the date of the notice was listed as 08/31/23; however, on page 2 the date of the notice was listed as 07/31/23. The reason for discharge was marked as "the safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident" and the location of transfer/discharge was noted as the hospital Emergency Room (ER). A physician's order dated 07/31/23 read, transfer to ER for evaluation. The discharge MDS assessment dated 07/31/23	F 626	past 30 days to ensure that the facility was following the transfer and discharge policy and procedure. This was completed on 12/6/23. No other issues were identified. * To ensure the deficient practice does not recur, the facility has put the following in place: The RDCS educated the Interdisciplinary Team (IDT) on the transfer and discharge policy and procedure and requirements regarding readmitting the facility's residents from the hospital. This was done on 11/21/23. Newly hired IDT members and IDT members unable to complete the education prior to 12/15/23 will be educated upon hire or prior to working their next scheduled shift. This education will be completed by the Administrator. * The administrator will audit all residents being discharged to the hospital for a period of 12 weeks to ensure that the facility is following the transfer discharge policy and that affected residents are permitted to return. The administrator will present the findings of this audit monthly at the Quality Assurance Process Improvement (QAPI) team meeting. This will continue for a period of 3 months unless deemed longer by the QAPI to ensure and maintain compliance. This plan may be changed by the QAPI is necessary to achieve compliance. Date of Compliance: 12/15/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 23	F 626		

was coded as "return not anticipated."

Review of the hospital records for Resident #87 revealed the following:
A case management note dated 07/31/23 read in part, received call from the Director of Nursing (DON) at the skilled nursing facility who reports he spoke with their SW and all the appropriate paperwork has been completed and gone through the Ombudsman, including the right to appeal notice, and Resident #87 was unable to return to the facility as he has been discharged.
An ER report note dated 08/01/23 read in part, Resident #87 presents from nursing home for aggressive behavior. They are not taking him back.
A case management note dated 08/02/23 read in part, ER Medical Doctor agrees to release IVC and refer Resident #87 to care management for placement assistance. Resident #87 is psychiatrically cleared. Several referrals sent out to secure memory care units.
An ER report dated 08/02/23 read in part, Resident #87 is waiting a safe discharge plan. Medically clear prior to this evaluation.
An ER report dated 08/04/23 read in part, Resident #87 continues to board in our emergency department pending community placement in a nursing facility. His IVC has been lifted and he is hemodynamically (referring to stable blood pressure and heart rate) stable.
An ER report dated 08/05/23 revealed in part, Resident #87 has been with us for approximately one week awaiting community placement after being sent from the skilled nursing facility under IVC.

During a telephone interview on 11/15/23 at 12:42 PM, Resident #87's Responsible Party (RP)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 24	F 626		

revealed she was notified by the facility SW on 07/31/23 that Resident #87 was being sent to the hospital due to behaviors and he would not be allowed to return to the facility. She stated she was shocked to hear Resident #87 had displayed behaviors while at the facility as she had not been informed previously. The RP could not recall the exact date but stated when Resident #87 was ready for discharge, the hospital found him placement at another skilled nursing facility. The RP stated the whole ordeal was not a good experience and even if the facility had agreed to accept Resident #87 back, she would not have wanted him to return to the facility.

During interviews on 11/15/23 at 2:16 PM and 11/17/23 at 10:50 AM, the SW revealed Resident #87 was issued an "immediate" discharge on 07/31/23 when he was sent back to the hospital via IVC due to his aggressive behaviors. The SW stated it was his understanding the facility did not have to accept a resident back when a discharge notice was issued to the resident upon their discharge to the hospital as the hospital would find appropriate placement for the resident. The SW confirmed he notified Resident #87's RP on 07/31/23 of his discharge and that he would not be allowed to return to the facility due to his behaviors. He stated he felt he would have told the RP about Resident #87's behaviors during his stay at the facility but did not document anything in Resident #87's medical record.

During a telephone interview on 11/16/23 at 12:15 PM, the former Admissions Director revealed when Resident #87 was initially admitted to the facility, they were made aware of his previous behaviors but since he had been stable while hospitalized, they felt they could manage him and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 25	F 626		

he was admitted to the facility. The former Admissions Director recalled when Resident #87 was sent out to the hospital in July 2023, she was told by administration that he would not be allowed to return to the facility upon his discharge from the hospital.

During an interview on 11/17/23 at 12:07 PM, the DON revealed when a resident was ready to be discharged from the hospital back to the facility, the Interdisciplinary Team (IDT) met to review the hospital records to determine if readmission was appropriate. The DON explained when a resident was sent to the hospital under IVC and they had behaviors that was or could be a danger to others down the road, which he explained was the case with Resident #87, the IDT and administration made the decision not to allow the resident to return to the facility and the hospital was good to find the resident alternate placement.

During interviews on 11/15/23 at 3:28 PM and 11/17/23 at 12:40 PM, the Administrator confirmed Resident #87 was discharged to the hospital on 07/31/23 and stated the facility was not equipped to handle residents with psych-related behaviors. The Administrator explained Resident #87 was ambulatory and exit-seeking and unfortunately, all the activity on the Memory Support Unit (MSU) seemed to agitate and irritate him. She stated one minute Resident #87 would be ok and the next minute he wanted to be left alone in his room. If someone happened to wander into his room, which happened a lot on MSU, he would get upset. The Administrator recalled the IDT talking about Resident #87 and if this facility was really the best place for him and they felt like he would do much better in a smaller facility with less stimulation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 26	F 626		

The Administrator confirmed a Notice of Transfer/Discharge was issued to Resident #87 when he was sent out to the hospital on 07/31/23 and stated it was her understanding from the SW that Resident #87's RP planned on taking him home when he was discharged from the hospital.

During a follow-up telephone interview on 11/17/23 at 3:37 PM, Resident #87's RP stated she never told the SW that she would take Resident #87 home when he discharged from the hospital. The RP explained she worked full-time and it would not be safe for Resident #87 to remain home alone while she was at work.

During a telephone interview on 11/17/23 at 3:24 PM, the Medical Director confirmed Resident #87 was discharged to the hospital on 07/31/23 due to increased behaviors. The Medical Director explained Resident #87 displayed unpredictable, aggressive behaviors that would have likely continued despite psychiatric medication adjustments. He stated Resident #87 resided on the MSU at the facility and would become upset when others wandered into his room/space which was what usually happened on a dementia unit. The Medical Director stated he felt Resident #87 needed a less stimulating environment than what could be provided at the facility.

2. Resident #184 was admitted to the facility on 05/23/23 with multiple diagnoses that included dementia with behavioral disturbance and bipolar disorder.

