PRINTED: 09/07/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C
NAME OF B	201/1252 02 01/221/52	345126	D. WING			08/	10/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	VILLE			20 VALLEY STREET		
				5	STATESVILLE, NC 28677		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGOLATORI GIVE	100 IDENTIFY TING INFORMATION)	IAG		DEFICIENCY)	\\L	
E 000	Initial Comments			000			
⊏ 000	initial Comments		-	UUU			
		VID-19 Focused Survey					
		03/22 through 08/05/22.					
		was obtained through					
		ne exit date was changed to					
		vas found in compliance					
	_	related to E-0024 (b)(6),					
		ents for Long Term Care					
E 000	Facilities. Event ID#			000			
F 000	INITIAL COMMENTS		F (	000			
		VID-19 Focused Infection					
		omplaint investigation were					
		22 with exit from the facility					
		al information was obtained					
		e, the exit date was changed					
	-	y was found in compliance					
		infection control regulations					
	Disease Control and	I the CMS and Centers for					
	recommended practic	` ,					
	COVID-19. There we	• •					
		the 14 were substantiated					
		the 14 was substantiated					
	without citation. Imm						
	identified at:	- 1 ,					
	CFR 483.25 at F684	at a scope and severity (K)					
	CFR 483.55 at F791	at a scope and severity (K)					
	CFR 483.70 at F835	at a scope and severity (K)					
		ited Substandard Quality of					
	Care.						
	Immodiata Icanardi	hogan on 10/12/21 and it is					
		began on 10/12/21 and it is					
E 505	ongoing.			E0F			0/15/22
F 585	Grievances CFR(s): 483.10(j)(1)-(	(4)	F:	585			8/15/22
A DODATODY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITI F		(X6) DATE

08/14/2022

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 08/10/2022
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 585	Continued From pag	ge 1	F 58	85	
	grievances to the farthat hears grievance reprisal and without reprisal. Such grievarespect to care and furnished as well as furnished, the behavesidents, and other facility stay.  §483.10(j)(2) The refacility must make presolve grievances to accordance with this §483.10(j)(3) The farefacility must make presolve grievances to the resident.  §483.10(j)(4) The farefacility agrievance policy to expect to the resident.  §483.10(j)(4) The farefacility agrievances regulated in this pareformation provider must give at the tesident. The include:  (i) Notifying resident postings in prominer facility of the right to (meaning spoken) of grievances anonymous of the grievance offician be filed, that is, address (mailing and	sident has the right to voice cility or other agency or entity es without discrimination or fear of discrimination or ances include those with treatment which has been that which has not been vior of staff and of other concerns regarding their LTC sident has the right to and the rompt efforts by the facility to he resident may have, in			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345128	B. WING			08/	10/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	/ILLE		52	TREET ADDRESS, CITY, STATE, ZIP CODE  20 VALLEY STREET  TATESVILLE, NC 28677		
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F 585	to obtain a written degrievance; and the coindependent entities to be filed, that is, the polyality Improvement Agency and State Looprogram or protection (ii) Identifying a Griev responsible for oversor receiving and tracking conclusions; leading by the facility; maintainformation associate example, the identity grievances submitted written grievance decoordinating with state necessary in light of so (iii) As necessary, take prevent further potentify the alleged investigated; (iv) Consistent with Screporting all alleged vabuse, including injuriand/or misappropriation anyone furnishing seleprovider, to the admir as required by State I (v) Ensuring that all winclude the date the grant of the steps taken to invisuomary of the pertir regarding the resident as to whether the grief	of the grievance; the right cision regarding his or her contact information of with whom grievances may be trinent State agency, Organization, State Survey and Term Care Ombudsman and advocacy system; ance Official who is beeing the grievance process, and grievances through to their any necessary investigations in the confidentiality of all divith grievances, for of the resident for those anonymously, issuing isions to the resident; and the and federal agencies as specific allegations; ing immediate action to the individual of the diviolation is being the sident property, by the confident property, by the confident of the nistrator of the provider; and	F	585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		345128	B. WING			C 8/10/2022
NAME OF PE	ROVIDER OR SUPPLIER	0.0.20		STREET ADDRESS, CITY, STATE, ZIP COD		0/10/2022
	101.02.1 01.1 00.1 2.2.1			520 VALLEY STREET	_	
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 585	Continued From page	e 3	F 5	85		
	taken by the facility a and the date the writt (vi) Taking appropriat accordance with Stat of the residents' right or if an outside entity the State Survey Age Organization, or loca confirms a violation for rights within its area of (vii) Maintaining evidence and years from the issurdecision.	s a result of the grievance, ten decision was issued; te corrective action in e law if the alleged violation is is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents'				
	family and staff interviprovide written responsive grievances for 2 of 2 grievances (Resident A review of the facility "Resident and Family 11/01/20 indicated a the facility must make facility to resolve griethave, in accordance document also indicate the made to resolve appossible. The Grieval provide the resident a written notification if a required to conduct a investigation. The resurritten summary of the	residents reviewed for a #1 and Resident #2).  y's grievance policy title or Grievances" implemented resident has the right to, and exprompt efforts by the evances the resident may with this paragraph. The sted the following: Efforts will all grievances as quickly as noce Officer, or designee, will and/or responsible party a paragraph and equitable sident will be provided a ne resolution and every effort de the summary within 48 expressions.		1. Corrective actions for afferesidents. On August 5, 2022 Nurse Consultant spoke with Member #1 to inform of Residental appointment for August 7:00 am. Family Member # accompany Resident #1 to he August 5, 2022, the Regional Consultant spoke with Residesister and informed her of Reappointment on August 16, 20 pm.  2. Corrective action for pote affected residents. On August the Administrator audited gried July 2022 to current to ensure and notification. All grievance resolved and proper notification provided.  3. Systemic Changes. On A 2022, the Director of Nursing/	the Reginal Family lent #1 t 23, 2022, 1 will er appt. On Nurse ent #2's sident #2's 22, at 2:00 entially t 12, 2022, vances from er resolution s have been on has been	

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			A. BOILDI	NG _		1	С	
		345128	B. WING				/10/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
400000		\m.i.=		52	20 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		s	TATESVILLE, NC 28677			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 585	Continued From page	e 4	F	585				
		nas received a written			Director of Nursing/Unit Managers beg	ıan		
		aintained with the grievance.			in-servicing all staff on the Resident ar			
		esident will receive a verbal,			Family Grievance policy. On August 1			
		ten response within 5			2022, the Regional Director of Operati			
		otified if the investigation			educated the Administrator and			
	required more time.	_			Department Heads regarding written			
	-				acknowledgment of grievance resolution	on		
	The findings included	<b>i</b> :			by residents and verbal notification for			
					non-residents. The education consiste	d of		
	1.Resident #1 was re	e-admitted to the facility on			documenting how the resolution was			
	07/09/21.				provided on the grievance form, in			
					addition to, the grievance log. The			
		Data Set (MDS) dated			Administrator/Director of Nursing/Socia	al		
		sident #1 was cognitively			Services Director will ensure when a			
	intact.				grievance is communicated, it is then			
					logged in the grievance book for tracki	-		
	_	y Administrator #1 was filed			purposes. The Administrator/Director	)Ť		
		dent #1's family regarding her			Nursing/Social Services Director will			
		stated findings include			communicate any outstanding grievan			
		an appointment scheduled.			from the log during morning meeting to	)		
		led for the grievance was an neduled on 08/23/22 for a			ensure resolution notification has occurred and is documented. The			
		extractions with intravenous			Administrator/Director of Nursing will			
		ral surgeon. The grievance			ensure all Department heads, to include	łe		
	was signed as compl				agency, who has not received this	.5		
	Administrator #1.	1722722 By			education by August 14, 2022, will not	be		
					allowed to work until education is	-		
	An interview was con	nducted with the Regional			complete. Any newly hired Departmen	t		
		08/04/22 at 2:50 PM. The			Head will receive education during fac			
		ne had been made aware			orientation in-person or via telephone	-		
	with delays regarding	g Resident #1's dental care.			to working.			
		owledge an appointment had			4. Quality Assurance. The			
	been made for 08/23	/22 as a result of a			Administrator/Director of Nursing will			
	_	he current Administrator by			monitor grievance written resolution			
	-	on 07/14/22. However, she			notification using a Quality Assurance			
		edge of delays in dental care			for Resident and Family grievance. Th			
	at that time.				monitoring will audit Resident and Fan	-		
					grievances written resolution notification			
	An interview was con	ducted via phone with the	1		on the individual arievance and arieva	nce	1	

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F 585	current Administrator The interview revea Resident #1's family (date unknown). The she discussed with regarding unresolve Resident #1's denta Administrator expre upset and angry the addressed.  An interview was con Family Member #1 The interview reveal unresolved concern dental hygiene. FM follow-up to the grie notify FM #1 of a so and time.  Interviews with Adm without success.  2. Resident #2 was 04/14/16.  A quarterly Minimum 07/25/21 revealed F cognitively impaired A grievance was file revealed he would I investigation finding contacted a local or an appointment for extractions under se informed the previous accommodate residents.	or on 08/04/22 at 5:10 PM.  Iled she recalled speaking to a during a visit in the facility ecurrent Administrator stated Resident #1's family member and concerns voiced about all status. The current seed the family was very exissue had not been conducted via phone with (FM) on 08/05/22 at 8:34 AM.  Iled FM #1 had significant is regarding Resident #1's in the contacted to sheduled appointment date.  In Data Set (MDS) dated Resident #2 was mildly	F 585	log. The QA monitoring will be conweekly times twelve weeks. The Administrator/Director of Nursing veport the results of the QA monitor the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revises. The date of compliance is 8/1	vill ring to e r ion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C <b>08/10/2022</b>		
	ROVIDER OR SUPPLIER  US HEALTH AT STATES		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			, 55.75.25		
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F 585	Continued From pag	e 6	F 5	585				
	surgery was unable to procedure and the farmonth (April).	to accommodate the cility was to check back next						
	on behalf of Residen with the facility at the concern revealed the expressed concerns was told would be inheard from the facilit The concern listed R with questions to incite dentist and told the extracted and went to previously who had to remove the teeth who and no staff member The resolution include Social Work Director Resident #2's family when it comes to his Resident #2 required	a few months prior that she vestigated, but she had not y regarding the concerns. esident #2's dental status ude- had he been seen by hat the teeth needed to be to the oral surgeons' office old him they could not lie he was in the wheelchair was present to transfer him. led: a phone call made by the and message left for member which indicated						
	Nurse Consultant on interview revealed sh with delays regarding She stated to her knobeen made seconda office were no longer	nducted with the Regional 08/04/22 at 2:50 PM. The ne had been made aware g Resident #2's dental care. by						
	current Administrator	nducted via phone with the on 08/04/22 at 5:10 PM. ed she recalled being made						

