STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/02/24 through 12/06/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MMG311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/02/24 through 12/06/24. Event ID# MMG311. The following intakes were investigated: NC00224517, NC00224170, NC00224110, NC00222814, NC00222510, NC00222526, NC00222515, NC00221930, NC00221635, NC00220844, NC00219872, NC00219799, NC00219461, NC00218945, NC00218552, NC00218337, NC00217995, NC00217979, NC00217390, NC00215994, NC00214976, NC00214000, NC00213404, NC00212250, and NC00212066. 22 of the 70 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553		1/3/25

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

Electronically Signed | 12/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 1 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to invite residents to participate and provide input in care planning for 2 of 3 sampled residents (Residents #50 and #11). Findings included: 1. Resident #50 was admitted to the facility on 07/06/23 with diagnoses that included diabetes, chronic pain, chronic post-traumatic stress disorder, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated 09/13/24 revealed Resident #50 had intact cognition.	F 553	The facility failed to invite residents to participate and provide input in care planning for 2 of 3 sampled residents (Residents #50 and #11). Care Plans were scheduled for resident #50 and #11 and completed on 12/27/2024. Current facility residents are at risk of being affected by the deficient practice. An audit of comprehensive minimum data sets (MDS) that were completed over the last 30 days was completed by the Regional Director of Clinical Reimbursement to ensure a care meeting was scheduled and residents were invited and able to participate and have input into their plan of care. The audit was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 2 Review of Resident #50's electronic medical record revealed no evidence she was invited to attend care plan meetings to discuss and provide input regarding her plan of care following the completion of the annual MDS assessment dated 07/04/24 or the quarterly MDS assessment 09/13/24. The comprehensive care plan for Resident #50 was last revised on 08/14/24. During an interview on 12/03/24 at 8:49 AM, Resident #50 stated she had not been invited to attend or had a care plan meeting scheduled since June 2024. During interviews on 12/4/24 at 2:28 PM and 12/06/24 at 3:52 PM, the Administrator revealed the Social Worker (SW) was responsible for keeping track of the care plan meeting schedule. He explained the SW left employment on 10/24/24 and since then, they had been actively interviewing candidates to fill the position. He explained that since the SW left employment, the care plan meeting schedule had not been updated and although the Interdisciplinary Team had conducted several initial 48-hour and quarterly care plan meetings with residents in their rooms, along with the resident's Responsible Party/Family Member on the phone, they had not documented the care plan meetings in the resident's medical record. The Administrator could not state for certain if a care plan meeting was held with Resident #50 following the completion of her annual MDS assessment dated 07/04/24 or quarterly MDS assessment dated 09/13/24. The Administrator stated he would expect for care plan meetings to be completed quarterly.	F 553	completed on 12/27/2024. Concerns were identified and care plan meetings were scheduled and to be completed by 1/3/2025. To ensure this deficient practice does not reoccur the following have been put into place: The Regional Director of Clinical Reimbursement educated the Administrator, Director of Nursing, MDS coordinators, and members of the interdisciplinary team (IDT) on the process of inviting the residents to the care plan meeting, the scheduling of the care plan meetings, and the residents right to provide input into their care plan. Education completed on 1/3/2025. Any staff in the IDT that is not educated by 1/3/2025 and newly hired IDT will be educated upon hire or prior to working their next shift. The RDCR will observe 5 residents who have had an MDS assessment completed weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month, to ensure the resident has been had a care plan scheduled, were invited, and given the opportunity to participate in their plan of care. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 3 2. Resident #11 was admitted to the facility on 11/11/22 with diagnoses that included congestive heart failure, colostomy status, epilepsy (brain disorder that causes seizures), chronic post-traumatic stress disorder, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated 09/27/24 revealed Resident #11 had moderate impairment in cognition. The comprehensive care plan for Resident #11 was last revised on 11/18/24. Review of Resident #11's electronic medical record revealed no evidence she was invited to attend a care plan meeting to discuss and provide input regarding her plan of care following the completion of the quarterly MDS assessment dated 09/27/24. Review of the facility's 2024 Care Plan Meeting Schedules provided by the Administrator revealed a care plan meeting was held with Resident #11's Family Member on 06/26/24 with no other scheduled meetings listed after that date. Further review revealed there were no care plan meetings listed on the schedule for any resident after 09/25/24. During an interview on 10/07/24 at 4:18 PM, Resident #11 did not recall being invited to participate in any care plan meetings. During interviews on 12/4/24 at 2:28 PM and 12/06/24 at 3:52 PM, the Administrator revealed the Social Worker (SW) was responsible for keeping track of the care plan meeting schedule.	