

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
--	---	--	---

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

(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	E 000		
F 000	INITIAL COMMENTS	F 000		
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§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 the Minimum Data Set (MDS) assessments in the area of Preadmission Screening and Resident Review (PASRR) Level II for 2 of 3 sampled residents reviewed for PASRR (Residents #40 and #41).</p> <p>Findings included:</p> <p>1. Resident #40 was admitted to the facility 02/24/21 with diagnoses that included dementia, anxiety and psychotic disorder.</p> <p>Review of the undated North Carolina Medicaid Uniform Screening Tool (NC MUST) revealed Resident #40 had a Level II PASRR with no expiration date.</p>	F 641	<p>1. On 8/3/2021, the MDS coordinator modified section A15010 for Resident 341 comprehensive MDS assessment for ARD 5/13/21 to accurately code level II PASRR condition of serious mental illness. On 8/3/21, the MDS coordinator modified section A1500 for Resident #40 comprehensive MDS assessment for ARD 3/7/21 to accurately code "yes" for a level II PASRR.</p> <p>2. On 8/10/21, the Social Worker and MDS coordinator completed an audit of current residents most recent comprehensive MDS assessment for accurate coding for level II PASRR/ Modifications to MDS coding completed by the MDS coordinator as identified.</p>	8/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE 08/10/2021
--	-------	-------------------------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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	<p>Continued From page 1</p> <p>The admission Minimum Data Set (MDS) dated 03/07/21 indicated under Section A1500 for PASRR that Resident #40 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability.</p> <p>Review of a facility document titled, Level II PASRR's, and dated 07/19/21 revealed Resident #40 was included on the list of current residents with a Level II PASRR.</p> <p>During an interview on 07/23/21 at 8:57 AM, the MDS Coordinator confirmed Resident #40 had a Level II PASRR upon his admission to the facility and the admission MDS dated 03/07/21 was incorrectly coded. She added Section A should have been marked "yes" to reflect Resident #40 had a Level II PASARR and a modification would be submitted.</p> <p>During an interview on 07/23/21 at 9:21 PM, the Social Worker (SW) explained they do not always receive a copy of the PASRR determination letter, so she checked the NC MUST system when a resident was admitted to the facility to ensure a PASRR number was in place and printed off a copy for their medical record. The SW confirmed Resident #40 had a Level II PASARR upon his admission to the facility on 02/24/21.</p> <p>During an interview on 06/02/21 at 6:02 PM, the Administrator stated they kept an updated list of all residents in the facility with a Level II PASSR and would expect for the MDS to be coded accurately.</p> <p>2. Resident #41 was admitted to the facility on</p>	F 641	<p>3. On7/27/21, the Regional CRC nurse provided education to the MDS coordinator and Social Worker on the comprehensive MDS assessment coding of section A1500 and A1510. Workers will receive education upon hire. The social worker will submit and review PASSR level II determination letters and notify MDS coordinator of rational of determination. MDS coordinator will update MDS A1500 as appropriate for accuracy.</p> <p>4. The DON or RN supervision will complete quality assurance monitoring of newly completed comprehensive MDS assessments for accuracy of PASRR level per section A1500 and A1510. Monitoring will be completed weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with accuracy of assessments.</p> <p>5. The completion date is 8/10/2021</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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	<p>Continued From page 2</p> <p>04/29/21 with diagnoses that included traumatic brain injury and depression.</p> <p>Review of the undated North Carolina Medicaid Uniform Screening Tool (NC MUST) revealed Resident #41 had a Level II PASRR with no expiration date.</p> <p>The admission Minimum Data Set (MDS) dated 03/07/21 indicated under Section A1500 for PASRR that Resident #41 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability.</p> <p>Review of a facility document titled, Level II PASRR's, and dated 07/19/21 revealed Resident #41 was included on the list of current residents with a Level II PASRR.</p> <p>During an interview on 07/23/21 at 8:57 AM, the MDS Coordinator confirmed Resident #41 had a Level II PASRR upon her admission to the facility which is why she marked Section A1500 "yes." The MDS Coordinator explained at the time the MDS assessment was completed, she did not know the reason why Resident #41 had a Level II PASRR and therefore, did not know what to code for the Level II PASRR conditions and left them blank. The MDS Coordinator stated it should have been coded to reflect a mental diagnosis and a modification would be submitted.