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 _____	02/27/2020

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 02/24/20 through 02/27/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# OTZ111.	E 000		
F 641 SS=E	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 appliances, diagnoses, hospice, prognosis, Preadmission Screening and Resident Review (PASRR), urinary continence, and weight loss for 7 of 13 residents reviewed for hospice, PASRR, resident assessments, unnecessary medications, and urinary catheter (Residents #2, #6, #21, #32, #33, #36, and #51). Findings included: 1. Resident #21 was admitted to the facility on 07/19/16 with multiple diagnoses that included chronic pain, major depression, anxiety disorder, and a progressive disease that affects the central nervous system. Review of a PASRR Level II determination letter indicated Resident #21 had a Level II PASRR effective as of 09/06/16 with no expiration date. Review of the Hospice Recertification Statement,	F 641	CORRECTIVE ACTIONS; Example #1: Corrective actin has ben accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #21. Minimum Data Set (MDS) assessment with Assessment Reference date (ARD) of 1-1-2020 has been modified to include Hospice Care in Section O0100K. The MDS for Res #21 is now current as per the Resident Assessment Instrument (RAI) guidelines to include Hospice Care. This was modified by the MDS nurse on 2-26-20. Example #2: Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #32. The MDS assessment with the ARD of 11-18-19 has been modified to include in Section HO100 Appliances code "Indwelling Catheter." The MDS for Resident #32 is now current as per the	3/26/20

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

Electronically Signed | 03/20/2020

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F 641	Continued From page 1 with an effective date of 09/18/19, indicated Resident #21 was certified to receive Hospice services for end of life care. The significant change MDS assessment dated 10/01/19 indicated under Section A1500 for PASRR that Resident #21 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. The quarterly MDS assessment dated 01/01/20 indicated under Section J1400 for Prognosis, Resident #21 had a condition or chronic disease that may result in a life expectancy of less than 6 months; however, under Section O for Special Treatments and Programs, it was not marked to indicate Resident #21 received hospice care. During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #21 was admitted under hospice care on 09/18/19 which was why the significant change MDS was completed on 10/01/19. He confirmed section O was coded incorrectly and should have reflected Resident #21 received hospice care. He explained it was an oversight and a modification would be submitted. During an interview on 02/26/20 at 3:30 PM the Social Worker (SW) shared he kept track of all residents who had a Level II PASRR but did not code section A of the MDS. He added the MDS Coordinator coded section A1500 for PASRR. During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not	F 641	RAI guidelines to include Section HO100 Appliance code "indwelling Foley Catheter." This modification was done by the MDS nurse on 2-26-20. Example #3: Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #36. The MDS assessment with the ARD of 1-13-20 has been modified to include in Section "does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? = YES. The MDS for Resident #36 is now current as per the RAI guidelines to include Section J1400. The modification was made by the MDS nurse on 2-26-20. Example #4 Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #51. MDS assessment with the ARD of 1-21-20 has been modified to reflect Section KO300=0 for NO or Unknown. The MDS for Resident #51 is now current as per the RAI guidelines. This was completed by the MDS nurse on 2-26-20. Example #5: Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #6. MDS assessment with the ARD of 11-25-19 has been modified by the MDS nurse on 2-26-20 to include PASRR	

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F 641	Continued From page 2 having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accurately coded. During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded. During a follow-up interview on 02/27/20, the MDS Coordinator #1 confirmed Resident #21 had a PASRR Level II and the significant change MDS dated 10/01/19 was miscoded in error. He added a modification would be submitted to accurately reflect Resident #21's Level II PASRR status. 2. Resident #32 was admitted to the facility on 05/27/13 with multiple diagnoses that included hemiplegia (paralysis on one side of the body), diabetes, and obstructive uropathy (condition in which the flow of urine is blocked). Review of Resident #32's medial record revealed a physician's order dated 02/09/18 that read in part, "Foley catheter (flexible tube inserted into the bladder to allow urinary drainage) with 16 french (catheter size) 10 cubic centimeters balloon. Change as needed for leakage or occlusion (blockage)." The quarterly MDS assessment dated 04/17/19 indicated under Section H for Bladder and Bowel that Resident #32 had an indwelling catheter. It was further noted urinary continence was marked as "always incontinent." The quarterly MDS assessment dated 11/18/19 indicated under Section H for Bladder and Bowel that Resident #32 had an external (condom)	F 641	Level=YES in section A1500. The MDS for Resident #6 is now current as per the RAI guidelines for Section A1500. Example #6 Corrective Action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #2. The MDS assessment with the ARD of 11-1-19 has been modified to include in Section J1400 "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?= YES/ the MDS for Resident #2 is now current as per the RAI guidelines to include Section J1400. The modification was made by the MDS nurse on 2-26-20. Example #7: Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #33. MDS assessment with the ARD of 1-9-20 was modified to include the diagnosis of Depression in Section I5800. The MDS for Resident #33 is now current as per the RAI guidelines to include the diagnosis of Depression. The MDS nurse modified this MDS to reflect accurate information on 2-26-20. Identifying Other That Could be Affected Example #1 All facility residents who were determined to be under Hospice Care have the potential to be affected by this alleged deficient practice. All Residents under Hospice Care will be reviewed for MDS compliance regulations regarding Hospice	