F 553	determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 4 He explained the SW left employment on 10/24/24 and since then, they had been actively interviewing candidates to fill the position. He explained that since the SW left employment, the care plan meeting schedule had not been updated and although the Interdisciplinary Team had conducted several initial 48-hour and quarterly care plan meetings with residents in their rooms, along with the resident's Responsible Party/Family Member on the phone, they had not documented the care plan meetings in the resident's medical record. The Administrator could not state for certain if a care plan meeting was held with Resident #11 and/or her Responsible Party/Family Member following the completion of her quarterly MDS assessment dated 09/27/24. The Administrator stated he would expect for care plan meetings to be completed quarterly.	F 553		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to ensure a dependent resident could access a light switch located at the left side of her bed for 1 of 1 resident reviewed for accommodation of needs (Resident #91). The findings included:	F 558	The facility failed to ensure a dependent resident could access a light switch located at the left side of her bed for 1 of 1 resident reviewed for accommodation of needs (Resident #91). The access to the light switch was corrected upon notification of need by the maintenance director on _12/6/2024_____.	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 5 Resident #91 was admitted to the facility on 05/13/24. The quarterly Minimum Data Set (MDS) assessment dated 08/16/24 indicated Resident #91 had severe cognitive impairment. The MDS coded Resident #91 with impairment of one side of lower extremity and walking between locations inside the room for more than 10 feet was not attempted during the assessment period due to medical condition or safety concerns. During an observation conducted on 12/02/24 at 1:09 PM, the switch for the light fixture on the left side of Resident #91's bed 5 feet from the floor was attached with a cord 3 inches in length. Resident #91 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #91 on 12/02/24 at 1:13 PM. She stated the switch cord had been broken since she moved into her room more than a month ago. She added she was bed-bound and unable to get up from the bed without assistance. It was very inconvenient for her as she could not reach the switch cord and had to rely on the staff to control the light fixture all the time. Subsequent observation conducted on 12/03/24 at 10:46 AM revealed the switch cord for the light fixture next to Resident #91's bed remained inaccessible. An interview was conducted with Nurse Aide #5 (NA) on 12/03/24 at 2:53 PM. He noticed the switch cord for Resident #91's light fixture had been broken for a while, but he did not notify the	F 558	Current facility residents are at risk of being affected by this deficient practice. The maintenance director completed an audit of each room throughout the facility to ensure that all residents had access to a light switch. The audit was completed on 12/10/2024 and 2 concerns were found. The 2 areas of concern were repaired on 12/10/2024. To ensure the deficient practice does not recur, the Administrator educated the maintenance director, maintenance assistant, and maintenance staff on ensuring all residents have access to a switch to turn on and off the light in their room, and the residents right to accommodation of needs. This education was completed on 12/10/2024. Facility and agency staff including nursing, housekeeping, and dietary department were educated on on utilizing the maintenance binders at each nursing station and the electronic system online to report areas within facility that need repairs completed. This education was completed by the staff development coordinator on 1/3/2025. Newly hired maintenance directors, maintenance assistants, maintenance staff, and facility and agency staff who are not educated by 1/3/25 will be educated upon hire or prior to working their next shift. The administrator or designee will audit 5 resident rooms weekly, to ensure the resident has access to a light switch, x 12 weeks. The facility will monitor the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 6 maintenance staff to fix it. Instead, he used the switch on the wall near the entrance door to switch on the light fixture next to Resident #91's bed. He stated he should have notified the maintenance staff to fix it as it was important for Resident #91 to have full accessibility to her light fixture at all time. During an interview conducted on 12/03/24 at 2:58 PM, Nurse #3 confirmed Resident #91 was bedridden and unable to get up from her bed or stand up on her feet to switch on the light fixture next to her bed. She explained she did not notice that the switch cord was broken when she provided care for Resident #91 in the past few weeks. During a joint observation conducted with the Maintenance Manager on 12/03/24 at 2:40 PM, he acknowledged that the switch cord for the light fixture was too short and unreachable for Resident #91, and it needed to be fixed as soon as possible. An interview was conducted with the Maintenance Manager on 12/03/24 at 2:47 PM. He stated he checked the entire facility including Resident #91's room and bathroom at least once every week. He did not know when the switch cord was broken and stated it was important for Resident #91 to have accessibility to her light fixture. He added he depended on residents and staff to report repair needs either verbally or through the work order. He typically checked the work orders at least once daily to ensure all repair needs were met in a timely manner. An interview was conducted with the Director of Nursing (DON) on 12/03/24 at 4:06 PM. She	F 558	corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 7 expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs. She added the maintenance staff should check repair needs on a regular basis and address the issues accordingly. It was her expectation for all the dependent residents to have full access and control of the light fixture all the time.