The admission Minimum Data Set (MDS) dated 05/30/23 revealed Resident #184 had moderate impairment in cognition. She wandered and displayed verbal behavioral symptoms directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 27	F 626		

toward others and other behavioral symptoms not directed toward others 1 to 3 days during the MDS assessment period.

The behavioral care plan initiated on 06/01/23 and last revised 06/05/23 revealed Resident #184 had a history of violent behaviors, sitting on the floor and feigning unresponsiveness. Interventions included to intervene as necessary to protect the rights and safety of others, divert attention and remain in line of sight of sitter 24/7.

The quarterly MDS assessment dated 06/07/23 revealed Resident #184 had moderate impairment in cognition. She wandered and displayed other behavioral symptoms not directed toward others 1 to 3 days during the MDS assessment period.

A physician's order dated 06/13/23 read, send to ER (Emergency Room) for psychiatric behavior management.

A Social Worker (SW) progress note dated 06/13/23 at 11:07 AM read in part, SW was informed that Resident #184 was hitting other residents and staff unprovoked today. It was recommended by administration to initiate Involuntary Commitment (IVC) to send her to the ER due to these behaviors. SW went to the Magistrate and initiated IVC.

The discharge MDS dated 06/13/23 for Resident #184 was coded as "return anticipated" and noted the discharge location was acute hospital.

Review of email correspondence provided by the SW revealed the following:
On 07/20/23 at 3:12 PM the SW sent an email to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 28	F 626		

the former Administrator, former Admissions Director and Director of Nursing that was subsequently forwarded by the former Administrator to the Regional Nurse Consultant and Regional Director of Clinical Operations on 07/20/23 at 3:14 PM. The email correspondence read in part, Case Manager #1 is asking if we are considering Resident #184 to return to our facility or not. He said he would understand if it is a hard no and they would seek placement elsewhere. However, if we are considering her return, he would send a medication administration record and other notes. I don't believe they have done much to change her medications. I need to let Case Manager #1 know something before the end of the day.
On 07/20/23 at 4:01 PM the SW sent an email to the former Administrator, former Admissions Director and Regional Nurse Consultant regarding Resident #184. The email correspondence read in part, SW just spoken with Case Manager #1 who stated they had to call a code due to Resident #184 being a flight risk. He is saying she really needs a behavioral health unit versus dementia unit. The ER doctor is now hesitant to release the IVC and referring back to psych at the moment.

During a telephone interview on 11/13/23 at 2:31 PM, Resident #184's Guardian revealed when Resident #184 was sent out to the hospital on 06/13/23, she had wanted Resident #184 to return to the facility. The Guardian recalled the facility went back and forth with the hospital on whether or not Resident #184 would be allowed to return; however, when she was ready for discharge, the facility refused to accept her back and the hospital found placement for her at another skilled nursing facility. The Guardian was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 29	F 626		

unable to recall the date Resident #184 was discharged from the hospital.

During a telephone interview on 11/13/23 at 10:43 AM, Case Manager #2 stated it had been a while since Resident #184 was at the hospital and she could not recall the exact date of her discharge. Case Manager #2 revealed when she contacted the facility to inquire about Resident #184's return, she was informed by facility staff they would not accept her back and as a result, the hospital had to locate alternate placement.

During an interview on 11/15/23 at 2:16 PM, the SW revealed Resident #184 was sent out to the hospital 06/13/23 via IVC due to her aggressive behaviors and was not sure what happened or why she didn't return to the facility. The SW explained there had been multiple conversations with other administrative staff as well as Case Manager #1 about Resident #184 and whether or not she would be appropriate to return to the facility upon her discharge from the hospital but he never told the hospital that the facility would not accept her back. The SW indicated the former Admissions Director would have been the one the hospital contacted when Resident #184 was ready for discharge.

A joint interview was conducted with the SW, Regional Nurse Consultant, and Regional Director of Clinical Operations (RDCO) on 11/15/23 at 2:59 PM. The RDCO stated they had followed Resident #184 while she was at the hospital and there had been a lot of conversations with hospital Case Manger #1. She recalled Case Manager #1 stating he felt Resident #184 needed permanent placement in a behavioral treatment/psych unit when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 30	F 626		

discharged. She explained the facility had a dementia unit that was geared more toward elopement specific behaviors, not geri-psych, and they felt they wouldn't be able to give Resident #184 the behavioral care treatment she needed. The RDCO stated the Interdisciplinary Team (IDT) had multiple conversations about what to do but they never made a definite decision not to accept Resident #184 back.

During a telephone interview on 11/16/23 at 12:15 PM, the former Admissions Director revealed when Resident #184 was initially admitted to the facility, they were made aware of her previous behaviors but since she had gone several days without any incidents while at the hospital, they felt they could manage her and she was admitted to the facility. The former Admissions Director recalled when Resident #184 was sent out to the hospital in July 2023 via IVC, other members of administration felt the facility wasn't equipped to handle her behaviors and it was pretty much implied she would not be allowed to return. She couldn't recall the exact dates but stated the hospital Case Managers had reached out to her on more than one occasion to see if the facility would accept Resident #184 back. She recalled having discussions with Case Manager #1 who was on the fence as to whether Resident #184 would be suitable to return to the facility and him stating as long as Resident #184 remained on the medications she was discharged with, she would be fine at the facility but if the medications were discontinued then she would be more appropriate for a behavioral health unit. She stated her last discussion was with Case Manager #2 who indicated Resident #184 was stable, her medications had been tweaked and she was ready for discharge. She told Case Manager #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 31	F 626		

the facility would not accept Resident #184 back and explained it was out of her hands as it was a Corporate decision. She recalled Case Manager #2 stating she understood the position the facility was in and they would find placement elsewhere for Resident #184.

Telephone attempts for interview with Case Manager #1 on 11/16/23 at 2:54 PM and 5:34 PM were unsuccessful.

During an interview on 11/17/23 at 12:07 PM, the DON revealed when a resident was ready to be discharged from the hospital back to the facility, the IDT met to review the hospital records to determine if readmission was appropriate. The DON explained when a resident was sent to the hospital under IVC and they had behaviors that was or could be a danger to others down the road, the IDT and administration made the decision not to allow the resident to return to the facility and the hospital was good to find the resident alternate placement. The DON stated Resident #184's behaviors were more psych-related than dementia-related and when she displayed behaviors, such as hitting others, she never had any remorse.

