	-	ID HUMAN SERVICES			FORM	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	E CONSTRUCTION	COMF	E SURVEY PLETED
		345010	B. WING			C /16/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT ASHEVII	LE		500 BEAVERDAM ROAD		
				ASHEVILLE, NC 28804		1
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	investigation survey v through 12/16/22. Th compliance with the r	ertification and complaint vere conducted on 12/12/22 ne facility was found in equirement CFR 483.73, ness. Event ID# L8F11.	F 000			
	recertification and con were conducted on 12 Tags F689, F755, and 12/16/22. However, r result of the recertification investigation survey t	hat was conducted at the sit. The facility is still out of				
F 580 SS=G	NC00194950, NC001 Five of the 17 allegati without deficiency and (F684). Notify of Changes (In	95042, NC00195443, 95307, and NC00195466. ions were substantiated, one d 4 resulting in deficiencies jury/Decline/Room, etc.)	F 580			1/9/23
	consult with the resid consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					01/10/2023

Electronically Signed

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345010	B. WING				C / 16/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	. <u> </u>	
400000				50	00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	LE		A	SHEVILLE, NC 28804		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580	clinical complications, (C) A need to alter tree a need to discontinue treatment due to advec commence a new form (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must at resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must re update the address (re phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite dia §483.5) must disclose its physical configurat locations that comprise part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by:	reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident bosite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations - is not met as evidenced	F	580	1 The facility failed to notify the		
		ew and interviews with the			1. The facility failed to notify the		

Facility ID: 922979

If continuation sheet Page 2 of 66

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED		
		345010	B. WING		1:	C 2/16/2022		
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COD				
				500 BEAVERDAM ROAD				
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804				
(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)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From page	e 2 staff, the facility failed to	F 58	0 physician a resident's pain wa	as not			
	notify the physician a controlled after the ac	resident's pain was not		controlled after the administra medication. The resident calle emergency medical services	ation of pain ed			
		liagnosed with acute nation of the gallbladder) that		evaluated for abdominal pain diagnosed with acute cholecy (inflammation of the gallbladd	vstitis ler) that			
	removal of the gallbla	o the hospital for the surgical adder for 1 of 2 residents zations (Resident #270).		required admission to the hos surgical removal of the gallbla 2 residents reviewed for hosp (Resident #270), Resident #2	adder for 1 of bitalizations			
	The findings included			(Resident #270). Resident #2 thorough pain evaluation com nurse practitioner (NP) on 12	npleted by /15/2022			
	05/15/20 with diagnos	dmitted to the facility on ses including a history of and quadriplegia. Resident		upon readmission from the ho continued current pain regime resident stating the current re	en due to			
	•	to the hospital on 11/22/22		pain adequately.2. All residents have potent	-			
		m Data Set dated 08/29/22 70 was assessed as being		affected by this deficient prac Director of Nursing (DON) and	tice. The			
	medications were rec	utine and as needed pain eived during the lookback nt reported his pain was		managers completed a pain a on all current facility residents on 12/20/2022. The physiciar	s completed			
	moderate, frequent, a activities. Opioids (na	and interfered with sleep and arcotic pain medications)		were notified of results of ass and medication adjustments	essments and care			
		during the lookback period. ation Administration Record		plan revisions were made as residents who reported insuffi control.				
	pain medication) 5-32	acetaminophen (a narcotic 25 milligrams every 6 hours anagement was given twice		3. The measures that have	heen nut into			
	on 11/22/22. The first level of 7 and the sec	dose at 3:56 PM for a pain cond dose at 10:06 PM for a		place to ensure the deficient not recur are as follows: The	practice does DON			
	pain level of 8. Both a documented as being			educated current facility and a licensed nurses on notifying t or NP in the event a resident	he physician			
	Review of the nurse p 11/22/22, written by N	progress note dated Nurse #4, revealed on		inadequate pain control and t facility and agency certified m	he current			

Facility ID: 922979

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· · /	G) ´c	OMPLETED
						С
		345010	B. WING			12/16/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ACCORD	US HEALTH AT ASHEVI	LIF		500 BEAVERDAM ROAD		
Accord				ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 580	Continued From page	e 3	F 5	80		
		ately 9:30 PM Resident		assistants (CMA) were edu	cated to notify	
		oxxxhole pain and asked to		the licensed nurse if they h		
		al. Nurse #4 obtained a set of		reporting or exhibiting beha		
		ned to the resident those		inadequate pain control, so		
		mits and his pain medication		assessment can be comple		
		ere was no clinical reason to		licensed nurse and follow-u	•	
		the hospital. The progress		to the physician or NP as n		
		ent #270 refused the pain		new orders . Education was		
N s		didn't work. The Director of		effective 01/06/2023. New	-	
		notified and agreed to not		agency licensed nurses and		
		the hospital for lack of a ver it was his right to call		staff unable to complete ed 1/6/2023 will be educated p	•	
		service (EMS). Nurse #4		their next shift.	noi to working	
		on to Resident #270 and				
	-	acility at 10:56 PM to transfer		4. The DON or Unit Mana	agers (UM) will	
	the resident to the ho	-		audit five (5) residents twice		
		'		weeks, then weekly for 8 w		
	Review of the hospita	al discharge summary		physician and NP are notifi		
	revealed Resident #2	270 was evaluated for		effectively managed with th	le resident ⊡s	
	abdominal pain using	g a computed tomography		current regimen. The facility	y will monitor	
		of the inside of the body) and		the corrective actions to en	sure that the	
		e cholecystitis. General		deficient practice is corrected		
		ed and on 11/24/22 Resident		recur by reviewing informat		
	#270's gallbladder wa	as surgically removed.		during audits and reporting	•	
	During a talankana in	toniow on 10/11/00 -+ 0.50		Assurance Performance Im		
		nterview on 12/14/22 at 9:56 ed after Resident #270		committee (QAPI) by the D three (3) months. At that tin	•	
		ig anal pain she obtained a		committee will evaluate the		
		those were within normal		of the interventions to deter		
	•	ain medication. Nurse #4		continued auditing or adjus		
		all Resident #270 say the		plan of correction are neces		
		ineffective, but her progress			2	
	•	at was done. Nurse #4		5. Completion Date: 01/0	9/2023	
) did not appear in distress,				
		een normal for the resident				
		ated she called the DON				
	-	is no clinical reason, but it				
		right to call EMS for transfer				
	to hospital. Nurse #4	confirmed she did not notify				1

If continuation sheet Page 4 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/18/2023 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345010	B. WING		_		C 16/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page the MD for guidance.		F 580				
	PM with Resident #27 told the nurse he was	mach pain on 11/22/22 and					
	PM with the DON. The called her about Resid hospital for anal pain a reason to send the the nurse told her. The recall the being inform	ducted on 12/16/22 at 4:46 e DON revealed Nurse #4 dent #270 wanting to the and she didn't think that was resident out based on what e DON revealed she didn't ned the pain medication was e had her first response hysician.					
F 584 SS=B	Medical Director reverse be notified Resident # the medications were could have evaluated Safe/Clean/Comfortat	ole/Homelike Environment	F 584				1/9/23
	§483.10(i) Safe Enviro The resident has a rig comfortable and home but not limited to rece supports for daily livin	ht to a safe, clean, elike environment, including iving treatment and					
	homelike environmen use his or her persona possible.	ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can					

Facility ID: 922979

If continuation sheet Page 5 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345010	B. WING				_ 16/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVI	LLE			00 BEAVERDAM ROAD SHEVILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	physical layout of the independence and do (ii) The facility shall e the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spe §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfor levels. Facilities initia 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on record rev interviews the facility colored substance ar base of the toilet (Roo Two of the rooms (Ro strong odor resemblin facility failed to remov and repair missing participants	vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for resident's property from loss recepting and maintenance o maintain a sanitary, orderly, for; bed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); the and comfortable lighting table and safe temperature lly certified after October 1, a temperature range of 71 to maintenance of comfortable T is not met as evidenced iew, observations, and staff failed to remove a black and repair caulking around the om #111, #116, #117, #118). poms #117 and #118) had a ng the smell of urine. The ve black colored corrosion aint to the portion of a metal	F	584	1. The facility failed to remove a blac colored substance and repair caulking around the base of the toilet (Room #1 #116, #117, #118). Two of the rooms (Rooms #117 and #118) had a strong odor resembling the smell of urine. The facility failed to remove black colored corrosion and repair missing paint to th portion of a metal door frame in contact	11, e	
	and repair missing pa door frame in contact				-	:t	

Facility ID: 922979

If continuation sheet Page 6 of 66

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	` '		· · · · · · · · · · · · · · · · · · ·	MPLETED	
			AL DOILDING			С	
		345010	B. WING		1	2/16/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
				500 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVII	LLE		ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIO DATE	
F 584	Continued From page	e 6	F 58	34			
		ock (Rooms #117 and #118)	1.00	failed to repair walls wit	h linear douges in		
		ne sheetrock (Room #119)		the sheetrock (Rooms #			
		viewed for safe, clean, and		and repair a hole in the	-		
	homelike environmen			#119) for 1 of 2 hallway			
				safe, clean, and homeli			
	The findings included	:		All repairs were comple			
	Peview of the facility'	s estimates and billing for		Maintenance Director e	liecuve 1/9/23.		
		revealed caulking the base		2. Current facility resid	dents have the		
		paint gouges and holes to		potential to be affected			
	damage sheetrock, a	nd removal of corrosion and		practice. The maintenar	nce director and		
	•	or were not included for the		housekeeping staff com	-		
	rooms observed with	environment issues.		environmental rounds to			
	1a An observation of	n 12/12/22 at 10:24 AM		areas needing repair an above cited issues. The	-		
		the toilet in the bathroom of		rounds were completed			
		stains and missing caulk.		and a schedule initiated			
		6		cleaning and repairs to			
		12/12/22 at 11:48 AM		clean, comfortable hom	elike environment		
		the toilet in the bathroom of		for residents			
	Room #116 had blacl	k stains and missing caulk.					
	c An observation on	12/12/22 at 11:57 AM		3. The measures that	have been put into		
		the toilet in the bathroom of		place to ensure the defi	-		
		k stains and missing caulk. A		not recur are as follows			
	strong odor resemblir	ng the smell of urine was		educated current house			
	noted in the bathroon	n and the room.		and maintenance direct			
	d An abas	40/40/00 -+ 0.40 PM		facility housekeeping st			
	d. An observation on	the toilet in the bathroom of		of cleanliness, repairs, maintenance reporting			
		k stains and missing caulk. A		maintenance request lo			
		ng the smell of urine was		facility and agency nurs	•		
	noted in the bathroon			education on reporting i	-		
				the Maintenance Binder			
	2. An observation on			nurses station. Education			
		ame of the bathroom door in		by 1/9/2023. New facilit			
		oded with a black substance eled off approximately 2		housekeeping staff and and agency staff unable	-		
		e frame was in contact with		education by 1/9/2023 v			

Facility ID: 922979

If continuation sheet Page 7 of 66

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/18/2023 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345010	B. WING _			1	C 2/16/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
400000				50	00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE		Α	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	Continued From page	a 7	F 5	201			
1 001		a strong odor that resembled		04	prior to working their next scheduled	shift.	
	12/13/22 at 9:00 AM 4:30 PM revealed no door. The room conti resembling the smell 3a. An observation of revealed the wall beh #117 had multiple line b. An observation on revealed the wall beh #118 had multiple line c. An observation on revealed the wall und	n 12/12/22 at 11:57 AM hind bed A and B in Room ear gouges in the sheetrock. 12/12/22 at 2:12 PM hind the bed A and B in Room ear gouges in the sheetrock. 12/12/22 at 3:30 PM lerneath the window in Room e sheetrock approximately			4. The Administrator will monitor 5 resident rooms and all common area twice weekly for 4 weeks and then we for 8 weeks to ensure facility is maintaining a homelike environment completing worklist per log and maintenance reporting system. The f will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by review information collected during audits ar reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly three (3) months. At that time the QA committee will evaluate the effectiver of the interventions to determine if continued auditing or adjustments to plan of correction are necessary.	eekly and acility /ing nd e for PI ness	
	issues was conducted through 1:34 PM with Administrator, and Re Operations. Rooms # #119 were observed with no sign of repair Maintenance Director the facility for 11 mon the Maintenance Dep the building at least of the repair issues sho to address those bec repairs that were nee Director stated usual	t111, #116, #117, #118, and to be in the same condition			5. Completion Date: 01/09/2023		

If continuation sheet Page 8 of 66

		MEDICAID SERVICES		ONSTRUCTION	OMB NO. 093 (X3) DATE SURVE	
	F CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLETED	
					с	
		345010	B. WING		12/16/20)22
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COD		
ACCORD	IUS HEALTH AT ASHEVI	LE		BEAVERDAM ROAD HEVILLE, NC 28804		
(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)	I SHOULD BE COM	(X5) IPLETION DATE
F 584	15		F 584			
	frames to resolve the nature of the repair. T and Administrator bot #117 and #118 resen could be caused by u flooring tiles and wou get rid of the smell. T	and it took different time issues depending on the The Maintenance Director th agreed the odors in Room abled the smell of urine and rine permeated between the Id require replacement to he Administrator and the revealed the new corporate				
F 000	office was aware of the planning to have some	ne current repair needs and lething done soon.	E 020		410/0	22
F 636 SS=E		0	F 636		1/9/2	23
	a comprehensive, ac	duct initially and periodically				
	A facility must make a assessment of a reside goals, life history and resident assessment	ent Assessment Instrument.				
	 (i) Identification and of (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. 	5.				
	 (vi) Mood and behavi (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis 	ell-being. hing and structural problems.				