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F 585	however, she had be surgeons would not source and therefore extracted under IV s	2's poor oral dentation; een told the local oral accept Resident #2's payor e could not have his teeth	F 58	5		
F 641 SS=E	§483.20(g) Accuracy The assessment muresident's status. This REQUIREMEN by: Based on observation resident and staff into accurately code the 2 of 2 resident's revi (Resident #1 and Resident #1 and Resident #1 and Resident #1 was 07/09/21 with diagnodiabetes.  A provider note date revealed Resident # dentition with multiple An Annual MDS date #1 to be cognitively obvious or likely cave.  An interview with ME	of Assessments. st accurately reflect the T is not met as evidenced on, record reviews, and erviews, the facility failed to Minimum Data Set (MDS) for ewed for dental services esident #2).  The admitted to the facility on osis that included anemia and do 3/16/22 written by NP #3 to continued to have poor e broken teeth.  The add 4/22/22 revealed Resident intact and without any ities or broken natural teeth.	F 64	F641- Accuracy of Assessments  1. On August 5, 2022, Resident #2 Annual Minimum Data Set (MDS) assessment dated 1/23/22 Section L Question L0200D has been modified t correctly code broken teeth and denta caries. The Modified Annual MDS assessment has since been complete transmitted and accepted on. On August 5, 2022, Resident #1 Annu MDS assessment dated 4/22/22 Secti Question L0200D has been modified t correctly code broken teeth and denta caries The Modified Annual MDS assessment has since been complete transmitted and accepted. 2. On August 8, 2022, the Regional Clinical Reimbursement Consultant (C and Minimum Data Set nurses audited section L on the MDS for all current Residents identified with broken teeth	I d, al on L o I d,	

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PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
status section of Residated 4/22/22 and had status inaccurately. Status section of Residated 1/23/22 and had status section of Residated 1/23/24 and had status section of Residated 1/	e had completed the oral dent #1's Annual MDS d documented her oral he explained she had not sessment or reviewed I record.  Regional Reimbursement acted on 08/05/22 at 10:45 realed he expected all ed accurately and the MDS the medical record before in the MDS.  Idmitted to the facility on sis that included hemiplegia actic intracerebral the right dominant side.  Id 1/19/22 written by the MD had requested he be ue to his teeth breaking and coted; however, the dentist eviously could not offer him aftered. It further indicated in the indicated in	F 64	dental caries for accurate coding dental status. Six residents were with incorrect coding of section I MDS. On August 8, 2022, the Re CRC and MDS nurses corrected and resubmitted.  3. On August 12, 2022, the Re Clinical Reimbursement Consult educated Minimum Data Set (MDS) R the Resident Assessment Instrumanual on coding of Section L D Status. Any newly hired MDS nureceive education during facility orientation in-person or via telep to working.  4. Quality Assurance. The Administrator/Director of Nursing monitor using a Quality Assurance MDS Accuracy related to dental The QA monitoring of five reside section L, Dental Status weekly weeks, four residents weekly weeks, four residents weekly weeks. The Administrator/Direct Nursing will report the results of monitoring monthly to the Quality Assurance Performance Improve (QAPI) committee for continued compliance and/or revision.  5. The date of compliance is 8	e noted L on their egional d the MDS egional tant DS) LPN RN from ment Dental urse will chone prior g will ce tool for services. ents MDS x 4 4 weeks, x 4 tor of the QA y ement		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	VIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE S20 VALLEY STREET STATESVILLE, NC 28677	1 06/	10/2022
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F 656 SS=E C Sin care	desident #2's medical in interview with the consultant was conducted. In The interview revides to be completed for the commenting answers develop/Implement CFR(s): 483.21(b)(1)  483.21(b) Comprehed 483.21(b)(1) The factor of the complement a comprehed are plan for each respectives and timefrated in the complete session of the complement. The complement are identified in the complement are identified in the complement are identified in the complement. The complement are identified in the complement are identified in the complement. The complement in the resident in the	Regional Reimbursement acted on 08/05/22 at 10:45 realed he expected all ad accurately and the MDS the medical record before in the MDS. omprehensive Care Plan ensive Care Plan ensive person-centered defent, consistent with the hat §483.10(c)(2) and cludes measurable ense to meet a resident's mental and psychosocial ed in the comprehensive care plan must entered e		641			8/15/22

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			A. BOILDI	_	<del></del>	، ا	С
		345128	B. WING				10/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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ACCORDI	US REALIR AT STATES	VILLE		S	TATESVILLE, NC 28677		
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F 656	Continued From page (iv)In consultation with resident's representation (A) The resident's good desired outcomes. (B) The resident's profuture discharge. Fact whether the resident's community was assellocal contact agencies entities, for this purpour (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation and staff interviews, comprehensive personal staff interviews, comprehensive personal staff interviews and staff interviews. Resident #2). The factorie plan to include the care plan	th the resident and the ative(s)- als for admission and beference and potential for collities must document be desire to return to the assed and any referrals to be and/or other appropriate bese. In the comprehensive care in accordance with the hain paragraph (c) of this for its not met as evidenced and the facility failed to develop a con-centered care plan for with multiple broken irregularly and collity also failed to develop a con-centered care plan for with multiple broken irregularly and collity also failed to develop a con-centered care plan for with multiple broken irregularly and collity also failed to develop a con-centered (Resident #1 and collity also failed to develop a con-centered (Resident #1).		656		sive L ken en On ted	DAIE
	A dentist note dated #2 was examined an 3, 5, 13, 16, 17-19, 2 root tips to teeth # 2, teeth # 6-8, 11, 25 ar	3/10/21 indicated Resident d he was missing teeth #1, 9 and #32. He had visible 9, 10, 12-14, 30 and 31 and and 26 were non-restorable.			Reimbursement Consultant modified the Annual MDS assessment dated 4-22-2 for Resident #1 Section L Question L0200D to correctly code broken teeth and dental caries. The Modified Annual MDS assessment has since been completed, transmitted and On August 2022, the MDS Nurse undated Reside	2 I 5,	