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F 641	Continued From page 3 catheter. The annual MDS assessment dated 01/09/20 indicated under Section H for Bladder and Bowel that Resident #32 had an indwelling catheter. It was further noted urinary continence was marked as "always incontinent." During an interview on 02/26/20 at 9:24 AM, the MDS Coordinator #1 confirmed Resident #32 had an indwelling catheter. He reviewed the MDS assessments dated 04/17/19, 11/18/19 and 01/09/20 and verbalized Section H Bladder and Bowel were incorrectly coded on each assessment. He explained bowel incontinence should have been marked as "not rated" instead of "always incontinent" on the MDS dated 04/17/19 and 01/09/20. He added appliances should have been marked as "indwelling catheter" instead of "external" on the MDS dated 11/18/19. The MDS Coordinator #1 stated the errors in coding were an oversight and modifications for the MDS assessments dated 04/17/19, 11/18/19 and 01/09/20 for Resident #32 would be submitted. During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accuracy coded. During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded.	F 641	Care in Section O0100K by 3-24-20 by the MDS nurses or regional corporate MDS consultant and any necessary corrections/modifications will be completed by 3-25-20. This monitor will be to check/review proper coding for section 0010K. Example #2 All facility resident who were determined to have met criteria for Indwelling foley Catheter have the potential to be affected by the alleged deficient practice. All Residents with an indwelling foley catheter will be reviewed for MDS compliance regulations related to Section HO100 Appliances to code "indwelling Foley Catheter" and be current by 3-24-20 by the MDS nurses. Any corrections/modifications necessary will be completed by the MDS nurse by 3-25-20 Examples #3 and #6 All facility residents who were determined to be under Hospice Care have the potential to be affected by the same alleged deficient practice. All residents under Hospice's Care will be reviewed for MDS compliance regulations related to Section J1400 "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? = YES by 3-24-20. The review will be completed by the MDS nurses by 3-24-20 and any necessary corrections/modifications will be made by 3-25-20.	

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F 641	Continued From page 4 3. Resident #36 was admitted to the facility 06/04/15 with multiple diagnoses that included hepatic (liver) failure, major depression, and anxiety disorder. Review of the Hospice Certification Statement, with an effective date of 01/03/20, indicated Resident #36 was certified to receive Hospice services for end of life care. The significant change MDS assessment dated 01/13/20 indicated under Section O for Special Treatments and Programs that Resident #36 received hospice care; however, under Section J1400 for Prognosis, Resident #36 was not coded as having a condition or chronic disease that might result in a life expectancy of less than 6 months. During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #36 was admitted under hospice care on 01/03/20 and explained he had been confused with the interpretation of the Resident Assessment Instrument (RAI) manual on how to code prognosis under Section J for MDS assessments. He confirmed the MDS assessment dated 01/13/20 should have been coded to reflect Resident #36 had a life expectancy of less than 6 months and verified a modification would be submitted to accurately reflect Resident #36's prognosis. During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON	F 641	Example #4: All facility residents have the potential to be affected by the same alleged deficient practice. All residents' most recent MDS assessment will be audited and reviewed for accuracy of Section K0300 Weight Loss for MDS compliance regulations by 3-34-20 and ay necessary corrections/modifications will be by 3-25-20. Example #5 All facility residents who were determined to have a Level II PASRR have the potential to be affected by this alleged deficient practice. All residents with a Level II PASRR will be reviewed for MDS compliance regulations regarding PASRR Level II in Section A1500 by the MDS nurse and Social Worker by 3-24-20 and any corrections/modification sill be made by 3-25-20 Example #7 All facility residents who were determined to have the diagnosis of Depression have the potential to be affected by the same alleged deficient practice. all residents with the diagnosis of depression's most recent MDS assessment will be reviewed for MDS compliance by the MDS nurses . The MDS nurses will be following the RAI guidelines for section I5800 and this will be completed by 3-24-20 with any and all necessary corrections/modifications being completed by the MDS nurses on or before 3-25-20. MEASURES PUT IN PLACE TO	