Facility ID: 922979

If continuation sheet Page 9 of 66

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/18/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345010	B. WING _		C 12/16/2022
NAME OF P	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP	CODE
	US HEALTH AT ASHEVII	16		500 BEAVERDAM ROAD	
ACCORDI	US REALTH AT ASHEVI			ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 636	Continued From page	9	F 6	36	
	regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The ass include direct observa- with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When	ing. of summary information nal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with nsed direct care staff			
	chapter, a facility must assessment of a resid timeframes specified through (iii) of this se prescribed in §413.34	st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes I3(b) of this chapter do not			
	excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary	days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility absence for hospitalization			
	by: Based on record rev facility failed to comp Minimum Data Set (M	e every 12 months. is not met as evidenced iew and staff interviews, the		1. The facility failed to c comprehensive Minimum assessments within 14 da Assessment Reference D	Data Set (MDS) ays of the

Facility ID: 922979

If continuation sheet Page 10 of 66

		MEDICAID SERVICES				NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · · ·	TE SURVEY MPLETED		
						С		
		345010	B. WING			2/16/2022		
NAME OF P	ROVIDER OR SUPPLIER		- <u>1</u>	STREET ADDRESS, CITY, STATE, ZIP CO				
				500 BEAVERDAM ROAD				
ACCORD	US HEALTH AT ASHEVI			ASHEVILLE, NC 28804				
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 636	Continued From page	e 10	F 63	3				
		sment period) for 8 of 9		day of the assessment perio	d) for 8 of 9			
	-	or Resident Assessments		residents reviewed for Resid	•			
	(Residents #15, #38,	#41, #45, #47, #60, #223,		Assessments (Residents #1	5, #38, #41,			
é	and #220).			#45, #47, #60, #223, and #2	,			
	Finalis en in stude de			#15 had assessment dated				
	Findings included:			completed on 12/13/2023. R had assessment dated 10/20				
	1 Resident #15 was	admitted to the facility on		completed on 11/30/2022. R				
	11/15/21.			had assessment dated 08/02				
				completed on 09/14/2022. R	esident #45			
	Review of Resident #			assessment dated 11/23/202				
		IDS assessment with an		completed on 12/13/2022. R				
	on 12/13/22.	was marked as completed		assessment dated 08/02/202 completed on 09/24/2022. R				
				assessment dated 07/30/202				
	During an interview on 12/14/22 at 11:00 AM, the			completed on 08/27/2022. R				
		plained that prior to her		assessment dated 08/24/202				
		in November 2022, the		completed on 09/14/2022. R				
		MDS Coordinator for ths and although staff from		assessment dated 11/01/202	22 was			
		l as corporate staff filled in		completed on 12/12/2022.				
		assessments got behind and		2. Current facility residents	s have the			
		catching up to do. The		potential to be affected by th	is deficient			
		rified Resident #15's annual		practice. An audit was comp				
	MDS assessment dat			Minimum Data Set (MDS) co				
	completed within the	regulatory time frame.		comprehensive MDS assess				
	During an interview o	on 12/16/22 at 5:24 PM, the		ARD dates between 11/20/2 12/20/2022 to ensure all wer				
		due to staffing shortages,		up to date, and submitted tin				
	they had been unable			12/20/2022. Late assessmer	-			
	assessments within t	he regulatory timeframes.		completed and submitted by				
	2 Resident #38 was	admitted to the facility on		coordinator and Regional Cli Reimbursement Specialist (F				
	10/27/21.	a service to the facility of		01/06/2023.				
	Review of Resident #	438's medical record						
		IDS assessment with an		3. The measures that have				
		was marked as completed		place to ensure the deficient				
	on 11/30/22.			not recur are as follows: Effe	ective 1/9/23,			

Facility ID: 922979

If continuation sheet Page 11 of 66

TATEMENT C	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	· · ·	DATE SURVEY
	CONTRECTION	DENTIFICATION NOMBER.	A. BUILDING			C
		345010	B. WING			12/16/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ACCORDI	JS HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 636	Continued From page	• 11	F 630	6		
	MDS Coordinator exp starting employment if facility was without a approximately 7 mont other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri MDS assessment dat completed within the During an interview of Administrator stated of they had been unable assessments within th 3. Resident #41 was 08/31/21. Review of Resident # revealed an annual M ARD of 08/02/22 that on 09/11/22. During an interview of MDS Coordinator exp starting employment if facility was without a approximately 7 mont other facilities as well as they could, MDS a	ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The ified Resident #38's annual ed 10/20/22 was not regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages, to complete MDS ne regulatory timeframes. admitted to the facility on 41's medical record IDS assessment with an was marked as completed IDS assessment with an was marked as completed		 education was provided to the coordinator and interdisciplination (IDT) by the RCRS on timely of comprehensive MDS s with of ARD per the Resident Asset Instrument (RAI) guidelines. 4. The IDT also implemented to their system of MDS completed to their system of MDS complemented as an ARD dates to ensign a shared calendar of ut MDS and ARD dates to ensign comprehensive assessments. Was completed by 01/06/2023 facility MDS staff and current to complete education by 1/6/educated prior to working their scheduled shift. 5. The MDS coordinator and monitor 5 random residents for completion of comprehensive assessments within 14 days of Monitoring will be completed to for 4 weeks, then weekly for 8 facility will ensure deficient pranot recur by reviewing informatic collected during audits and re Quality Assurance Performant Improvement committee (QAF Director of Nursing (DON) monthree (3) months. At that time committee will evaluate the effort the interventions to determine the intervention is the intervention in the intervention is the intervention in the intervention is the intervention intervention intervention intervention is the intervention intervention intervention intervention intervention is the intervention intervention intervention intervention intervention is done intervention interventi	ary team completion hin 14 days essment ed an update etion by pcoming sure oletion of Education 8. New staff unable 2023 will be r next d/or DON will or timely of ARD. wice weekly sweeks. The actice does ation porting to ce PI) by the inthly for the QAPI fectiveness	
	MDS assessment dat	ified Resident #41's annual ed 08/02/22 was not regulatory time frame.		continued auditing or adjustm plan of correction are necessa		

Facility ID: 922979

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345010	B. WING				C 16/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORD	US HEALTH AT ASHEVIL	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	 they had been unable assessments within the 4. Resident #45 was 12/09/20. Review of Resident # revealed an annual M ARD of 11/23/22 that on 12/12/22. During an interview of MDS Coordinator explicitly was without a approximately 7 monto other facilities as well as they could, MDS as they now had a lot of MDS Coordinator ver MDS assessment dat completed within the During an interview of Administrator stated of they had been unable assessments within the 5. Resident #47 was 07/27/22. Review of Resident # revealed an admissio ARD of 08/02/22 that on 09/24/22. During an interview of Resident # revealed an admission ARD of 08/02/22 that on 09/24/22. 	due to staffing shortages, e to complete MDS ne regulatory timeframes. admitted to the facility on 45's medical record IDS assessment with an was marked as completed n 12/14/22 at 11:00 AM, the plained that prior to her n November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The ified Resident #45's annual ed 11/23/22 was not regulatory time frame. n 12/16/22 at 5:24 PM, the due to staffing shortages, e to complete MDS ne regulatory timeframes. admitted to the facility on	F	636			

Facility ID: 922979

If continuation sheet Page 13 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345010	B. WING				C / 16/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	US HEALTH AT ASHEVIL	16		50	00 BEAVERDAM ROAD		
ACCORD	US NEALTH AT ASHEVIL	-LE		Α	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	starting employment i facility was without a approximately 7 monto other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri admission MDS asser- not completed within f During an interview of Administrator stated of they had been unable assessments within th 6. Resident #60 was 07/18/22. Review of Resident # revealed an admissio ARD of 07/30/22 that on 08/27/22. During an interview of MDS Coordinator exp starting employment i facility was without a approximately 7 monto other facilities as well as they could, MDS aster not completed within f During an interview of MDS Coordinator veri admission MDS asser- not completed within f	in November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in issessments got behind and catching up to do. The ified Resident #47's ssment dated 08/02/22 was the regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages, to complete MDS ne regulatory timeframes. admitted to the facility on 60's medical record n MDS assessment with an was marked as completed In 12/14/22 at 11:00 AM, the blained that prior to her in November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in issessments got behind and catching up to do. The ified Resident #60's ssment dated 07/30/22 was the regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages,	F	636			
	not completed within the During an interview of Administrator stated of they had been unable assessments within the 6. Resident #60 was 07/18/22. Review of Resident #7 revealed an admission ARD of 07/30/22 that on 08/27/22. During an interview of MDS Coordinator expostrating employment if facility was without a approximately 7 monto other facilities as well as they could, MDS a steey now had a lot of MDS Coordinator veri admission MDS asses not completed within the facility was stated of Administrator sta	the regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages, a to complete MDS the regulatory timeframes. admitted to the facility on 60's medical record n MDS assessment with an was marked as completed In 12/14/22 at 11:00 AM, the blained that prior to her in November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in issessments got behind and catching up to do. The ified Resident #60's ssment dated 07/30/22 was the regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages,					

Facility ID: 922979

If continuation sheet Page 14 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			PLETED
		345010	B. WING				C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	10/2022
ACCORDI	US HEALTH AT ASHEVIL	.LE					
				-	ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
F 636	Continued From page	9 14	F	636	5		
	7. Resident #223 wa 08/18/22.	s admitted to the facility on					
		223's medical record n MDS assessment with an was marked as completed					
	During an interview on 12/14/22 at 11:00 AM, the MDS Coordinator explained that prior to her starting employment in November 2022, the facility was without a MDS Coordinator for approximately 7 months and although staff from other facilities as well as corporate staff filled in as they could, MDS assessments got behind and they now had a lot of catching up to do. The MDS Coordinator verified Resident #223's admission MDS assessment dated 08/24/22 was not completed within the regulatory time frame.						
	Administrator stated of they had been unable	n 12/16/22 at 5:24 PM, the due to staffing shortages, e to complete MDS ne regulatory timeframes.					
	8. Resident #220 wa 10/25/22.	s admitted to facility on					
	data set (MDS) with a	nt 220's admission Minimum In assessment reference 22 was observed as "in plete.					
	PM with MDS nurse. work for the facility or nurse was filling in he	ducted on 12/12/22 at 3:40 She stated she started to n 11/18/22. Another MDS er position on "as needed" her employment. She did not					

Facility ID: 922979

If continuation sheet Page 15 of 66

-					FORM	APPROVED 0. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	345010	B. WING				_ 16/2022
ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
US HEALTH AT ASHEVIL	LE					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE
		F	636			
MDS Coordinator on acknowledged that Re MDS had been late. H not have a full time M months in the past. Th assistance from a PR facility and he had to	12/12/22 at 3:42 PM, he esident #220's admission de explained the facility did DS nurse for more than 6 he facility received N MDS Nurse from another fill in the position most of the					
with the Administrator expectation for all the	revealed it was his MDS to be completed as					
(DON) on 12/16/22 at facility did not have a past few months. It we MDS to be completed regulation in timely m Qrtly Assessment at L	3:21 PM, she explained the full time MDS nurse in the as her expectation for all the l as required by the anner.	F	538			1/9/23
A facility must assess quarterly review instru- and approved by CMS once every 3 months. This REQUIREMENT by: Based on record revi facility failed to compl	a resident using the ument specified by the State S not less frequently than is not met as evidenced ew and staff interviews, the ete quarterly Minimum Data			 The facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the 		
	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER US HEALTH AT ASHEVIL SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR I Continued From page know that Resident #2 incomplete. During an interview ca MDS Coordinator on acknowledged that Re MDS had been late. H not have a full time M months in the past. TI assistance from a PR facility and he had to time in the past few m An interview conducte with the Administrator expectation for all the scheduled according manner. During an interview w (DON) on 12/16/22 at facility did not have a past few months. It w MDS to be completed regulation in timely m Qrtly Assessment at L CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instru- and approved by CM3 once every 3 months. This REQUIREMENT by: Based on record revi facility failed to completed	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345010 ROVIDER OF DESTICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 know that Resident #220's admission MDS was incomplete. During an interview conducted with the Regional MDS Coordinator on 12/12/22 at 3:42 PM, he acknowledged that Resident #220's admission MDS had been late. He explained the facility did not have a full time MDS nurse for more than 6 months in the past. The facility received assistance from a PRN MDS Nurse from another facility and he had to fill in the position most of the time in the past few months. An interview conducted on 12/16/22 at 10:49 AM with the Administrator revealed it was his expectation for all the MDS to be completed as scheduled according to the regulation in timely manner. During an interview with the Director of Nursing (DON) on 12/16/22 at 3:21 PM, she explained the facility did not have a full time MDS nurse in the past few months. It was her expectation for all the MDS to be completed as required by the regulation in timely manner. Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	ES FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT DOP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT BUILDI 345010 B. WING ROVIDER OR SUPPLIER 345010 B. WING US HEALTH AT ASHEVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 15 Know that Resident #220's admission MDS was incomplete. F6 During an interview conducted with the Regional MDS Coordinator on 12/12/22 at 3:42 PM, he acknowledged that Resident #220's admission MDS had been late. He explained the facility did not have a full time MDS nurse for more than 6 months in the past. The facility received assistance from a PRN MDS Nurse from another facility and he had to fill in the position most of the time in the past few months. An interview conducted on 12/16/22 at 10:49 AM with the Administrator revealed it was his expectation for all the MDS to be completed as scheduled according to the regulation in timely manner. During an interview with the Director of Nursing (DON) on 12/16/22 at 3:21 PM, she explained the facility did not have a full time MDS nurse in the past few months. It was her expectation for all the MDS to be completed as required by the regulation in timely manner. F6 Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) F6 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and appr	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345010 B. WING	SFOR MEDICARE & MEDICAID SERVICES OF DEFINICIENCIES (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345010 8. WING ROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZIP CODE US HEALTH AT ASHEVILLE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG Continued From page 15 know that Resident #220's admission MDS was incomplete. F 636 During an interview conducted with the Regional MDS Coordinator on 12/12/22 at 3:42 PM, he acknowledged that Resident #220's admission MDS had been late. He explained the facility did not have a full time MDS nurse form another facility and he had to fill in the position most of the time in the past. The facility received assistance from a PRN MDS Nurse form another facility and he had to 12/16/22 at 10:49 AM with the Administrator revealed it was his expectation for all the MDS to be completed as scheduled according to the regulation in timely manner. F 638 During an interview with the Director of Nursing (DON) on 12/16/22 at 3:21 PM, she explained the facility failed to as reguined by the regulation in timely manner. F 638 QH33.20(c) Quarterly Review Assessment Afacility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. F 638 GH34.30(c) Quarterly Minimum Data Set (MDS) 1. Th	MENT OF HEALTH AND HUMAN SERVICES OMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC PERFICIENCIES (X) PROVERENSUPPLENCIA. IDENTIFICATION NUMBER 345010 E. WIG SITURET ADDRESS, CITY, STATE, ZP CODE 500 BEAUTH AT ASHEVILLE SITURET ADDRESS, CITY, STATE, ZP CODE 500 BEAUTH AT ASHEVILLE SITURET ADDRESS, CITY, STATE, ZP CODE 500 BEAUTRA ASHEVILLE SITURET ADDRESS, CITY, STATE, ZP CODE 500 BEAUTRA ASHEVILLE, NC 28804 SILINAMY STATEMENT OF DEFICIENCIES (CADI DEFICIENCY WIST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTFYING INFORMATION) Continued From page 15 know that Resident #220's admission MDS was incomplete. During an interview conducted with the Regional MDS Coordinator on 12/12/22 at 3.42 PM, he acknowledged that Resident #220's admission MDS had ben late. He explained the facility did noths in the past. The facility received assistance from a PRIN MDS Nurse for more than 6 months in the past. The facility received assistance from a PRIN MDS Nurse form most of the time in the past. The facility received assistance from a PRIN MDS Nurse form most of the time in the past. The facility received assistance from a PRIN MDS Nurse form most of the time in the past. The facility received assistance from a PRIN MDS Nurse for most of the time in the past. The scalifity received assisted at the full time MDS nurse for most of the time in the past. The scalify the explained the facility and he had to fill in the Director of Nursing (DON) on 12/16/22 at 3:21 PM, she explained the facility did not have a full time MDS nurse in the past few months. A facility matter by CMS not tess frequently than once every 3 months. This REQUIREMENT is not met as evidenced by. Based on record review and staff interviews, the facility failed to complete guarterly Minimum Data Set (MDS)