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 8 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 3 residents reviewed for advanced directives (Resident #65). Findings included: Resident #65 was admitted to the facility on 07/14/21. Resident #65's advanced directive care plan, initiated on 07/15/21, with the most recent revision on 03/26/2024 had Resident #65 Care planned as a Full Code. Care Plan Goal listed as: Resident's advanced directives are in effect and their wishes and directions will be carried out in accordance with their advanced directives. Interventions included: Allow resident if able to discuss feelings regarding their Advanced Directives, An Advanced Directive can be revoked or changed if the resident and or appointed Health Care Representative changes their mind about the medical care they want	F 578	The facility failed to maintain accurate advanced directives throughout the medical record for 1 of 3 residents reviewed for advanced directives (Resident #65). Resident #65's care plan was corrected to show appropriate code status on 12/4/24. Current facility residents are at risk of being affected by the deficient practice. The minimum data set (MDS) coordinator completed an audit on current facility residents to ensure the advanced directives were correct throughout the medical record. The audit was completed on 12/10/24. The audit was completed and 0 concerns were noted. The Staff Development Coordinator educated facility and contract licensed nurses including the MDS nurses, and the interdisciplinary team (IDT) on ensuring the resident's advanced directives are accurate throughout the resident's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 9 delivered, Complete and update MOST form as needed. Honor residents and family wishes. Review advance directives at least quarterly and PRN. The appointed Health Care Representative will make all health care decisions if the resident is incapacitated. The quarterly Minimum Data Set (MDS) dated 09/20/2024 revealed Resident #65 was severely cognitively impaired. Review of the Code Book revealed Resident #65's revealed a Medical Orders for Scope of Treatment (MOST) form dated 09/23/2024 that indicated his preference for a Do Not Resuscitate (DNR) status in the event he had no pulse and was not breathing. The form was signed by Resident #65's Responsible Party. On the profile page of Resident #65's electronic health record, Resident #65's code status was listed as a "DNR". Review of Resident #65's Physician orders, revealed an order dated 9/23/2024 for a Medical Orders for Scope of Treatment (MOST) form dated 09/23/2024 that indicated his preference for a Do Not Resuscitate (DNR) status in the event he had no pulse and was not breathing. During an interview on 12/04/2024 at 11:44am Nurse # 1 stated a Resident's code status could be found in the Code Book located at the desk and in the resident's electronic medical record or chart. Nurse #1 stated new orders for advanced directives were received by the nurse, the social worker used to update the charts and care plan, now it was completed by nursing.	F 578	medical record. The education was completed on 12/27/2024. Newly hired facility and contract licensed nurses and IDT members or facility and contract licensed nurses including MDS nurses, and IDT members not educated by 1/3/2025 will be educated upon hire or prior to working their next scheduled shift. The Director of Nursing or designee will audit 5 resident□s medical records weekly to ensure their advanced directives are accurate throughout medical record weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 10 During an interview on 12/04/2024 at 2:42pm Unit Manager #1 stated nurses share the responsibility to make sure new orders for advanced directives were updated in the chart, face sheet and Code Book, and the Minimum Data Set (MDS) nurse updated the care plan. During an interview on 12/04/2024 at 2:47pm, the MDS Coordinator #2 stated the social worker used to update advanced directives in the resident's care plan but was not aware who was responsible to keep them updated now. The MDS Coordinator #2 verified Resident #65's order for a DNR did not match the Care Plan for Full code in his electronic medical record. During an interview on 12/4/2024 at 3:23pm, the Director of Nursing (DON) stated the nurse who received the order would make any notifications needed to family and social work. The DON stated since the facility did not have a social worker, the DON had taken the responsibility to keep advanced directive care plans updated. The DON verified that Resident #65's care plan for a Full Code did not match the order in Resident #65's chart. The DON stated she expected for a resident's advanced directives to match throughout the medical record. During an interview 12/06/24 4:20 PM the Administrator stated he would expect a resident's advanced directive status to match across all areas of the resident's chart. The Administrator stated it had been the social worker's responsibility to update advanced directive care plans, but due to the social work position being vacant, the DON had assumed that responsibility.