During interviews on 11/15/23 at 3:28 PM and 11/17/23 at 12:40 PM, the Administrator revealed she had not yet started at the facility when Resident #184 was discharged to the hospital on 06/13/23 but was told there was a lot of discussion about what kind of facility/treatment would be best for Resident #184 upon her discharge from the hospital. She explained the hospital felt her behaviors were more psych-related rather than due to dementia and the facility was not equipped to handle residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 626	Continued From page 32 with psych-related behaviors. During a telephone interview on 11/17/23 at 3:24 PM, the Medical Director confirmed Resident #184 was discharged to the hospital on 06/13/23 due to increased behaviors. He recalled she would just hit someone and remember doing it but was not able to explain why. The Medical Director stated he did not feel Resident #184 was appropriate to remain at the facility as her cognition was not that bad and her behaviors were primarily psych-related.	F 626		
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 Preadmission Screening and Resident Review (PASRR), injections, hospice, oxygen use, and pressure ulcers for 3 of 29 sampled residents reviewed (Residents #71, #46, and #2). Findings included: 1. Resident #71 was admitted to the facility on 02/25/23 with multiple diagnoses that included diabetes, bipolar disorder and anxiety. a. A PASRR Level II Determination Notification Letter dated 02/24/23 revealed Resident #71 had a time-limited Level II PASRR with an expiration date of 03/26/23.	F 641	* The facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), injections, hospice, oxygen use, and pressure ulcers for 3 of 29 sampled residents reviewed (Residents #71, #46, and #2). Modifications were made to MDS for resident #71, #46, and #2 and submitted upon notification of the inaccuracies. The corrections were submitted on 11/17/23 by the Regional Clinical Reimbursement Nurse. * Current facility residents are at risk of being affected by the deficient practice. The regional clinical reimbursement nurse (RCRN) audited MDS completed in the	12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 33 The admission Minimum Data Set (MDS) assessment dated 03/04/23 indicated Resident #71 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. b. A physician's order dated 08/11/23 for Resident #71 read, Dulaglutide (injectable medication used to treat type 2 diabetes) solution pen-injector 1.5 milligram (mg)/milliliter (ml) - inject 1.5 mg subcutaneously (under the skin) one time a day every Friday for diabetes. Review of the September 2023 medication administration record for Resident #71 revealed Dulaglutide was initialed as administered on 09/01/23. The quarterly MDS assessment dated 09/04/23 revealed Resident #71 received no injections during the 7-day MDS assessment period. During an interview on 11/17/23 at 10:59 AM, the Regional MDS Consultant revealed he was filling in for the MDS Nurse who was on vacation. The Regional MDS Consultant confirmed Resident #71 had a Level II PASRR that should have been reflected on the MDS assessment dated 03/24/23 and was an oversight. He also reviewed Resident #71's September 2023 MAR and confirmed she received an injection of Dulaglutide that should have been reflected on the MDS assessment dated 09/04/23 and was an oversight. During an interview on 11/17/23 at 12:40 PM, the Administrator stated it was her expectation for	F 641	last 30 days for inaccuracies with PASRR, injections, hospice, oxygen use, and pressure ulcers. Inaccuracies identified had corrections completed and were resubmitted. * To ensure the deficient practice does not recur the facility has put the following into place: the Regional Director of Clinical Reimbursement nurse educated the interdisciplinary team (IDT) on accuracy of MDS assessments and Resident Assessment Instrument (RAI) manual instructions for coding injections, PASRR, hospice, oxygen use, and pressure ulcers on 11/21/23. New members of the IDT and IDT members unable to complete education by 12/15/23 will be educated upon hire or before working next scheduled shift by the MDS Coordinator or Regional Director of Clinical Reimbursement. * The Director of Nursing (DON) or Regional Director of Clinical Services (RDCS) will audit 5 MDS assessments 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks to ensure they are free from inaccuracies with coding of PASRR, injections, hospice, oxygen use, and pressure ulcers. The DON will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 34 MDS assessments to be completed accurately. 2. Resident #46 was admitted to the facility on 05/26/23 with multiple diagnoses that included chronic obstructive pulmonary disease (difficulty breathing) and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues). A physician's order dated 05/26/23 for Resident #46 read in part, oxygen via nasal cannula at 5 liters per minute. A physician's order dated 05/27/23 for Resident #46 read in part, admit with hospice, do not call 911. The Care Area Assessment (CAA) summary associated with the admission MDS assessment dated 06/02/23 revealed Resident #46 had a terminal prognosis and was admitted to the facility on hospice services and was oxygen dependent. The quarterly Minimum Data Set (MDS) assessment dated 09/01/23 revealed Resident #46 had a condition or chronic disease that may result in a life expectancy of less than six months. The MDS did not indicate that she was receiving hospice care or used oxygen. During an interview 11/17/23 at 10:59 AM, the Regional MDS Consultant revealed he was filling in for the MDS Nurse who was on vacation. The Regional MDS Consultant confirmed Resident #71 was receiving hospice care and supplemental oxygen during the MDS assessment period. He stated both should have been reflected on the MDS assessment dated 09/01/23 and was an oversight.	F 641	Date of Compliance: 12/15/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 641	Continued From page 35 During an interview on 11/17/23 at 12:40 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately. 3. Resident #2 was admitted to the facility on 09/30/19 and the active diagnoses included dementia, anxiety, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/13/23 revealed Resident #2 had one unstageable pressure ulcer that was not present on admission. Review of the significant change MDS assessment dated 10/20/23 revealed Resident #2 had one unstageable pressure that was present on admission. Review of Resident #2's medical records revealed the resident had not left facility from 10/13/23 through 10/20/23. During an interview on 11/17/23 at 11:04 AM the Regional MDS Consultant stated Resident #2 had an unstageable pressure ulcer on the sacrum she acquired while at the facility. He stated the significant change MDS dated 10/20/23 was an error in coding the pressure was present on admission. An interview was conducted with the Administrator on 11/17/23 at 4:12 PM. The Administrator stated she expected the MDS to be accurate.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		12/15/23

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F 644	Continued From page 36 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan that incorporated the Preadmission Screening and Resident Review (PASRR) Level II determination recommendations for a resident with an active diagnosis of a serious mental illness for 1 of 1 resident reviewed for PASRR (Resident #71). Findings included: Resident #71 was admitted to the facility on 02/25/23 with multiple diagnoses that included bipolar disorder and anxiety. A PASRR Level II Determination Notification Letter for Resident #71 dated 02/24/23 had an expiration date of 03/26/23 and noted nursing placement was appropriate for a limited nursing	F 644	* The Facility failed to develop a care plan that incorporated the Preadmission Screening and Resident Review (PASRR) Level II determination recommendations for a resident with an active diagnosis of a serious mental illness for 1 of 1 residents reviewed for PASRR (Resident # 71). PASRR Level II care plan was initiated for resident #71 upon notification of the care plan not being in place. This was completed on 11/17/23. * Current facility residents with a PASRR Level II are at risk of being affected by the same deficient practice. The Social Worker (SW) audited current facility residents with a PASRR Level II to ensure care plans were in place. This was	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 644	Continued From page 37	F 644		

facility stay, lasting no more than 30 calendar days.