Facility ID: 922979

If continuation sheet Page 16 of 66

				E OONOTO:			D. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRU		(X3) DATE COMF	SURVEY PLETED
			A. BUILDING				С
		345010	B. WING				0 /16/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE	1 12	10/2022
				500 BEAVER	RDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLI	E, NC 28804		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 638	Continued From page	e 16	F 63	8			
	1.5	ce Date (ARD, the last day			sment Reference Date (ARD, t	the	
		riod) for 6 of 9 residents			y of the observation period) fo		
	reviewed for Residen	t Assessments (Residents		-	ents reviewed for Resident		
	#41, #45, #46, #47, #	£56 and #60).			ments (Residents #41, #45, #		
	Ein die en in derde de				56 and #60). Resident #41 qua	arterly	
	Findings included:				ment dated 11/02/2022 was eted on 12/13/2022. Resident :	#15	
	1 Resident #41 was	admitted to the facility on			rly assessment dated 10/10/20		
	08/31/21.				mpleted on 11/12/2022. Resid		
					arterly assessment dated		
	Review of Resident #			08/05/2	2022 was completed 09/24/20	22.	
		MDS assessment with an			nt #47 quarterly assessment		
	ARD of 11/02/22 that on 12/13/22.	was marked as completed		12/04/2	2022 was marked completed o 2022. Resident #56 quarterly ment dated 10/14/2022 was	on	
	During an interview o	on 12/14/22 at 11:00 AM, the			eted on 11/16/2022. Resident	#60	
		plained that prior to her			rly assessment dated 10/30/20		
	starting employment	in November 2022, the			mpleted on 12/12/2022.		
	facility was without a				sments completed by the MDS	6	
		ths and although staff from			nator and submitted by the		
		l as corporate staff filled in			nal Clinical Reimbursement		
		assessments got behind and catching up to do. The		Specia	list (RCRS).		
	MDS Coordinator ver			2. Ci	urrent facility residents have th	ne	
		sment dated 11/02/22 was			al to be affected by this deficie		
	not completed within	the regulatory time frame.			e. An audit was completed on		
					22 by the Minimum Data Set (MDS)	
		on 12/16/22 at 5:24 PM, the			nator on quarterly MDS		
	they had been unable	due to staffing shortages,			ments with ARD dates betwee 2022 and 12/20/2022 to ensur		
	-	he regulatory timeframes.			ompleted, audit completed on		
		J ,			2022. Late quarterly MDSs we		
	2. Resident #45 was 12/09/20.	admitted to the facility on			eted and submitted as identifie		
				3. Th	e measures that have been p	ut into	
	Review of Resident #				o ensure the deficient practice		
		MDS assessment with an			ur are as follows: Education w		
		was marked as completed			ed to the MDS coordinator by t		
	on 11/12/22.				on timely completion of quarter	SILA	

Facility ID: 922979

If continuation sheet Page 17 of 66

		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/18/2023 APPROVED 0: 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING				C 16/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
400000				50	00 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVIL	LE		A	SHEVILLE, NC 28804			
(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 APPROPRIM		(X5) COMPLETION DATE	
					DEFICIENCY)			
F 638	MDS Coordinator exp starting employment i facility was without a l approximately 7 mont other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri quarterly MDS assess not completed within the During an interview of Administrator stated of they had been unable assessments within the	n 12/14/22 at 11:00 AM, the lained that prior to her n November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The fied Resident #45's sment dated 10/10/22 was the regulatory time frame. In 12/16/22 at 5:24 PM, the lue to staffing shortages, to complete MDS he regulatory timeframes. admitted to the facility on	F6	338	 MDS s per Resident Assessment Instrument (RAI) guidelines. The IDT a implemented an update to their system MDS completion by having a shared calendar of upcoming MDS s and ARI dates. Education was completed by 01/06/2023. New facility MDS nurses a IDT members and current staff unable complete education by 1/6/2023 will be educated prior to working their next scheduled shift. 4. The MDS coordinator and/or DON monitor 5 random residents for timely completion of quarterly MDS assessme within 14 days of ARD. Monitoring will completed twice weekly for 4 weeks, th weekly for 8 weeks. The facility will monitor the corrective actions to ensur- that the deficient practice is corrected a does not recur by reviewing information collected during audits and reporting to 	will ents be and and and and		
	revealed a quarterly M ARD of 08/05/22 that on 09/24/22. During an interview of MDS Coordinator exp starting employment i facility was without a l approximately 7 mont other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri quarterly MDS assess not completed within the	IDS assessment with an was marked as completed in 12/14/22 at 11:00 AM, the lained that prior to her n November 2022, the MDS Coordinator for hs and although staff from as corporate staff filled in ssessments got behind and catching up to do. The			 Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing (DON) monthly for three (3) months. At that time the QAP committee will evaluate the effectivene of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	l ss		

Facility ID: 922979

If continuation sheet Page 18 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SUI COMPLET	
		345010	B. WING				C / 16/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT ASHEVIL	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 638	 they had been unable assessments within the 4. Resident #47 was 07/27/22. Review of Resident # revealed a quarterly M ARD of 10/27/22 that on 12/04/22. During an interview of MDS Coordinator explored a generating employment in facility was without a 1 approximately 7 month other facilities as well as they could, MDS as they now had a lot of MDS Coordinator veri quarterly MDS assession to completed within the 5. Resident #56 was 04/06/22. Review of Resident # revealed a quarterly MDS assession to facility as a stated of they had been unable assessments within the 5. Resident #56 was 04/06/22. Review of Resident # revealed a quarterly MDS assession to facility and they not hat a lot of they had been unable assessments within the facility and they not a stated of they had been unable assessments within the facility and they not a stated of they had been unable assessments within the facility and they not facility	due to staffing shortages, e to complete MDS ne regulatory timeframes. admitted to the facility on 47's medical record MDS assessment with an was marked as completed n 12/14/22 at 11:00 AM, the plained that prior to her n November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The ified Resident #47's sment dated 10/27/22 was the regulatory time frame. n 12/16/22 at 5:24 PM, the due to staffing shortages, e to complete MDS ne regulatory timeframes. admitted to the facility on	F	638			

Facility ID: 922979

If continuation sheet Page 19 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345010	B. WING				C 16/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
	US HEALTH AT ASHEVIL	15		5	500 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVIL	LE		4	ASHEVILLE, NC 28804			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 638	facility was without a approximately 7 monto other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri- quarterly MDS assess not completed within f During an interview of Administrator stated of they had been unable assessments within th 6. Resident #60 was 07/18/22. Review of Resident # revealed a quarterly M ARD of 10/30/22 that on 12/12/22. During an interview of MDS Coordinator exp starting employment i facility was without a approximately 7 monto other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri- quarterly MDS assess not completed within f During an interview of Administrator stated of they had been unable	n November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The ified Resident #56's sment dated 10/14/22 was the regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages, to complete MDS the regulatory timeframes. admitted to the facility on 60's medical record MDS assessment with an was marked as completed In 12/14/22 at 11:00 AM, the blained that prior to her in November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The ified Resident #60's sment dated 10/30/22 was the regulatory time frame. In 12/16/22 at 5:24 PM, the due to staffing shortages, e to complete MDS	F	638				
	MDS Coordinator exp starting employment i facility was without a approximately 7 mont other facilities as well as they could, MDS a they now had a lot of MDS Coordinator veri quarterly MDS assess not completed within During an interview of Administrator stated of they had been unable	blained that prior to her n November 2022, the MDS Coordinator for ths and although staff from as corporate staff filled in ssessments got behind and catching up to do. The ified Resident #60's sment dated 10/30/22 was the regulatory time frame. n 12/16/22 at 5:24 PM, the due to staffing shortages,						

Facility ID: 922979

If continuation sheet Page 20 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345010	B. WING				C 16/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 655 SS=D	CFR(s): 483.21(a)(1)- §483.21 Comprehense Planning §483.21(a) Baseline (C §483.21(a)(1) The fact implement a baseline that includes the instre effective and person- that meet professional The baseline care plat (i) Be developed within admission. (ii) Include the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary services. (F) PASARR recomm §483.21(a)(2) The fact comprehensive care p care plan if the compr (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fact resident and their rep of the baseline care p limited to: (i) The initial goals of (ii) A summary of the	sive Person-Centered Care Care Plans care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information reare for a resident ted to- l on admission orders. endation, if applicable. care plan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not	F	655			1/9/23
	dietary instructions.						

Facility ID: 922979

If continuation sheet Page 21 of 66

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		10. 0938-039 FE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		345010	B. WING		C 12/16/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				500 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVI			ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC			(X5) COMPLETION DATE	
F 655	Continued From page	0.21	Гег				
1 000			F 65	D			
	(iii) Any services and						
	on behalf of the facilit	acility and personnel acting					
		rmation based on the details					
		e care plan, as necessary.					
		Γ is not met as evidenced					
	by:						
		iew and staff interviews, the		1. The facility failed to develo	•		
		op and implement a baseline		implement a baseline care plan			
		ours of admission to address		hours of admission to address			
		for 1of 5 residents reviewed		immediate needs for 1of 5 resid			
	for new admissions (I	Resident #50).		reviewed for new admissions (F #50). Resident #50 comprehen			
	The findings included	4.		plan was completed on 12/07/2			
	The mange moladed	a.		place to help guide care of resi			
	Review of the hospita	al discharge summary dated					
		esident #50 had fallen at		2. Newly admitted residents h	nave the		
	home, was sent to the	e hospital and diagnosed		potential to be affected by the c	deficient		
	-	ankle. After an orthopedic		practice. The Director of Nursin	,		
		uction and internal fixation		audited for dates between 11/2			
		as done on 10/26/22 to		12/20/2022 to ensure there was			
	•	(le. Resident #50 was		baseline care plan in place with			
		uctions including to only bear right lower extremity, elevate		forty-eight (48) hours of admiss completed on 12/20/2022. No a			
		ing, apply a controlled ankle		residents were affected.			
		the right ankle when out of					
	bed, and to use fall p			3. The measures that have be	een put into		
				place to ensure the deficient pr			
		lmitted to the facility on		not recur are as follows: Educa			
	-	ses including Alzheimer's, a		provided by the Regional Direc			
		nkle, and chronic respiratory		Clinical Services (RDCS) on tin			
	ialiure with hypoxia (decreased oxygen levels).		completion of baseline care pla			
	Review of the physici	ian order dated 11/16/22		current facility and agency licer nurses, activities director, certif			
		on of an inhaled albuterol (a		manager, and MDS coordinato	-		
		ne airways of the lungs to		Education was completed by 0			
		be given every 6 hours.		New facility and agency MDS s			
	. 37	, ,		licensed nurses, social services			
	Review of the physici	ian order dated 11/17/22		dietary manager, activities direc			

Facility ID: 922979

If continuation sheet Page 22 of 66

ATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	i	C
		345010	B. WING		12/16/2022
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CCORDI	US HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 655	Continued From page	22	F 65	5	
		on of oxygen at 2 liters per structive pulmonary disease.		current staff unable to complete events by 1/6/2023 will be educated prior working their next scheduled shift.	to
		an order dated 11/18/22 ff to observe for pain every		4. The Director of Nursing (DON audit all new admissions three (3) week for four (4) weeks and then	times a
	Review of Resident # revealed there was no within 48 hours of adr	baseline care plan in place		for eight (8) weeks to ensure a ba care plan is completed within 48 h admission. The facility will monitor	selines ours of
	immediate need for fa interventions in place the use of oxygen.	Ill precautions and for the fractured ankle, and		corrective actions to ensure that the deficient practice is corrected and recur by reviewing information col	will not lected
	PM with the Director of Administrator. The Ac admitting nurse was i baseline care plan for			during audits and reporting to Qua Assurance Performance Improver committee (QAPI) by the Director Nursing (DON) monthly for three (months. At that time the QAPI cor will evaluate the effectiveness of t interventions to determine if contin auditing or adjustments to the plan correction are necessary.	nent of 3) nmittee he nued
F 660 SS=D	Discharge Planning F CFR(s): 483.21(c)(1)(F 66	5. Completion Date: 01/09/2023	1/9/23
	effective discharge pl on the resident's disc of residents to be acti transition them to pos reduction of factors le readmissions. The fac	elop and implement an anning process that focuses harge goals, the preparation ve partners and effectively t-discharge care, and the			

If continuation sheet Page 23 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING				C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 660	 (i) Ensure that the disresident are identified development of a discresident. (ii) Include regular reidentify changes that discharge plan. The dupdated, as needed, to discharge plan. The dupdated as needed to discharge plan and the resident's or duperson(s) capacity and required care, as part discharge needs. (v) Involve the resider representative in the discharge plan and in resident representative in the discharge plan and in resident representative (vi) Address the resider treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indit to the community, the referrals to local conta appropriate entities must up comprehensive care pappropriate entities. (C) If discharge to the to not be feasible, the made the determination and the discharge to the to not be feasible, the made the determination appropriate and the discharge to the to not be feasible, the made the determination appropriate and the discharge to the to not be feasible, the made the determination appropriate and the discharge to the to not be feasible, the made the determination appropriate and the discharge to the to not be feasible, the made the determination appropriate and the discharge to the to not be feasible, the made the determination appropriate and the discharge to the to not be feasible, the made the determination appropriate appropriate and the discharge to the to not be feasible, the made the determination appropriate appropriate	charge needs of each and result in the charge plan for each evaluation of residents to require modification of the lischarge plan must be to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support d capability to perform of the identification of the and resident development of the form the resident and e of the final plan. ent's goals of care and s. resident has been asked receiving information the community. cates an interest in returning facility must document any act agencies or other ade for this purpose. date a resident's olan and discharge plan, as ase to information received contact agencies or other	F	660			

Facility ID: 922979

If continuation sheet Page 24 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION	(X3) DATE	
		345010	B. WING _				C 16/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				500	0 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	LE		AS	SHEVILLE, NC 28804		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	SNF or who are disch LTCH, assist resident representatives in sel provider by using data limited to SNF, HHA, patient assessment data the data is available. If the post-acute care set assessment data, data data on resource use the resident's goals of preferences. (ix) Document, compli- on the resident's need record, the evaluation needs and discharge evaluation must be di- resident's representat information must be di- resident's representat information must be di- resident's representat information must be di- resident's representat information go transfer. This REQUIREMENT by: Based on record revi- interviews, the facility planning process in p- resident in the develo- that addressed the re- post-discharge needs to discharge to the co- residents (Resident # Findings included: Resident #45 was add	arged to a HHA, IRF, or s and their resident ecting a post-acute care a that includes, but is not IRF, or LTCH standardized ata, data on quality on resource use to the extent The facility must ensure that candardized patient a on quality measures, and is relevant and applicable to f care and treatment ete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the scussed with the resident or tive. All relevant resident noorporated into the litate its implementation and delays in the resident's f is not met as evidenced ew, resident and staff failed to have a discharge lace that incorporated the pment of a discharge goals and for a resident who wished mmunity for 1 of 2 sampled 45).	F	660	 The facility failed to have a discharplanning process in place that incorporated the resident in the development of a discharge plan that addressed the resident's discharge goa and post-discharge needs for a resident who wished to discharge to the community for 1 of 2 sampled residents (Resident #45). An updated discharge assessment was completed on 12/29/2022 by licensed nurse. All current facility residents have th potential to be affected by this deficient 	als t	