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NAME OF FI	NOVIDER OR SUFFLIER							
ACCORDI	US HEALTH AT STATE	SVILLE			20 VALLEY STREET			
				S	STATESVILLE, NC 28677			
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F 656	Continued From pa	nge 11	F	656				
	·	eversible pulpitis and			#1's care plan to include false allegation	ns		
		nal note on 2/24/21 that said			delusions and attention seeking	.,,		
		oken a tooth and the area was			behaviors.			
	**	ns. The note further detailed			Resident #1 allegation of sexual assau	ılt		
		ained of pain and cutting his lip			from 11/8/21 was investigated and fou			
		ooth #6 and requested a full			to be unsubstantiated.			
		ith an oral surgeon so he can			2. On August 8, 2022, the Regional			
		ent #2 requested full mouth			Clinical Reimbursement Consultant an	d		
	upper and lower de	entures following extractions.			MDS Nurses conducted an audit of all			
	An oral surgery refe	erral was left with the Director			current residents identified with broker	i		
	of Nursing.				teeth, dental caries, and dental issues			
					care plans in place. Thirty-one resider	nt		
	A provider note writ			care plans were updated to address				
		1D) indicated an oral			dental issues. On August 13, 2022, the			
		vealed Resident #2 had poor			Administrator audited allegations over	the		
		nultiple broken teeth and			past 12 months that were found to be			
	multiple dental cari	es.			unsubstantiated due to behaviors			
	A dontist note date	d 10/12/21 indicated Resident			including delusions and false allegation to ensure the presence of a behavior of			
		teeth #2, 9, 10, 12, 13, 14, 30			plan. Three resident allegations which			
		2 had non-restorable teeth			were unsubstantiated were noted and			
		6. He had visual heavy plaque,			residents care plans reviewed to ensur	re		
		nmation. Resident #2 was			appropriate behaviors documented.	•		
	· ·	or a routine oral exam which			3. On August 5, 2022, the Regional			
	revealed had an ab	scess to tooth #3.			Clinical Reimbursement Consultant			
					re-educated the Minimum Data Set (M	DS)		
	A provider noted da	ated 1/19/22 written by the MD			Nurses from the Resident Assessment	•		
		#2 had requested he be			Instrument manual on Coding of Section	on L		
	·	/ due to his teeth breaking and			Dental Status and updating care plans			
	would like them ext	racted.			On August 13, 2022, the Regional Dire			
					of Operations educated the Administra			
		ted 1/23/22 revealed Resident			on reviewing care plans for residents v	vith		
	, ,	nitively impaired and without			unsubstantiated allegations due to			
		y cavities or broken natural			behaviors including delusional thought	S		
	teeth.				and false allegations.			
	D : 1 ( "C'				4. Quality Assurance. The			
		orehensive care plan did not			Administrator/MDS Nurse/Designee w			
	include oral care co	oncerns.			monitor using a Quality Assurance too			
					Care Plan development related to den	(al		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _	B. WING		08/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	V.V.20		ST	REET ADDRESS, CITY, STATE, ZIP CODE	00	110/2022
				52	0 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 12	F 6	56			
F 030	An interview with MD conducted on 08/05/2 interview revealed sh status section of Residated 1/23/22 and ha status inaccurately ar prompted to develop Resident #2.  An interview with the Consultant was cond AM. The interview revesidents to have a corperson-centered care should have had an order of the consultant was 07/09/21 with diagnost and diabetes.  A provider note dated indicated Resident #1 that date due to swell tooth infection. The n #1's left cheek and ja  A dental hygienist not Resident #1 was see facial pain, discomfor The note further indicated the facial pain and the facial pai	S Coordinator was 22 at 10:30 AM. The e had completed the oral ident #2's Annual MDS d documented his oral nd therefore she was not an oral care plan for  Regional Reimbursement ucted on 08/05/22 at 10:45 yealed he expected all omprehensive e plan and Resident #2 oral care plan.  Te-admitted to the facility on ses that included anemia  1 10/21/21 written by NP #1 I was seen for a sick visit on ing of the face related to a ote also indicated Resident we were noticeably swollen.  Te dated 11/02/21 indicated in in-house for mouth or t, or difficulty with chewing ated Resident #1 had fractured teeth including 20, 25 and 31. Resident #1 on-restorable teeth extracted	F 6	56	issues and delusional thoughts and/or behaviors. The QA monitoring of five residents care plan for dental issues weekly x 4 weeks, four residents week 4 weeks, and then three residents week x 4 weeks.  The Administrator will audit all resident with allegations that are found to be unsubstantiated due to behaviors including delusional thoughts and accusations for the presence of a behavior care plan weekly x 12 weeks. The Administrator/Director of Nursing report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.  5. The date of compliance is 8/15/22	ly x ekly :s will	
	#1 was seen in the fa						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C <b>08/10/2022</b>	
	ROVIDER OR SUPPLIER	VILLE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 656	#24 and heavy calcific Recommendations we maintain oral hygiener and extractions of all to be extracted. Staff to access the internet therefore the dentist of x-rays at the time of the therefore the dentist of x-rays at the time of the therefore the dentist of x-rays at the time of the therefore the dentist of x-rays at the time of the therefore the dentist of x-rays at the time of the therefore the dentist of the time of the therefore the dentist of the time of the therefore the dentist of the time of time of the time of the time of the time of time of the time of time of the time of the time of time of the time of time of the time of time o	es to tooth #21, 22, 23 and cation located in the mouth. ere made that Resident #1 and be referred for x-rays teeth as all root tips needed indicated they were unable to obtain results and was unable to perform dental he visit.  d 4/2/22 indicated Resident not examined, but all areas abnormalities  ethensive care plan did not cerns.  4/11/22 indicated Resident n-house dental who the #1 had expressed she had weeks ago. It further nation of Resident #1's not antibiotic was ordered ure building up similar in the thad when the previous d. It also mentioned were all decayed or root tips removed by an oral surgeon. On 04/11/22.  S Coordinator was 22 at 10:30 AM. The ehad completed the oral ident #1's Annual MDS documented her oral status refore it did not trigger her to re MDS Coordinator	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345128		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			08/10/2022		
	ROVIDER OR SUPPLIER	SVILLE		STREET ADDRESS, CITY, STATE, ZIP C 520 VALLEY STREET STATESVILLE, NC 28677	CODE	00/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO 1  DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 656	plan for Resident #1  An interview with the Consultant was cond AM. The interview reresidents to have a deperson-centered car should have had an 2b. Resident #1 was 07/09/21 with diagnod depression and schill The quarterly Minimassessment dated 1 made herself undersintact. There were not MDS.  A review of the Phys 11/08/21 revealed R allegation of sexual and An interview was conditionally be a conditionally after the all was made which reviolation. The MD standers and thoughts are lated to her diagnor of A review of Resident 04/05/22 revealed the developed to address thoughts and or accelerated.	Regional Reimbursement ducted on 08/05/22 at 10:45 evealed he expected all comprehensive e plan and Resident #1 oral care plan.  admitted to the facility on oses that included anxiety, zophrenia.  The Data Set (MDS) 0/03/21 revealed Resident #1 stood and was cognitively to behaviors noted on the desident #1 made an assault.  Inducted with the Medical 05/22 at 4:30 PM who examined Resident #1 on legation of sexual assault ealed no indication of sexual ated she felt the Resident's of the sexual nature were osis of schizophrenia.  It #1's care plan revised dere was no care plan is the Resident's delusional usations.	F	656				
	_	conducted with the Minimum r (MDSC) #1 on 08/05/22 at						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	COMPLETED
345128 B. WING	С
	08/10/2022
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP O	CODE
ACCORDIUS HEALTH AT STATESVILLE	
STATESVILLE, NC 28677	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF	F CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT	DATE.
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIENCE	IIILAI I NOI NIAIL
	,
F 656 Continued From page 15	
6:30 PM the MDSC explained that she	
remembered the sexual assault accusation made	
by Resident #1 in November 2021 because she	
had to interview the Resident about the event.	
The MDSC indicated that even though the	
Resident's delusional behavior was	
unsubstantiated, a care plan should have been	
developed but she must have overlooked it.	
During an interview with the Director of Nursing	
(DON) on 08/05/22 at 6:35 PM the DON	
explained that on 11/08/21 Resident #1 made an	
accusation of sexual assault against a male	
nurse aide which was investigated by the facility	
and found to be unsubstantiated. The DON stated	
the decision to care plan the Resident's	
delusional behavior should have been discussed	
by the interdisciplinary team but her personal	
opinion was that the delusional behavior should	
have been care planned so that everyone would	
by aware of and report the behavior.	
An interview was conducted with the Regional	
Director of Operations and the Vice President of	
Regulatory Services (VPRS) on 08/05/22 at 6:40	
PM. The VPRS explained that she did not expect	
the Resident's delusional accusations to be care	
planned because she felt it would deter the staff	
from reporting her behaviors.	
F 684 Quality of Care F 684	8/15/22
SS=K CFR(s): 483.25	
§ 483.25 Quality of care	
Quality of care is a fundamental principle that	
applies to all treatment and care provided to	
facility residents. Based on the comprehensive	
assessment of a resident, the facility must ensure	
that residents receive treatment and care in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 08/10/2022	
NAME OF PE	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2022
					20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
040.45	CUMMADVCT	ATEMENT OF DEFICIENCIES	<u></u>	_	·		0(5)
(X4) ID PREFIX TAG			ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 16	F 6	684			
	accordance with profe	essional standards of					
		nensive person-centered					
	care plan, and the res						
	This REQUIREMENT	「 is not met as evidenced					
	by:						
		ns, record reviews and Practitioner (NP), and			F 684- Quality of Care- Dental Service	:S	
		interviews, the facility failed			1. Resident #1 has broken and deca	ved	
		vell- being by not providing			teeth with recurrent pain and abscess	,	
		prevent oral abscesses and			requiring an oral surgeon for extraction	١.	
	unresolved dental pa				The resident's spouse met with the		
	(Resident #1 and Resident #2). Resident #1 was				current Administrator regarding dental		
	seen by NP #1 on 10	/21/21 and was prescribed			services and an appointment was mad	е	
	antibiotics for a tooth	abscess and a STAT			for 8/23/22 for the oral surgeon.		
	(without delay) denta	l appointment for the					
	abscess was request	ed. Resident #1 reported a			Resident #2 has broken, decayed teeth	1	
		m 7-10 from 10/21/21			with recurrent pain, abscess and troub	e	
		sident #1 was not seen until			eating. On 8/4/22 the Regional Nurse		
		dentist at the facility on			Consultant scheduled an appointment		
		e a recommendation was			with the oral surgeon on 8/16/22.		
		r the extraction of all teeth				_	
	-	nt #1 was seen by the dentist			On 8/7/22 Resident #1 and Resident #		
		ted pressure similar to when			were assessed by the Nurse Manager		
	=	ad occurred. Resident #1			have no complaint of oral pain and are		
	=	ntibiotic for the abscess and			able to eat their current diet without		
		ranging from 8-10 from			difficulty or pain. Nutritional status is	اما	
		5/22. Resident #2 was seen			being monitored during the daily Clinica	al	
	•	by the dentist at the facility prescribed antibiotics for an			meeting and weekly Risk meeting.		
		a recommendation was			2. By 8/7/22 the Nurse Managers		
	given for a referral for				completed an audit of current residents	e to	
	•	ident #2 reported a pain			identify those with complaints of dental		
	~	of 1-10 (10 being the worst			pain. This audit included an observatio		
		efore and while the abscess			the oral cavity for abnormalities of the	5.	
		dentist note dated 6/14/22			teeth, redness, odor, or signs and		
	•	2 had swelling around a tooth			symptoms of infection. The Physician	ĺ	
		nmation but not currently an			was notified of any abnormalities and r	new	
		2 reported a pain level of 7			orders for treatments and interventions		
		er this visit from the dentist.			including pain management and dietar		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING			С	
NAME OF D	201/1050 00 01 1001 150	343120	B: Wilte		TREET ADDRESS SITV STATE ZID SODE	08/	10/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT STATES	/ILLE			20 VALLEY STREET		
				S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE			
F 684	684 Continued From page 17		F	684			
F 684	Resident #1's appoint not scheduled until 07 Resident #2's dental a on 8/4/22 (after the standard paint facility failed to obtain Resident #2 for the exteeth. Immediate jeorongoing.  Findings included:  1. Resident #1 was re 07/09/21 with diagnost and diabetes.  A quarterly Minimum 10/3/21 revealed Resident Lit further reveareceived pain medical limited her day-to-day pain rating it as mild a of opioid medications.  A nurse note, written revealed Resident #1 pain and her left lower to the touch. It also in the MD book (a communication of the standard point paint pain and the left lower to the MD book (a communication).	tment for extractions was 7/21/22 for 08/23/22 and appointment was scheduled curvey began) for 8/16/22.  began on 10/12/21 when the dental services for extraction of all remaining pardy is present and  be-admitted to the facility on sees that included anemia  Data Set (MDS) dated ident #1 was cognitively led Resident #1 had tions; however, it had not activities as a result of the and she had received 4 days for pain management.  by Nurse #2, dated 10/20/21 had complained of tooth r jaw was swollen and warm dicated: A note was left in nunication binder where	F	684	consults implemented. On 8/7/22, additional residents were identified who required dental follow up. On 8/11/22, Director of Nursing confirmed the next scheduled on-site dental clinic with Aria Dental on 8/16/22.  3. On 8/7/22, the Nurse Managers completed re-education of the Licensed Nurses including agency staff, to complete oral cavity observations for reswollen gums, odor, and/or other teeth abnormalities on admission, during routine care, and with residents that complain of mouth pain. Issues identified by the Licensed Nurse and Nurse Aide be reported to the Nurse Manager. The Physician will be notified by the Licensed Nurse and/or the Nurse Manager of an abnormalities and new orders for treatments and interventions including pain management and dietary consults implemented.  On 8/7/22, the Nurse Managers completed re-education of the Nurse Aides including agency staff, to report cavity observations for red swollen gun odor, and/or other teeth abnormalities admission, during routine care, and wit residents that complain of mouth pain of	the  a  d  ed  will  e  ed  y  oral  ns,  on  h	
	a residents' medical s the condition.	providers when changes in status had occurred) about			difficulty chewing. Issues identified will reported to the Licensed Nurse or Unit Manager.	be	
	A provider note dated indicated Resident #1	lurse #2 were unsuccessful.  10/21/21 written by NP #1  was seen for a sick visit on ing of the face related to a			On 8/7/22, the Director of Nursing completed re-education of the Unit Managers and Licensed Nurses, includagency staff regarding the process for	ling	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345128	<b>345128</b> B. WING _			08/10/2022		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
A C C O D D I	HO HEALTH AT CTAT	ECVII I E		52	20 VALLEY STREET			
ACCORDI	US HEALTH AT STAT	ESVILLE		STATESVILLE, NC 28677				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 684	Continued From page	age 18	F 6	684				
		e note also indicated Resident			communicating new physician orders f	or		
		ft cheek and jaw were noticeably swollen		dental services to the Director of				
		#1 had expressed the area was			(DON).	9		
	painful which resul			(2 0.1).				
		g a full oral examination by the			On 8/7/22, the Regional Director of			
		ident #1 did open her mouth			Clinical Services completed re-educati	on		
	slightly which allow			of the Director of Nursing, Nurse				
	visualized which w			Managers, and the Administrator				
	obvious signs of in			regarding the clinical morning meeting				
		r x-rays) at that time but			process to review the Physician Order			
	agreed to oral antil	biotics and to see the dentist.			Listing report including orders for denta			
	A review of Decide	ent #11a nhuninian!a ardar			services, pain medication orders, dieta	-		
		ent #1's physician's order rs dated 10/21/21. They read as			consults, and New Admissions to identifications with physician orders for den			
	follows:	3 dated 10/21/21. They read as			services to validate dental services are			
	lollows.				scheduled and these orders completed			
	Please schedule a	STAT (a medical term used to				-		
		or without delay) dental			The process is as follows:			
	appointment for inf	fected tooth.			•			
					<ul> <li>Licensed Nurses and Nurse Aides</li> </ul>	will		
		375-125mg (milligram) (an			complete oral cavity observations for re	ed		
		on taken by mouth used to treat			swollen gums, odor, and other teeth			
		nister one tablet by mouth			abnormalities on admission, during			
	every 12 hours for	10 days for tooth abscess.			routine care, and with residents that			
	A 4-1	Services as advated with ND #4			complain of mouth pain. Any issues			
		ew was conducted with NP #1 7 PM. NP #1 revealed she no			identified will be reported to the Licens Nurse or the Nurse Manager. The	ea		
		red at the facility; however, she			Physician will be notified by the Licens	ad		
		Resident #1 for an oral			Nurse or Nurse Manager of any	cu		
		of 2021 (exact date unknown			abnormalities and new orders for			
		ad access to the electronic			treatments and interventions including			
		Resident #1). NP #1 indicated			pain management and dietary consults	;		
	Resident #1 was a	ssessed with significant			implemented.			
	_	e and jaw from a "terrible			Licensed nurses will enter orders			
		e placed Resident #1 on			received for dental services, pain			
	antibiotic therapy.				management or dietary consults into			
					electronic medical record.			
		tober 2021 Medication			The Nurse Manager will print the			
Administration Record (MAR) revealed Resident				Order Listing Report to include dental				