A PASRR Level II Determination Notification Letter for Resident #71 dated 03/30/23 had an expiration date of 05/29/23 and noted nursing placement was appropriate for a 60-day period.

A PASRR Level II Determination Notification Letter for Resident #71 dated 07/31/23 had an expiration date of 09/29/23 and noted nursing placement was appropriate for a 60-day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services to include mental health follow-up and rehab.

A PASRR Level II Determination Notification Letter for Resident #71 dated 09/29/23 had an expiration date of 12/28/23 and noted nursing placement was appropriate for a 90-day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services to include mental health follow-up and rehab.

Review of Resident #71's active care plans, last reviewed/revised 10/25/23, revealed no care plan that addressed the Level II PASRR determination.

During an interview on 11/17/23 at 11:08 AM, the Social Worker (SW) explained he kept up with residents' Level II PASRRs to submit requests for review/re-evaluation when needed but the MDS Nurse was the one who would develop a resident's care plan.

During an interview on 11/17/23 at 10:59 AM, the Regional MDS Consultant revealed he was filling

completed on 12/8/23. No further issues were identified.

* To ensure the same deficient practice does not recur, the facility has put the following in place: the Interdisciplinary team (IDT) was educated by the Regional Director of Clinical Reimbursement (RDCR) on incorporating the PASRR Level II determination recommendations in to the care plan for a resident with an active diagnosis of a serious mental illness. This was done on 11/21/23. Newly hired IDT members and IDT members unable to complete the education prior to 12/15/23 will be educated upon hire or prior to working their next scheduled shift by the Administrator or RCDR.

* The Director of Nursing (DON) or Regional Director of Clinical Services (RDCS) will audit 5 residents with a Level II PASRR to ensure PASRR level II recommendations are incooperated into the residents care plan three times a week for four weeks, then twice a week for four weeks, and then weekly for four weeks. Deficient practice identified in these audits will be corrected immediately. The results of this audit will be presented by the DON at the monthly Quality Assurance Process Improvement (QAPI) meeting. This will continue for a period of 3 months or longer if deemed necessary by the QAPI team. The QAPI team may adjust this plan if deemed necessary to achieve compliance.

Date of Compliance: 12/15/23

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F 644	Continued From page 38 in for the MDS Nurse who was on vacation. The Regional MDS Consultant confirmed Resident #71 had a Level II PASRR and no care plan was developed that addressed her PASRR needs. He stated it was an oversight. During an interview on 11/17/23 at 12:40 PM, the Administrator revealed it was her expectation that residents with a Level II PASRR determination would have care plans developed that reflected their PASRR needs.	F 644		
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 interviews with staff and the Medical Director (MD), the facility failed to check capillary blood glucose prior to administering insulin lispro (a rapid acting medication used to treat high blood sugar) for 1 of 2 resident reviewed for insulin administration (Resident #88). Findings included: Resident #88 was admitted to the facility on 01/30/23 with diagnoses including peripheral vascular disease, type 2 diabetes mellitus, and	F 684	* The facility failed to check capillary blood glucose (CBG) prior to administering insulin lispro (a rapid acting medication used to treat high blood sugar) for 1 of 2 residents reviewed for insulin administration (Resident #88). Resident #88 no longer resides in the facility and facility is unable to provide corrective action. * Current facility residents who are prescribed rapid acting insulin are at risk of being affected by the deficient practice.	12/15/23

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F 684	Continued From page 39 vascular dementia. Resident #88 was discharged back to the community on 02/18/23. Review of the admission Minimum Data Set assessment dated 02/01/23 indicated Resident #88's cognition was moderately impaired and insulin injections were received during the lookback period. The care plan focus area for diabetes initiated on 01/30/23 included interventions to administer medication as ordered and monitor and document for side effects and effectiveness; obtain fasting serum blood sugar (capillary blood glucose levels) as ordered by the doctor; monitor and document and report as needed any signs or symptoms of hypoglycemia or hyperglycemia. Review of the physician orders for insulin lispro were to inject 6 units subcutaneously with meals and inject 4 units subcutaneously in the evening for diabetes. Insulin lispro per sliding scale before meals for a capillary blood glucose reading of 201-250 inject 2 units; 251-300 inject 3 units; 301-350 inject 5 units; 351-400 inject 7 units and if greater than 400 notify the MD for orders. Insulin lispro per sliding scale at bedtime for a capillary blood glucose reading of 201-250 inject 1 unit; 251-300 inject 2 units; 301-350 inject 3 units; 351-400 inject 5 units and if greater than 400 notify the MD for new orders. The orders were started on 01/30/23. Review of the Medication Administration Records (MAR) for Resident #88 revealed on 01/30/23 the physician's orders for insulin lispro were transcribed and included the documented capillary blood glucose checks with sliding scale at mealtimes and bedtime. The documented	F 684	The Regional Director of Clinical Services (RDCS) audited current residents on rapid acting insulin to ensure CBG were ordered to be checked prior to administration. This audit was completed on 11/20/23. No further issues were noted during the audit. * To ensure the deficient practice does not recur the facility has put the following into place: the Director of Nursing (DON) educated current facility and agency licensed nurses on 1) ensuring that a CBG is checked prior to administering rapid acting insulin; 2) to ensure when confirming rapid acting insulin orders the order prompts nurses to check CBG and enter into supplemental documentation; 3) if the order is missing the prompt for CBG, the nurse will obtain order clarificaton from provider to add CBG to order. This education was completed by 12/15/23. Newly hired facility staff and agency licensed nurses unable to complete education by 12/15/23 will be educated upon hire or prior to working next scheduled shift. Effective 12/15/23, residents receiving rapid acting insulin will have a CBG checked prior to administration and the electronic health record order will prompt testing. New rapid acting insulin orders will be reviewed during clinical morning meeting by DON and unit managers to ensure orders are prompting CBG prior to administration. * The DON or RDCS will audit 5 residents with orders for rapid acting insulin 3 times a week for 4 weeks, then 2 times a week	