Facility ID: 922979

If continuation sheet Page 25 of 66

		ID HUMAN SERVICES				FORI	M APPROVED
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED
		345010	B. WING				C /16/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	10/2022
10 112 01 11					00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	LE			ASHEVILLE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 660	Continued From page	25					
1 000	15		F	660			
	breathing), congestive	e heart failure and			practice. Current resident plans of care		
	depression.				were audited by minimum data set (MI		
		reas note written by the			nurse and was completed on 01/06/20	23	
	Social Worker (SW) c	gress note written by the			to ensure they had a person-centered discharge care plan in place. Resident	c	
		proved for a Medicaid			identified that did not have a discharge		
	program that helped i				care plan in place were interviewed by		
		tion to their home in the			mds coordinator and discharge		
	community with supp				assessments and care plan revisions		
					were completed by the IDT 01/06/2023	3.	
	The quarterly Minimu	m Data Set (MDS) dated					
		esident #45 had moderate			3. The measures that have been put	into	
	impairment in cognitio	on. The MDS noted active			place to ensure the deficient practice of		
	discharge planning w	as in place and a referral			not recur are as follows: Education wa	s	
	was made to the loca	I contact agency			provided by the Regional Clinical		
		sible for providing counseling			Reimbursement Specialist (RCRS) nu	rse	
	-	lents regarding community			on the process of ensuing		
	support options).				person-centered discharge care plans		
					completed to current director of nursing	g,	
		gress note written by the SW			activities director, certified dietary		
		art, "SW sat with Resident			manager, and MDS coordinator.	~~	
	#45 and explained ho	busing."			Education was completed by 01/06/20		
	Poviow of Posidont #	45's comprehensive care			New facility and agency MDS staff, so services director, dietary manager,	ciai	
		vised 12/07/22, revealed no			activities director, and current staff una	able	
	discharge care plan.				to complete education by 1/6/2023 will		
					educated prior to working their next	50	
	During interviews on	12/12/22 at 10:26 AM and			scheduled shift.		
		I, Resident #45 stated his					
		partment and return to the			4. The MDS coordinator will audit fiv	e (5)	
		t #45 explained he had			residents including planned discharges	. ,	
		ng to a family members			three (3) times a week for four (4) wee		
	home last year but it	was cancelled due to			and then weekly for eight (8) weeks to		
		be able to climb the stairs			ensure the resident has a		
	-	n that was located on the			person-centered discharge care plan in	n	
	-	oartment. Resident #45			place. The facility will monitor the		
		oke with the facility's SW			corrective actions to ensure that the		
	-	rn to the community and			deficient practice is corrected and will		
	they had reviewed the	e paperwork for housing			recur by reviewing information collecte	d	

Facility ID: 922979

If continuation sheet Page 26 of 66

		ND HUMAN SERVICES MEDICAID SERVICES				M APPROV 0. 0938-03	
ATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345010	B. WING		1:	C 12/16/2022	
IAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD			
				500 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804			
(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) COMPLETIO DATE	
F 660	Continued From page	e 26	F 66	0			
	options; however, the	e SW had since left		during audits and reporting to	Quality		
	•	had not heard anything		Assurance Performance Impre			
	further regarding the	process.		committee (QAPI) by the MDS			
	A taland the f			monthly for three (3) months.			
		on 12/15/22 at 9:21 AM for		the QAPI committee will evalue effectiveness of the intervention			
	interview with the for	mer SW was unsuccessful.		determine if continued auditin			
	During interviews on	12/15/22 at 3:54 PM and		adjustments to the plan of cor	-		
		the Administrator revealed		necessary.			
	the SW was respons	ible for developing discharge					
		ting them as discharge plans					
		ministrator explained the		5. Completion Date: 01/09/2	2023		
		without a SW and he was					
		until the position was filled. ated Resident #45 spoke with					
		wanting to discharge home					
	• •	Resident #45 he would					
	review the former SV	V's documentation to					
		was in the process and					
		The Administrator stated he					
	-	I the SW to develop a hat addressed Resident					
	#45's goal to return to						
F 684	Quality of Care		F 68	4		1/9/23	
SS=G	CFR(s): 483.25						
	§ 483.25 Quality of c						
	•	indamental principle that					
		nt and care provided to					
	-	ed on the comprehensive					
		dent, the facility must ensure e treatment and care in					
		essional standards of					
	•	hensive person-centered					
	care plan, and the re	sidents' choices.					
		Γ is not met as evidenced					
	by:				1-4		
	Based on record rev	iew and interviews with the		1. The facility failed to comp	lete a		

Event ID: L8FI11

Facility ID: 922979

If continuation sheet Page 27 of 66

	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345010	B. WING	B. WING			/16/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVII	LLE			BEAVERDAM ROAD HEVILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 27	F 68	34			
		staff the facility failed to			thorough assessment of a resident		
		assessment of a resident			requesting to go to the emergency roo	om	
		e emergency room due to			due to increased pain. The resident ca		
		resident called emergency			emergency medical services and was		
		was transported to the			transported to the hospital and diagno		
	hospital and diagnose	ed with acute cholecystitis			with acute cholecystitis (inflammation	of	
		gallbladder) that required			the gallbladder) that required surgical		
		e gallbladder for 1 of 2			removal of the gallbladder for 1 of 2		
		r hospitalization (Resident			residents reviewed for hospitalization		
	#270).				(Resident #270. Resident #270 had		
					thorough pain assessment completed	•	
	The findings included	l:			nurse practitioner (NP) on 12/15/2022		
		Resident #270 was admitted to the facility on			upon readmission from the hospital. N		
		•			continued current pain regimen due to		
	-	ses including a history of			resident stating the current regime tre	ats	
		and quadriplegia. Resident I to the hospital on 11/22/22.			pain adequately.		
					2. All current facility residents have		
		m Data Set dated 08/29/22			potential to be affected by this deficier		
		70 was assessed as being			practice. The Director of Nursing (DO	,	
		utine and as needed pain			and unit managers (UMs) completed a		
		eived during the lookback			pain assessment on all current facility		
		nt reported his pain was and interfered with sleep and			residents on 12/20/2022. The physicial and nurse practitioner were notified of		
		and interfered with sleep and arcotic pain medications)			results of assessments and medicatio		
		during the lookback period.			adjustments and care plan revisions v		
		ading the lookback period.			made as needed for residents who		
	Review of the Medica	ation Administration Record			reported insufficient pain control.		
	(MAR) revealed a phy				,		
		ophen (a narcotic pain					
	-	lligrams every 6 hours as			3. The measures that have been pu	t into	
		agement. The MAR revealed			place to ensure the deficient practice		
		h 11/21/22 Resident #270			not recur are as follows: The DON		
		it of 84 available for his pain			educated current facility and agency		
	and doses received v	vere considered effective.			licensed nurses on notifying the physi	cian	
	No pain medication w	as administered on			and NP in the event a resident is having	ng	
	11/18/22 and 11/19/2	2. On 11/20/22 one dose			inadequate pain control and the curre	nt	
	was administered at	7:38 PM and consider			facility and agency certified medication	n	
	effective. On 11/21/22	2 one dose was			assistants (CMA) and certified nurse		

Facility ID: 922979

If continuation sheet Page 28 of 66

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
						С
		345010	B. WING		1	2/16/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVI	LLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 684	Continued From page	e 28	F 68	4		
	administered at 7:51		1.00	aides (CNA) were educated to	notify the	
	effective. On 11/22/2			nurse if a resident reports pain		
		PM and considered effective		exhibiting behaviors indicative		
		as given at 10:06 PM and		inadequate pain control such a		
	considered effective.	-		grimacing, tearfulness, etc. so	-	
				assessment can be completed	•	
	Review of the nurse			licensed nurse and follow-up ne		
		Nurse #4, revealed on		to physician or NP made as ne		
		ately 9:30 PM Resident		new orders to manage resident	•	
		oxxxhole pain and asked to al. Nurse #4 obtained a set of		Education was completed on 0 New facility and agency license		
		ned to the resident those		and CMA s and staff unable to		
		mits and his pain medication		education by 1/09/2023 will be		
		ere was no clinical reason to		prior to working their next shift.	outoutou	
		the hospital. The progress		F		
		ent #270 refused the pain		4. The DON or Unit Manager	s (UM) will	
	medication stating it	didn't work. The Director of		audit five (5) residents twice we	ekly for 4	
		notified and agreed to not		weeks, then weekly for 8 week		
		he hospital for lack of a		a comprehensive pain assessn		
		ver it was his right to call		completed, and physician/NP a		
		service (EMS). Nurse #4		if pain is not effectively manage		
		on to Resident #270 and		residents current regimen. The		
	the resident to the ho	icility at 10:56 PM to transfer		monitor the corrective actions t that the deficient practice is con		
		ospital.		will not recur by reviewing infor		
	Review of the hospita	al discharge summary		collected during audits and rep		
	-	270 was evaluated for		Quality Assurance Performance		
	abdominal pain using	a computed tomography		Improvement committee (QAPI		
		of the inside of the body) and		DON monthly for three (3) mon		
	-	cholecystitis. General		time the QAPI committee will e		
		ed and on 11/24/22 Resident		effectiveness of the intervention		
	#∠70's gallbladder wa	as surgically removed.		determine if continued auditing		
	During a telephone in	nterview on 12/14/22 at 9:56		adjustments to the plan of corre	ection are	
		ed after Resident #270		necessary.		
		ig anal pain she obtained a				
		those were within normal		5. Completion Date: 01/09/20)23	
		ain medication. Nurse #4				
		all Resident #270 say the				

Facility ID: 922979

If continuation sheet Page 29 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING				C 16/2022
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			0 BEAVERDAM ROAD SHEVILLE, NC 28804		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Nurse #4 stated Resid distress, and everythi resident that day. Nur DON who agreed the but it was Resident #2 transfer to hospital. N #270 did call EMS an hospital. An interview was com PM with Resident #27 told the nurse he was breathing and had sto had to call EMS beca During an interview of DON revealed Nurse Resident #270 comple hurting and he neede DON stated she didn' send the resident out was telling her and did the resident's pain me The DON revealed Resider previous weekend an wasn't admitted and w the same day. During an interview of Medical Director reve be notified Resident #27	neffective, but she e did in her progress note. dent #270 did not appear in ng had been normal for the se #4 stated she called the re was no clinical reason, 270's right to call EMS for urse #4 revealed Resident d was transferred to the ducted on 12/14/22 at 4:21 70. Resident #270 stated he having a difficult time omach pain on 11/22/22 and use the nurse wouldn't. n 12/16/22 at 4:46 PM the #4 called her stating ained his bxxhole was d to go to the hospital. The t think that was a reason to based on what the nurse dn't recall the nurse saying edication was not effective. esident #270 did call EMS nsferred to the hospital. The ent #270 had called EMS the d went to the hospital and vas sent back to the facility n 12/16/22 at 4:29 PM the aled would have expected to 4270 was having pain and not relieving the pain so he	F 64	84			
F 745 SS=E		Related Social Service	F 74	45			1/9/23

Facility ID: 922979

If continuation sheet Page 30 of 66

		D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C / 16/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 745	CFR(s): 483.40(d) §483.40(d) The facility medically-related soci maintain the highest p and psychosocial well This REQUIREMENT by: Based on record revi and staff interviews, the residents for consultar order for 2 of 4 sample and #45). Findings included: 1. Resident #38 was 10/27/21. His diagnown stenosis of unspecified or blockage of the large the neck) and personal ischemic attack (mini- temporary disruption in the brain). An active MD order da #38 read in part, "refer carotid artery stenosis Review of Resident # revealed no document appointment with a Variantic Stenosis of the stenosis Review of Resident #	y must provide al services to attain or practicable physical, mental l-being of each resident. is not met as evidenced ew, Medical Doctor (MD) he facility failed to refer tion appointments per MD ed residents (Resident #38 admitted to the facility on ses included occlusion and d carotid artery (narrowing ge arteries on either side of al history of transient stroke caused by a in the blood supply to part of ated 08/31/22 for Resident erral to Vascular MD (a s in the treatment of arteries stenosis." lated 12/07/22 for Resident erral to Vascular MD for s."	F 7	 The facility failed to refer resid consultation appointments per MD for 2 of 4 sampled residents (Resid #38 and #45). Physician notified of missed referrals and Resident #38 was sent to consulting physician at appointment scheduled. Resident at was referral sent to consulting physican and appointment scheduled. All current facility residents ha potential to be affected by this defin practice. Director of nursing (DON) Unit Managers reviewed all current residents for referral orders to ensu- referrals had been placed. Audit completed on 01/06/2023. No addit concerns identified. The measures that have been place to ensure the deficient practi- not recur are as follows: The Regio Director of Clinical Services (RDCS educated the DON and unit manage process of reviewing orders daily of morning clinical meeting to validate referral orders were successfully fa- consulting physician and appointm made timely as appropriate. The D 	order ent referral dd 445 sician ve cient and facility ure all tional put into ce does nal s) ers on uring e that xed to ent ON	
	During an interview of	n 12/15/22 at 2:54 PM, the		and unit managers are responsible		