</p> <p>During an interview on 07/23/21 at 9:21 PM, the Social Worker (SW) explained they do not always receive a copy of the PASRR determination letter, so she checked the NC MUST system when a resident was admitted to the facility to ensure a PASRR number was in place and printed off a</p>	F 641			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 3 copy for their medical record. The SW confirmed Resident #41 had a Level II PASARR upon her admission to the facility on 04/29/21.  During an interview on 06/02/21 at 6:02 PM, the Administrator stated they kept an updated list of all residents in the facility with a Level II PASSR and would expect for the MDS to be coded accurately.	F 641			
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)  §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 request a Preadmission Screening and Resident Review (PASRR) review for a resident with a new mental health diagnosis for 1 of 3 sampled residents reviewed for PASRR	F 644	1. On 8/3/2021, the Administrator completed and submitted a level II PASRR review to North Carolina Medicaid Uniform Screening Tool (NC MUST) for resident #12 related to a new mental	8/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 644	<p>Continued From page 4 (Resident #12).</p> <p>Findings included:</p> <p>Resident #12 was admitted to the facility on 02/20/20 with diagnoses that included diffuse Traumatic Brain Injury (TBI) with loss of consciousness of unspecified duration.</p> <p>Review of the PASRR Level I Determination Notification letter dated 01/14/20 read in part, Resident #12 did not meet the federal definition for mental illness/mental retardation and no further PASRR screening was required unless a significant change occurred indicative of a mental illness/mental retardation and if present, suggested a change in treatment needs for those conditions.</p> <p>The admission Minimum Data Set (MDS) dated 02/27/20 indicated under Section A1500 for PASRR that Resident #12 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Further review revealed he had no documented psychosis, behaviors or active psychiatric/mood disorders during the MDS assessment period.</p> <p>Review of a Psychiatrist progress note dated 04/06/20 for Resident #12 read in part, "follow-up psychiatric evaluation after an unprovoked altercation with another resident. Resident #12 was apparently delusional and experienced auditory hallucinations. In the past, he denied having any hallucinations of any form. Diagnosis: possible schizoaffective disorder."</p> <p>Review of a Nurse Practitioner progress note for</p>	F 644	<p>health diagnosis of schizoaffective disorder on 5/4/21. Upon determination of review, the MDS coordinator will complete a modification to the comprehensive MDS assessment if indicated.</p> <p>2. On 8/10/21, the Social Worker and MDS coordination completed an audit of residents with newly evident or possible serious mental health disorders for accurate PASRR level assessment. A review of active diagnosis reports for resident current medical record in PCC and of Psych consult notes were compared to residents most recent comprehensive MDS assessment for accuracy of PASRR level. The Social Worker and/or Administrator will complete and submit level II PASRR reviews to NCMUST if indicated.</p> <p>3. On 7/27/21, the Regional CRC nurse provided education to the Social Worker and MDS coordinator on the process of referring all residents with newly evident or possible serious mental disorders for level II resident review upon a significant change in status assessment. The SW and/or MDS coordinator will identify residents needing PASRR review by monitoring Psych consult notes and new orders for newly evident or possible serious mental health disorders. The SW will submit level II PASRR reviews as indicated. Newly hired SWs and MDS coordinators will receive education upon hire.</p> <p>4. The DON or RN supervisor will complete quality assurance monitoring of Psych consult notes and physician orders to identify residents with newly evident or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 644	<p>Continued From page 5</p> <p>Resident #12 read in part, "he presented with ongoing and increasing hallucinations treated with Risperdone (antipsychotic medication used to treat schizophrenia). His dose is increased today due to his increased occurrence of hallucinations that have him out in the hall, exit seeking and going into other Resident rooms. He has a history of TBI which could be the possible etiology of the hallucinations. New order: Risperdone 0.5 milligrams (mg) three times a day starting on 04/21/20."</p> <p>Review of a Psychiatrist progress note dated 05/04/20 for Resident #12 read in part, "follow-up psychiatric evaluation after recent medication change. Since our last visit, Resident #12 reports still hearing voices and occasionally having some scary hallucinations that he describes as more of a monster like character telling him things, such as to get out of there. Diagnosis: possible schizoaffective disorder."