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and Nurse Practitioner (NP) interviews and record review, the facility failed to notify the Physician when a urinalysis was not completed for 1 of 2 residents reviewed for notification of change (Resident #38). The findings included: Resident #38 was admitted to the facility on 11/5/23 with diagnosis that included bacteremia. Resident #38 had a physician's order for a urinalysis (UA) with culture and sensitivity for urinary pain one time only for one day. This was ordered on 9/24/2024 and marked completed on 9/25/2024. Review of the treatment administration record (TAR) for September 2024 revealed the UA was documented as completed on 9/25/2024. Review of the lab results revealed that there were no results for the UA ordered on 9/24/2024 for Resident #38. A phone interview on 12/06/2024 at 9:54 AM with	F 580	The facility failed to notify the Physician when a urinalysis was not completed for 1 of 2 residents reviewed for notification of change (Resident #38). The medical director was notified of resident's refusal of urine specimen collection by Vice President of Clinical Operations on 12/4/2024 and resident #38 assessed by MD and new orders received. Current facility residents who have had an order for urinalysis (UA) are at risk of being affected by the deficient practice. A 100% audit of UA's ordered in the last 30 day was completed by 12/09/24 to ensure the medical provider notified of result or refusal of testing. The audit was completed on and there were 0 concerns were noted. To ensure the deficient practice does not recur the Staff Development Coordinator (SDC) educated facility and contract licensed nurses on ensuring the resident's urinalysis testing is completed and to notify medical provider of resident refusals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13 Nurse #6 revealed revealed that she had completed and collected the UA specimen for Resident #38 on 9/25/2024 and placed it in the refrigerator for the lab to collect. She stated that if the specimen is left in refrigerator too long the lab or an employee would throw the specimen out because it is no longer useable. She stated that could be why there were no results for the UA ordered on 9/24/2024. Nurse #6 indicated she was not aware that there were no results for the UA and therefore had not notified the Physician. An interview on 12/06/2024 at 8:36 AM with the Nurse Practitioner (NP) revealed that she was not notified that the September UA did not have any results returned from the laboratory and that she would want to be notified if the staff were unable to complete the UA or if it needed to be reordered. She stated that Resident #38 had not experienced harm or a negative outcome by the UA not being completed. An interview on12/06/2024 at 12:33 PM with the Director of Nursing (DON) revealed that the breakdown was the Nurse who collected the specimen and did not fill out the requisition. She stated that if she had found the specimen sooner than today, she would have followed up with the NP to obtain a new order for the UA and she would have followed up with the Nurse as well about the specimen. She stated that her expectation was that laboratory test results, or lack thereof should be communicated to the Physician. An interview on 12/06/24 at 3:54 PM with the Administrator revealed that his expectation was if a lab order does not make it to the lab for whatever reason the NP would be notified so they	F 580	of testing. The education was completed on 12/27/2024. Newly hired facility and contract licensed nurses or facility and contract licensed nurses not educated by 1/3/2025 will be educated upon hire or prior to working their next scheduled shift. The Director of Nursing or designee will audit 5 resident's weekly to ensure the medical provider is notified of refusals for lab testing weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14 could make the decision to order another lab or not.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 15 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to secure an overbed light fixture that was positioned above a resident's head to the wall (room 318-B); ensure the overbed light worked (room 318-B, 327-A, and 331-B); replace the light bulbs in a fixture above the sink (room #318); ensure the water temperature from a bathroom sink was comfortable and not too cool (room 319); ensure the shower room air vent was clean (Hall B shower room); ensure the overbed table and dresser did not have exposed sharp edges (room 229-B); ensure a shared bathroom toilet and floor were clean and address a strong lingering odor resembling urine (room 224); ensure ceiling, walls, flooring, baseboards, and overbed tables were clean and in good repair (rooms 227, 229-A, 318, 319, 321, 327-A, and 330); provide a clean privacy curtain (room 224); and ensure the toilet paper holder was in place for a shared bathroom (rooms 218 and 220) on 2 of 2 halls reviewed for environment (Halls A and B). Findings included: 1. a. During an observation and interview on 12/02/24 at 3:51 PM of in room 318-B the resident was resting in bed with an overbed light positioned directly above the head of the bed. Resident #82 revealed the overbed