Facility ID: 922979

If continuation sheet Page 31 of 66

			E CONSTRUCTION	(X3) DATE SURVEY	
	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		A. BOILDING		с	
	345010	B. WING		12/16/2022	
OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
			500 BEAVERDAM ROAD		
LTH AT ASHEVI	LLE		ASHEVILLE, NC 28804		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETI	
ued From page	e 31	F 745	5		
ant Business C ed she was res in appointment insportation Air ver. She adde uit in December is of arranging o schedule ther of the referral. as not informed 08/31/22 for a nfirmed an app ed. The Assis ead the MD pro- onotified of the copy of the MD rom the MD but a joint intervier g (DON) and F 15/22 at 4:17 F is was to review and confirm all Nurse Practition or a referral was xed to the MD' to make the app f the MD order or Transportati ware and ensu- ed. The DON ned to her too I dated 08/31/2	ffice Manager (BOM) sponsible for scheduling s until October 2022 when de started employment and d when the Transportation er 2022, she resumed the resident appointments and n as soon as she was made The Assistant BOM stated d of Resident #38's MD order referral to a Vascular MD pointment had not been tant BOM explained she ogress notes and was referral when staff brought order or she received an at that didn't always happen. w with the Director of Regional Nurse Consultant PM, the DON explained her w the 24-hour order listing new orders with the MD poner. She added once the as confirmed, the information s office for them to call the oppointment and a printed was given to the Assistant on Aide when hired, so they are the appointment was stated when the MD ay that Resident #38's 22 had not been made, she		 faxing referrals and scheduling the appointment upon receipt of the recorder. Education was completed b 01/09/2023. New facility and agen and unit managers and staff unab complete education by 1/9/2023 we educated prior to working their net. 4. The DON will audit five (5) ret three (3) times a week for four (4) and then weekly for eight (8) weel ensure all referrals appointments a made timely as ordered. The facilit monitor the corrective actions to e that the deficient practice is correct will not recur by reviewing informat collected during audits and reporti Quality Assurance Performance Improvement committee (QAPI) b DON monthly for three (3) months time the QAPI committee will eval effectiveness of the interventions of determine if continued auditing or adjustments to the plan of correction necessary. 5. Completion Date: 01/09/2023 	eferral by locy DON le to vill be xt shift. sidents weeks ss to are ty will nsure oted and tion ing to y the s. At that uate the to ion are	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I and Business C ed she was res nt appointment ansportation Aid ver. She adde juit in December of the referral. as not informed 08/31/22 for a onfirmed an app ged. The Assist read the MD pr y notified of the copy of the MD from the MD bu g a joint intervie g (DON) and F 15/22 at 4:17 F ss was to review and confirm all Nurse Practitio for a referral wa axed to the MD' to make the ap of the MD order or Transportati aware and ensu- pond to her toda al dated 08/31/2	IDENTIFICATION NUMBER: 345010 OR SUPPLIER LTH AT ASHEVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) And Business Office Manager (BOM) ed she was responsible for scheduling nt appointments until October 2022 when ansportation Aide started employment and ver. She added when the Transportation juit in December 2022, she resumed the ss of arranging resident appointments and o schedule them as soon as she was made of the referral. The Assistant BOM stated as not informed of Resident #38's MD order 08/31/22 for a referral to a Vascular MD onfirmed an appointment had not been ged. The Assistant BOM explained she read the MD progress notes and was y notified of the referral when staff brought copy of the MD order or she received an from the MD but that didn't always happen. a joint interview with the Director of fig (DON) and Regional Nurse Consultant 15/22 at 4:17 PM, the DON explained her as was to review the 24-hour order listing and confirm all new orders with the MD • Nurse Practitioner. She added once the for a referral was confirmed, the information wed to the MD's office for them to call the vo make the appointment and a printed of the MD order was given to the Assistant or Transportation Aide when hired, so they aware and ensure the appointment was ged. The DON stated when the MD oned to her today that Resident #38's al dated 08/31/22 had not been made, she	TION IDENTIFICATION NUMBER: A. BUILDING 345010 B. WING OR SUPPLIER ID LTH AT ASHEVILLE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID nued From page 31 F 745 ant Business Office Manager (BOM) ed she was responsible for scheduling nt appointments until October 2022 when ansportation Aide started employment and ver. She added when the Transportation upti in December 2022, she resumed the ss of arranging resident appointments and o schedule them as soon as she was made of the referral. The Assistant BOM stated as not informed of Resident #38's MD order 08/31/22 for a referral to a Vascular MD onfirmed an appointment had not been ped. The Assistant BOM explained she read the MD progress notes and was y notified of the referral when staff brought copy of the MD order or she received an from the MD but that didn't always happen. g a joint interview with the Director of ng (DON) and Regional Nurse Consultant 115/22 at 4:17 PM, the DON explained her ss was to review the 24-hour order listing and confirm all new orders with the MD · Nurse Practitioner. She added once the for a referral was confirmed, the information tixed to the MD's office for them to call the ' to make the appointment and a printed of the MD order was given to the Assistant or Transportation Aide when hired, so they aware and ensure the appointment was yee. The DON stated when the MD oned to her today that Resident #38's al dated 08/31/22 had not been made, she	TION IDENTIFICATION NUMBER: A. BUILDING 345010 B. WING OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) D PREVIX TAG PROVIDERS PLAN OF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) nued From page 31 ant Business Office Manager (BOM) ed she was responsible for scheduling nt appointments until October 2022 when anaportation Aide started employment and ver. She added when the Transportation juit in December 2022, she resumed the so chedule them as scon as she was made of the referral. The Assistant BOM stated as not informed of Resident #38's MD order 08/31/22 for a referral to A Vascular MD onfirmed an appointment had not been read the MD progress notes and was y notified of the referral, When stated as not informed of Resident #38's MD order 09/31/22 for a referral to A Vascular MD onfirmed an appointments and to schedule them as scon as she was nade timely as ordered. The facili monitor the corrective actions to e that the deficient practice is correct will not recur by reviewing informs and confirm all new orders with the MD rowere of continued auditing or adjustments to the plan of correct inccessary. g a joint interview with the Director of for a referral was confirmed, the information tweed to the MD's office for them to call the to make the appointment and a printed of the MD order was given to the Assistant for a referral was confirmed, the assistant or Transportation Aide when hired, so they ware an ensure the appointment was yed. The DON stated when the MD oned to her today that Resident #38's 102 Date: 0	

Facility ID: 922979

If continuation sheet Page 32 of 66

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		IO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	, <i>,</i>		· · · ·	MPLETED		
					С			
		345010	B. WING		1	2/16/2022		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C					
ACCORDI	US HEALTH AT ASHEVI	LLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE		
F 745	Continued From page	a 32	F 74	5				
1745		er stated nursing staff should	Г /4;					
		copy of the MD order to the						
	The joint interview wi	th the Director of Nursing						
		Nurse Consultant continued.						
	, , .	Consultant explained their						
		rals was for the MD to enter						
		ident's medical record and						
		ON pulled the 24-hour order						
		w during clinical meeting.						
		Consultant stated the MD g issues with referrals not						
		she explained to the MD if						
	- ·	aware when the issues were						
		ould have addressed or fixed						
		gional Nurse Consultant						
		ck of communication was						
		ons referrals were missed						
	place would be more	system they now had in efficient.						
		on 12/14/22 at 3:01 PM and						
		nterview on 12/16/22 at 4:26						
		d whenever he made a						
		ne typically entered the order						
		edical record, documented it						
		and notified facility staff via						
	· ·	e. The MD stated he was						
		ointment was not made red Resident #38's referral						
		itment on 08/31/22. The MD						
		is no harm caused due to the						
		e appointment for Resident						
	#38, he wanted the a	ppointment scheduled with						
		medical management of						
	Resident #38's caroti	d artery stenosis. The MD						
		or referral appointments to						

Facility ID: 922979

If continuation sheet Page 33 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345010	B. WING				/16/2022
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT ASHEVII	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 745	be made as requeste During an interview of Administrator stated i appointments to be a 2. Resident #45 was 12/09/20. His diagno loosening of internal p An active MD order d #45 read in part, "plea Orthopedic appointment hemiarthroplasty (sur of the hip is replaced) Review of Resident # revealed no document with an Orthopedic M December 2022. During an interview of Assistant Business O revealed she was ress outside appointments the Transportation Aid took over. She addee Aide quit in December process of arranging was unaware of Resident During a joint interview	d and per order. n 12/16/22 at 5:24 PM, the t was his expectation for rranged per MD order. admitted to the facility on ses included mechanical prosthetic joint. ated 11/23/22 for Resident ase ensure he has an ent for loose, right hip gical procedure where half b. 45's medical record tation of an appointment D in November 2022 or n 12/15/22 at 2:54 PM, the ffice Manager (BOM) ponsible for scheduling until October 2022 when de started employment and d when the Transportation r 2022, she resumed the resident appointments and dent #45's MD order for an ent. w with the Director of	F	74			
	on 12/15/22 at 4:17 F process was to review report and confirm all and/or Nurse Practitio	Regional Nurse Consultant M, the DON explained her v the 24-hour order listing new orders with the MD oner. She added once the as confirmed, the information					

Facility ID: 922979

If continuation sheet Page 34 of 66

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/18/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í					LETED
		345010	B. WING					C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			00 BEAVERDAM ROAD SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 745	facility to make the ap copy of the MD order BOM, or Transportation were aware and ensu- arranged. The DON as Resident #45's MD or appointment dated 11 should have been sch The joint interview with Nurse Consultant con Consultant explained referrals was for the M the resident's medica the DON pulled the 24 review during clinical Nurse Consultant stat having issues with ref and she explained to made aware when the they could have addre The Regional Nurse O the lack of communicar reasons referrals were the system they now efficient. During an interview of follow-up telephone in PM, the MD explained referral for resident, h into the resident's me in his progress notes email correspondence expected for referral a requested and per ord	s office for them to call the pointment and a printed was given to the Assistant on Aide when hired, so they re the appointment was stated she was not sure how oder for an Orthopedic /23/22 was missed and it heduled. The Regional Nurse their new process for //D to enter the order into I record and each morning, 4-hour order listing report to meeting. The Regional ted the MD had mentioned ferrals not being completed the MD if they had been e issues were first identified, essed or fixed the process. Consultant stated she felt ation was one of the main e missed but felt confident had in place would be more in 12/14/22 at 3:01 PM and therview on 12/16/22 at 4:26 d whenever he made a e typically entered the order dical record, documented it and notified facility staff via e. The MD stated he appointments to be made as	F	745				

Facility ID: 922979

If continuation sheet Page 35 of 66

	S FOR MEDICARE &			CONSTRUCTION	OMB NO. 0938-
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		с
		345010	B. WING	12/16/2022	
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•
			50	00 BEAVERDAM ROAD	
ACCORDI	JS HEALTH AT ASHEVIL	LE	A	SHEVILLE, NC 28804	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE
F 745	Continued From page	e 35	F 745		
		t was his expectation for			
		rranged per MD order.			
F 756 SS=D	Drug Regimen Review CFR(s): 483.45(c)(1)(w, Report Irregular, Act On (2)(4)(5)	F 756		1/9/23
	§483.45(c) Drug Regi	imon Poviow			
		ug regimen of each resident			
		east once a month by a			
	licensed pharmacist.				
	5492.45(a)(2) This rep	view must include a review			
	of the resident's medi	view must include a review ical chart.			
		armacist must report any tending physician and the			
	-	ctor and director of nursing,			
	and these reports mu	•			
		de, but are not limited to, any			
	(d) of this section for	riteria set forth in paragraph			
	· · /	noted by the pharmacist			
	.,	st be documented on a			
	separate, written repo	ort that is sent to the			
		nd the facility's medical			
		of nursing and lists, at a			
		it's name, the relevant drug, e pharmacist identified.			
		sician must document in the			
	resident's medical rec				
		reviewed and what, if any,			
		n to address it. If there is to			
		nedication, the attending ument his or her rationale in			
	the resident's medica				
		cility must develop and procedures for the monthly			
	maintain policies and				

Facility ID: 922979

If continuation sheet Page 36 of 66

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/18/2023 M APPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345010	B. WING			C / 16/2022
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
				500 BEAVERDAM ROAD		
ACCORDI	JS HEALTH AT ASHEVIL	LE		ASHEVILLE, NC 28804		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 756	the process and steps when he or she identi- requires urgent action This REQUIREMENT by: Based on record revi- resident, staff, Consu Practitioner (NP), and Consultant Pharmacis irregularities and prov- of 5 residents reviewe medications (Residen The findings included Review of the lipid gu by the American Colle American Heart Asso should be conducted weeks after statin the dosage was adjusted should be repeated o needed. Resident #44 was add 09/24/21 with diagnos hyperlipidemia and hi Review of physician's #44 had obtained ord atorvastatin 80 milligr bedtime for high chole 06/03/22, dosage of a 40 mg once daily in th	s for the different steps in s the pharmacist must take ifies an irregularity that n to protect the resident. is not met as evidenced iew and interviews with the ditant Pharmacist, Nurse d Medical Director (MD), the st failed to identify drug vide recommendations for 1 ed for unnecessary nt #44). : idelines published in 2019 ege of Cardiology and ciation indicated lipid panel at baseline, then 4 to 12 vrapy was started or when . Afterwards, lipid panel test nce every 3 to 12 months as mitted to the facility on ses that included igh blood pressure. s orders revealed Resident lers to receive 1 tablet of rams (mg) once daily at esterol since 09/24/21. On atorvastatin was reduced to ne morning. Starting an changed atorvastatin	F 75		ovide dents vations ultant ent #44 on nd lipid taking nia have eficient t facility e urse dered and d with d oring uled as of these en put into ctice does gional CS) ant on endations	
	A review of medicatio	n administration records		Education was completed on 01/ The Director of Nursing (DON) w		

Facility ID: 922979

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	ATE SURVEY DMPLETED
						С
		345010	B. WING			12/16/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
ACCORDI	US HEALTH AT ASHEVI	LIF		500 BEAVERDAM ROAD		
Accordi				ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From page	e 37	F 75	56		
		sident #44 had received		pharmacy consultant report	and	
		ed since statin therapy was		recommendations monthly t		
	initiated on 09/24/21.			residents on hyperlipidemia		
				reviewed by the consulting		
		s for Resident #44 revealed a		with appropriate recommend		
	admission on 09/24/2	ever been done since her 21.		for lab monitoring to identify irregularities.	arug	
	The annual Minimum	n Data Set (MDS) dated		4. The DON will monitor 5	residents	
		Resident #44 with intact		taking medications to treat h		
	cognition.			to ensure consulting pharma		
				recommendations as neces		
		#44's medical records		drug irregularities. Monitorir		
	revealed the Consult			completed twice weekly for		
		n regimen reviews monthly h 11/15/22. The Consultant		weekly for 8 weeks. The fac monitor the corrective action		
		e one recommendation to		that the deficient practice is		
		past 6 months on 06/09/22,		will not recur by reviewing in		
		to cholesterol monitoring.		collected during audits and Quality Assurance Performa	reporting to	
	Review of vital signs	from 11/27/21 through		Improvement committee (Q		
		esident #44's BP and pulse		DON monthly for three (3) n	, .	
	were within the norm	al limits most of the time.		time the QAPI committee w		
	During og intervisur s			effectiveness of the interver		
		conducted on 12/14/22 at #44 could not recall having		determine if continued audit adjustments to the plan of c	-	
		ince being admitted to the		necessary.		
	facility.					
	An interview conduct			5. Completion Date: 01/09	9/2023	
		revealed she had measured				
		signs and indicated that they				
		mits. She could not find any				
		tests and did not recall panel test for Resident #44.				
	-	conducted with the NP on				
		she stated Resident #44				
	∣ should have a lipid pa	anel test in place to monitor				

Facility ID: 922979

If continuation sheet Page 38 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/18/2023 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345010	B. WING		_		C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 756	changes in June 2022 Consultant Pharmacis provider to order a lip monitoring. During a phone interv Pharmacist on 12/15// that he had conducted regimen reviews (MR He was aware that Re therapy since admissi been decreased in Ju Resident #44's electro all the labs uploaded not notice lipid panel I Resident #44's electro all the labs uploaded not notice lipid panel I Resident #44 since he 15 months ago. He ex recent monthly MRRs #44's statin therapy p the MAR. Because of the provider to consid for cholesterol level m During an interview co Nursing (DON) on 12/ acknowledged that lip place for Resident #4- was her expectation for provider in timely mar test for cholesterol mod Interview conducted v 12/16/22 at 10:49 AM expectation to monito residents who were re- the guidelines.	especially after the dosage 2. She expected the at to recommend the id panel test for cholesterol iew with the Consultant 22 at 9:34 AM, he stated d Resident #44's medication Rs) in the past 6 months. esident #44 had statin on and the dosage had ne 2022. He had access to onic health records including by the facility's staff. He did had not been completed for er admission approximately cplained when he did the , he did not review Resident rior to 10/07/22 as shown in this, he did not recommend er ordering lipid panel test nonitoring.	F 756				
	expectation to monito residents who were re	r cholesterol level of all the eceiving statin therapy per					