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	· ,	(X3) DATE SURVEY COMPLETED C 08/10/2022		
				08			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•			
			520 VALLEY STREET				
ACCORDIUS HEALTH AT STATESVII	.LE		STATESVILLE, NC 28677				
PREFIX (EACH DEFICIENCY N			EFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
of #10 and it was docur  A Situation-Background-A tion (SBAR) form (a too facilitate prompt and ap to a medical provider), was initiated on 10/21/2 had pain and inflammat recommendation section  Attempts to contact Nur unsuccessful.  According to the Octobe was administered Norce 9:57 PM for a pain leve documented to be effect oral antibiotics twice on abscess.  A nurses note dated 10 #4, revealed Resident # therapy but continued to tooth.  Attempts to contact Nur According to the Octobe	orco ), (a narcotic pain on 10/20/21 for a pain level mented to be effective.  Assessment-Recommenda I used by nurses to propriate communication completed by Nurse #3, 21 revealed Resident #1 ion in the left cheek. The n was blank.  The se #3 via phone were  Per 2021 MAR, Resident #1 to 5/325 mg on 10/22/21 at I of #7 and it was tive. She also received 10/22/21 for a tooth  10/24/21, written by Nurse 11 remained on antibiotic 12 complain of pain to the  13 complain of pain to the  14 complain of pain to the  15 complain of pain to the  16 complain of pain to the  17 complain of pain to the  18 complain of pain to the  19 complain of pain to the  10 complain of pain to the  10 complain of pain to the  10 complain of pain to the  11 complain of pain to the  12 complain of pain to the  13 complain of pain to the  14 complain of pain to the  15 complain of pain to the  16 complain of pain to the  17 complain of pain to the  18 complain of pain to the  19 complain of pain to the  19 complain of pain to the  10 complain of pain to the  10 complain of pain to the  10 complain of pain to the  11 complain of pain to the  12 complain of pain to the  13 complain of pain to the  14 complain of pain to the  15 complain of pain to the  16 complain of pain to the	F 6	services orders, pain medical and dietary consults to review DON and Medical Records Dir the daily Clinical Morning Mee  The Medical Records Dir report on scheduling and comdental services appointments daily Clinical Stand Down Me  The Medical Records Dir report any difficulties with schithe DON daily for resolution.  The DON will keep a maresidents receiving dental ser update daily during the Clinic meeting. This log will be use outside scheduled appointme in-house dental appointments.  The DON will reconcile the by validating outside dental and in-house dental appointments and in-house ducation. Any new hires, inconursing agency staff will receiprior to the start of their shift.  4. The DON/Designee will converted to the start of the Dental Audit 5 times weekly x times weekly x 4 weeks to review documentation from outside compointments and in-house dappointments to ensure dentarecommendations from the deprovider and physician are im The results of the Dental Audir eported to the QAPI Commit	with the irector during eting. rector will appletion of a during the eting. rector will areduling to ster log of rvices and al morning do to track ents and s. his log daily ppointments are to a during the education of the educa			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 08/10/2022	
	ROVIDER OR SUPPLIER	VILLE	•	520	EET ADDRESS, CITY, STATE, ZIP CODE VALLEY STREET ATESVILLE, NC 28677	1 00.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		3E	(X5) COMPLETION DATE
F 684	and complained of brackets and complained of brackets.  According to the Octowas administered No 4:14 PM for a pain led documented to be efforal antibiotics twice abscess.  A nurses noted dated #2 indicated Residen therapy and complain According to the Octowas administered No 12:57 PM for a pain led documented to be efforal antibiotics twice abscess.  A record review reveausessed by the NP/I completed.  A dental hygienist not Resident #1 was see facial pain, discomfor The note further indices several root tips and teeth #9, 10, 11, 12, 2	I continued on antibiotics eakthrough pain.  Ober 2021 MAR, Resident #1 rco 5/325 mg on 10/26/21 at vel of #7 and it was fective. She also received on 10/26/21 for a tooth  I 10/27/21 written by Nurse at #1 continued on antibiotic ned of oral pain.  Ober 2021 MAR, Resident #1 rco 5/325 mg on 10/27/21 at	F	584	5. The date of compliance is 8/15/2	2.	
	#1 was seen in the fa exam. It further indica tips to tooth #9, 10, 1	12/1/21 indicated Resident icility on a routine periodic ated Resident #1 had root 1, 12, 20, 25 and 31 as well es to tooth #21, 22, 23 and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345128	B. WING			08/	10/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE		5	STREET ADDRESS, CITY, STATE, ZIP CODE  20 VALLEY STREET  STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 684	Recommendations we maintain oral hygiene and extractions of all to be extracted.  A provider note dated revealed Resident #1 dentition with multiple. A provider note dated revealed Resident #1 dentition with multiple. According to the April was administered No 8:40 PM for pain leve. According to the April was administered No 9:51 PM for pain leve. A dentist note dated #1 was seen by the indocumented Residen an abscess a couple detailed, upon examin mouth on that date, a secondary to a pressileft side of her lip as i abscess had occurred. A review of Resident revealed an order datas follows:  Amoxicillin 500m times a day for 10 datas.	cation located in the mouth. ere made that Resident #1 e and be referred for x-rays teeth as all root tips needed  1 1/6/22, written by NP #1, continued to have poor e broken teeth.  1 3/16/22, written by NP #3, continued to have poor e broken teeth.  2022 MAR, Resident #1 rco 5/325 mg on 04/07/22 at I of #10.  2022 MAR, Resident #1 rco 5/325 mg on 04/08/22 at I of #8.  1/11/22 indicated Resident n-house dentist who t #1 had expressed she had weeks ago. It further nation of Resident #1's n antibiotic was ordered ure building up similar in the t had when the previous d.  #1's physician's orders teed 4/11/22. The order read ug: give one tablet three	F	684			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 08/10/2022		
	ROVIDER OR SUPPLIER  US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	00/10/2022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETION		
F 684	8:59 PM for pain let According to the Ap was administered N 8:35 PM for a pain I An observation and were conducted on Resident #1 opened revealed all visible and brown stained, tooth fragments. Reneeded to see the cextracted because infections which has swelling, and at tim difficulty chewing was much when this A telephone interview revealed I unresolved concern "neglected" dental I expressed Resident teeth extracted, des recommendations a Resident #1 with painfections.  An interview conducted to 18/23/22 at 7 AM facility on 07/21/22.	lorco 5/325 mg on 04/13/22 at yel of #8.  Init 2022 MAR, Resident #1 lorco 5/325 mg on 04/15/22 at evel of #8.  Interview with Resident #1 08/03/22 at 3:18 PM. Interview hard smiled which teeth appeared to be yellow and jagged-irregularly shaped esident #1 vocalized she really dentist to have her teeth she had multiple oral dicaused her pain, facial es, caused her not want to eat occurred.  In www seconducted with Family on 08/05/22 at 8:34 AM. The FM #1 had significant is regarding Resident #1's had a pending appointment with Office Manager (OM) office on 08/10/22 at 9:06 AM is a pending appointment with which was made by the	F 68	34			
		onducted with the Medical 8/05/22 at 3:50 PM. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 08/10/2022	
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP COE 520 VALLEY STREET STATESVILLE, NC 28677		(A) 13/2322	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	needs were handled dentist at the time but occurred. She elaborate being provided promp abscesses could be a status. She also voca outcomes could have related to her poor or could have resulted in or endocarditis from the could have a could have resulted in or endocarditis from the carries. A provider note writted (MD) dated 9/27/21 in that revealed Resider with multiple broken to carries. The note furth had voiced he had be dental extractions see and the MD wrote she details from the social #2 to a dentist who carries who carried to have expendituded in the pain as Review of the pain as R	r first or second oral Resident #1's dental care by NP #1 and the in-house t was made aware they had ated that Resident #1 not of care for recurrent oral a "detriment" to her health dized serious adverse occurred to Resident #1 all hygiene if left untreated in sepsis from the abscesses untreated dental caries.  dmitted to the facility on ses that included hemiplegia atic intracerebral the right dominant side.  In by the Medical Director indicated an oral assessment int #2 had poor oral dentition eeth and multiple dental er indicated Resident #2 een unable to obtain his condary to anesthesia issues e needed to obtain further I worker and refer Resident an perform this procedure.  er 2021 Medication d (MAR), Resident #2 was erienced a level #7 in pain	F6	584			