light did not work and was unsure how long it had not. When	F 584	The facility failed to secure an overbed light fixture that was positioned above a resident's head to the wall (room 318-B); ensure the overbed light worked (room 318-B, 327-A, and 331-B); replace the light bulbs in a fixture above the sink (room #318); ensure the water temperature from a bathroom sink was comfortable and not too cool (room 319); ensure the shower room air vent was clean (Hall B shower room); ensure the overbed table and dresser did not have exposed sharp edges (room 229-B); ensure a shared bathroom toilet and floor were clean and address a strong lingering odor resembling urine (room 224); ensure ceiling, walls, flooring, baseboards, and overbed tables were clean and in good repair (rooms 227, 229-A, 318, 319, 321, 327-A, and 330); provide a clean privacy curtain (room 224); and ensure the toilet paper holder was in place for a shared bathroom (rooms 218 and 220) on 2 of 2 halls reviewed for environment (Halls A and B). Cited findings were repaired by 1/3/2025. Current facility residents are at risk of being affected by deficient practice. The administrator and Maintenance Director did a 100% audit of all resident rooms to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 16 the light switch chain was pulled the fixture moved and was not secured to wall. During an interview on 12/04/24 at 8:44 the Maintenance Manager revealed he completed weekly checks by selecting random resident rooms on each hall to identify environmental issues and he was the person responsible to fix concerns when noted. The Maintenance Manager explained environment issues were shared with him during the morning meeting, and he could be notified by staff using a computer generated or paper work order and paper work orders were kept in a binder placed at each nurse station that he checked daily. A follow-up observation and interview with the Maintenance Manager was conducted on 12/04/24 at 10:11 AM. The Maintenance Manager observed the overbed light in room 318-B was not secured to the wall and moved when the chain was pulled and did not turn on. The Maintenance Manager revealed the fixture needed to be secured to the wall to prevent it from falling when the light switch chain was pulled and could injure the resident if they were in bed, and it fell off the wall. The Maintenance Manager revealed he was not aware the overbed light was not secured to the wall or that it did not work. b. During an observation on 12/02/24 at 3:51 PM the lights above the sink in room 318 did not work properly when turned on. The light fixture had two bulbs and when turned on only one would dimly light and flickered on and off. An observation and interview with the Maintenance Manager was conducted on 12/04/24 at 10:11 AM. The Maintenance	F 584	identify further concerns related to the cited areas of overbed lights, sink lights, water temperatures, air vents in shower rooms, overbed tables and dressers free of sharp edges and functioning properly, clean floors free of odor and stains, stains to walls, textured spackling on ceilings, holes in plaster, privacy curtains in need of cleaning, and toilet paper holders. Many areas of related concerns identified. Repairs are to be completed when ordered supplies arrive. Facility has receipt of proof of ordering. Facility has recruited assistance in completing the necessary repairs within a reasonable time dependent upon time of order receival. To ensure the deficient practice does not recur, the Vice President of Operations educated the maintenance director, Environmental Services Director, Environmental Services Department, and the maintenance assistants on providing residents with a safe homelike environment. Newly hired maintenance directors and maintenance assistants and maintenance staff who are not educated by 1/3/25 will be educated upon hire or prior to working their next shift. The administrator or designee will audit 5 resident rooms to ensure the resident has a safe homelike environment completed weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17 Manager observed the lights above the sink in room 318 did not work and stated the bulbs needed replaced. The Maintenance Manager revealed he was not aware the light bulbs above the sink needed to be replaced. c. During an observation on 12/02/24 at 3:51 PM the ceiling in room 318 had approximately three areas of different sizes where the textured spackling was missing. During an interview and observation on 12/04/24 at 10:11 AM the Maintenance Manager revealed he was not aware the textured spackling needed to be repaired in room 318. He revealed the resident would need to be out of the room for him to repair the ceiling. 2. During an observation on 12/02/24 at 10:41 AM the overbed light in room 331-B did not work and the light switch pull chain was missing. During an interview on 12/04/24 at 9:14 AM the Maintenance Manager revealed he was aware the overbed light in room 331-B did not work and needed replaced. He revealed the new light was ordered but he could not find the purchase order to show when and would order another one today (12/04/24). 3. a. During an interview on 12/03/24 at 9:01 AM the resident in room 319 revealed the water in the bathroom did not get warm enough. An interview and observation with Maintenance Manager was conducted on 12/04/24 at 10:03 AM. The Maintenance Manager tested the water temperature from the bathroom sink in room 319 using his thermometer. The temperature did not	F 584	information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 18	F 584		