If continuation sheet Page 39 of 66

	IEDICAID SERVICES				1 APPROVE 0. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMPI	LETED
	345010	B. WING		C 12/16/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	DE	
ACCORDIUS HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
 were taking atorvastat and not under hospice test in place to monito the guidelines. Otherw Consultant Pharmacis F 757 Drug Regimen is Free CFR(s): 483.45(d)(1)-4 §483.45(d) Unnecessa Each resident's drug r unnecessary drugs. A drug when used- §483.45(d)(1) In excess duplicate drug therapy §483.45(d)(2) For excess §483.45(d)(2) For excess §483.45(d)(3) Without use; or §483.45(d)(4) Without use; or §483.45(d)(5) In the pr consequences which in reduced or discontinued §483.45(d)(6) Any con- stated in paragraphs (section. This REQUIREMENT by: Based on record revise resident, staff, Consul- Practitioner (NP), and facility failed to monito 	he expected residents who in for cholesterol control e care to have a lipid panel r the cholesterol level per vise, he would expect the t to remind the provider. from Unnecessary Drugs (6) ary Drugs-General. egimen must be free from on unnecessary drug is any sive dose (including v); or essive duration; or adequate monitoring; or adequate indications for its resence of adverse ndicate the dose should be	F 7	56	itor sidents edications vas ordered,	1/9/23

Facility ID: 922979

If continuation sheet Page 40 of 66

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/18/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345010	B. WING			C 12/16/2022
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY	, STATE, ZIP CODE	
	US HEALTH AT ASHEVII	16		500 BEAVERDAM ROA	D	
ACCORDI	00 HEALIN AI AGHEVIL			ASHEVILLE, NC 288	04	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	
F 757	Continued From page	e 40	F 75	7		
-	(Resident #44).			physician on 12/	/16/2022.	
				, ,	-	
	by the American Colle American Heart Asso should be conducted weeks after statin the dosage was adjusted should be repeated o needed. Resident #44 was ad 09/24/21 with diagnos hyperlipidemia and hi Review of physician's #44 had obtained ord atorvastatin 80 milligr	idelines published in 2019 ege of Cardiology and ciation indicated lipid panel at baseline, then 4 to 12 grapy was started or when . Afterwards, lipid panel test nce every 3 to 12 months as mitted to the facility on ses that included		statin medication cholesterol have affected by this of Effective 1/9/23, (DON) complete current residents medication thera cholesterol and has been completed were reported to practitioner and completed for re- were reported by physician and/of indicated with la	acility residents receiving a therapy to treat high a the potential to be deficient practice. the Director of Nursing and an audit to identify s receiving statin apy to treat high to identify if lab monitori eted as required. Findin to the physician and nurs orders were obtained and esidents identified. Resu y the licensed nurse to ta r NP with follow-up as b monitoring orders heduled as appropriate.	ing gs ie nd ilts the
	06/03/22, dosage of a 40 mg once daily in th 10/07/22, the physicia order to 40 mg once o	atorvastatin was reduced to ne morning. Starting an changed atorvastatin daily at bedtime.		place to ensure not recur are as Nursing (DON) e and nurse practi	res that have been put i the deficient practice do follows: The Director of educated the physician tioner (NP) on ensuring	bes
	(MARs) indicated Res	n administration records sident #44 had received ed since statin therapy was		receiving statin r high cholesterol regime is free fro	toring for residents medication therapy to tra- to ensure residents dru om unnecessary drugs. completed on 01/09/202	g
	lipid panel test had ne admission on 09/24/2			Newly hired phy receive education medications with monitoring was	sicians and NPs will on upon hire. A list of n recommended lab provided to the medical	
		Data Set (MDS) dated esident #44 with intact		quick reference.	osted at nurses station f vill audit five (5) resident	

Facility ID: 922979

If continuation sheet Page 41 of 66

	S FOR MEDICARE & DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0 (X3) DATE SUF	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLET	ED
			D 14/110		С	
		345010	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	12/16/2022	
NAME OF P	ROVIDER OR SUPPLIER			BIREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE		ASHEVILLE, NC 28804		
(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 CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) OMPLETIOI DATE
F 757	Continued From page	e 41	F 757			
F 131	During an interview of 11:56 AM, Resident # any lipid panel test sin facility. An interview conducted 12/14/22 at 4:33 PM n any records of lipid pa performing any lipid p During an interview of 12/15/22 at 9:00 AM, should have a lipid pa her cholesterol level, changes in June 2022 During a phone interv Pharmacist on 12/15/ that he had conducted regimen reviews (MR He was aware that Re therapy since admissible admis	onducted on 12/14/22 at 444 could not recall having ince being admitted to the ed with Nurse #3 on revealed she could not find anel tests and did not recall banel test for Resident #44. onducted with the NP on she stated Resident #44 anel test in place to monitor especially after the dosage 2. view with the Consultant 22 at 9:34 AM, he stated d Resident #44's medication Rs) in the past 6 months. esident #44 had statin ion and the dosage had one 2022. He had access to onic health records including by the facility staff. He did	F /5/	 receiving statin medication theraphigh cholesterol twice weekly for fight (8) wappropriate lab monitoring. The famonitor the corrective actions to be that the deficient practice is correct will not recur by reviewing informatical collected during audits and report Quality Assurance Performance Improvement committee (QAPI) be DON monthly for three (3) months time the QAPI committee will eval effectiveness of the interventions determine if continued auditing or adjustments to the plan of correct necessary. 5. Completion Date: 01/09/2023 	our (4) eeks for acility will ensure cted and ation ing to y the s. At that uate the to ion are	
		nend the provider in timely pid panel test for cholesterol				

Facility ID: 922979

If continuation sheet Page 42 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/18/2023 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345010	B. WING			_		C 16/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			00 BEAVERDAM ROAD SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 757	residents who were re- timely manner per the During a phone interv 12/16/22 at 4:24 PM, were taking atorvasta and not under hospice test in place to monito the guidelines. Otherw	revealed it was his r cholesterol level of all the eceiving statin therapy in guidelines. iew with the MD on he expected residents who tin for cholesterol control e care to have a lipid panel or the cholesterol level per vise, he would expect the	F	757				
F 758 SS=D	CFR(s): 483.45(c)(3)(§483.45(e) Psychotro §483.45(c)(3) A psych	chotropic Meds/PRN Use e)(1)-(5) pic Drugs. notropic drug is any drug that	F	758				1/9/23
		associated with mental ior. These drugs include, drugs in the following						
	resident, the facility m §483.45(e)(1) Resider psychotropic drugs ar	ensive assessment of a ust ensure that nts who have not used e not given these drugs is necessary to treat a						
	specific condition as c in the clinical record;	liagnosed and documented						

Facility ID: 922979

If continuation sheet Page 43 of 66

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/18/2 FORM APPRO OMB NO. 0938-0	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/16/2022	
		345010	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVI	LLE		500 BEAVERDAM ROAD		
				ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLET	
F 758	Continued From pag	o 43	F 75	0		
1750			F / 5	0		
	behavioral intervention contraindicated, in an drugs;	n effort to discontinue these				
	§483.45(e)(3) Reside	ents do not receive ursuant to a PRN order				
		on is necessary to treat a				
		ondition that is documented				
	in the clinical record;					
		orders for psychotropic drugs				
	-	s. Except as provided in attending physician or				
	prescribing practition					
		RN order to be extended				
	beyond 14 days, he	or she should document their				
	rationale in the reside indicate the duration	ent's medical record and for the PRN order.				
		orders for anti-psychotic				
		4 days and cannot be				
		attending physician or				
	the appropriateness	er evaluates the resident for of that medication. Γ is not met as evidenced				
	by:	terre en al trades de la Maria				
		view and interviews with the		1. The facility failed to ensur		
	the facility failed to en	e and the Medical Director		needed psychotropic medication used for a limited duration of ti		
	-	tion was used for a limited		days or provide a rational to co		
		l days or provide a rational to		use for 1 of 5 residents review		
		1 of 5 residents reviewed for		unnecessary medications (Res		
	unnecessary medica	tions (Resident #50).		Resident #50 as needed psych		
	The findings included	i:		medication was discontinued of 12/14/2022.	n	
	Review of the hospita	al discharge summary dated		2. Current facility residents of	on as	
	11/16/22 listed the m	edications Resident #50 was		needed psychotropic medication	ons have	
	to continue taking an	d included instructions to		potential to be affected by this	deficient	

Facility ID: 922979

If continuation sheet Page 44 of 66

			()(0) (
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
			A. BUILDIN	IG			С
		345010	B. WING			12/16/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	12	10/2022
					00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	LLE		A	SHEVILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 758	Continued From page						
F 730			F 7	58			
		ntidepressant medication) 50			practice. All current facility residents a		
	milligrams (mg) every			needed psychotropic medications wer			
	for insomnia.			audited by the Director of Nursing (DC	NN)		
	Booidont #50 was ad	mitted to the facility on			on 12/21/2022 to ensure each had		
				appropriate stop dates per Centers for			
	11/16/22 with diagnos			Medicare and Medicaid Services (CM			
		onic respiratory failure with			regulation. No further residents identified	ea	
		oxygen levels), and chronic			during audit.		
		dent #50 was discharge to					
	the hospital on 12/13/	122.			2 The measures that have been put	+ into	
	Boviow of the physici	an ordere revealed			3. The measures that have been put		
	Review of the physici			place to ensure the deficient practice of			
	insomnia was started	e 1 tablet as needed for			not recur are as follows: Effective 1/9/ the DON educated current facility and	23,	
	Insomina was started	011 11/10/22.			agency licensed nurses and physician	and	
	Review of the admiss	ion Minimum Data Set			nurse practitioner (NP) on guidelines f		
		led Resident #50's cognition			unnecessary as needed psychotropic	UI	
		ng severely impaired and			medications and ensuring appropriate		
		ations were received for 7			stop dates are in place with physician		
	days during the lookb				rationale for continued use if extending	r	
					beyond 14 days. Education also include		
	A care plan for the us	e of psychotropic			that as needed antipsychotic medication		
	medications related to				are excluded from extending beyond 1		
	depression, and insor				days. Newly hired facility and agency	•	
		ns included to administer			licensed nurses not receiving education	n	
		ions as ordered by the			by 01/09/23 will receive education price		
		t with pharmacy and the			next worked shift.		
		nsider dosage reduction					
		priate and at least quarterly.			4. The DON will audit five (5) reside	nts	
					on as needed psychotropic medication		
	Review of the Medica	ation Administration Records			twice weekly for four (4) weeks and th		
	(MAR) for November				weekly for eight (8) weeks to ensure		
	. ,	n's order for trazodone 50			appropriate stop dates and physician		
		eeded for insomnia and was			rationale for any use beyond 14 days		
	started on 11/16/22 a				(excluding antipsychotics) are in place	per	
		evealed Resident #50			guidelines. The facility will monitor the		
		trazodone on 11/22/22 for			corrective actions to ensure that the		
	insomnia that was co				deficient practice is corrected and will	not	
					recur by reviewing information collected		

Facility ID: 922979

If continuation sheet Page 45 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/18/2023 MAPPROVED). 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345010	B. WING				C 16/2022
NAME OF PR	OVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDIU	IS HEALTH AT ASHEVIL	LE			00 BEAVERDAM ROAD SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761 SS=E	Pharmacist in Charge reviewed the medicati admitted to the facility stated trazodone was and if used as needed be in place and reeva use of the medication An interview was cone PM with the Medical ID Director stated trazod medication and if orde he would expect a 14 Label/Store Drugs and CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the facil biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled of the Comprehensive D	 12/16/22 at 11:40 AM the revealed the consultant ons when a resident was The Pharmacist in Charge a psychotropic medication d a 14 day stop dated should luated by the prescriber for ducted on 12/16/22 at 4:29 Director. The Medical one was a psychotropic ered to be used as needed, day stop date. d Biologicals 1)(2) f Drugs and Biologicals used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and ity must store all drugs and permit only authorized 		758	during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the DON monthly three (3) months. At that time the QAP committee will evaluate the effectivene of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5. Completion Date: 01/09/2023	l ss	1/9/23

Facility ID: 922979

If continuation sheet Page 46 of 66

						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDING			С
		345010	B. WING		12/16/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	US HEALTH AT ASHEVII			500 BEAVERDAM ROAD		
ACCORDI	US REALTH AT ASHEVI			ASHEVILLE, NC 28804		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 761	Continued From page	- 46	F 76	1		
1 /01		the facility uses single unit		1		
		ition systems in which the				
		imal and a missing dose can				
	be readily detected.					
		is not met as evidenced				
	by: Based on observatio	n, staff interviews and		1. The facility failed to store u	nononod	
	record reviews, the fa	-		medications at the temperature		
ι		is in the temperatures		by manufacturer's guidelines fo	•	
		turer's guidelines for 2 or 4		medications carts observed (Ea		
		served (East Front and East		and East Back medication carts	, .	
		s) during medication storage		medication storage checks. The	e Director	
	checks.			of Nursing (DON) disposed of medications that were not store	d correctly	
	The findings included	:		as identified on 12/16/2022.	a conectly	
	1. Review of manufacturer's package insert for			2. All current facility residents	have	
		ed unused insulin Aspart		potential to be affected by this of		
		refrigerator between 36° to		practice. The DON and unit ma	•	
		nce opened, the insulin pen		audited all medication carts and		
	up to 28 days.	m temperature up to 86 F for		medication storage rooms to er medication requiring refrigeration		
	ap to 20 days.			properly stored and properly da		
	Review of manufactu	rer's package insert for		labeled when removed from ref		
		s reveled unopened bottle		and placed on the medication of	art for	
		er refrigeration between 36°		resident use. Audit completed o	on	
		d from light. Once opened,		12/23/2022.		
	up to 77F for up to six	stored at room temperature				
				3. The measures that have be	een put into	
	An observation was c	conducted on 12/13/22 at		place to ensure the deficient pr	•	
		Front medication cart in the		not recur are as follows: The D	NC	
	· ·	. The observation revealed		educated current facility and ag	-	
	-	of Latanoprost eye drop still		licensed nurses and certified m		
		d 1 unopened pen of insulin in the plastic seal. Both		aides (CMAs) on proper medica storage and placed reference to		
		is were stored in the room		nursing station. Licensed nurse		
	-	scribed for Resident #44.		CMA s are responsible for imm		

Facility ID: 922979

If continuation sheet Page 47 of 66

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CC	OMPLETED
		345010	B. WING			С
		545010		STREET ADDRESS, CITY, STATE, ZIP CO		12/16/2022
NAME OF P	ROVIDER OR SUPPLIER				JDE	
ACCORD	US HEALTH AT ASHEVI	LLE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 761	Continued From page	e 47	F 76	1		
	Review of physician's administration record #44 had a current ord insulin and eye drops An interview was cor 12/13/22 at 4:09 PM. were instructed to ch medication cart at lea medication cart at lea medication cart at lea medication cart was i Manager (UM) this m why the unopened in stored in room temper cart. During an interview v 4:17 PM, she stated (DON) had set up rou at least once weekly and free of expired m consultant pharmacis medication cart chec explained she put the medication cart this r pen was almost deple both the insulin pen a stored in the refrigera be used. 2. An observation wa 5:25 PM for the East presence of Nurse #2 one unopened bottle	s orders and medication ls (MARs) revealed Resident der to receive the mentioned s. aducted with Nurse #1 on She stated the hall nurses eck their respective ast once weekly for expired er storage. She added this indeed checked by the Unit norning. She did not know sulin and eye drops were erature in the medication with the UM on 12/13/22 at the Director of Nursing utine medication cart checks to ensure proper storage hedications. In addition, the st would conduct random ks once monthly. She e new insulin pen in the norning as the old insulin eted. She acknowledged that and the eye drops should be ator until they were ready to as conducted on 12/13/22 at Back medication cart in the 2. The observation revealed of Latanoprost eye drop c seal for Resident #43 mperature.		 removal from refrigeration a on medication cart for reside Education completed by 01, facility and agency licensed CMA and sand staff unable to education by 01/09/2023 wiprior to working their next sl The DON and unit man all medication carts and me twice weekly for four (4) we weekly for eight (8) weeks f medication storage and prodating/labeling of refrigerate upon placement onto the m for resident use. The facility the corrective actions to ensideficient practice is correcter recur by reviewing informati during audits and reporting Assurance Performance Im committee (QAPI) by the DO three (3) months. At that tim committee will evaluate the of the interventions to deter continued auditing or adjust plan of correction are necess 5. Completion Date: 01/09 	ent use /09/2023. New nurses and complete II be educated hift. aggers will audit dication rooms eks and then or proper per ed medications edication cart will monitor sure that the ed and will not on collected to Quality provement DN monthly for he the QAPI effectiveness mine if ments to the sary.	