` /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP COI 520 VALLEY STREET STATESVILLE, NC 28677	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
F 684	was identified to have pain on 10/11/21 and 11:42 PM.  A dentist note dated #2 had root tips for te and 31. Resident #2 #6-8, 11, 25 and 26. calculus, and inflamm seen on this date for revealed he had an a Recommendations in full mouth series and antibiotics for the abs  According to the Octowas identified to have pain without analges.  A review of Resident revealed an order datas follows:  Amoxicillin 500 mg to times daily for 10 day.  A review of Resident 2021 indicated the air	bber 2021 MAR, Resident #2 e experienced a level #7 in I analgesics were provided at  10/12/21 indicated Resident beth #2, 9, 10, 12, 13, 14, 30 had non-restorable teeth He had visual heavy plaque, nation. Resident #2 was a routine oral exam which abscess to tooth #3. included Resident #2 have a was placed on oral seess.  bber 2021 MAR, Resident #2 e experienced a level #7 in ics provided on 10/12/21.  #2's physician's orders ted 10/12/21. The order read ablet: give one tablet three //s for an infected tooth.  #1's MAR dated October intibiotic was not started until ed see a nurses note; notes were located in	F	684			
	through 10/14/21 to r delay in starting the c indicated he received and 10/13 at bedtime According to the Octowas identified to have	reflect the reason for the oral antibiotic. It further drain medications on 10/11					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 08/10/2022	
	NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT STATESVILLE			5	STREET ADDRESS, CITY, STATE, ZIP CODE  20 VALLEY STREET  STATESVILLE, NC 28677	<u> </u>	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Resident #2 was idented level of a #7 and analyse level of a pain a the MAR on 10/20/21 to have reached a pashift and analgesics which was identified to have pain on 10/20/21 during were provided at 10:10. A provider noted date MD, indicated she wooral/dental status with #2 reported difficulty to medical decline if he have level and a pain a the June MAR, on 6/1 identified to have reach analgesics were not pain and the June MAR, on 6/1 identified to have reach analyse level level and 31. Resident #2 he had root tips for te and 31. Resident #2 he had inflamment with the second pain and the second	ssessment on 10/14/21, attified to have reached a pain agesics were not provided.  by Nurse #10, dated sident #2 was started on a tooth infection with no assessment documented on Resident #2 was identified in level of a #7 during day were not provided.  beer 2021 MAR, Resident #2 experienced a level #7 in an analgesics in administration as Resident #2's an administration as Resident eating which may contribute the stopped eating.  ssessment documented on 10/22, Resident #2 was ched a pain level of a #7 and provided.  6/14/22 indicated Resident eth #2, 9,10, 12, 13, 14, 30 and non-restorable teeth He had visual heavy plaque, nation. Resident #2 was cherevealed Resident #2 was cherevealed Resident #2 had	F	684			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 684	Continued From pag		F 68	4	
	inflammation of some abscess.	e sort but not currently an			
	the June MAR, on 6/	assessment documented on /15/22, Resident #2 was ached a pain level of a #7 and provided.			
	According to a pain assessment documented on the June MAR, on 6/22/22, Resident #2 was identified to have reached a pain level of a #7 and analgesics were not provided.				
	were made on 08/04 opened his mouth ar visible teeth appears stained, and jagged fragments. Resident see the dentist to ha because of the poor expressed his mouth	n had hurt when he had an had caused him to have			
	on 08/04/22 at 1:17 INP #1 recalled Residents abscess last fall; how assessed and handle the time (exact date has access to the ele Resident #2). NP #1 vocalized concerns and any delays in call adverse effects to Residents and any delays in call adverse effects to Residents.				
		nducted with the Regional NC) on 08/04/22 at 2:50 PM.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 08/10/2022
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F 684	aware of concerns rin dental care. How knowledge of delays of a pending dental A follow-up interview 9:00 AM cofirmed R scheduled on 08/04 appointment on 08/ An interview was concerned pain or of any pending dental An interview revealed saware of Resident # however, she was reexperienced pain or of any pending dental An interview was concerned pain or of any pending dental An interview revealed saware they have revealed saware they have recurrent or all absorbations and concerned to Resider hygiene if left untreasons.	led she had been made egarding Resident #2's delay ever, she had no further in in dental care or knowledge appointment at that time.  If with RNC on 08/05/22 at esident #2 had been /22 for a pending oral surgeon 16/22.  Inducted via phone with 08/04/22 at 5:10 PM. The he recalled being made f2's poor oral dentition; ot aware Resident #2 abscess as a result nor recall all appointments.  Inducted with the Medical /05/22 at 3:50 PM. The he had not assessed is oral abscess occurred as I care needs were handled by provider at the time but was ad occurred. The MD stated, the occurred, it could result in east and could be a earth status. She also diverse outcomes could have at #2 related to his poor oral at the could resulted in cess or endocarditis from	F 6	34		
F 791 SS=K	08/05/22 at 8 PM.	fied of immediate jeopardy on  Dental Srvcs in NFs	F 79	91		8/15/22

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		N SHOULD BE COMPLETION DATE
n ()(g)) neet ered sted, m the refer vithin ion of ill eat that	791	
	B. WING  JLL ON)  F	B. WING  STREET ADDRESS, CITY, STATE, ZIP COE 520 VALLEY STREET STATESVILLE, NC 28677  JUL PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)  F 791  F 791  The provider's PLAN OF CC (EACH CORRECTIVE ACTION DEFICIENCY)  F 791  The provider's PLAN OF CC (EACH CORRECTIVE ACTION DEFICIENCY)  F 791  The provider's PLAN OF CC (EACH CORRECTIVE ACTION DEFICIENCY)  F 791  The provider's PLAN OF CC (EACH CORRECTIVE ACTION DEFICIENCY)  The provider's PLAN OF CC (EACH CORRECTIVE ACTION DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENC

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED  C 08/10/2022	
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ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677			
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F 791	Continued From page	e 29	F 7	91			
	eligible and wish to p reimbursement of der medical expense und This REQUIREMENT by: Based on observation Nurse Practitioner (No oral surgeon office mand resident interview STAT (without delay)	ssist residents who are articipate to apply for ntal services as an incurred ler the State plan.  T is not met as evidenced ons, record reviews and P), Medical Director (MD), anager (OM), staff, family, ws, the facility failed to obtain dental services for Resident #1 on 10/21/21 due to a		F 791- Dental Services  1. Resident #1 has broken ar teeth requiring an oral surgeon extraction. On 10/21/21 an ord written for a STAT dental visit of	for der was		
	tooth abscess. Resider outline visit by the detailed 12/01/21 at which time given for a referral for and root tips. Resider outline visit by the detailed 10/12/21 and was preabscessed tooth and given for a referral for remaining teeth. The	dent #1 was not seen until a entist at the facility on the a recommendation was been to the extraction of all teeth ent #2 was seen during a entist at the facility on the escribed antibiotics for an a recommendation was been the extraction of all facility failed to obtain dental		abscess She was seen by the dentist 12/21 and extractions we recommended. The resident perocedure occur with IV sedations refuses other alternatives. The provided a note dated 8/4/22 esthere are no Oral Surgeons in the market that accept Medicaid for extractions requiring IV sedations resident's spouse met with the	e In-House vere prefers this on and e facility explains the local or teeth on. The current		
	Resident #2 were tre with oral antibiotics a from the infections who per resident interview requests by the denti Resident #1's appoin not scheduled until 0' Resident #2's was so survey began) for 8/1 services put Resident for sepsis or endocar occurred for 2 of 3 re services (Resident #2	ns. Both Resident #1 and ated for tooth abscesses and they experienced pain hich decreased their appetite is. Despite subsequent st and the medical providers, the terms of the extractions was 7/21/22 for 08/23/22 and sheduled on 8/4/22 (after the 6/22. The delay in dental the the terms of the extractions was 1 and Resident #2 at risk risk ditis. This deficient practice sidents reviewed for dental 1 and Resident #2).		Administrator regarding dental and an appointment was made 23rd for the oral surgeon.  Resident #2 has broken, decay On 10/6/21 an order was writte oral surgeon related to dental earlier the resident prefers this procewith IV sedation and refuses of alternatives. There are no Ora in the local market that accept for teeth extractions requiring I' On 6/14/22- he was seen by the dentist who stated there was so around tooth #21 but does not be an abscess and Resident #2	yed teeth. en to consult extractions. dure occur ther al Surgeons Medicaid V sedation. ee in-house welling appear to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128 B. WING				C 08/10/2022	
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	, 10, 2022
					20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	SVILLE			STATESVILLE, NC 28677		
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F 791	Continued From pag	F	791				
	facility failed to obta			wanted to wait for IV sedation for			
	Resident #2 for the			extractions. On 8/4/22 the Regional			
	teeth. The immediate jeopardy is present and				Nurse Consultant scheduled an		
	ongoing.				appointment with the local oral surgeor	า	
					after the resident #2 daughter was able	∍ to	
	Findings included:				persuade him to consider Nitrous Oxid as alternative to IV sedation.	е	
	Resident #1 was re-	admitted to the facility on					
		osis that included anemia and			2. All other residents have the potent	tial	
	diabetes.				to be affected. On 8/7/22, the Nurse		
					Managers completed a review of all		
	A quarterly MDS dat	ed 10/3/21 revealed Resident			current resident medical records to		
	#1 was cognitively in	ntact, had no rejection of care,			identify physician's orders for dental ca	ire	
	and required limited	assistance by staff with			and ensure these have been complete	d	
	personal hygiene. It	further revealed Resident #1			and to identify dental visit status, include	gnit	
	had received pain m	edications; however, it had			the last dental visit, follow up		
	not limited her day-t	o-day activities as a result of			recommended and validation of		
	the pain rating it as i	mild and she had received 4			scheduled appointments. On 8/7/22,		
	days of opioid medic	cations for pain management.			additional residents requiring dental		
		Resident #1 had no mouth or			follow-up were identified. On 8/11/22,	the	
	facial pain, discomfo	ort, or difficulty with chewing.			Director of Nursing confirmed the next		
					scheduled on-site Dental Clinic with Au	ıria	
		d 10/20/21 revealed Resident			Dental on 8/16/22.		
		of tooth pain and her left					
	•	en and warm to the touch. It			3. On 8/7/22, the Director of Nursing		
		e was left in the providers			completed re-education of the Unit		
		tion binder used between the			Managers and Licensed Nurses, include	ling	
	_	medical provider to alert the			agency staff regarding the process for		
		ges occurred to a resident)			communicating new physician orders f		
	about the condition.				dental services to the Director of Nursi (DON).	ng	
	Α						
		id-Assessment-Recommenda			The process is as follows:		
	, , ,	tool used by nurses to					
		l appropriate communication			Licensed nurses will enter orders		
		r) dated 10/21/21 revealed			received for dental services into electro	onic	
	Resident #1 had pai	esident #1 had pain and inflammation in the left			medical record.		
	cheek.				The Unit Manager will print the de		
					services orders and review with the DC	NC	