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F 641	Continued From page 5 stated she would expect for MDS assessments to be accuracy coded. During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded. 4. Resident #51 was admitted to the facility on 01/05/10 with multiple diagnoses that included diabetes, dysphagia (difficulty swallowing), epilepsy (seizures), and a condition that affects movement, muscle tone, balance, and posture. Review of Resident #51's medical record revealed the following recorded weights: 98 pounds on 08/27/19. 95 pounds on 09/24/19. 98 pounds on 10/15/19. 96 pounds on 11/26/19. 95 pounds on 12/24/19. 94 pounds on 01/21/20. The quarterly MDS assessment dated 01/21/20 indicated Resident #51 had a weight loss of 5% (percent) or more in the last month or 10% or more in the last 6 months and was not on a physician-prescribed weight loss regimen. During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 stated either he or the Certified Dietary Manager (CDM) typically coded Section K, Nutritional Status on the MDS. He reviewed Resident #51's recorded weights and verbalized it was incorrectly coded to indicate weight loss. He added a modification would be submitted to accurately reflect Resident #51 did not have a weight loss during the MDS assessment period.	F 641	PREVENT A RECURRANCE: Example #1 1) The MDS nurses, SW, CDM, Administrator, DON, and Activity Director (AD) were inserviced on the accuracy of the MDS assessments on 3-13-20 by the MDS consultant. 2) Residents who are receiving Hospice Care with open ARDs of the MDS assessments will be audited weekly for 1 month, then bi-weekly for 1 month, then monthly thereafter by the Interdisciplinary Team (IDT) for 3 months staring 3-16-20. 3) all results will be documented on the Audit tool that was created to monitor for compliance and will be used to ensure proper coding on the affected MDS assessments by the IDT starting the week of 3-16-20. Example #2 Measures put in place to ensure the alleged deficient practice does not recur include: 1) The MDS nurses, SW, CDM, AD, DON, and Administrator have been inserviced on the accuracy of the MDS assessments by the MDS consultant on 3-13-20 regarding Section H0100 Appliances 2) Residents with Indwelling Foley Catheters with open ARD for completion of their MDS assessments will be audited for Section H0100 Appliances=Indwelling foley Catheter weekly for 1 month, then bi-weekly for 1 month, then monthly thereafter by the IDT for 3 months with finding documented on the Audit Tool for compliance. 3) These Audit Tools will be used to ensure proper coding on the affected MDS assessment by the MDS nurse starting the week of	

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F 641	Continued From page 6 During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accuracy coded. During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded. During an interview on 02/26/20 at 2:40 PM, the CDM confirmed she completed Section K, Nutritional Status on the MDS assessment dated 01/21/20 for Resident #51. The CDM recalled she initially checked weight loss on the MDS assessment for Resident #51 but after clarifying his recorded weights, she realized his weight had actually remained stable during the assessment period. She explained she forgot to change the MDS assessment and weight loss was coded in error. 5. Resident #6 was admitted to the facility on 05/14/07. Her diagnoses included vascular dementia with behavioral disturbance, schizoaffective disorder and depressive disorder. Medical record review for Resident #6 revealed the Resident's PASARR number ended in "B" indicative of PASARR Level II status. Resident #6's PASARR Level II determination letter was dated 05/21/09. The significant change minimum data set assessment dated 11/25/19 for Resident #6 revealed the resident was severely cognitively	F 641	3-16-20. Examples #3 and #6 Measures put in place to ensure the alleged deficient practice does not recur include: 1) The MDS nurses, SW, CDM, AD, DON, and administrator have been inserviced no accuracy of the MDS assessments on 3-13-20 by the MDS consultant as related to Section J1400. 2) Residents who are receiving Hospice Care with open ARD for completion of the MDS assessments will be audited for Section J1400 "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?=YES based on the availability of Hospice's most current Admission to Hospice Care or Recertification documentation, based on the RAI's Steps for Assessment weekly for 1 month, then bi-weekly for 1 month and then monthly thereafter by the IDT for a period of 3 months. 3) all results will be documented on the Audit Tool which will be used to ensure proper coding on the affected MDS assessments by the IDT starting the week of 3-16-20. Example #4 Measures put in place to ensure the alleged deficient practice does not recur include: 1) the MDS nurses, SW, CDM, AD, DON, and administrator were inserviced on the accuracy of the MDS assessments on 3-13-20 by the MDs consultant in regards to Section K0300 2) all residents with open ARD of the MDS assessments will be audited weekly	