</p> <p>Review of the nursing staff progress notes for Resident #12 revealed an entry dated 05/04/20 that read, new orders for gradual dose reduction of AM dose of Risperdone to 0.5 mg and 1 mg at bedtime for diagnosis of schizoaffective disorder with hallucinations.</p> <p>During an interview on 07/21/21 at 10:53 AM, the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW confirmed Resident #12 had a Level 1 PASRR upon his admission to the facility and after reviewing the Psychiatrist progress notes, the SW confirmed a PASRR review should have been initiated when Resident #12 was newly diagnosed with schizoaffective disorder on 05/04/20. The SW added at the time</p>	F 644	<p>possible serious mental disorders for PASRR level II screening. Monitoring will be comped weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with level II PASRRs.</p> <p>5. The completion date is 8/10/2021</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 644	Continued From page 6 Resident #12 was diagnosed with a mental illness, no onsite evaluations were being conducted due to the COVID-19 pandemic and the opportunity to submit a referral for PASRR Level II review was missed.  During an interview on 07/21/21 at 2:14 PM, the Administrator explained they would not normally request a Level II PASRR review for a new mental health condition; however, if the resident exhibited a decline or new behavior then a referral for PASRR review would be made. The Administrator explained since Resident #12 had no history of auditory hallucinations prior to or upon his admission to the facility, it would have been appropriate for them to request a PASRR Level II review when he was diagnosed with schizoaffective disorder with hallucinations on 05/04/20.	F 644			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		8/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 656	<p>Continued From page 7</p> <p>under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to develop a comprehensive care plan for a pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident #182).</p> <p>The findings included:</p> <p>Resident #182 was admitted to the facility on 9/9/20 with diagnoses that included vascular dementia, fracture of the right femur, and the presence of an artificial right hip joint. Resident</p>	F 656	<ol style="list-style-type: none"> <li>1. Resident #182 discharged from the facility on 10/3/20.</li> <li>2. On 8/5/21, the DON completed an audit of four (4) with pressure wounds and validated that a comprehensive care plan was in place.</li> <li>3. On 7/27/21 and 8/10/21, the Regional CRC nurse provided education to the interdisciplinary team (MDS coordinator, Social Worker, Activities, Dietary Manager, DON, Medical Director or FNP, and direct-care nurse aide) on developing and implementing a comprehensive care</li> </ol>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 656	<p>Continued From page 8</p> <p>#182 was discharged to the community on 10/3/20.</p> <p>The document titled "Weekly Pressure Wound Observation Tool," dated 9/15/20 identified Resident #182 acquired a stage 3 pressure ulcer.</p> <p>The admission Minimum Data Set (MDS) dated 9/16/20 assessed Resident #182's cognition as being severely impaired and functional status as needing extensive assistance with bed mobility, transfers, and toilet use. The MDS skin conditions identified 1 stage 3 pressure ulcer that was not present upon admission. The Care Area Assessment (CAA) indicated Resident #182 was newly admitted from the hospital after a fall at home that resulted in a right hip fracture and received a partial hip replacement. Resident #182 required extensive assistance and now had a stage 3 pressure ulcer.</p> <p>Resident #182's care plan revealed there was no plan developed for the care of pressures ulcers.</p> <p>During an interview on 7/23/21 at 5:39 PM the MDS Coordinator stated her process was to do the care plan with the admission MDS assessment. She would review the CAA to see what triggered then develop the comprehensive care plan. The MDS Coordinator stated her process for Resident #182's care plan was interrupted but didn't recall the specifics. The MDS Coordinator also stated she thought Resident #182 was expected to discharge sooner from the facility.</p>	F 656	<p>plan within 7 days following completion of the comprehensive MDS assessment to include a resident specific plan of care for residents with pressure wounds. The MDS coordinator will continue to ensure residents with pressure wounds have a comprehensive care plan developed timely. Newly hired interdisciplinary team members will receive education upon hire.</p> <p>4. The DON or RN Supervisor will complete quality assurance monitoring for resident with pressure wounds to ensure a comprehensive care plan is developed and implemented timely. Monitoring will be completed weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with comprehensive care plans.</p> <p>5. This completion date is 8/10/2021</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 656	Continued From page 9	F 656			