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			08/10/2022		
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE		52	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET TATESVILLE, NC 28677	, 33.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 791	indicated Resident # that date due to swe tooth infection. The r #1's left cheek and ja and that Resident #1 painful which resulte resistive to allowing a however, Resident # which allowed the left which was shown to signs of infection. Re (labs and/or x-rays) a antibiotics and to see  A review of Resident revealed two orders follows:  1. Please schedule a to mean immediately appointment for infect 2. Amoxicillin tablet 8 antibiotic medication an infection): adminis every 12 hours for 10  A provider note date indicated Resident # the infected tooth-ab swelling to Resident substantially and swe	d 10/21/21 written by NP #1  1 was seen for a sick visit on lling of the face related to a note also indicated Resident aw were noticeably swollen had expressed the area was d in Resident #1 being a full examination by the NP; 11 did open her mouth slightly fit lower gum to be visualized be swollen with obvious esident #1 refused testing at that time but agreed to oral exthe dentist.  1 #1's physician's order dated 10/21/21. They read as a STAT (a medical term used or without delay) dental cted tooth.  275-125mg (milligram) (an taken by mouth used to treat ster one tablet by mouth 0 days for tooth abscess.  1 10/22/21 written by NP #1 1 was seen for a follow-up to scess. The note revealed #1's jaw had decreased	F 7	791	and Medical Records Director during the daily Clinical Morning Meeting.  The Medical Records Director will report on scheduling and completion of dental services appointments during the daily Clinical Stand Down Meeting.  The Medical Records Director will report any difficulties with scheduling to the DON daily for resolution.  The DON will keep a master log or residents receiving dental services and update daily during the Clinical morning meeting. This log will be used to track outside scheduled appointments.  The DON will reconcile this log da by validating outside dental appointments and in-house dental appointments.  The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior the start of their shift.  On 8/7/22, the Regional Director of Clinical Services completed re-education of the Director of Nursing, Nurse Managers, and the Administrator regarding the clinical morning meeting process to include a review of the Physician Order Listing report for residents with physician orders for den	fee  off  gg  illy  nts		
	revealed Resident#	rk.  n by Nurse #2 dated 10/24/21 1 remained on antibiotic d to complain of pain to the			services to validate dental services are scheduled and these orders completed. The DON will review documentation da from outside dental appointments and in-house dental appointments to ensure	l. nily		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 08/10/2022	
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	/ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE  520 VALLEY STREET  STATESVILLE, NC 28677			10/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE
F 791	indicated Resident #1 follow-up on the left kinfection and stated F swelling had decreas indicated she was unappointments scheduled. A nurses note written indicated Resident #1 and complained of brown A nurses note written indicated Resident #1 therapy and complained of brown A nurses note written indicated Resident #1 therapy and complained A dental hygienist note Resident #1 was see facial pain, discomfor The note further indicated from the pain indicated from the pain indicated from the oral surgeon.  A provider note dated indicated Resident #1 an appointment to be extractions.  A provider note dated Medical Director (MD seen and was awaitin scheduled due to an and A dentist note dated from the date	10/25/21 written by NP #1 was again seen to ower jaw tooth abscess and Resident #1's jaw pain ed significantly. The note sure of a time for any dental led by the facility.  by Nurse #3 dated 10/26/21 continued on antibiotics eakthrough pain.  by Nurse #2 dated 10/27/21 continued on antibiotic ed of oral pain.  de dated 11/02/21 indicated in in-house for mouth or t, or difficulty with chewing. ated Resident #1 had fractured teeth including 20, 25 and 31. Resident #1 on-restorable teeth extracted  11/8/21 written by NP #1 was seen and was awaiting scheduled for dental  11/8/21 written by the indicated Resident #1 was ig an appointment to be	F	791	dental service recommendations from dental provider and physician are implemented.  4. The Director of Nursing/Designee complete a Dental Audits 5 times week 4 weeks, 3 times weekly x 4 weeks, the 2 times weekly x 4 weeks. The results the Dental Audit will be reported to the QAPI Committee monthly x 3 for review and revision of the plan.  5. The date of compliance is 8-15-20.	will kly x en of	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING				0 10/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 791	tips to tooth #9, 10, 1 as decay and fracture #24 and heavy calcifi Recommendations w maintain oral hygiene and extractions of all to be extracted.  A quarterly MDS date #1 had no dental abn  A provider note dated revealed Resident #1 dentition with multiple  A provider note dated revealed Resident #1 dentition with multiple  An annual MDS date #1's oral status was r documented had no a broken teeth or oral of  A nurses' note dated was on the list to see 4/11/22.  A dentist note dated #1 was seen by the in documented Residen an abscess a couple detailed, upon examin mouth on that date, a secondary to a press left side of her lip as i abscess had occurred	ated Resident #1 had root 1, 12, 20, 25 and 31 as well es to tooth #21, 22, 23 and cation located in the mouth. ere made that Resident #1 e and be referred for x-rays teeth as all root tips needed  ed 1/2/22 indicated Resident formalities.  d 1/6/22 written by NP #1 continued to have poor e broken teeth.  d 3/16/22 written by NP #3 continued to have poor e broken teeth.  d 4/2/22 indicated Resident for examined, but all areas abnormalities to include caries.  4/7/22 indicated Resident #1 the in-house dentist on  4/11/22 indicated Resident for the in-house dentist who for the in-house denti	F	791			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _	····		C <b>08/10/2022</b>	
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	SVILLE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 791	A referral was made  A review of Resident revealed an order da as follows: Amoxicilli three times a day for  A modified quarterly Resident #1 had no a discussed with the reconcerns regarding In The discussion inclubeen seen by an in-twas in a process to a scheduled. This wouthe facility scheduler The note included a continued to have possible to the seen to the seen to the seen to the facility scheduler the note included a continued to have possible to the seen to the s	removed by an oral surgeon. on 04/11/22.  If #1's physician's orders ated 4/11/22. The order read in 500mg: give one tablet of 10 days for oral abscess.  MDS dated 5/12/22 indicated dental abnormalities.  If the following the MD dental at the provider dental and family present resident and family present resident #1's dental status. ded the fact Resident #1 had house dentist and the facility	F 7	, , , , , , , , , , , , , , , , , , ,			
	Family Member (FM dental care follow-up appointment needed resolution provided f 07/22/22 and indicat scheduled on 08/23/ extractions with intra oral surgeon.  An interview was con Family Member #1 (In the interview reveal unresolved concerns	) #1 regarding Resident #1's b. The stated findings include I to be arranged. The or the grievance was dated ed an appointment was 22 for a dental evaluation for venous (IV) sedation by an anducted via phone with FM) on 08/05/22 at 8:34 AM. ed FM #1 had significant is regarding Resident #1's ygiene by the facility and lack					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		<b>345128</b> B. WING				C 08/10/2022	
	NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 520 VALLEY STREET STATESVILLE, NC 28677		3.10,2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 791	concerns about Resi hygiene and poor de Resident #1 had yet performed. FM #1 fu upset that she arrive "perfect" teeth that w and no cavities were teeth were presently shape. FM #1 vocalis staff member (unable hygiene could possik "get sick more often. dissatisfaction and s prompt resolution, R to decline and she w When asked if FM # scheduled appointme "no, I was only told a made." FM #1 explai aware of the date/tim appointment. FM #1 discussed Resident i concern for delays in provider appointmen  An observation and i were conducted on O Resident #1 opened revealed all visible te and brown stained a jagged-irregularly sh Resident #1 vocalize the dentist to have h she had multiple ora her pain, facial swell	oth extracted despite dations and provider ed they had been expressing dent #1's declining oral ntition since early 2021 and to have the extractions rther stated they were very d at the facility in 2020 with vere not broken or missing present and Resident #1's all broken off and in "terrible" zed they had been told by a e to recall) that her poor oral by be making Resident #1 "FM #1 voiced erious concern that without esident #1's would continue rould have to suffer further. I was aware of the ent on 08/23/22, they stated in appointment would be ned they were not made ne/location of the scheduled stated the facility had not #1's payor source as being a resident #1's oral surgery ts.	F 7	91			

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		345128	B. WING _		08/4	;  0/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/1	072022
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 791	An interview was contransportation Aided #1) on 08/04/22 at revealed he had be about a month ago #1's appointment he with a local oral survocalized there had transportation such which delayed here and care provided.  Review of the facilities 8/4/22 revealed Rewith the oral surgeon An interview was continued to require times to schedule as the recently became needed her teeth powould need to be more than the date she was not appointment for 08/08/23/22 at 7 Alfacility on 07/21/22	h when this occurred.  conducted with the former e/Appointment Scheduler (TA 9:10 AM. The interview ten the transportation aide until at recently been scheduled regeon for 08/23/22. TA #1 at not been any delays in as the van being unavailable appointment being scheduled reproducted with the current TA 2 at 9:40 AM. The interview assistance from TA #1 at appointments. TA #2 indicated the aware that Resident #1 ulled and an appointment ande. TA #2 could not recall officed, but she scheduled the /23/22 at 7:30 AM.  Could with Office Manager (OM) office on 08/10/22 at 9:06 AM #1 had a pending appointment of which was made by the	F 7:	91		
	08/04/22 at 1:17 PM #1 recalled assessi	M. The interview revealed NPing Resident #1 for an oral of 2021 (exact date unknown				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 08/10/2022	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	00/10/2022	
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 791	as she no longer had medical record for FR esident #1 was as swelling to her face abscess" which she antibiotic therapy are consult. NP #1 elab #1's family had ask Resident #1 had no teeth extracted and Administrator (Admappointments would initial refusal in earl she provided the fact to be provided "STA arrangements to be prevent any potential resident. The was a #1 at increased risk An interview was concare. She stated to appointment had be result of a grievance Administrator by Re 2022. However, she delays in dental car An interview was concared and interview revealed and interview r	di access to the electronic Resident #1). NP #1 indicated sessed with significant and jaw from a "terrible elected Resident #1 on and requested a STAT dental corated to indicate Resident ed on multiple occasions why the yet been seen to have her was told by the previous inistrator #2) no further the demander of secondary to her yet 2021. NP #1 explained when collity with an order for any care with the world at complications to the ble to validate it put Resident of potential medical illness.  Anducted with the Regional RNC) on 08/04/22 at 2:50 PM. Bled she had been made earding Resident #1's dental her knowledge an elem made for 08/23/22 as a set filed with the current esident #1's family in July the had no further knowledge of the at that time.  Anducted via phone with the obsoluted via phone vi	F 791			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 08/10/2022	
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 791	family was very upser not been addressed admitted to the facility always been "very property pand teeth." The international teeth. The international teeth. The international teeth and the interview. The interview was concorred to made but didn't the interview.  An interview was concorred as the interview revealed so the intervie	istrator #1 expressed the et and angry the issue had because Resident #1 had ty with "pretty teeth" and had rideful about her appearance view further revealed written up the grievance new an appointment had to know the date at the time of anducted with the Medical 105/22 at 3:50 PM. The ne had not assessed er first or second oral as Resident #1's dental care by NP #1 and the in-house at was made aware they had ated she had spoken to the ding their ongoing concerns aral care and the need for explained when an order is referral, the appointment made. She did not feel the in-house dentist on 12/1/21 areasonable follow-up to a on 10/21/21. She elaborated being provided prompt care seesses could be a salth status. She also exerse outcomes could have to the treated to her poor oral ted could have resulted in the esses or endocarditis from the interest of the model of th	F 79			

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _		C 08/10/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 791	following a nontraum hemorrhage affecting.  A provider note writte Medical Director (MD assessment that reverse oral dentition with me multiple dental caries. Resident #2 had voice obtain his dental extranesthesia issues are to obtain further deta and refer Resident # perform this procedu.  A review of Resident revealed an order datas follows:  Please consult an oral A dentist note dated. #2 had root tips for the and 31. Resident #2 #6-8, 11, 25 and 26. calculus, and inflammate on this date for revealed he had an affurther explained Referral was made for was placed on oral and A review of Resident revealed an order datas follows: Amoxicillis.	sis that included hemiplegia atic intracerebral g the right dominant side.  en dated 9/27/21 by the opinicated an oral ealed Resident #2 had poor altiple broken teeth and is. The note further indicated each had been unable to eactions secondary to and the MD wrote she needed ils from the social worker 2 to a dentist who can	F7	91	

		(X3) DATE COMP	SURVEY LETED				
		345128	B. WING				C <b>10/2022</b>
	ROVIDER OR SUPPLIER	VILLE		520	EET ADDRESS, CITY, STATE, ZIP CODE  VALLEY STREET  ATESVILLE, NC 28677	1 001	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE	
F 791	2021 indicated the an was not started until on nurses note dated for nurses notes were located and in starting the offurther indicated he re 10/11/21 and 10/13/2  A nurse note written to 10/14/21 indicated Reference indicated	#1's Medication d (MAR) dated October htibiotic for the infected tooth 10/14/21 and indicated see a 10/13/21; however, no cated in Resident #2's d to the site of pain nor haral antibiotic as ordered. It eceived pain medications on 1 at bedtime.	F	791			
	A provider noted date indicated Resident #2 referred to dentistry dwould like them extra who evaluated him prediction which he will be a carried included Resident #2 extraction of remaining discuss with administration of the she had discussed with Administration at some not recall any dates we place.	and 1/19/22 written by the MD 2 had requested he be lue to his teeth breaking and cted; however, the dentist reviously could not offer him referred. It further indicated liple broken teeth and a Recommendations undergo a whole mouthing teeth and the MD would ration as Resident #2 ling and may contribute to stops eating. The MD said					