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F 641	Continued From page 7 impaired and exhibited verbal behaviors directed towards others on 4-6 days of the look back period. It was coded that Resident #6's behaviors put her at risk for physical injury and significantly impacted her care. The assessment indicated under Section A1500 for PASRR that Resident #6 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Resident #6's care plan reviewed and continued on 12/15/19 revealed that Resident #6 had a behavior problem which included refusal of care, throwing briefs on the floor and cursing. Interventions noted that Resident #6 was a level II PASARR elated to a schizoaffective disorder. During an interview on 02/25/20 at 3:02 PM the MDS Coordinator #1 confirmed Resident #6 had a PASRR Level II and the significant change MDS dated 11/25/19 was miscoded in error. He added a modification would be submitted to accurately reflect Resident #6's Level II PASARR status. During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) confirmed she was aware of the issues identified with MDS accuracy and felt it was a result of MDS Coordinator #1 not having consistent help with completing MDS assessments the majority of the year. The DON stated she would expect for MDS assessments to be accuracy coded. During an interview on 02/26/20 at 1:08 PM, the Administrator stated she would expect for MDS assessments to be accurately coded. 6. Resident #2 was admitted to the facility on 06/28/19 with multiple diagnoses that included	F 641	for 1 month, then bi-weekly for 1 month and then monthly thereafter for a period of 3 months by the IDT. 3) All results will be documented on the Audit Tool created to monitor compliance. 4) These audit tools will be used to ensure proper coding on the affected MDS assessments by the MDS nurses starting the week of 3-16-20 Example #5 Measures put in place to ensure the alleged deficient practice does not recur include: 1) The MDS coordinators, SW, CDM, AD, DON, and administrator have been inserviced on the accuracy of the MDS assessments on 3-13-20 by the MDS consultant specifically as it relates to Level II PASRR. 2)Residents who are determined to have Level II PASRRs with open ARDs for their MDS assessments will be audited weekly for 1 month, then bi-weekly for 1 month and then monthly thereafter by the IDT for a period of 3 months. 3) All results will be documented on the Audit Tool that was created to monitor for compliance and to ensure that the affected MDS assessments are coded properly by the IDT starting the week of 3-16-20. Example #7 Measures put in place to ensure the alleged deficient practice does not recut include: 1) The MDS coordinators, SW, CDM, AD, DON and administrator were inserviced by the MDS consultant on 3-13-20 regarding the accuracy of the MDS assessments specifically regarding Section I5800. 2) Residents who have a	

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F 641	Continued From page 8 heart failure, Alzheimer's disease, dementia, anxiety, and depression. Review of the Hospice Recertification Statement indicated Resident #2 was certified to receive Hospice services for end of life care with an effective date of 10/18/19. Review of progress notes dated 10/18/19 revealed Resident #2 started to receive Hospice services on the same day. Review of the significant change in status assessment Minimum Data Set (MDS) dated 11/01/19 indicated under Section J-1400 for Prognosis, Resident #2 was not coded with a condition or chronic disease that may result in a life expectancy of less than 6 months. In addition, under Section O for Special Treatments and Programs, it was not coded to indicate Resident #2 received hospice care. During an interview on 02/25/20 at 2:57 PM, the MDS Coordinator #1 stated the significant change MDS dated 11/01/19 was completed for Resident #2 due to her admission to Hospice on 10/18/19. He confirmed the coding for section J-1400 and section O-0100 of the significant change MDS dated 11/01/19 were incorrect. MDS Coordinator #1 explained he was confused about section J as he thought he had to have physician's documentation to indicate Resident #2 had less than 6 months of life expectancy. For section O, MDS Coordinator #1 stated it was miscoded due to his carelessness. He further stated he would modify the MDS to reflect Resident #2's actual care needs and re-submit the correction as soon as possible.	F 641	diagnosis of Depression with an open ARD of the MDS assessments will be audited weekly for 1 month, then bi-weekly for 1 month and then monthly thereafter by the IDT for a period of 3 months. 3) all results will be entered on to the Audit Tool created to monitor compliance. 4) These audit tools will be used to ensure proper coding on the affected MDS assessments by the NDS nurses starting the week of 3-16-20. How does the facility plan to monitor this: Examples #1, #2, #3, #4, #5, #6, and #7 The results of the audit tools will be presented to the QAPI committee by the MDS nurse monthly for a period of 3 months or longer as necessary to ensure compliance with this alleged deficient practice. The QAPI committee will review the progress of this plan and make suggestions/adjustments with the plan/monitor as deemed necessary to ensure compliance * Completion date 3-26-20	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9	F 641		

During an interview on 02/27/20 at 9:01 am, the Director of Nursing (DON) acknowledged that she was aware of the issues identified with MDS accuracy. She stated MDS Coordinator #1 was working by himself without consistent staffing support most of the year. The DON would expect the MDS Coordinator to correct the errors and re-submit the correction as soon as possible. It was her expectation for all the MDS assessments to be coded accurately.

During an interview on 02/27/20 at 11:40 AM, the Administrator stated it was her expectation for all the MDS to be coded accurately.

7. Resident #33 was admitted to the facility on 06/29/19 with diagnosis of fractures and other multiple trauma.

A signed physician's order dated 09/20/19 indicated Resident #33 was to receive Zoloft (antidepressant) 50 milligrams (mg) 1 tablet one time a day for depression.

A review of psychiatric practitioner progress note dated 12/03/19 indicated Resident #33 had diagnoses of adjustment disorder with depressed mood and goal of treatment was to improve depression.