F 657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p>	F 657		8/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 657	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to revise and update a care plan related to use of a splint device and palm protector for 1 of 1 sampled resident reviewed for limited range of motion (Resident #71).</p> <p>Findings included:</p> <p>Resident #71 was admitted to the facility on 02/01/13 with diagnoses that included Alzheimer's disease and contracture of muscles, multiple sites.</p> <p>Review of Resident #71's medical record revealed a physician's order dated 11/22/19 that read in part, "left hand finger separator and dark blue palm protector to be in place at all times except during bath and cleansing. Cover with sock to prevent resident from taking it off." The order was discontinued on 02/22/21 with the reason noted as "healed."</p> <p>The annual Minimum Data Set (MDS) dated 07/04/21 coded Resident #71 with severe cognitive impairment. The MDS noted she required extensive to total staff assistance with all Activities of Daily Living (ADL) and had impairment on both sides of upper and lower extremities.</p> <p>Review of Resident #71's active ADL Care Plan, last reviewed/revised July 2021, revealed she had an ADL self-care performance deficit related to dementia, contractures, and limited mobility with the goal her needs would be identified and met with staff's assistance and interventions. An</p>	F 657	<ol style="list-style-type: none"> <li>1. On 7/29/2021, the MDS coordinator updated Resident #71 care plan discontinued use of splint and finger separators and then on 8/10/20 got a new order for palm guard to left hand and the care plan was updated accordingly.</li> <li>2. On 8/5/2021, the DON completed an audit of residents with splints and palm guard orders to ensure care plans are in place as appropriate. 7 residents were identified for splints and care plans reviewed and revised as needed.</li> <li>3. On 7/27/21 and 8/10/21, the Regional CRC nurse and or Administrator provided education to the Interdisciplinary Team (MDS coordinator, Social Worker, Dietary Manager, Activities, Medical Director/FNP and direct-care nurse aide) on care plan timing and revision per RAI guidelines. The IDT will continue to update and revise car plans for residents with palm guards and braces. Newly hired IDT members will receive education during orientation. The interdisciplinary team will review in clinical morning meeting new orders or discontinued orders for splints/palm guards and that the MDS coordinator will update and revise the care plan to reflect the changes.</li> <li>4. The DON or RN Supervisor will complete quality assurance monitoring of residents with new or discontinued palm guards and splints for appropriate care plan revisions. Monitoring will be completed weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the</li> </ol>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(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 657	Continued From page 11 intervention added on 02/21/21 and revised on 05/07/21 read, "left hand finger separator and dark blue palm protector to be in place at all times except during bath and cleansing."  Observations conducted of Resident #71 on 07/19/21 at 10:46 AM, 07/20/21 at 9:37 AM and 07/21/21 at 8:35 AM revealed she had no palm guard or finger separator in place.  During an interview on 07/23/21 at 8:57 AM, the MDS Coordinator reviewed the physician's order dated 11/22/19 for Resident #71's palm guard and finger separator and confirmed it had been discontinued on 02/22/21. The MDS Coordinator stated she took her laptop to the morning clinical meetings so she could revise resident care plans when notified of new orders or interventions. She added the care plan should have been updated and intervention resolved when the order was discontinued on 02/22/21.  During an interview on 07/23/21 at 10:30 AM, the Director of Nursing (DON) explained Resident #79 developed an ulcer from wearing the finger protectors and palm guard; therefore, the order was discontinued on 02/22/21. The DON stated Resident #71's care plan should have been updated when the physician's order was discontinued on 02/22/21.	F 657	monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes as necessary to maintain compliance with care plan timing and revision.  5. The completion date is 8/10/2021		