get above 89.6 F after approximately 5 minutes. The Maintenance Manager stated he was not aware the water temperature was not getting warm enough.

b. During an observation on 12/03/24 at 9:01 AM the ceiling in room 319 had an area approximately 4 inches by 4 inches where the textured spackling had broken off.

An interview and observation with Maintenance Manager was conducted on 12/04/24 at 10:03 AM. The Maintenance Manager revealed he was not aware the ceiling in room 319 had damage where the textured spackling was missing. He revealed he used spray on textured spackling and could repair the ceiling.

4. An observation and interview with the Maintenance Manager was conducted on 12/04/24 at 9:53 AM of the ceiling in room 321. There were approximately 8 areas on the ceiling where the textured spackling was missing. The Maintenance Manger revealed he did not have a work order and was not aware of the damage.

5. An observation and interview was conducted with the Floor Technician on 12/04/24 at 9:25 AM. Two air vents located in the Hall B shower room had a significant amount of dust buildup. The Floor Technician revealed he was responsible for cleaning the air vents in the shower room and it was done daily. He stated he had not cleaned the air vent in Hall B shower room on 12/4/24.

During an interview on 12/06/24 at 3:52 PM, the Administrator he expected overbed lights to work properly and staff were to notify the Maintenance Director when repairs were needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 19	F 584		

6. An observation of the dresser of room 229-B on 12/02/24 at 11:32 AM revealed an area of missing wood to the top of the dresser on the side closest to the bed, leaving an exposed sharp corner.

Additional observations of the dresser of room 229-B on 12/03/24 at 8:55 AM, on 12/04/23 at 7:42 AM, and 12/05/24 at 7:34 AM revealed an area of missing wood to the top of the dresser on the side closest to the bed, leaving an exposed sharp corner.