The quarterly Minimum Data Set (MDS) assessment dated 01/09/20 indicated Resident #33 had not been coded under Section I Active Diagnoses as having a diagnosis of depression.

A review of the Medication Administration Record (MAR) for the month of January 2020 indicated per staff documentation on the MAR that Resident #33 received Zoloft 50 mg 1 tablet one

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 _____	02/27/2020

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F 641	Continued From page 10	F 641		

time a day for depression during the 7 day look back period.

On 02/26/20 at 11:00 AM an interview was conducted with the MDS Coordinator Assistant who stated she was responsible for coding Section I on Resident #33's quarterly MDS assessment dated 01/09/20. The MDS Coordinator Assistant verified that Resident #33 had a physician's order that indicated a diagnosis of depression which she did not code under Section I on the quarterly MDS assessment. The MDS Coordinator Assistant verbalized that she would need to submit a modification to the quarterly MDS assessment dated 01/09/20 to accurately reflect Resident #33 had a diagnosis of depression.

On 02/26/20 at 12:13 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the quarterly MDS assessment dated 01/09/20 would have been accurately coded to reflect Resident #33 had a diagnosis of depression. The DON shared her expectation was that the quarterly MDS dated 01/09/20 would be modified and submitted to indicate Resident #33 had diagnosis of depression.

On 02/26/20 at 1:15 PM an interview was conducted with the Administrator who stated her expectation was that the quarterly MDS assessment dated 01/09/20 would have been accurately coded to reflect Resident #33 had diagnosis of depression. She verbalized her expectation was that the quarterly MDS assessment dated 01/09/20 would be modified and submitted to accurately reflect Resident #33 had diagnosis of depression.

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the state mental health authority when residents with a Level II Preadmission Screening and Resident Review (PASRR) had a significant change in condition for 3 of 4 residents (Residents #6, #21 and #36) reviewed for PASRR and resident assessments. Findings included: 1. Resident #21 was admitted to the facility on 07/19/16 with multiple diagnoses that included dysphagia (difficulty swallowing), chronic pain, major depression, and anxiety disorder. Review of a PASRR Level II determination letter indicated Resident #21 had a Level II PASRR effective as of 09/06/16 with no expiration date. The significant change Minimum Data Set (MDS) assessment dated 10/01/19 revealed Resident #21 had severe impairment in cognition, required extensive to total staff assistance with activities of daily living and displayed verbal behaviors directed toward others 4 to 6 days during the MDS assessment period. It was noted under Section A1500 for PASRR that Resident #21 had not been evaluated by Level II PASRR and determined to have a serious mental illness	F 646	* Corrective action for residents #6, #21, and #36 could not be done because the action was time sensitive. * The MDS nurse reviewed all MDS assessments performed due to a Significant Change for the last 3 months (Dec 2019- Feb 2020) and identified those that were completed for residents that had a Level II PASRR. Of the 5 that were identified, there was only 1 with a Level II PASRR and that particular resident was identified in the survey as resident #36. this was completed on 3-13-20. * Measures put into place to prevent this citation from recurring include: 1) the administrator inserviced the social worker and the MDS nurses on this regulation and its importance on 3-16-20, 2) a checklist has been developed and implemented. This will be completed by the SW weekly as MDS assessments are scheduled. This check list identifies the PASRR levels of those having a SIG CHANGE done and the date of the State's notification of the significant change for the residents with a Level II PASRR. The notification will be done by the Social	3/26/20

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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

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F 646	Continued From page 12 and/or intellectual disability. During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #21 had a Level II PASRR and was admitted under hospice care on 09/18/19 which was why the significant change MDS was completed on 10/01/19. The MDS Coordinator #1 explained he completed Section A of the MDS but it was the Social Worker (SW) who would have notified the state mental health authority of Resident #21's change in condition. During an interview on 02/26/20 at 3:30 PM the Social Worker (SW) shared he notified the state mental health authority whenever a resident with a Level II PASRR had a significant change in their mental condition but was unaware they also needed to be notified when there was a significant change in the resident's physical condition. He confirmed he did not notify the state mental health authority of Resident #21's significant change in physical condition when the MDS assessment dated 10/01/19 was completed. During an interview on 02/26/20 at 1:08 PM, the Administrator explained they had not known the state mental health authority needed to be notified when a resident with a Level II PASRR had a significant change in physical condition. She added moving forward, she would expect for the state mental health authority to be notified any time a resident with a Level II PASRR had a significant change in mental or physical condition. 2. Resident #36 was admitted to the facility 06/04/15 with multiple diagnoses that included hepatic (liver) failure, schizophrenia, bipolar disorder, major depression, and anxiety disorder.	F 646	Worker. This was implemented the week of 3-16-20, 3) The monitor will be reviewed by the social worker and the administrator weekly for completion. 4) The MDS nurses will keep a list of all residents having a SIG CHANGE MDS assessment completed and this will be compared to the list kept by the SW to ensure that there were none missed/omitted from the list. This comparison will also be done weekly, 5) The SW will immediately address any that may have been omitted from the list/monitor. * The SW will present the above noted monitor to the QAPI committee monthly for a period of 3 months or possibly longer until compliance has been achieved. The QAPI committee may implement change to the plan/monitor as necessary to affect change and achieve compliance. * completion date 3-26-20	

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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 646	Continued From page 13	F 646		

Review of Resident #36's medical record revealed she had a Level II PASRR with an effective date of 11/03/11.