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F 684	Continued From page 40 blood glucose results done on 01/30/23 at 4:20 PM was 161 and 01/30/23 at 9:00 PM was 292 and 01/31/23 at 6:17 AM was 230 and at 1:30 PM was 335. Review of the physician's progress note revealed on 01/31/23 the MD saw Resident #88 and planned to discontinue both the mealtime and bedtime sliding scales for insulin lispro that included capillary blood glucose checks and increase the mealtime dose to 8 units. Review of the physician order dated 01/31/23 for insulin lispro inject 8 units subcutaneously before meals for diabetes. The physician orders for sliding scale insulin at mealtimes and bedtime were discontinued on 01/31/23. Review of MAR revealed the new physician order dated 01/31/23 was transcribed to inject 8 units of lispro insulin subcutaneously before meals scheduled to be administered at 6:30 AM, 11:30 AM, and 4:30 PM. There were no documented blood glucose checks on the MAR prior to the administration insulin lispro from 02/01/23 through 02/18/23 and Resident #88 received 53 injections. Review of nurse progress notes written on 02/01/23, 02/07/23, and 02/18/23 indicated Resident #88 was not in distress. During a phone interview on 11/17/23 at 2:00 PM Nurse #9 confirmed her initials on the MAR for Resident #88 for 02/08/23, 02/09/23, 02/13/23, 02/14,23, 02/15/23, and 02/16/23. She revealed if the physician order included checking capillary blood glucose, she would have done it otherwise she used her nursing judgement of when to	F 684	for 4 weeks, and then weekly for 4 weeks to ensure CBG is being checked prior to administering medication. The DON will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance. Date of Compliance: 12/15/23	

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F 684	Continued From page 41	F 684		

check a resident's capillary blood glucose.

During a phone interview on 11/17/23 at 3:14 PM the MD revealed he assumed the capillary blood glucose checks were automatically added to insulin orders. The MD stated he discontinued the mealtime and bedtime sliding scales on 01/31/23 but wanted the capillary blood glucose checks to remain in place prior to the administration of insulin lispro. He explained when capillary blood glucose checks were not done, and insulin administered there was a risk of hypoglycemia if Resident #88's blood sugar was low prior to administering insulin lispro.

An interview was conducted on 11/17/23 at 3:46 PM with the Director of Nursing (DON). The DON revealed he was not the acting DON when Resident #88 resided at the facility and had not reviewed the physician orders for insulin lispro. The DON explained the process for new orders was the MD puts the orders in the system and the nurse or himself confirms the order before it becomes active. The DON stated the MD would have to provide an order to check Resident #88's capillary blood glucose when administering insulin lispro and should be clarified by the nurse if not included. The DON revealed if the blood sugar was low prior to administering insulin it put Resident #88 at risk for hypoglycemia.

During an interview on 11/17/23 at 4:08 PM the Administrator revealed she would expect MD orders were followed and if there was not an order to check the capillary blood glucose prior to the administration of insulin the nurse would clarify with the MD to ensure the checks were included.

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F 693	Continued From page 42	F 693		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff the facility failed to administer a water flush via gastrostomy tube (a feeding tube inserted into the stomach to provide nutrition and hydration) as ordered by the physician for 1 of 1 resident reviewed for tube feeding (Resident #67). Findings included: Resident #67 was admitted to the facility on 10/13/22 with diagnoses including dysphagia	F 693	* The facility failed to administer a water flush via gastrostomy tube (a feeding tube inserted into the stomach to provide nutrition and hydration) as ordered by the physician for 1 of 1 resident reviewed for tube feeding (Resident #67). The nurse obtained the correct water flush amount and flushed Resident #67□s gastrostomy tube when notified of error. * Current facility residents receiving hydration flushes via gastrostomy tube are	12/15/23

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F 693	Continued From page 43 (difficulty with swallowing) and aphasia (difficulty with speech) following a cerebral infarction. Review of the annual Minimum Data Set (MDS) assessment dated 10/20/23 indicated Resident #67 received fluids via tube feeding. The care plan revised on 11/13/23 indicated Resident #67 required tube feeding via gastrostomy tube related to the diagnosis of dysphagia and included interventions to provide water flushes as ordered by the physician and evaluations by the Registered Dietitian (RD) quarterly and as needed. Review of the RD evaluation dated 11/14/23 revealed Resident #67 was receiving 100 milliliters (ml) water flush before and after each bolus feeding. The RD recommended increasing the water flush to 125 ml before and after each bolus feeding to provide a total of 1000 ml of water. Review of the physician order for Resident #67's tube feeding was for 125 ml water flush before and after each bolus feeding four times a day providing 1000 ml of water with an active date 11/15/23. During a continuous observation and interview on 11/15/23 at 12:56 PM from 1:17 PM Nurse #10 measured 125 ml of water and entered the room of Resident #67 to provide bolus feeding and water flush via gastrostomy tube. Nurse #10 flushed approximately 60 ml of the 125 ml of water prior to the bolus feeding. After the bolus feeding was completed Nurse #10 flushed the remaining 65 ml of water providing a total of 125 ml of water before and after. Nurse #10 was	F 693	at risk of being affected by the deficient practice. The Regional Director of Clinical Services (RDCS) audited one resident who would be affected to ensure flush amounts were clearly transcribed in order and being administered as ordered. This audit was completed on 12/4/23. No issues were observed during the audit. * To ensure the deficient practice does not recur the facility has put the following in place: current facility and agency licensed nursing staff were educated by the Director of Nursing (DON) or Unit Manager on ensuring to follow physicians order when administering hydration flushes for residents to be completed by 12/15/23. Newly hired facility and agency licensed nursing staff or staff unable to be educated by 12/15/23 will be educated upon hire or prior to working next scheduled shift. Effective 12/15/23 licensed nursing staff will follow physicians orders for administering hydration flushes to residents with gastrostomy tubes. * The DON or RDCS will audit residents with orders for hydration flushes via gastrostomy tube 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks to ensure the hydration flush order is being followed as written. The DON will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to	

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F 693	Continued From page 44 asked to review the physician's order and confirmed the order read provide 125 ml before and after the bolus feeding equaled a total 250 ml water flush. Nurse #10 stated she needed to administer an additional 125 ml water flush and had misread the physician's order. During an interview on 11/15/23 at 4:43 PM the Director of Nursing (DON) stated he was made aware Nurse #10 misread and did not follow the current physician's order for the water flush. The DON revealed Nurse #10 misunderstood the physician's order to administer 125 ml of water before and after and training would be provided. An interview was conducted on 11/17/23 at 4:13 PM with the Administrator. The Administrator stated she expected nurses to follow physician orders and administer the correct amount of water flush.	F 693	maintain compliance Date of Compliance: 12/15/23	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to clean the water chamber of a continuous positive airway pressure (CPAP) machine for 1 of 2 sampled residents	F 695	* The facility failed to clean the water chamber of a continuous positive airway pressure (CPAP) machine for 1 of 2 sampled residents reviewed for	12/15/23