If continuation sheet Page 48 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345010	B. WING				_ 16/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT ASHEVIL	LE			00 BEAVERDAM ROAD SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 761 F 812 SS=F	5:27 PM, he explained unopened Latanopros medication under room not been working with for a while. He acknow should be stored in the ready to be used. An interview was com- 12/13/22 at 5:33 PM. staff missed the insuli- routine medication ca- was her expectation f stored in the tempera- manufacturer's guidel Interview with the Adr 10:49 AM revealed it nursing staff to follow storage guidelines. Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu- (ii) This provision doe facilities from using pro-	st. ith Nurse #2 on 12/13/22 at d he was not sure why the st was stored in the m temperature as he had a East Back medication cart wledged that Latanoprost e refrigerator until it was ducted with the DON on She did not know why the n and Latanoprost despite rt checks were conducted. It or all the medications to be ture as specified by the ines. ninistrator on 12/16/22 at was his expectation for the drug manufacturer's ore/Prepare/Serve-Sanitary 2) y requirements. e food from sources ed satisfactory by federal, es. pod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility		312			1/9/23
		ompliance with applicable					

Facility ID: 922979

If continuation sheet Page 49 of 66

		ND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		345010	B. WING		C 12/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
			4	500 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 812	Continued From page	a 19	F 812			
1 012			F 012			
	safe growing and foo					
		es not preclude residents Is not procured by the facility.				
		prepare, distribute and				
		ance with professional				
	standards for food se	3				
		Γ is not met as evidenced				
	by:	n - internition				
	Based on observatio			1. The facility failed to date, re		
		nendations, the facility failed		discard potentially hazardous for		
		iscard potentially hazardous		for use with signs of spoilage, s	lore loods	
		with signs of spoilage, store		in sealed containers and store	. This	
	foods in sealed conta			nonperishable foods off the floo		
	-	off the floor. This failure		failure occurred in 1 of 3 refrige		
		rigeration units, 1 of 1		units, 1 of 1 freezer and 1 of 1 of		
	-	/ storage rooms with the		rooms with the potential to affect		
	potential to affect 65	of 67 residents.		residents. All identified items we		
	The findings in studes	1.		discarded by the dietary manag	er on	
	The findings included	1.		12/12/2022.		
	1. An observation of	reach-in refrigerator #2 on		2. Current facility residents ha	ave the	
		with the Food Service		potential to be affected by this of		
	Manager (FSM) reve			practice. The dietary manager of		
		ag of red grapes, open to air,		a 100% audit of food storage in		
	with white/black, hair	-like growth; no date of		refrigerators, freezers, dry stora	ige, and	
	opening/use by date.			nourishment rooms to ensure a	II food was	
	b. A sixteen-ounce ba	ag of green grapes, open to		within usage dates, properly sto	ored,	
	air; no date of openin			labeled, and items properly disp	oosed of as	
	c. Six stalks of celery	with a manufacturer pack		identified. Audit completed on 1	2/29/2022.	
		ed in a box open to air, brown				
	discoloration, wilted,	and wrinkled without date of				
	opening/use by.			3. The measures that have be	een put into	
		ar plastic bag of coleslaw		place to ensure the deficient pra	actice does	
	mix (shredded cabba	ge and shredded carrots)		not recur are as follows: The Re	egional	
		of $\frac{11}{10}$ and		Dietary Manager completed edu	ucation	
	with a received date	01 11/10/22 and		Dictary Manager completed ea	1	
		date of 11/19/22, observed		with all current and agency diet		
	manufacturer use by				ary staff on	

Facility ID: 922979

If continuation sheet Page 50 of 66

STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION		NO. 0938-039
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:			ĹĹ	OMPLETED
		345010	B. WING			С
	ROVIDER OR SUPPLIER	545010		STREET ADDRESS, CITY, STATE, ZIP CODI	I	12/16/2022
NAME OF P	ROVIDER OR SUPPLIER			500 BEAVERDAM ROAD	=	
ACCORD	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 812	Continued From page	e 50	F 81	2		
F 812	 yogurt with a manufa 11/30/22. 2. An observation of 1 12/12/22 at 10:05 AW following: a. Four clear plastic k per bag, with a manufa the second second	cturer expiration date of reach-in refrigerator #3 on 1 with the FSM revealed the bags of 12 preboiled eggs facturer use by date of eff open to air. her of whole fat milk with a date of 12/9/22. commercially prepared tuna cturer use by date of ers were inflated and a salad was brown, soupy, the walk-in freezer on 1 with the FSM revealed the ts stored in a clear plastic labeled with a date of use by date. aped pork patties stored dry storage on 12/12/22 at 6M revealed one case of floor with 3 cases of sodas with the FSM on 12/12/22 at that cold and dry storage aily for expired foods, foods ainers, labeled with a date of date. He stated that he and had not had a chance to ince he arrived. He further	F 81:	 Dietary staff are responsible for maintaining this practice throug shift while handling food produced and the Education was completed on the New facility dietary staff unable complete education by 01/09/2 educated prior to working their The dietary manager or do audit refrigerators, freezers, do and nourishment rooms to ensigh was within usage dates, proper and labeled three (3) times a way four (4) weeks and weekly for weeks. The facility will monito corrective actions to ensure the deficient practice is corrected recur by reviewing information during audits and reporting to Assurance Performance Improcommittee (QAPI) by the admin monthly for three (3) months. The QAPI committee will evalue effectiveness of the intervention determine if continued auditing adjustments to the plan of corrine necessary. Completion Date: 01/09/2 	ghout their ucts. 01/09/2023. e to 2023 will be r next shift. esignee will ry storage, sure all food erly stored, week for eight (8) r the and will not collected Quality ovement inistrator At that time ate the ons to g or rection are	

Facility ID: 922979

If continuation sheet Page 51 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345010	B. WING _			/16/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE		500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 812 F 867 SS=F	once weekly on Thurs for putting stock away foods should not be s discarded the expired the expired foods had residents. An interview with the (RDM) on 12/14/22 at when the previous FS practices were droppe expected daily monito foods to be labeled/da and all expired foods manufacturer recomm During an interview w 12/15/22 at 12:35 PM made aware of the foi identified in the dietar the dietary staff to ma manufacturer recomm QAPI/QAA Improvem CFR(s): 483.75(c)(d)(§483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu- following: §483.75(c)(1) Facility systems to obtain and from direct care staff,	sdays, he was responsible y and that nonperishable tored on the floor. He I foods and confirmed that a not been served to Regional Dietary Manager t 12:52 PM revealed that SM left, some daily dietary ed. The RDM stated that he bring of cold storage and all ated, used first in, first out to be discarded per mendations. With the Administrator on I, he stated that he was od storage concerns ty department and expected aintain food storage per mendations. ent Activities (e)(g)(2)(i)(ii) feedback, data systems and sh and implement written	F 8			1/9/23

Facility ID: 922979

If continuation sheet Page 52 of 66

	-	D HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345010	B. WING			1	C 2/16/2022
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 867	are high risk, high vol opportunities for impre- §483.75(c)(2) Facility systems to identify, co information from all de not limited to the facili §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methodod development, monitor §483.75(c)(4) Facility including the methodod systematically identify analyze and use data adverse events in the facility will use the data prevent adverse event §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implement policies ad	ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will 7, report, track, investigate, and information relating to facility, including how the ta to develop activities to its. systematic analysis and cility must take actions e improvement and, after ctions, measure its success, e to ensure that alized and sustained. cility will develop and ddressing: a systematic approach to	F	867			

Facility ID: 922979

If continuation sheet Page 53 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/18/2023 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY LETED
		345010	B. WING			_	(12/	C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVIL	LE			00 BEAVERDAM ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	will be designed to eff level to prevent quality safety problems; and (iii) How the facility wi of its performance imp ensure that improvem §483.75(e) Program a §483.75(e)(1) The face performance improved high-risk, high-volume consider the incidence of problems in those a outcomes, resident sa resident choice, and c §483.75(e)(2) Perform activities must track m resident events, analy implement preventive that include feedback facility. §483.75(e)(3) As part improvement activities distinct performance i number and frequenc conducted by the facil and complexity of the available resources, a assessment required Improvement projects annually a project that problem-prone areas	ems; elop corrective actions that fect change at the systems y of care, quality of life, or all monitor the effectiveness provement activities to pents are sustained. activities. clity must set priorities for its ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. nance improvement nedical errors and adverse yze their causes, and actions and mechanisms and learning throughout the of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility	F	867				

OF DEFICIENCIES						
CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	E SURVEY	
		A. BUILDING			<u>^</u>	
	345010	B WING		C		
	545010			12/16/2022		
ROVIDER OR SUPPLIER						
US HEALTH AT ASHEVIL	LE					
			ASHEVILLE, NC 28804			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
Continued From page	e 54	F 86	7			
§483.75(g) Quality as	sessment and assurance.					
assurance committee	reports to the facility's					
functioning as a gove activities, including im program required unc	rning body regarding its plementation of the QAPI ler paragraphs (a) through					
action to correct ident (iii) Regularly review a data collected under to resulting from drug re- available data to mak This REQUIREMENT by: Based on observatio interviews, the facility Assurance (QAA) Con-	iffied quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced ns, record review, and staff 's Quality Assessment and mmittee failed to maintain		Assurance (QAA) Committee faile maintain implemented procedures	ed to		
interventions that the following a focused in completed on 01/04/2 complaint investigation 01/28/22, and a follow investigation survey of This was for one reper COVID-19 testing of n originally cited on 01/ infection control surve deficiencies in the are homelike environment	committee put into place fection control survey 21, a recertification and on survey completed on v-up revisit and complaint completed on 05/05/22. eat deficiency in the area of residents and staff that was 04/21 during a focused ey and eight repeat eas of safe, clean and t, comprehensive		committee put into place following focused infection control survey completed on 01/04/21, a recertifi and complaint investigation surve completed on 01/28/22, and a foll revisit and complaint investigation completed on 05/05/22. This was repeat deficiency in the area of C4 testing of residents and staff that originally cited on 01/04/21 during focused infection control survey a	cation y ow-up survey for one OVID-19 was a nd eight		
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page (c) and (d) of this sec §483.75(g) Quality as §483.75(g)(2) The qu assurance committee governing body, or de functioning as a gove activities, including im program required unc (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under to resulting from drug re available data to mak This REQUIREMENT by: Based on observatio interviews, the facility Assurance (QAA) Coo implemented procedu interventions that the following a focused in completed on 01/04/2 complaint investigation 01/28/22, and a follow investigation survey of This was for one repe COVID-19 testing of r originally cited on 01/ infection control surve deficiencies in the are homelike environment	US HEALTH AT ASHEVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced	345010 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 54 (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAP1 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAP1 program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interviews, the facility's quality Assessment and complaint investigation survey completed on 01/28/22, and a follow-up revisit and complaint investigation survey completed on 01/28/22, and a follow-up revisit and complaint investigation survey completed on 01/24/21 during a focused infection control survey and eight repeat deficiencies in the areas of safe, clean and homelike environment, comprehensive	345010 STOUTOER OR SUPPLIER STOUTOER OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFING INFORMATION) PREVIDEN OF CORRECT (C) and (d) of this section. \$483.75(g) (2) The quality assessment and assurance. \$483.75(g) (2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the OAPI program required under paragraphs (a) through (e) of this section. The committee plans of action to correct identified quality deficiencies; (ii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regime reviews, and at on available data to make improvements. This REQUIREMENT is not met as evidenced by: 1. The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and montor the interventions that the committee put into place following focused infection control survey completed on 01/04/21, a recertification and complaint investigation survey completed on 01/04/21, a recertification surve completed on 01/04/21, a recertification surve completed on 01/04/21, a recertification survey completed on 01/04/21, a recertification surve completed on 01/04/21, a recertification surve completed on 01/04/21, a recertification surve completed on 01/04/21, a rec	345010 STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES SEQUATORY OR LSC DENTIFYING INFORMATION) D REQUATORY OR LSC DENTIFYING INFORMATION) D Seque consective and comparison F 867 Continued From page 54 F 867 (c) and (d) of this section. F 867 Seque consective and comparison being compari	

Facility ID: 922979

If continuation sheet Page 55 of 66

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/18/202 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345010	B. WING		C 12/16/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				500 BEAVERDAM ROAD	
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 867	medication storage, a under sanitary condit on 01/28/22 during a investigation survey a complaint investigation continued failure of th	related social services, and prepare/store/serve food ions that were originally cited recertification and complaint and/or revisit survey and on on 05/05/22. The ne facility during four federal ow a pattern of the facility's	F 867	months, baseline care plan, develop/implement comprehensiv plans, provision of medically relate services, medication storage, and prepare/store/serve food under sa conditions that were originally cite 01/28/22 during a recertification a complaint investigation survey and revisit survey and complaint inves	ed social initary d on nd d/or
	Assessment and Ass The findings included This tag is cross refe	urance Program. I:		on 05/05/22. The continued failure facility during four federal surveys record shows a pattern of the facil inability to sustain an effective Qu Assessment and Assurance Progr Facility had an Ad Hoc QAPI mee	of the of lity's ality ram.
	investigation survey of to remove a black col caulking around the b #111, #116, #117, #11 (Rooms #117 and #1	ertification and complaint of 12/16/22, the facility failed lored substance and repair base of the toilet (Room 18). Two of the rooms 18) had a strong odor of urine. The facility failed to		01/06/2023 to review repeat citation plans put in place to prevent future citations and have a successful ar productive Quality Assurance and Performance Improvement (QAPI Committee.	ons and e nd
	missing paint to the p in contact with the ba and failed to repair w sheetrock (Rooms #1 hole in the sheetrock	a corrosion and repair portion of a metal door frame throom floor (Room #118); alls with linear gouges in the 17 and #118) and repair a (Room #119) for 1 of 2 r safe, clean, and homelike		2. All residents have the potentia affected by this deficient practice. facility initiated a weekly QAPI risk meeting to review the results of th ongoing audits per the plan of corr and its continued effectiveness on 1/6/2023. Changes will be made to plan as necessary to maintain corr and to ensure and effective QAPI	The c e rection o the npliance
	to ensure residents' of closets, bathrooms a good repair and persi- labeled and covered. ensure missing basel	tion and complaint of 01/28/22, the facility failed overbed tables, rooms, nd walls were clean and in onal care equipment was The facility also failed to board in the nourishment nd the resident shower room		 and to ensure and enective QAPT to prevent repeat citations. 3. The measures that have been place to ensure the deficient pract not recur are as follows: The Vice President of Quality Assurance (V educated QAPI committee member) 	n put into lice does /PQA)