An interview with the Maintenance Director on 12/04/24 at 10:57 AM revealed he was not aware of the top of the dresser in room 229-B having missing wood resulting in a sharp corner being exposed. He stated he relied on nursing staff to notify him of rough edges on furniture since he was busy working on other projects. The Maintenance Director stated the dresser would need to be replaced.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected furniture to be in good repair or be replaced.

7. An observation of the overbed table of room 229-B on 12/02/24 revealed an area of broken plastic on the top of the table leaving sharp edges exposed.

Additional observations of the dresser of room 229-B on 12/03/24 at 8:55 AM, 12/04/24 at 7:42 AM, and 12/05/24 at 7:34 AM revealed an area of broken plastic on the top of the table leaving sharp edges exposed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 20	F 584		

An interview with the Maintenance Director on 12/04/24 at 10:57 AM revealed he was not aware of the top of the overbed table in room 229-B having broken plastic resulting in sharp edges being exposed. He stated he relied on nursing staff to notify him of rough edges on furniture since he was busy working on other projects. The Maintenance Director stated the overbed table would need to be replaced.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected furniture to be in good repair or be replaced.

8. a. An observation of the bedside commode placed over the toilet in the shared bathroom of room 224 on 12/02/24 at 11:11 AM revealed a large amount of brown material on the seat, dried brown stains to the outside of the toilet bowl, and brown discoloration was noted to the base of the toilet.

b. An observation of the bedside commode placed over the toilet in the shared bathroom of room 224 on 12/03/24 at 2:07 PM revealed dried brown material on the seat, brown discoloration to the base of the toilet, and a dried yellow stain extending from the base of the toilet almost to the bathroom door. An overwhelming odor resembling urine was noted in the bathroom.

c. An observation of the bedside commode placed over the toilet in the shared bathroom of room 224 on 12/04/24 at 7:32 AM revealed the seat was raised and multiple dried splatters were noted to the underside of the lid, brown discoloration was noted to the base of the toilet, and a dried yellow stain extended from the base of the toilet almost to the bathroom door. An

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 21	F 584		

overwhelming odor resembling urine was noted in the bathroom.

d. An observation of the bedside commode placed over the toilet in the shared bathroom of room 224 on 12/05/24 at 7:30 AM revealed the seat was raised and dried brown material was noted to the underside of the lid, brown discoloration was noted to the base of the toilet, and a dried yellow stain extended from the base of the toilet almost to the bathroom door. An overwhelming odor resembling urine was noted in the bathroom.

An interview with the Housekeeping Supervisor on 12/05/24 at 8:13 AM revealed daily room cleaning consisted of dusting, sweeping, mopping, cleaning the bathroom, and removing the trash. She stated she had instructed her housekeepers to round on this bathroom a couple of times each shift, but she could not go behind her staff and check all their work.

A follow-up interview with the Housekeeping Supervisor on 12/05/24 at 2:48 PM revealed she expected bathrooms to be clean and free of odor.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected resident bathrooms to be clean and free of odor.

9. An observation of the room divider curtain in room 224 on 12/02/24 at 11:12 AM revealed a circular brown stain.

Additional observations of the room divider curtain in room 224 on 12/03/24 at 2:07 PM, 12/04/24 at 7:31 AM, and 12/05/24 at 7:30 AM revealed a circular brown stain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 22	F 584		

An interview with the Housekeeping Supervisor on 12/05/24 at 2:48 PM revealed she had developed a new deep cleaning schedule which included changing room divider curtains, but she educated her staff to notify her if they noticed a stain on a room curtain before it was scheduled for deep cleaning, and she would change it. She stated she expected room divider curtains to be clean.
An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected room divider curtains to be clean.

10. An observation of the wall behind the bed in room 229-A on 12/02/24 at 11:26 AM revealed multiple dried brown stains.

Additional observations of the wall behind the bed in room 229-A on 12/03/24 at 8:56 AM, 12/04/24 at 7:43 AM, and 12/05/24 at 7:33 AM revealed multiple dried brown stains.