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 695	Continued From page 45 reviewed for respiratory care (Resident #22). Findings included: Resident #22 was admitted to the facility on 12/09/20 with multiple diagnoses including dementia, Alzheimer's disease, and obstructive sleep apnea. Review of the care plan that was initiated on 03/21/21 revealed Resident #22 was at risk for altered respiratory status due to diagnosis of obstructive sleep apnea. Interventions included monitoring for signs and symptoms of respiratory distress and reporting to the physician as needed. The physician's order dated 08/04/21 revealed the nursing staff was instructed to wash the CPAP mask, tubing, and hoses with soap and warm water once daily, then air dry for evening CPAP use. The order did not include anything about cleaning the water chamber. The quarterly Minimum Date Set (MDS) dated 08/01/23 coded Resident #22 with severely impaired cognition. He required extensive to total staff assistance for most of his activities of daily living except for eating. Review of the medication administration records (MAR) for the past 2 months revealed the CPAP was last used by Resident #22 on 11/11/23. He refused to use it on 11/12/23 and 11/13/23. The MAR was charted by nursing staff daily for washing the CPAP mask, tubing, and hoses with soap and warm water. An observation of the CPAP was conducted with the presence of Nurse #1 on 11/13/23 at 4:18	F 695	respiratory care (Resident#22). The Director of Nursing (DON) immediately cleaned the water chamber of CPAP for Resident #22 when notified it appeared unsanitary which was on 11/14/23. * Current facility residents using CPAP machines are at risk of being affected by the alleged deficient practice. Regional Director of Clinical Services (RDCS) audited residents with orders for CPAP machines for cleanliness. The audit was completed on 11/21/23. No concerns were noted during the audit. Effective 12/15/23 CPAP water chambers will be cleaned by the licensed nursing staff as ordered and remain sanitary. * To ensure the deficient practice does not recur the facility has put the following into place: the DON educated the current facility and agency licensed nurses on the importance of ensuring the water chambers are cleaned on a regular basis and as ordered. Education was completed by 12/15/23. The DON also ensured an order was in place on the resident's chart to clean the water chamber of the CPAP machines. Newly hired facility and agency nurses and staff unable to complete education by 12/15/23 will be educated upon hire or prior to working next scheduled shift. The DON will provide this education. * The DON or RDCS will audit residents with orders for CPAP machines 3 times a week for 4 weeks, then 2 times a week for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 695	Continued From page 46	F 695		

PM. The plastic water chamber to humidify the air for the CPAP was noted with a thin layer of slimy brownish buildup at the bottom of the chamber. The brownish build up came off the bottom of the chamber when rubbed with a cotton swab. The CPAP was in working order when the surveyor tested the machine.

Attempt to interview Resident #22 on 11/13/23 at 4:32 PM was unsuccessful. He was unable to engage in the conversation.

During an interview conducted on 11/13/23 at 4:21 PM, Nurse #1 stated staff had changed the water for the CPAP daily, but she was not sure how long it had been since the water chamber had been cleaned. She added she noticed the water chamber with a thin brownish deposit at the bottom and thought it was the nature of the plastic chamber due to chemical reactions between the distilled water and the plastic. She acknowledged that the water chamber had to be cleaned immediately and added Resident #22 had a history of refusing his CPAP at times.

An interview was conducted on 11/14/23 at 9:31 AM with the Unit Manager (UM). The UM attributed the incident to some nursing staff who perceived the cleaning of the water chamber for the CPAP as a low priority task and was overlooked. It was her expectation for staff to perform the job as ordered to keep the water chamber clean all the time.

During an interview conducted on 11/14/23 at 10:14 AM, the Director of Nursing (DON) explained the order to clean the CPAP should be more specific to include the cleaning of the water chamber. It was his expectation for the water

4 weeks, and then weekly for 4 weeks to ensure the machines water chamber is clean and sanitary. The DON will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance. The administrator is responsible or implementing and overseeing this plan of correction.

Date of Compliance: 12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 695	Continued From page 47 chamber and the CPAP to remain clean all the time. An interview was conducted with the Administrator on 11/16/23 at 2:36 PM. It was her expectation for all of the CPAP machine, especially the water chamber, to remain clean at all times.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		12/15/23

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F 761	Continued From page 48 Based on observations, staff interviews and record reviews, the facility failed to remove expired medications in accordance with manufacturer's expiration dates for 1 of 3 medication storage rooms and 1 of 6 medications carts observed during medication storage checks (South Wing medication storage room and Memory care unit medication cart). The findings included: 1. A medication storage audit was conducted on 11/15/23 at 11:08 AM for the South Wing medication storage room in the presence of Nurse #2. One bottle containing approximately 130 milliliters (ml) of used Omeprazole (medication used to treat heartburn) 2 milligrams (mg)/ml suspension that expired on 11/03/23 was found in the locked refrigerator within the locked metal box and was ready to be used. At the same time, 4 unopened bottles of Lorazepam (medication used to treat anxiety) 2 mg/ml injection liquid that expired on 05/31/23 were found in the same metal box and were ready to be used as well. During an interview conducted on 11/15/23 at 11:11 AM, Nurse #2 stated that she was instructed to check each medication for expiration before administration. One of the nurses working on Sunday evening was designated to audit the medication storage room and all the medication carts in South Wing once weekly. She added that the refrigerator was checked last Sunday evening and stated that the incident could be an oversight. An interview was conducted with the Unit Manager on 11/15/23 at 11:26 AM. She stated that she had just audited this medication storage	F 761	* The facility failed to remove expired medications in accordance with manufacturer's expiration dates for 1 of 3 medication storage rooms and 1 of 6 medications carts observed during medication storage checks (South Wing medication storage room and Memory care unit medication cart). Expired medications were removed and discarded by the unit manager immediately when notified of the expiration date on 11/16/23. * Current facility residents are at risk of being affected by the deficient practice. The Director of Nursing (DON) and unit managers (UM) completed a 100% audit of medication storage to ensure no expired medications were present. This audit was completed on 12/7/23. No additional expired medications were noted during the audit. * To ensure the deficient practice does not recur the facility has put the following into place: The DON educated current facility and agency licensed nurses, certified medication aides (CMA), and central supply clerk on medication and biological storage policy and the process for routine monitoring of storage rooms and medication carts (for expired meds). This was completed by 12/15/23. Newly hired licensed nurses, certified medication aides, and central supply clerks and agency licensed staff unable to complete education by 12/15/23 will be educated upon hire or prior to working their next scheduled shift. This will be done by the DON. Effective 12/15/23 the facility will	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 761	Continued From page 49 room with Nurse #2 last Saturday and acknowledged that it was an oversight. It was her expectation for all the medication storage rooms and medication carts to remain free of expired medications. 2. A medication storage check of the only medication cart in the Memory care unit was conducted on 11/16/23 at 11:15 AM in the presence of Nurse #3. There was one used blister card containing 16 tablets of Metoprolol (medication used to treat high blood pressure) 25 mg that expired on 10/31/23 was found in the medication cart and ready to be used. An interview was conducted with Nurse #3 on 11/16/23 at 11:53 AM. She stated this was her first time working in this hall in the past 3 months. She did not know when this medication cart was last audited by the nursing staff. She acknowledged that the expired Metoprolol needed to be returned to the pharmacy. During an interview conducted on 11/16/23 at 2:11 PM, the Director of Nursing stated that all expired medications, including controlled medications that required refrigeration, should be pulled and labelled as "Return to Pharmacy" and stored in the locked refrigerator. It was his expectation for the facility to remain free of expired medication all the time. An interview was conducted with the Administrator on 11/16/23 at 2:36 PM. She stated that the facility had a system in place to check for expired medications on a regular basis and she attributed the above incidents as the oversight of the nursing staff. It was her expectation for the facility to remain free of	F 761	ensure expired medications are removed in accordance with manufacturer's expiration dates. * The DON or Regional Director of Clinical Services (RDCS) or Unit Managers will audit medication storage areas 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks to ensure no expired medications are present. The DON will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance. The administrator is responsible for implementing and overseeing this plan of correction. Date of Compliance: 12/15/23	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 761	Continued From page 50 expired medications all the time.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on a breakfast meal tray line observation, record review, and staff interviews the facility failed to serve fortified oatmeal in a six-ounce portion per the menu. This failure had the potential to affect 15 residents receiving fortified foods.	F 803	* The facility failed to serve fortified oatmeal in a six-ounce portion per the menu. This failure had the potential to affect 15 residents receiving fortified foods. The Regional Director of Culinary Services completed immediate education	12/15/23