The significant change Minimum Data Set (MDS) assessment dated 01/13/20 revealed Resident #36 had severe impairment in cognition, required extensive to total staff assistance with activities of daily living and displayed no behaviors during the MDS assessment period. It was noted under Section A1500 for PASRR that Resident #36 was evaluated by Level II PASRR and determined to have a serious mental illness.

During an interview on 02/25/20 at 3:06 PM, the MDS Coordinator #1 confirmed Resident #36 had a Level II PASRR and was admitted under hospice care on 01/03/20 which was why the significant change MDS was completed on 01/13/20. The MDS Coordinator #1 explained he completed Section A of the MDS but it was the Social Worker (SW) who would have notified the state mental health authority of Resident #36's change in condition.

During an interview on 02/26/20 at 3:30 PM the Social Worker (SW) shared he notified the state mental health authority whenever a resident with a Level II PASRR had a significant change in their mental condition but was unaware they also needed to be notified when there was a significant change in the resident's physical condition. He confirmed he did not notify the state mental health authority of Resident #36's significant change in physical condition when the MDS assessment dated 01/13/20 was completed.

During an interview on 02/26/20 at 1:08 PM, 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 _____	02/27/2020

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

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F 646	Continued From page 14	F 646		

Administrator explained they had not known the state mental health authority needed to be notified when a resident with a Level II PASRR had a significant change in physical condition. She added moving forward, she would expect for the state mental health authority to be notified any time a resident with a Level II PASRR had a significant change in mental or physical condition.

3. Resident #6 was admitted to the facility on 05/14/07. Her diagnoses included vascular dementia with behavioral disturbance, schizoaffective disorder and depressive disorder.

Medical record review for Resident #6 revealed the Resident's PASARR number ended in "B" indicative of PASARR Level II status. Resident #6's PASARR Level II determination letter was dated 05/21/09.

The quarterly minimum data set assessment dated 11/04/19 for Resident #6 revealed the resident was severely cognitively impaired and had not exhibited any behaviors. Resident #6 required extensive assistance with bed mobility and toileting, limited assistance with personal hygiene and was independent with transferring.

The significant change minimum data set assessment dated 11/25/19 for Resident #6 revealed the resident was severely cognitively impaired and exhibited verbal behaviors directed towards others on 4-6 days of the look back period. It was coded that Resident #6's behaviors put her at risk for physical injury and significantly impacted her care. Resident #6 required extensive assistance with bed mobility, toileting, personal hygiene and transferring.

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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F 646	Continued From page 15 Resident #6's care plan reviewed and continued on 12/15/19 revealed that Resident #6 had a behavior problem which included refusal of care, throwing briefs on the floor and cursing. Interventions noted that Resident #6 was a level II PASARR related to a schizoaffective disorder. During an interview on 02/26/20 at 1:53 PM the Social Worker (SW) stated he was responsible for PASARR referrals. He stated he had not notified PASARR that Resident #6 had experienced a significant change. The SW indicated he was not aware PASARR needed to be notified when a physical significant change had occurred in addition to psychological changes in condition. He stated because the resident's significant change was related to a physical decline and did not include psychological changes, he did not know it was necessary to perform a PASARR referral. During an interview on 02/27/20 at 12:23 PM the Administrator stated that it was not in the forefront of her mind that needed to be notified with all significant changes in condition. The Administrator further reported that moving forward she expected to be notified of all significant changes in condition for all residents with a level II PASARR.	F 646		
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.	F 812		3/26/20