Facility ID: 922979

If continuation sheet Page 56 of 66

		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 01/18/2023 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345010	B. WING		1	C 2/16/2022
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
A00000				500 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 867	Continued From page was clean and sanita		F 86	maintaining an effective C and monitoring system to	prevent repeat	
	investigation survey of to complete compreh (MDS) assessments	of 12/16/22, the facility failed ensive Minimum Data Set	citations on 01/03/2023. QAPI mee be held weekly, monthly, and as ne by the facility QAPI committee with oversight by the regional team.		and as needed hittee with	
	reviewed for Residen	od) for 8 of 9 residents It Assessments (Residents 447, #60, #223, and #220).		4. The Regional Director Services (RDCS) or VPQ, weekly for 4 weeks then, months for compliance wi	A will monitor monthly for 2	
	to complete compreh	tion and complaint of 01/28/22, the facility failed ensive Minimum Data Set within 14 days of the ARD.	daily/weekly/monthly/PRN A		beat tags for tiveness by tain an effective	
	investigation survey of to complete quarterly assessments within 1 Reference Date (ARI observation period) for for Resident Assessm	or 6 of 9 residents reviewed nents (Residents #41, #45,		QAPI program that prever citations by effective moni of monitoring will be prese Quality Assurance Perforr Improvement committee (administrator monthly for months. At that time the C and RDCS or VPQA will e	itoring. Results ented to the mance QAPI) by the three (3) QAPI committee evaluate the	
		ation and complaint of 01/28/22, the facility failed ly Minimum Data Set (MDS)		effectiveness of the interv determine if continued au adjustments to the plan of necessary.	diting or f correction are	
	investigation survey of to develop and imple within 48 hours of ad	ertification and complaint of 12/16/22, the facility failed ment a baseline care plan mission to address the 1of 5 residents reviewed for sident #50).		5. Completion Date: 01/	/09/2023	
	During the recertification survey of the second sec	tion and complaint of 01/28/22, the facility failed				

Facility ID: 922979

If continuation sheet Page 57 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345010	B. WING				C / 16/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT ASHEVII	LE			00 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 867	 to complete baseline with resident and/or r to provide the resider with a written summa F656: During the recinvestigation survey of to develop a dialysis of individualized intervent treatment for 1 of 1 sa #15). During the recertification survey of to implement a resider for falls and develop a who smoked. During the revisit and survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of the recertification survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of the recertification survey of 05/05/22, the care plan for a resider the survey of 05/05/22, the care plan for a resider care. F745: During the recertification survey of 05/05/21, the care plan for a resider care. F761: During the recertification survey of 05/05/21, the care plan for a survey of 05/05/21, the care plan for a resider for 05/05/21, the care plan for a resider for 05/05/22, the care plan for a resider for 05/05/21, the care plan for a resider for 05/05	care plans in conjunction esponsible party and failed at or their responsible party ry of the baseline care plan. ertification and complaint of 12/16/22, the facility failed care plan to include ntions related to dialysis ampled resident (Resident tion and complaint of 01/28/22, the facility failed ent's care plan interventions a care plan for a resident complaint investigation ne facility failed to develop a nt related to respiratory ertification and complaint of 12/16/22, the facility failed consultation appointments or 2 of 4 sampled residents (5). tion and complaint of 01/28/22, the failed to I referrals as ordered by the ertification and complaint of 12/16/22, the failed to I referrals as ordered by the	F	867			

Facility ID: 922979

If continuation sheet Page 58 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/18/2023 MAPPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345010	B. WING			_		C 16/2022
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, ST	ATE, ZIP CODE	,	
				500	0 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVIL	LE		AS	SHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	during medication sto During the recertificat investigation survey of discard expired intrav with the manufacturer During the revisit and survey of 05/05/22, the medications from medications from medications from medications from medications from medications from medications with the manufacturer F812: During the recer investigation survey of to date, remove, or different foods stored for use w foods in sealed contain nonperishable foods of occurred in 1 of 3 refir freezer and 1 of 1 dry potential to affect 65 of During the recertificat investigation survey of to discard bags of shir signs of spoilage and hair covered during 2 which had the potentia food served to resider F886: During the recertificat investigation survey of to maintain COVID-19 residents' medical recor-	Back medication carts) rage checks. ion and complaint of 01/28/22, the failed to enous fluids in accordance dise sepiration date. complain investigation refailed to remove expired dication carts in accordance dication carts in accordance dise sepiration date. ertification and complaint of 12/16/22, the facility failed scard potentially hazardous with signs of spoilage, store iners and store off the floor. This failure igeration units, 1 of 1 storage rooms with the of 67 residents. ion and complaint of 01/28/22, the facility failed redded lettuce with visible ensure dietary staff had all separate meal services al for cross-contamination of nts. ertification and complaint of 12/16/22, the facility failed	F 84	67		DEFICIENCY)		
		fection control survey of						

Facility ID: 922979

If continuation sheet Page 59 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED C	
		345010	B. WING				
	ROVIDER OR SUPPLIER	LE	•	500 BE	T ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY				(X5) COMPLETION DATE
F 867 F 886 SS=B	01/04/22, the facility f testing of staff and res Disease Control and upon identification of During an interview o Administrator reveale review the systems p issues identified durin however, due to ongo not always have the r ensure the systems w The Administrator sta management and inte facility now had in pla ownership who provid felt they were headed going forward, he felt resolved quickly. COVID-19 Testing-Re CFR(s): 483.80 (h)(1) §483.80 (h) COVID-1 must test residents and individuals providing s and volunteers, for CO for all residents and fa individuals providing s and volunteers, the L §483.80 (h)((1) Condi- parameters set forth f but not limited to: (i) Testing frequency;	ailed to conduct COVID-19 sidents per the Centers for Prevention (CDC) guidelines a positive staff member. In 12/16/22 at 5:26 PM, the d they had continued to ut into place to correct the og monthly QAPI meetings; oing staffing issues they did nanagement staff needed to vere consistently executed. ted with the new erdisciplinary team the ce along with new ded much more support, he in the right direction and the issues would be esidents & Staff h-(6) 9 Testing. The LTC facility nd facility staff, including services under arrangement OVID-19. At a minimum, acility staff, including services under arrangement TC facility must: uct testing based on by the Secretary, including of any individual specified in bsed with		867			1/9/23

If continuation sheet Page 60 of 66

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345010	B. WING				C 16/2022
NAME OF PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDIUS HEALTH AT ASHEVILLE					000 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 886	this paragraph with sy consistent with COVII suspected exposure to (iv) The criteria for co- asymptomatic individu paragraph, such as th COVID-19 in a county (v) The response time (vi) Other factors spec- help identify and preve transmission of COVI §483.80 (h)((2) Cond- is consistent with curr conducting COVID-19 §483.80 (h)((3) For ea- (i) Document that test results of each staff to (ii) Document in the re- was offered, complete to the resident's testin each test. §483.80 (h)((4) Upon individual specified in symptoms consistent with COVII for COVID-19, take at transmission of COVI §483.80 (h)((5) Have residents and staff, in services under arrang- refuse testing or are u	of any individual specified in (mptoms D-19 or with known or o COVID-19; nducting testing of uals specified in this ne positivity rate of (; e for test results; and cified by the Secretary that ent the D-19. uct testing in a manner that rent standards of practice for D tests; ach instance of testing: ting was completed and the est; and esident records that testing ed (as appropriate ng status), and the results of the identification of an this paragraph with D-19, or who tests positive ctions to prevent the D-19. procedures for addressing cluding individuals providing gement and volunteers, who	F	886			

If continuation sheet Page 61 of 66

		ND HUMAN SERVICES				1 APPROVE		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345010				PLE CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED		
		B. WING			C 12/16/2022			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
ACCORDI	US HEALTH AT ASHEVI	LIF		500 BEAVERDAM ROAD				
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				ASHEVILLE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 886	Continued From page	e 61	F 88	36				
		testing supply shortages,						
	and local health departments to assist in testing efforts, such as obtaining testing supplies or							
	processing test result This REQUIREMENT by:	ts. Γ is not met as evidenced						
	-	iew and staff interviews, the		1. The facility failed to main	ntain			
		ain COVID-19 test results in		COVID-19 test results in the				
		al record for 5 of 5 sampled		medical record for 5 of 5 san				
		Resident #6, Resident #21,		residents reviewed (Residen				
	Resident #43, Reside	ent #52, and Resident #56).		#21, Resident #43, Resident Resident #56). Resident # 2				
	Findings included:			#6, Resident #43, Resident #				
	r mangs moladea.			Resident #56 s COVID test				
	The facility's COVID-	19 test results binders		uploaded into the electronic				
		apid antigen tests were		(EHR) effective 1/6/23 by the				
	· ·	nts during the following 22 to 06/04/22, 06/05/22 to		records clerk.				
		06/18/22, 06/26/22 to		2. All residents have the po				
		o 11/26/22, 11/27/22 to		affected by this deficient practice of the second s				
	12/03/22, and 12/04/	22 to 12/10/22.		current residents COVID tes completed after 11/21/2022	•			
	1. Resident #6 was a	admitted to the facility on		uploaded into their EHR by 1				
	07/06/20.			medical records clerk.				
	Review of Resident #	6's medical record revealed						
	· •	e dated 11/30/22 at 4:23 PM		3. The measures that have				
	that noted Resident #			place to ensure the deficient				
		eview revealed no additional		not recur are as follows: The				
	documentation of CC December 2021.	VID-19 test results since		Nursing (DON) educated the				
				records clerk on ensuring res test records have been uploa				
	A joint interview was	conducted with the Director		EHR in a timely manner and				
	-	d Regional Nurse Consultant		of maintaining residents com				
		PM. The DON explained		medical records. The medica				
	each resident's COV	ID-19 rapid antigen test		is responsible for uploading				
		ed individually on a facility		COVID testing in the EHR. E	ducation was			
	form and stored in a	monthly binder by the date		completed by 01/09/2023.				

Facility ID: 922979

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	· · ·	(X3) DATE SURVEY COMPLETED		
ND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING				
		345010	B. WING		12	C 2/16/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ACCORDIUS HEALTH AT ASHEVILLE				500 BEAVERDAM ROAD ASHEVILLE, NC 28804				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 886	the test was complete test results were typic resident's medical rec and was unaware all should be maintained record. During an interview of Administrator stated H regulation and was un COVID-19 test results the resident's medical stated he would exper records to contain do COVID-19 test results 2. Resident #21 was 05/16/18. Review of Resident # revealed no documer results since March 2 A joint interview was of Nursing (DON) and on 12/14/22 at 4:04 F each resident's COVI result was documente form and stored in a n the test was complete test results were typic resident's medical rec and was unaware all should be maintained record.	ed. The DON stated positive cally documented in the cord via staff progress notes COVID-19 test results in the resident's medical an 12/16/22 at 5:24 PM, the he was aware of the nable to explain why is had not been maintained in il record. The Administrator for resident's medical cumentation of all is. admitted to the facility on 221's medical record nation of COVID-19 test 2021. conducted with the Director d Regional Nurse Consultant PM. The DON explained iD-19 rapid antigen test ed individually on a facility monthly binder by the date ed. The DON stated positive cally documented in the cord via staff progress notes COVID-19 test results it in the resident's medical	F 88	 4. The DON will audit five (5) r twice weekly for four (4) weeks, weekly for eight (8) weeks for pre- record keeping of COVID test re- facility will monitor the corrective to ensure that the deficient pract corrected and will not recur by re- information collected during audir reporting to Quality Assurance Performance Improvement comme (QAPI) by the administrator mon- three (3) months. At that time the committee will evaluate the effect of the interventions to determine continued auditing or adjustment plan of correction are necessary 5. Completion Date: 01/09/202 	then oper sults. The actions ice is eviewing its and nittee thly for e QAPI stiveness if ts to the			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
		345010	B. WING				C 16/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT ASHEVIL	LE			500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 886	the resident's medical stated he would experecords to contain doo COVID-19 test results 3. Resident #43 was 07/27/22. Review of Resident # revealed a Nurse Pra- dated 11/29/22 that no positive for COVID-19 review revealed no ac COVID-19 test results A joint interview was of of Nursing (DON) and on 12/14/22 at 4:04 P each resident's COVI result was documented form and stored in a re- the test was completed test results were typic resident's medical rec- and was unaware all should be maintained record. During an interview of Administrator stated he regulation and was un COVID-19 test results the resident's medica stated he would exper- records to contain doo COVID-19 test results	s had not been maintained in I record. The Administrator ct for resident's medical cumentation of all s. admitted to the facility on 43's medical record ctitioner progress note oted Resident #43 tested 0 on 11/28/22. Further dditional documentation of s. conducted with the Director d Regional Nurse Consultant M. The DON explained D-19 rapid antigen test ed individually on a facility monthly binder by the date ed. The DON stated positive cally documented in the cord via staff progress notes COVID-19 test results in the resident's medical n 12/16/22 at 5:24 PM, the ne was aware of the nable to explain why s had not been maintained in I record. The Administrator ct for resident's medical	F	886			

Facility ID: 922979

If continuation sheet Page 64 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345010	B. WING				C / 16/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDIUS HEALTH AT ASHEVILLE					500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 886	S HEALTH AT ASHEVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 10/12/21. Review of Resident #52's medical record revealed no documentation of COVID-19 test results since December 2021. A joint interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 12/14/22 at 4:04 PM. The DON explained each resident's COVID-19 rapid antigen test result was documented individually on a facility form and stored in a monthly binder by the date the test was completed. The DON stated positive test results were typically documented in the resident's medical record via staff progress notes and was unaware all COVID-19 test results should be maintained in the resident's medical record. During an interview on 12/16/22 at 5:24 PM, the Administrator stated he was aware of the regulation and was unable to explain why COVID-19 test results had not been maintained in the resident's medical record. The Administrator stated he would expect for resident's medical records to contain documentation of all COVID-19 test results. 5. Resident #56 was admitted to the facility on D4/06/22. Review of Resident #56's medical record revealed a no documentation of COVID-19 test results.		F	886				
	of Nursing (DON) and on 12/14/22 at 4:04 F each resident's COVI	conducted with the Director I Regional Nurse Consultant M. The DON explained D-19 rapid antigen test ed individually on a facility						

Facility ID: 922979

If continuation sheet Page 65 of 66

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/18/2023 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345010	B. WING			_	C 12/16/2022	
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDIUS HEALTH AT ASHEVILLE				000 BEAVERDAM ROAD ASHEVILLE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 886	form and stored in a r the test was complete test results were typic resident's medical rec and was unaware all should be maintained record. During an interview o Administrator stated h regulation and was u COVID-19 test results the resident's medical	monthly binder by the date ed. The DON stated positive cally documented in the cord via staff progress notes COVID-19 test results I in the resident's medical n 12/16/22 at 5:24 PM, the ne was aware of the nable to explain why s had not been maintained in I record. The Administrator cot for resident's medical cumentation of all	F	886				

Facility ID: 922979

If continuation sheet Page 66 of 66