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F 803	Continued From page 51 Findings included: The recipe for the breakfast meal on 11/15/23 revealed residents receiving fortified food were to receive a six-ounce portion of fortified oatmeal. In an interview with Cook #1 on 11/15/23 at 7:35 AM he stated the recipe contained information on portion size and indicated which size scoop or utensil should be used to plate the food. A continuous observation of the breakfast meal tray line on 11/15/23 from 7:37 AM through 8:10 AM revealed Cook #1 began plating food and used a number eight scoop (which contained four ounces) to serve fortified oatmeal to residents receiving fortified food. An interview with the Regional Director of (Culinary) Operations on 11/17/23 at 12:44 PM revealed each individual tray ticket contained the portion size of each item the resident was to receive, and she expected portions to be served according to the menu. She stated the reason residents with orders to receive fortified food received four-ounce portions instead of six-ounce portions was due to Cook #1 being nervous and the kitchen environment being "discombobulated". An interview with the Administrator on 11/17/23 at 2:46 PM revealed she expected residents to receive the correct portions of food as directed by the menu.	F 803	on 11/15/23 with dietary staff regarding serving the correct portion sizes per menu to ensure correct nutritive value is provided. * Current facility residents that have orders for fortified foods are at risk of being affected by the deficient practice. The Regional Director of Culinary Services completed a 100% audit on the tray line on 11/16/23 and no further issues were noted during serving the fortified foods on the tray line. * To ensure the deficient practice does not recur the facility has put the following into place: the Regional Director of Culinary and Environmental Services educated current facility dietary staff on serving the correct portion sizes per menu to ensure correct nutritive value is provided and which scoop to use depending on what portion size the menu calls for. This education was completed by 12/15/23. Newly hired dietary staff and dietary staff unable to complete education by 12/15/23 will be educated by Certified Dietary Manager or Regional Director of Culinary and Environmental Services. A color-coded chart identifying portion sizes based on the color of the handle of the spoon/scoop was posted in the serving room on 11/16/23 by the Regional Director of Culinary and Environmental Services. Education about this posting was also conducted by the Regional Director of Culinary and Environmental Services on 11/16/23.	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 803	Continued From page 52	F 803	* The Certified Dietary Manager (CDM) or Regional Director of Culinary and Environmental Services will audit 5 random resident (trays) receiving fortified foods 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks to ensure correct portion sizes are served per menu. The Certified Dietary Manager or Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance. Date of Compliance: 12/15/23	
F 812 SS=E	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	F 812		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 53 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and facility staff interview the facility failed to maintain a clean walk-in cooler for 1 of 1 walk-in coolers and maintain the tiled floor where the steam table was located in good repair. Findings included: 1. An initial observation of the walk-in cooler on 11/13/23 at 9:16 AM revealed a black/brown substance that was easily removable with a wet paper towel on all 4 walls of the cooler and scattered stains to the floor. An interview with the Interim Dietary Manager on 11/13/23 at 9:17 AM revealed she became the Interim Dietary Manager on 11/10/23 but she expected the cooler walls and floor to be clean. An interview with the Administrator on 11/17/23 at 2:46 PM revealed she expected the walk-in cooler to be clean and free of debris. 2. An observation of the floor in the room where the steam table was located on 11/13/23 at 9:20 AM revealed multiple broken tiles with exposed concrete flooring throughout the room. An interview with the Maintenance Director on 11/16/23 at 1:57 PM revealed the floor in the room where the steam table was located had cracked tiles with exposed concrete flooring since he began employment 10 years ago. He stated he did not perform rounds in the kitchen and relied on dietary staff to notify him of any items that needed to be repaired and no one had	F 812	* The facility failed to maintain a clean walk-in cooler for 1 of 1 walk-in coolers and maintain the tiled floor where the steam table was located in good repair. The walk-in cooler and the tiled floor where the steam table is located were cleaned and repaired on or by 12/15/23 by maintenance staff and dietary staff. * All residents in this facility have the potential to be affected by this same alleged deficient practice; however, none were and the identified areas of concern have been and will be corrected by 12/15/23. * The Regional Director of Culinary and Environmental Services (RDCES) educated the current dietary staff on cleanliness and sanitation requirements of the kitchen and how to report maintenance issues and needs to be repaired. Education was completed by 12/15/23. Newly hired dietary staff and not educated by 12/15/23 will be educated by Certified Dietary Manager (CDM) or RDCES upon hire or before next scheduled shift. Effective 12/15/23 the dietary staff will maintain a clean and sanitary walk-in cooler and ensure the kitchen is in good repair. In the event there is a need for repair of an issue in the dietary department when the CDM is in the facility, staff will report the issue to the CDM to place a work order in the electronic maintenance program. During	