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,	F 812		8/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 12</p> <p>state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to remove expired food from 1 of 1 walk-in coolers, failed to date nutritional supplements to identify their use by date, failed to maintain a sanitary milk cooler and failed to ensure the milk cooler was free of standing water for 1 of 1 milk cooler, failed to maintain a sanitary reach-in cooler for 1 of 1 reach-in cooler, failed to maintain a sanitary ice machine for 1 of 1 ice machine, failed to maintain sanitary nourishment room refrigerators for 2 of 2 nourishment refrigerators (200 hall nourishment refrigerator and 300 hall nourishment refrigerator), and failed to ensure food and beverages were labeled and dated for 2 of 2 nourishment refrigerators and freezers.</p> <p>Findings included:</p> <p>1. a. An initial observation of the walk-in cooler on 07/19/21 at 09:04 AM revealed a large pan of turkey casserole available for use with an expiration date of 07/18/21 and an opened bag of</p>	F 812	<p>1. On 7/23/21, the Dietary Manager properly disposed of identified expired, unlabeled food items and thoroughly cleaned kitchen coolers, ice machines and nourishment rooms to ensure sanitary food procurement, storage, preparation and service to residents.</p> <p>2. On 8/9/2021, the Administrator completed an audit of the kitchen and nourishment rooms to ensure sanitary food procurement, storage, preparation and services. Identified concerns addressed as identified.</p> <p>3. On 8/5/2021, the Dietary Manager completed education to dietary staff on food procurement, storage, preparation and sanitary service of food and nutrition items. Education included the responsibility of the dietary staff to monitor kitchen and nourishment rooms daily and to follow cleaning schedule. The Dietary Manager will monitor completion of Manager's Daily Checklist and cleaning</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 13</p> <p>shredded carrots with an opened date of 06/21/21. The carrots appeared brown and mushy.</p> <p>An interview with the Dietary Manager on 07/19/21 at 09:04 AM revealed the turkey casserole should have been used or discarded by 07/18/21. The Dietary Manager stated the shredded carrots were good for 30 days after opening but should have been discarded due to signs of spoilage.</p> <p>b. An observation of the reach-in cooler on 07/19/21 at 09:10 AM revealed 53 thawed and undated nutritional supplements.</p> <p>An interview with the Dietary Manager on 07/19/21 at 09:10 AM revealed the nutritional supplements should have been dated when they were placed in the cooler to thaw and he was not sure when the nutritional supplements were placed in the cooler. He stated the nutritional supplements were good for 14 days from the time they were placed in the cooler.</p> <p>c. An observation of the reach-in cooler on 07/19/21 at 09:10 AM revealed a black substance easily removable with a paper towel to the inside of both cooler doors and dried substances to the cooler vent at the bottom of the cooler.</p> <p>An interview with the Dietary Manager on 07/19/21 at 09:10 AM revealed the inside and outside of the reach-in cooler was supposed to be cleaned monthly and had probably been cleaned at the beginning of the month. He confirmed the cooler should be free of black substances and dried debris.</p>	F 812	<p>schedules (including the ice machine)for compliance. Newly hired dietary staff will receive education upon hire.</p> <p>4. The Administrator will complete quality assurance monitoring of the kitchen and nourishment rooms for compliance. Monitoring will be completed two (2) times weekly for four (4) weeks, then weekly for four (4) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with the food sanitation.</p> <p>5. The completion date is 8/10/2021</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 14</p> <p>d. An observation of the ice machine on 07/19/21 at 09:13 AM revealed a black substance easily removable with a paper towel and dried debris to 3 sides of the machine.</p> <p>An interview with the Dietary Manager on 07/19/21 at 09:13 AM revealed he thought maintenance cleaned the inside and outside of the ice machine but he wasn't sure. He stated since he began employment at the facility in April 2021 the ice machine had not been cleaned by dietary staff.</p> <p>An interview with the Maintenance Director on 07/21/21 at 02:43 PM revealed maintenance had been responsible for cleaning the ice machine in the past but kitchen staff were currently responsible for cleaning the inside and outside of the ice machine. He stated he could not remember the exact date the kitchen staff began to be responsible for cleaning the ice machine but it was not a new change.</p> <p>e. An observation of the milk cooler on 07/19/21 at 09:19 AM revealed dried debris to the outside of the cooler, approximately a half inch of standing water in the bottom of the cooler, and a black substance easily removable with a cloth to all seals on the milk cooler door. There were 7 plastic bins of milk in the cooler that were not in direct contact with the standing water.