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 _____	02/27/2020

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F 812	Continued From page 16 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired food from 1 of 1 kitchen walk-in refrigerators. The findings included: On 02/24/20 at 9:05 AM during the initial tour of the kitchen with the Food Service Director (FSD) observations were made of the facility's walk-in refrigerator. The walk-in refrigerator was observed to contain a five-pound container of ricotta cheese, with one quarter remaining, with an expiration date of 12/04/19. No additional containers of Ricotta cheese were observed in the walk-in refrigerator. Review of facility menus revealed ricotta cheese was used to make lasagna and lasagna had been served on 12/31/19 and 01/28/20. An interview was conducted with the FSD on 02/26/20 at 2:31 PM who reported that the expired container of ricotta cheese should not have been in the walk-in refrigerator, it should	F 812	* Corrective action regarding the identification of an expired container of ricotta cheese was taken at the time it was found. The Certified Dietary manager (CDM) disposed of the ricotta cheese on 2-24-20. * The CDM performed a thorough check of the walk-in cooler, freezer, and dry storage on 2-24-20 to ensure that there were no other expired foods or beverages present. There were none identified. * Measures put into place to ensure that this alleged deficient practice does not recur include: 1) The administrator conducted an in-service with the CDM sharing information regarding this citation and its importance as well as the Facility's policy. This occurred on 3-11-20. 2) The CDM provided an in-service to the dietary staff sharing with them the information regarding this citation, its importance, and the Facility's policy.	

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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

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F 812	Continued From page 17 have been discarded. The FSD stated that she had ordered fresh ricotta cheese for the lasagna served on 12/31/10 and 01/28/20 and therefore the expired product would not have been used. The FSD further indicated that facility cooks were responsible for monitoring the walk-in refrigerator and discarding expired items. An interview was completed with Cook #1 on 02/27/20 at 12:27 PM who indicated that he checked the walk-in refrigerator daily for expired products. Cook #1 further reported he had seen the ricotta cheese in the refrigerator but did not see the expiration date located on the bottom of the container. Cook #1 stated that if he had seen the expiration date he would have discarded the item. The Administrator was interviewed at 12:19 PM on 02/27/20 who explained that food items that have expired should have been thrown out and should not remain in the walk-in refrigerator.	F 812	Dietary staff were also inserviced on the First In, First Out (FIFO) method when putting up stock. All expired foods or beverages are to be disposed of immediately. All dietary staff were inserviced by 3-17-20 with the exception of one who is on an extended leave and she will be inserviced upon return to work. Newly hired dietary staff will be educated about this upon hire by the CDM. 3) Daily, as a part of their daily routine, the cook on the day shift and evening shift will dispose of any expired foods/ beverages in the dry storage, walk-in cooler, and freezer. This was communicated to the cooks by the CDM on or before 3-17-20 during inservices. 4) Weekly, a thorough monitor of the walk-in cooler, freezer, and dry storage will be conducted by the CDM. The monitor and its finding will be reviewed weekly by the CDM and the administrator beginning the week of 3-16-20. if this monitor identifies any expired foods or beverages, the expired item will be disposed of immediately by the staff member finding it. * These monitors will be presented monthly to the QAPI committee by the CDM for a minimum of 3 months and longer as deemed necessary by the QAPI committee. if these monitors fail to ensure compliance with this regulation, the CDM or QAPI committee may suggest/implement changes to the plan/monitors so that compliance will be achieved. * Completion date 3-26-20	

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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

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F 842	Continued From page 18	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		3/26/20

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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F 842	Continued From page 19 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document in the medical record the actual date and time of a resident's discharge from the facility for 1 of 1 resident reviewed for discharge (Resident #74). Findings included: Resident #74 was admitted to the facility on	F 842	* Corrective action for this citation could not be made due to the fact that the situation was time sensitive. The Facility received a citation for failure to document in the medical record the actual date and time of the resident's discharge. * the Medical Records Clerk reviewed all discharges from 2-1-20 to present and	

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F 842	Continued From page 20 11/01/19 with multiple diagnoses that included displaced fracture of base of neck of left femur (thigh bone), osteoarthritis, and dementia. The admission Minimum Data Set (MDS) dated 11/07/19 indicated Resident #74 had severe impairment in cognition and required limited to total staff assistance with all activities of daily living. Further review revealed an active discharge plan was in place for Resident #74 to return to the community. Review of the physician's orders for Resident #74 revealed an order dated 12/12/19 that read in part, discharge to assisted living facility on 12/16/19. Review of Resident #74's discharge summary, signed as complete on 12/13/19, revealed plans for her to discharge to an assisted living facility on 12/16/19 at 8:00 AM. The discharge MDS assessment dated 12/16/19 indicated Resident #74 discharged to the community. Review of the nurse progress notes for Resident #74 revealed the last entry was a daily nursing note dated 12/15/19. There was no entry on the day of her discharge, 12/16/19, that indicated what time she left the facility, her disposition at the time of her discharge, mode of transportation, or paperwork provided to her upon discharge. During an interview on 02/25/20 at 2:50 PM, Nurse #1 confirmed she was the nurse who was assigned to work with Resident #74 on the day of her discharge. Nurse #1 explained when a resident discharged from the facility, she typically	F 842	checked to make sure that the medical record reflected the date and time of the discharge. * Measures put into place to ensure compliance with this regulation include: 1) The Director of Nursing (DON) and Staff Development Coordinator (SDC) inserviced all licensed nurses on this regulation and its importance. This inservicing was completed by 3-18-20. Due to illness, some licensed nurses were inserviced via telephone by the SDC. Any newly hired nurses will be educated on this during orientation by the SDC. 2) daily,(M-F), in the morning meeting, the electronic recored of discharged residents from the day or days prior will be reviewed for proper documentation to include date and time of discharge. This will be done by the MDS nurse, Social Worker, or DON. This will be gin 3-13-20 and noted on the "Stand-up Worksheet" which is completed by the Administrator. If the documentation is inadequate, it will be addressed and resolved by the director of Nursing immediately and additional education provided as necessary by the DON. 3) A log will be kept by the DON regarding the discharges noting whether or not the discharge documentation was present on the medical record starting 3-16-20. * This log will be presented by the DON at the monthly QAPI meeting for review for a period of 3 months and possibly longer as deemed necessary by the QAPI committee to ensure compliance with this	