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	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 812	Continued From page 54 mentioned concerns with the floor in the room where the steam table was located. In an interview with the Regional Director of (Culinary) Operations on 11/17/23 at 12:44 PM she confirmed the floor in the room where the steam table was located had cracked tiles with exposed concrete flooring and that was a tripping hazard for staff and made steering meal carts difficult. She explained the dietary department were not facility employees and the facility was responsible for maintaining the kitchen floor in good condition. An interview with the Administrator on 11/17/23 at 2:46 PM revealed the kitchen was 80 years old but she expected the floor of the room where the steam table was located to be maintained in an appropriate condition.	F 812	hours the CDM is not at facility, the dietary staff will write repair need on paper log to be entered into electronic maintenance program by CDM. * The Regional Director of Culinary and Environmental Services or Certified Dietary Manager will audit the walk-in cooler and the tiled floors around steam table to ensure the areas are clean and in good repair 3 times a week for 4 weeks, then 2 times a week for 4 weeks, and then weekly for 4 weeks. The Regional Director of Culinary and Environmental Services or Certified Dietary Manager will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance. Date of Compliance: 12/15/23	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F 867		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 867	Continued From page 55	F 867		

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

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ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 867	Continued From page 56	F 867		

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

§483.75(e) Program activities.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 57 collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the complaint investigation survey completed on 09/20/21 and the recertification survey completed on 06/03/22. This was for two repeat deficiencies, one in the area quality of care originally cited on 09/20/21 during a complaint investigation survey and one in the area of food procurement, store/prepare/serve originally cited on 06/03/22 during a recertification survey. Both deficiencies were subsequently recited on 11/17/23 during the recertification and complaint investigation survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain	F 867	* The facility's Quality Assurance Process Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the complaint investigation survey completed on 09/20/21 and the recertification survey completed on 06/03/22. This was for two repeat deficiencies, one in the area quality of care originally cited on 09/20/21 during a complaint investigation survey and one in the area of food procurement, store/prepare/serve originally cited on 06/03/22 during a recertification survey. Both deficiencies were subsequently recited on 11/17/23 during the recertification and complaint investigation	

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F 867	Continued From page 58 an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F684: Based on record review and interviews with staff and the Medical Director (MD), the facility failed to check capillary blood glucose prior to administering insulin lispro (a rapid acting medication used to treat high blood sugar) for 1 of 2 resident reviewed for insulin administration (Resident #88). During the complaint investigation survey of 09/20/21, the facility failed to have a dependent resident assessed by a licensed medical professional when the resident complained of pain and swelling was noted to her leg that was subsequently determined to be a fracture which caused a delay of treatment. F812: Based on observations and facility staff interviews the facility failed to maintain a clean walk-in cooler for 1 of 1 walk-in coolers and maintain the tiled floor where the steam table was located in good repair. During the recertification survey of 06/03/22, the facility failed to discard expired food items from the kitchen and nourishment room refrigerators and discard thickened liquids and a nutritional supplement stored for use in the kitchen dry storage area. During an interview on 11/17/23 at 4:33 PM, the Administrator revealed the management team met daily to discuss various issues to determine	F 867	survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. Facility had an Ad Hoc QAPI meeting on 12/7/23 to review repeat citations and plans put in place to prevent future citations and have a successful and productive Quality Assurance and Performance Improvement (QAPI) Committee. * All residents have the potential to be affected by this deficient practice. The facility initiated a weekly QAPI meeting to review the results of the ongoing audits per the plan of correction and its continued effectiveness on 12/15/23. Changes will be made to the plan as necessary to maintain compliance and to ensure an effective QAPI program to prevent repeat citations. * The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Regional Director of Clinical Services educated QAPI committee members on maintaining an effective QAPI program and monitoring system to prevent repeat citations on 11/21/2023. QAPI meetings to be held weekly, monthly, and as needed by the facility QAPI committee with oversight by the regional team. * The Regional Director of Clinical Services (RDCS) or Vice President of Quality Assurance will monitor weekly for 4 weeks then, monthly for 2 months for	

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F 867	Continued From page 59 what needed to be looked into further and if needed, determine a root cause analysis and develop a Performance Improvement Plan (PIP). The Administrator explained there had been a lot of turnover with the kitchen Department Manager position which she felt contributed to the repeat concerns. The Administrator revealed the QA committee would be reviewing the areas of concern identified during the current survey and discussing what needed to be done to ensure compliance going forward.	F 867	compliance with daily/weekly/monthly/PRN, the Ad Hoc QAPI review of audits of repeat tags for proper monitoring of effectiveness by QAPI committee to maintain an effective QAPI program that prevents repeat citations by effective monitoring. Results of monitoring will be presented to the Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee and RDCS or VPQA will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. * Date of Compliance: 12/15/23	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345208	A. BUILDING: _____ B. WING _____	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	**115 N COUNTRY CLUB ROAD BREVARD, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a baseline care plan within the first 48 hours of a resident's admission to the facility for 1 of 3 sampled residents reviewed for baseline care plan (Resident #46). Findings included: Resident #46 was admitted on 05/26/23 with diagnoses that included chronic pain syndrome and chronic obstructive pulmonary disease.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 655	Continued From Page 1

Review of Resident #46's initial baseline care revealed it was dated and completed on 05/30/23, four days after her admission.

The quarterly Minimum Data Set (MDS) dated 09/01/23 revealed Resident #46 was cognitively intact and receiving opioid (pain medication) daily in the 7-day review periods.

During an interview conducted on 11/17/23 at 11:26 AM, the Social Worker (SW) stated that after a resident was admitted and settled in, he would gather the floor nurse, resident, and/or the responsible party/family to initiate an initial care plan meeting. He recalled Resident #46's family requested to have the initial care plan meeting on 05/30/23. He did not realize that the baseline care plan for resident #46 was late as he thought it had to be completed within the first 72 hours after admission instead of 48 hours.

An interview was conducted with the Director of Nursing (DON) on 11/17/23 at 11:45 AM. He stated that after the initial care plan meeting, the SW needed a Registered Nurse (RN) to sign off the baseline care plan to make it effective per the facility's policy. He planned to let the administrative RNs do it on weekends and after hours from now on to lessen SW's workload. It was his expectation for the staff to complete all the baseline care plans within the first 48 hours after the resident was admitted as required by the regulations.

During an interview conducted with the Administrator on 11/17/23 at 12:09 PM, she expected the staff to follow the regulations to ensure all the baseline care plans being completed within the first 48 hours after admission.