</p> <p>An interview with the Dietary Manager on 07/19/21 at 09:19 AM revealed the inside and outside of the milk cooler were wiped down each Tuesday and a wet/dry vacuum was used weekly to drain the standing water out of the cooler. He explained he felt the standing water in the milk cooler was due to condensation accumulating</p>	F 812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 15</p> <p>and no drain plug to let the water out. The Dietary Manager stated he had been employed in the kitchen since April 2021 and the milk cooler had standing water in it periodically since that time. He stated he was going to check with maintenance to see if a drain plug could be installed but he had not had a chance to speak with the maintenance department yet.</p> <p>2. a. An observation of the 300 hall nourishment room refrigerator on 07/19/21 at 09:56 PM revealed a dried orange substance at the bottom of the refrigerator.</p> <p>b. An observation of the 200 hall nourishment room freezer on 07/19/21 at 02:52 PM revealed an undated and unlabeled ice cream bar and an opened 10 pound bag of ice stuck in a yellow substance in the freezer.</p> <p>c. An observation of the 200 hall nourishment room refrigerator on 07/19/21 at 02:56 PM revealed 2 opened and unlabeled and undated containers of mayonnaise, an opened and unlabeled and undated bottle of salad dressing, an unlabeled and undated jar of pickle relish, an unlabeled and undated bottle of sports drink, an opened and undated and unlabeled bottle of cranberry juice, an unlabeled and undated soft drink, an unlabeled and undated energy drink, an opened bag of unlabeled and undated cherries, and a thawed and undated nutritional supplement. A dried sticky substance was noted in the bottom of the refrigerator.</p> <p>An interview with Cook #1 on 07/19/21 at 02:56 PM revealed the cleaning of the nourishment room refrigerators and freezers, labeling and dating food items, and discarding unlabeled and</p>	F 812			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 16</p> <p>undated food items was a joint effort between dietary and nursing staff. She stated she checked the nourishment room refrigerators and freezers once a day for expired and unlabeled and undated food items, but she was not working 07/18/21 and didn't know when dietary had last checked the nourishment room refrigerators.</p> <p>An interview with the Dietary Manager on 07/20/21 at 08:13 AM revealed dietary was responsible for cleaning nourishment room refrigerators and freezers and discarding expired or unlabeled or undated food. He stated the dietary staff member who delivered snacks to the nourishment room refrigerators should be checking for undated and unlabeled food and discarding them if appropriate. The Dietary Manager further stated if a staff member from dietary or nursing noticed a spill in either of the nourishment room refrigerators or freezers, he would expect them to clean up the mess. He stated nursing staff should be labeling and dating food when they placed the food item in the refrigerator or freezer.</p> <p>d. An observation of the 200 hall nourishment room refrigerator on 07/21/21 at 08:03 AM revealed 2 unlabeled, unopened, and undated bottles of water and an unlabeled energy drink in the door of the refrigerator. A dried red substance was noted inside the door and inside the bottom of the refrigerator. An observation of the 200 hall nourishment freezer at the same date and time revealed 3 unlabeled, unopened, and undated bottles of water and an unlabeled and undated ice cream sandwich.</p> <p>e. An observation of the ice machine on 07/21/21 at 08:53 AM revealed a black substance easily</p>	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>ACCORDIUS HEALTH AT HENDERSONVILLE LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE CIRCLE</b> <b>HENDERSONVILLE, NC 28791</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 17</p> <p>removable with a paper towel and dried debris remained on 3 sides of the machine.</p> <p>f. An observation of the 300 hall nourishment room refrigerator on 07/22/21 at 08:08 AM revealed an open unlabeled and undated container of pimiento cheese, and an unlabeled container of yogurt.</p> <p>An interview with the Unit Manager on 07//22/21 at 01:55 PM revealed the dietary department was responsible for cleaning the nourishment room refrigerators and freezers and discarding unlabeled and undated items or expired food items. She stated if nursing staff placed items in the refrigerator or freezer they were expected to label and date the item.</p> <p>An interview with the Administrator on 07/22/21 at 02:32 PM revealed the dietary department was responsible for cleaning nourishment room refrigerators and freezers, checking for unlabeled or undated food items, and discarding expired items. She stated she expected food in the facility kitchen to be used or discarded before the expiration date. The Administrator stated she was aware of one instance of standing water in the milk cooler but did not realize it was an ongoing problem. She stated the standing water in the milk cooler being an ongoing problem should have been reported to herself or maintenance for repair. The Administrator stated the kitchen was responsible for keeping up with cleaning the inside and outside of the ice machine but she was unsure how often the ice machine needed to be cleaned.</p>	F 812			