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	345208	A. BUILDING _____ B. WING _____	02/27/2020

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 842	Continued From page 21 made herself a note of what was discussed with the resident and/or their family, the resident's disposition, and the time they left the facility for her to enter a nurse note when she completed her charting for the day. Nurse #1 could not recall the time but stated she provided Resident #74's family member with her discharge paperwork when they arrived to transport her to another facility on 12/16/19 and she left without incident. Nurse #1 added she should have written a nurse progress note on the day of Resident #74's discharge but she must have forgotten. During an interview on 02/26/20 at 12:18 PM, the Director of Nursing (DON) explained when a resident discharged from the facility, the nurse completing the discharge was expected to write a nurse progress note in the resident's medical record that included information such as the resident's disposition, date and time the resident left the facility, and who transported the resident. The DON confirmed there was no nurse progress note dated 12/16/19 for Resident #74 and stated she would have expected Nurse #1 to have documented in the medical record when Resident #74 discharged from the facility on 12/16/19.	F 842	practice. The QAPI committee may also suggest or amend this plan or the monitor as deemed necessary to affect change and compliance. * Completion date is 3-26-20	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867		3/26/20

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F 867	Continued From page 22 Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain and implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 02/14/19. This was for one recited deficiency that was originally cited in February 2019 and subsequently recited on the current recertification of 02/27/20. The recited deficiency was in the area of accuracy of assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F-641: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Sets (MDS) in the areas of appliances, diagnoses, hospice, prognosis, Preadmission Screening and Resident Review (PASRR), urinary continence, and weight loss for 7 of 13 residents reviewed for hospice, PASRR, resident assessments, unnecessary medications, and urinary catheter (Residents #2, #6, #21, #32, #33, #36, and #51). During the annual recertification survey of 02/14/19 the facility was cited for failure to code the MDS assessment to accurately reflect diagnosis for a resident reviewed for unnecessary medication. On 02/27/20 at 12:26 PM an interview was conducted with the Administrator who stated the	F 867	* on 3-13-20, the Facility's QAPI (FQAPI) committee held a meeting to review the purpose and function of the QAPI committee and review on-going compliance issues. The administrator, Director of Nursing (DON), MDS nurse, Business Office Manager (BOM), Staff Development Coordinator (SDC), and Activities Director were all in attendance and will continue to attend these monthly meetings as well as other assigned staff as deemed appropriate. * Corrective action has been taken for the identified concerns related to the F 641 citation in that corrections to the affected MDS assessments were made and submitted by the MD nurse. Corrected assessments for Residents #21, #32,#36, #51, #6, #2, and #7 were submitted on 2-26-20. * On 3-13-20, the Regional Vice President of Operations inserviced the administrator regarding the appropriate functions of the QAPI committee nd the purpose of the committee to include identifying issues and correct repeat deficiencies related to F 641. On 3-13-20, the administrator inserviced the department managers related to the appropriate functions of the QAPI committee and the purpose of the committee to include the identification of issues and to correct repeat deficiencies related to F 641. * The FQAPI committee will meet at a minimum of monthly and the Executive QAOI (EQAPI) committee will meet	

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F 867	Continued From page 23 average daily census increased and the MDS Coordinator was trying to keep up with the work load of completing MDS assessments without assistance. The Administrator shared that the facility recently added a part time MDS nurse to assist the MDS Coordinator with MDS assessments.	F 867	quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. The EQAPI committee will continue to meet quarterly and the FQAPI will continue to meet monthly with oversight from a corporate staff member. The EQAPI will include the Facility's Medical Director. The EQAPI will review the complied FQAPI reports and information and review trends/patterns and corrective actions. Recommendations for plan revisions may be made by the EQAPI to ensure compliance. The administrator will be responsible for ensuring committee concerns are addressed through further training or other necessary intervention. The administrator is responsible for implementation of the acceptable plans of corrections. * completion date 3-26-20	