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		345128	B. WING _			C / <b>10/2022</b>
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 791	#2 revealed he would investigation was con and the findings inclucentated a local ora an appointment for Rextractions in May 20 Transportation Aide//#1) was informed the unable to accommod have extractions under each out to another included oral surgery accommodate the process of the proces	led on 2/11/22 by Resident delike his teeth removed. The impleted by Administrator #2 ided medical records I surgeons office to schedule desident #2 to have 1021. The former Appointment Scheduler (TA is previous dental office was late residents' preference to er sedation and should provider. Resolution was unable to occedure and the facility was bonth (April).	F 7			
	office would be unab to the severity of his detailed TA #1 contar offices around the cit took Medicaid or did residents. One office term care residents, making appointments to an overwhelming reffice advised TA #1	s told the oral surgeon's le to sedate Resident #2 due needs. The note further cted multiple oral surgeon's y of the facility, but none not see long term care indicated they took long but they were currently not s for Medicaid patients due number of consults. The to call back the next month ad TA #1 would follow-up				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				0 10/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	VILLE		5	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		
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F 791	A review of Resident revealed no further nadditional efforts had schedule an oral surg Resident #2.  A quarterly MDS date Resident #2 had no dental about 42 had no dental about 42 had no dental about 42 had root tips for the and 31. Resident #2 #6-8, 11, 25 and 26. Calculus, and inflamm seen on this date whis swelling around tooth an abscess. It further wanted to have extra he wanted to be seddunable to locate an oso he has waited. The facility monitor aroun brushing of teeth two mouth rinse if appropriate A follow-up formal grion behalf of Resident with the facility at the concern revealed the expressed concerns was told would be invited from the facility. The concern listed Resident in the concern listed Resident in the facility and form the facility.	#2's medical record otes after 3/1/22 to indicate been made by TA #1 to gery appointment for  ed 4/22/22 indicated dental abnormalities.  ed 5/11/22 indicated Resident formalities.  I 6/14/22 indic	F	791			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING		C 08/10/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATE	SVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/10/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	O BE COMPLETION
F 791	extracted and went previously who had remove the teeth whand no staff member The resolution inclus Social Work Director Resident #2's family when it comes to his Resident #2 require available oral surge Medicaid patients a not include a resolus appointment was made and were made on 08/00 opened his mouth a visible teeth appear stained and had murjagged-irregularly stained and had and had and had and had and had and had had and had and had had and had had had had had had had had had h	that the teeth needed to be to the oral surgeons' office told him they could not hile he was in the wheelchair er was present to transfer him. ded: a phone call made by the or and message left for member which indicated sedental appointment, deseation and the only on was not taking new to this time. The grievance did tion date attached. No ade for Resident #2 until interview with Resident #2 until interview with Resident #2 and smiled which revealed all ed to be yellow and brown	F 79		
	Transportation Aide #1) on 08/04/22 at 9 revealed he had be about a month ago. had not had any red surgeon appointme surgeon due to no o source (Medicaid) a	onducted with the former /Appointment Scheduler (TA Ø:10 AM. The interview en the transportation aide until He explained Resident #2 cent outside dental/oral ints scheduled with a local oral one took Resident #2's payor unymore. TA #1 said he had surgeons in the county of the			

EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  (X3) D/  CC	
	345128	B. WING		C 08/10/2022
IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 00/10/2022
(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
cility but had not a 4 #1 was unable to the made to locate esident #2's extrain interview was continued to require the recently became the recently became ereded his teeth pure ere were no local mich took Resider erefore had not mal surgeon appoint interview was continued to require erefore had not mal surgeon appoint interview was continued to the recalled Resider #2 had continued to the recalled Resider #2 had continued to the recalled them to be the recalled them.	broadened his search further. To verify if further follow-up had be a provider to perform factions after 3/1/22.  Conducted with the current TA 2 at 9:40 AM. The interview decrease assistance from TA #1 at appointments. TA #2 indicated the aware that Resident #2 fulled and was told by TA#1 that for all surgeons in the area and the east tempts to schedule any interest for Resident #2.  Conducted with NP #1 on M. The interview revealed NP interest for Resident #2.  Conducted with NP #1 on M. The interview revealed NP interview revealed NP interview revealed NP interview decrease and interview as assessed inchouse dentist at the time who as she no longer has a cility. NP #1 explained concerns with his poor oral an order was provided, she are followed and initiated at the delays in care could cause affects to Resident #2.  Conducted with the Regional on 08/04/22 at 2:50 PM. The she had been made aware of esident #2's dental care. She edge no appointment had lary to local oral surgeon'	F 79	1	
	SUMMARY (EACH DEFICIE REGULATORY CONTINUED FROM PARTY CONTINUED FROM PAR	345128	IDER OR SUPPLIER  HEALTH AT STATESVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  ID PREFIX TAG  TO Intinued From page 44  continued From page 4  continued From page 4  continued From page 4  continued F	JAS128  JAS128

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE :	_ETED
		345128	B. WING		00/	; 10/2022
	ROVIDER OR SUPPLIER  US HEALTH AT STATE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	06/	10/2022
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F 791	Continued From pa	ge 45	F 7	91		
	9:00 AM cofirmed R	with RNC on 08/05/22 at esident #2 had been //22 for a pending oral surgeon 16/22.				
	current Administrator The interview revea aware of Resident # however, she had b surgeons would not	nducted via phone with the r on 08/04/22 at 5:10 PM. led she recalled being made 2's poor oral dentition; leen told the local oral accept Resident #2's payor le could not have his teeth ledation.				
	Director (MD) on 08 interview revealed services	nducted with the Medical /05/22 at 3:50 PM. The he had not assessed is first oral abscess occurred ntal care needs were handled tal provider at the time but ey had occurred. The MD er was provided for a referral ects an appointment to be diff there were delays which nging care ordered by the rated that Resident #2 not not care for recurrent oral a "detriment" to his health ralized serious adverse e occurred to Resident #2 ral hygiene if left untreated in sepsis from the abscess or intreated dental caries.				
F 835	The facility was noti jeopardy on 08/05/2 Administration	fied of the immediate 2 at 8 PM.	F 83	35		8/15/22
SS=K						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 08/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•	J8/10/2022	
				520 VALLEY STREET			
ACCORDI	US HEALTH AT STATES	VILLE		STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 835	enables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation Nurse Practitioner (Noral surgeon office mand resident interview provide leadership are ensure dental referratextractions were scherecommended by the Physician. The Admineffective process that interdisciplinary teamensure needed care for residents.  Immediate Jeopardy facility failed to have dental services for Rofall remaining teeth present and ongoing.  Findings included:	on. ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. Γ is not met as evidenced ons, record reviews and IP), Medical Director (MD), nanager (OM), staff, family, ws Administration failed to nd oversight to facility staff to als for abscesses and eduled for residents as e dentist and ordered by the nistration failed to have an t involved the n and explored all options to and services were provided began on 10/12/21 when the systems in place to obtain esident #2 for the extraction Immediate jeopardy is	F 8	F 835- Administration  1. The Administration failed leadership and oversight to the staff to ensure that Physician dental consults were complewere no effective systems to referrals and Physician's ordeconsults with an oral surgeor through with recommendation services. The lack of effective process resulted in residents pain, infection, and difficulty of the state of the state of the position of the state	d to provide he facility n ordered ted. There manage ers for n and follow ns for needed e systemic experiencing eating.  otential to be t, the Nurse residents' n orders es to identify I visit, and intments. No		
	F684 - Based on obs and resident, staff, N Medical Director (MD to ensure residents' v	rred to F684 and 791.  ervations, record reviews urse Practitioner (NP), and b) interviews, the facility failed well-being by not providing prevent oral abscesses and		additional residents were ide  3. On August 8, 2022, the I Director of Operations (RDO the Administrator on the facili care and services are provide residents to include dental se	Regional ) educated ity ensuring ed for the		

PRINTED: 09/07/2022 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB MC	). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		PLETED
		345128	B. WING			1	C 10/2022
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2022
					20 VALLEY STREET		
ACCORDI	US HEALTH AT STATES	VILLE			TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	and Resident #2). Re routine visit by the de 10/12/21 and was preabscessed tooth and given for a referral for remaining teeth. Resilevel of 7 on a scale opain) several days be was being treated. A indicated Resident #2 #21 which was inflam abscess. Resident #2 on two occasions after Resident #1 was seen was prescribed antibility and a STAT (without of or the abscess was reported a pain level 10/21/21 through 10/2 seen until a routine vifacility on 12/01/21 at recommendation was extraction of all teeth was seen by the dent pressure similar to who occurred. Resident #2 was prescribed antibility on 12/01/21 at recommendation was extraction of all teeth was seen by the dent pressure similar to who occurred. Resident #2 antibiotic for the abscelevel ranging from 8-4/15/22. Resident #2 (after the survey begater and seed to the surv	n for 2 of 3 (Resident #1 sident #2 was seen during a ntist at the facility on escribed antibiotics for an a recommendation was the extraction of all ident #2 reported a pain of 1-10 (10 being the worst fore and while the abscess dentist noted dated 6/14/22 had swelling around a tooth mation but not currently an experted a pain level of 7 for this visit from the dentist. In by NP #1 on 10/21/21 and otics for a tooth abscess delay) dental appointment equested. Resident #1 ranging from 7-10 from 27/21. Resident #1 was not sit by the dentist at the which time a given for a referral for the and root tips. Resident #1 ist on 4/11/22 and reported an erso and reported a pain 10 from 04/07/22 through s was scheduled on 8/4/22 an) for 8/16/22 and Resident	F	835	Regional Director of Clinical Services (RDCS) educated the Director of Nursi (DON) and Nurse Managers on the facility's revised process for managing in-house and outside dental services. The revised process of dental care and services will be validated during daily Stand-Up meeting with the Interdisciplinary Team (IDT) to include Nursing Administration, Social services Director, Dietary Manager, Director of Rehabilitation, and Medical Records Coordinator/Transportation Aide to rev status of outstanding dental services needed. This education included the verification of services provided (appointments scheduled) per physicial orders.  4. The RDO and RDCS will provide onsite support and validation using a Cool of daily Stand-Up/QAPI meetings validate oral care and follow-up services are provided timely and effectively per physician orders. The QA monitoring was be completed twice weekly x 4 weeks, then weekly x 8 weeks.  QAPI meetings will be held weekly x 4 weeks, then monthly on-going includin the NHA, DON, RDO, RDCS, and VP Regulatory will be held to ensure	d d s iew nn QA do es will	
	Nurse Practitioner (N oral surgeon office m				compliance with outstanding regulatory issues, new concerns identified and plant for improvement.  5. The date of compliance is 8/15/22	ans	

STAT (without delay) dental services for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345128			` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		B. WING _			C 08/10/2022		
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP COD 520 VALLEY STREET STATESVILLE, NC 28677		0.10.2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 867	tooth abscess. Resider routine visit by the de 12/01/21 at which tim given for a referral for and root tips. Resider routine visit by the de 10/12/21 and was preabscessed tooth and given for a referral for remaining teeth. The services for extraction Resident #2 were treawith oral antibiotics at from the infections where resident interview requests by the dentist Resident #1's appoint not scheduled until 07 Resident #2's was so survey began) for 8/1 services put Resident for sepsis or endocard occurred for 2 of 3 reservices (Resident #1 Facility administration jeopardy on 08/05/22 QAPI/QAA Improvem CFR(s): 483.75(g)(2)(2)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	#1 on 10/21/21 due to a ent #1 was not seen until a ntist at the facility on e a recommendation was the extraction of all teeth at #2 was seen during a ntist at the facility on escribed antibiotics for an a recommendation was the extraction of all facility failed to obtain dental as. Both Resident #1 and ated for tooth abscesses and they experienced pain nich decreased their appetite is. Despite subsequent at and the medical providers, ament for extractions was 7/21/22 for 08/23/22 and heduled on 8/4/22 (after the 6/22. The delay in dental at #1 and Resident #2 at risk ditis. This deficient practice sidents reviewed for dental and Resident #2).  In was notified of immediate at 8:00 PM. ent Activities (iii)	F 8			8/15/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDI		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
345128			B. WING _			08/10/2022	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE		
400000		·0./// . F		520 VALLEY STREET			
ACCORDI	US HEALTH AT STATE	SVILLE		STATESVILLE, NC 28677			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ACTION SHOULD BE COMPLETION DATE		
F 867	Continued From pa by: Based on observa		F 8		nent Activities		
	Based on observatinterviews, the facil Assurance (QAA) Complemented proces interventions that the deficiency for Grieva a complaint investiga 8/10/22. For a defic Assessments which recertification and completed on 9/3/2 completed 2/23/22 and complaint investiga 8/10/22. For a defic which was cited ducomplaint investiga 9/3/21, the complaint investiga 8/10/22. For a defic which was cited ducomplaint investiga 8/10/22. For a defic which was cited ducomplaint investiga 8/10/22. For a defic which was cited ducomplaint investiga 8/10/22. For a defic which was cited ducomplaint investiga 8/10/22. For a defic which was cited duromplaint investiga 8/10/22. For a defic was cited during the investigation survey complaint investigation survey deficiency for QAPI complaint investigation survey conducted complaint investigation survey conducted complaint investigation survey conducted complaint investigation survey conducted complaint investigation survey complaint investigation survey complaint investigation survey deficiency for QAPI complaint investigation survey complaint investigation survey complaint investigation sur	tions, record review, and staff ity's Quality Assessment and Committee failed to maintain dures and monitor the ne committee put in place for a rances which was cited during gation survey conducted on sility's current revisit and tion survey conducted on siency for Accuracy of new as cited during the complaint investigation survey 1, the complaint investigation survey 1, the complaint investigation and the facility's current revisit estigation survey conducted on siency for Quality of Care ring the recertification and tion survey completed on int investigation completed sility's current revisit and tion survey conducted on siency for Dental Services ring the recertification and tion survey completed on sity's current revisit and tion survey conducted on ciency for Administration which are recertification and complaint of completed 2/23/22 and are revisit and completed 2/23/22 and are revisit and complaint of conducted on 8/10/22. For a 1/QAA which was cited during a tion survey conducted on and complaint investigation on 4/1/22 and 5/25/22, and the isit and complaint investigation on 8/10/22. The continued		1. On August 10, 2022, the Assurance Committee met at the purpose and function of Assurance Performance (QACommittee as well as the or compliance issues regarding F684, F791, and F835.  2. On August 10, 2022, the Director of Operations educated Nursing Home Administrator appropriate functioning of the Committee and the purpose Committee to include identific correcting repeat deficiencies F585, F641, F684, F791, and Education included identifying of concern during the Quality Improvement (QI) process, for review of grievance/concern of rounding tools, daily review Click Care documentation, and observation during leadersh 3. On August 10, 2022, the educated the QAPI committee consisting of, the Medical Didirector of Nursing, Assistar Nursing, Infection Prevention Coordinators, Medical Records/Transportation Aide Office Manager, Minimum Director, Dietary Manager, Enhabilitation, Social Worker Maintenance Director, and Pharm Consultant at (minimum quality).	e Quality and reviewed the Quality API) n-going g F585, F641, e Regional ated the r (NHA) on the le QAPI of the rying and es related to, nd F835. ng other areas y for example: n logs, review lew of Point and ip rounds. e Administrator ee members irector, nt Director of nist, Unit e, Business leata Set lea, Activities Director of ler, ronmental macy		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING _		C 08/10/2022
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F 867	Continued From pa	age 50	F 8	367	
	of record show a pa	ty during five federal surveys attern of the facility's inability to e Quality Assurance Program.		weekly QA review of audit compliance and/or revisior addition to weekly QA mee committee will continue to 4. The monitoring process the plan of correction is of	n needed. In etings, the QAPI meet monthly. dure to ensure
	This tag is cross re	ferred to:		the plan of correction is eff specific cited deficiencies corrected and/or in compli	remains
F585- Based on observations, record review resident, family and staff interview, the facilit failed to provide written response for resoluti to grievances for 2 of 2 residents reviewed for grievances (Resident #1 and Resident #2).  During the complaint survey dated 2/23/22, to regulation was cited for failure to address file grievances for 1 of 1 resident reviewed for grievances.  F641- Based on observation, record reviews resident and staff interviews, the facility faile accurately code the Minimum Data Set (MDS)		d staff interview, the facility itten response for resolutions of 2 residents reviewed for ent #1 and Resident #2).  Int survey dated 2/23/22, this d for failure to address filed 1 resident reviewed for eservation, record reviews, and interviews, the facility failed to be Minimum Data Set (MDS) for		regulatory requirements is corporate staff monthly x 3 oversight will validate the f progress, review corrective dates of completion. The A be responsible for ensuring committee concerns are at through further training or interventions.  5. The date of compliance	B. Corporate facility's e actions and Administrator will g QAPI ddressed other
	(Resident #1 and F During the complai regulation was cite an admission minir height and dischar- reviewed. During the recertific regulation was cite the Minimum Data reviewed for dischar- reviewed for unnec- of 5 residents reviewed	wiewed for dental services Resident #2).  Int survey dated 2/23/22, this d for failure to accurately code num data set assessment for ge planning for 1 of 3 residents  cation survey on 09/03/21, this d for failure to accurately code Set (MDS) for 1 of 2 residents arge, for 1 of 5 residents ressary medications, and for 1 rewed for resident assessment.			

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* *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMP	SURVEY
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		345128	B. WING				10/2022
NAME OF PR	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 55/	,
				5:	20 VALLEY STREET		
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(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
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			+				
F 867	Continued From page	e 51	F	867			
		Practitioner (NP), and					
		) interviews, the facility failed					
	,	well-being by not providing					
		prevent oral abscesses and					
	unresolved dental pain for 2 of 3 residents						
	(Resident #1 and Resident #2). Resident #2 was						
	seen during a routine						
	facility on 10/12/21 a						
	for an abscessed tooth and a recommendation						
	was given for a referral for the extraction of all						
	remaining teeth. Resident #2 reported a pain						
	level of 7 on a scale of 1-10 (10 being the worst						
	pain) several days before and while the abscess						
	was being treated. A						
	indicated Resident #2						
		nmation but not currently an 2 reported a pain level of 7					
		er this visit from the dentist.					
		n by NP #1 on 10/21/21 and					
		iotics for a tooth abscess					
		delay) dental appointment					
	for the abscess was requested. Resident #1 reported a pain level ranging from 7-10 from 10/21/21 through 10/27/21. Resident #1 was not						
	seen until a routine visit by the dentist at the						
	facility on 12/01/21 at	t which time a					
		s given for a referral for the					
	extraction of all teeth and root tips. Resident #1						
	was seen by the dentist on 4/11/22 and reported					ſ	
	pressure similar to when a previous abscess had					ſ	
		occurred. Resident #1 was prescribed an				ſ	
		antibiotic for the abscess and reported a pain				ſ	
		10 from 04/07/22 through				ſ	
		's dental appointment was (after the survey began) for				ſ	
		t #1's appointment for				ſ	
		cheduled until 07/21/22 for				ſ	
	08/23/22.					I	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 08/10/2022		
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT STATESVILLE				520	REET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET ATESVILLE, NC 28677	1 001	10/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 867	Continued From page	e 52	F	367				
	regulation was cited f orders for treatment to follow physician order foot ulcer and to follow	survey dated 2/23/22, this or failure to follow physician o a venous stasis ulcer, to r for treatment to a diabetic w physician order for wounds for 3 of 5 residents						
	regulation was cited f anticoagulation medic residents reviewed fo and failed to provide	tion survey on 09/03/21, this for failure to hold an cation as ordered for 1 of 5 r unnecessary medications a daily treatment as ordered iewed for skin condition.						
	Nurse Practitioner (N oral surgeon office mand resident interview STAT (without delay) #1 as ordered by NP tooth abscess. Resider outline visit by the de 12/01/21 at which time given for a referral for and root tips. Resider routine visit by the de 10/12/21 and was preabscessed tooth and given for a referral for remaining teeth. The services for extraction Resident #2 were treawith oral antibiotics at from the infections where the services by the dentification in the services by the services by the dentification in the services by the dentification in the services by	e a recommendation was the extraction of all teeth at #2 was seen during a antist at the facility on ascribed antibiotics for an a recommendation was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BU		FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 08/10/2022	
NAME OF PROVIDER OR SUPPLIER  ACCORDIUS HEALTH AT STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	•	VO. 10.2022	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ORRECTION ON SHOULD BE E APPROPRIATE )	(X5) COMPLETION DATE	
F 867	survey began) for 8/s services put Resider for sepsis or endocate occurred for 2 of 3 reservices (Resident # During the recertificate regulation was cited care by a dentist for or teeth with dental reviewed for dental # F835- Based on obstinterviews of resider Director, the Adminical leadership and over ensure that physicial was conducted.  During the complain regulation was cited leadership and over systems were in pla (Prothrombin Time Tratio) as ordered by communicating labor for monitoring and record blood thinner) described to the services of the	cheduled on 8/4/22 (after the 16/22. The delay in dental at #1 and Resident #2 at risk arditis. This deficient practice esidents reviewed for dental #1 and Resident #2).  ation survey on 09/03/21, this for failure to obtain dental a resident with broken teeth caries for 1 of 1 resident services.  Servation, record reviews, and ats, staff, and the Medical stration failed to provide sight to the facility staff to an ordered dental consults  It survey dated 2/23/22, this for failure to provide sight to ensure effective as for obtaining PT/INRs  Test/ International Normalized of the MD/NP and ratory results of the PT/INRs agulating of Coumadin (an osage. The facility also failed needed for staff to obtain the esident reviewed for	F	B67			
	regulation was cited housekeeping and la residents had clean for their bed, and cle	ation survey on 09/03/21, this for failure to have sufficient aundry staff to ensure the clothes available, clean linen ean gowns available as the e accustom to wearing, the					

STATEMENT OF DEFICIENCIES (X1) P AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
345128			B. WING _			C 08/10/2022	
	ROVIDER OR SUPPLIER  US HEALTH AT STATES	l		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	<b>'</b> E	00/10/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 867	Continued From page facility also failed to have resident rooms on 2 of the facility also failed to have a side	nave enough staff to clean	F8	67			