An interview with the Housekeeping Supervisor on 12/05/24 at 8:13 AM revealed she had developed a new deep cleaning schedule which included cleaning walls, but she educated her staff to go ahead and clean the wall if they noticed a stain instead of waiting for the room to be deep cleaned. She stated she expected resident room walls to be clean.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected resident room walls to be clean and free of stains.

11. An observation of the floor beside the bed in room 229-A on 12/02/24 at 11:26 AM revealed multiple dried brown stains.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 23	F 584		

Additional observations of the floor beside the bed in room 229-A on 12/03/24 at 8:56 AM, 12/04/24 at 7:43 AM, and 12/05/24 at 7:33 AM revealed multiple dried brown stains.

An interview with the Housekeeping Supervisor on 12/05/24 at 8:13 AM revealed daily room cleaning consisted of dusting, sweeping, mopping, cleaning the bathroom, and removing the trash.

A follow-up interview with the Housekeeping Supervisor on 12/05/24 at 2:48 PM revealed she expected resident room floors to be clean.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected resident room floors to be clean.

12. An observation of the wall between 227-A and 227-B on 12/03/24 at 8:46 AM revealed multiple dried brown stains.

Additional observations of the wall between 227-A and 227-B on 12/04/24 at 7:36 AM, and 12/05/24 at 7:38 AM revealed multiple dried stains.

An interview with the Housekeeping Supervisor on 12/05/24 at 8:13 AM revealed she had developed a new deep cleaning schedule which included cleaning walls, but she educated her staff to go ahead and clean the wall if they noticed a stain instead of waiting for the room to be deep cleaned. She stated she expected resident room walls to be clean.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected resident room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 24	F 584		

walls to be clean and free of stains.

13. An observation of room 330 on 12/02/24 at 11:57 AM revealed a circular hole with exposed plaster in the middle of the wall by the bathroom door.

An additional observation of room 330 on 12/04/24 at 8:15 AM revealed the condition of the wall by the bathroom door remained unchanged.

An interview and tour was conducted with the Maintenance Director on 12/04/24 at 10:40 AM. The Maintenance Director revealed he was in the process of going room-to-room on each hall to make a list of repairs needed but had not made it to all the rooms yet and he relied on staff to notify him when repairs were needed. He stated he was not made aware of the hole in the wall by the bathroom door of room 330 and the hole would need to be patched, sanded and painted.

During an interview on 12/06/24 at 3:52 PM, the Administrator he expected overbed lights to work properly and staff were to notify the Maintenance Director when repairs were needed.

14. a. An observation of room 327 on 12/03/24 at 8:49 AM revealed the overbed light fixture attached to the wall beside the A bed did not turn on when the light switch chain was pulled.

Additional observations conducted on 12/04/24 at 8:18 AM and 12/5/24 at 12:33 PM revealed the overbed light fixture did not turn on when the light switch chain was pulled.

During an interview on 12/06/24 at 3:52 PM, the Administrator he expected overbed lights to work

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 25	F 584		

properly and staff were to notify the Maintenance Director when repairs were needed.

b. An observation of room 327 on 12/03/24 at 8:49 AM revealed the overbed table would not stay in a fixed position when it was raised to the maximum height and the table would lower when a minimal amount of weight was placed on top of the table surface.

Additional observations conducted on 12/04/24 at 8:18 AM and 12/5/24 at 12:33 PM revealed the condition of the overbed table remained the same.

An interview and tour was conducted with the Maintenance Director on 12/04/24 at 10:40 AM. The Maintenance Director revealed he was in the process of going room-to-room on each hall to make a list of repairs needed but had not made it to all the rooms yet and he relied on staff to notify him when repairs were needed. The Maintenance Director stated he was not aware the overbed light in room 327-A did not work. He stated it was one of the older light fixtures and would need to be replaced. He revealed a new light fixture was ordered but he could not find the purchase order to show when and stated he would order another one today (12/4/24). The Maintenance Director observed the overbed table in room 327-A and confirmed it would not stay in a fixed position when the table was raised to the maximum height. He removed the overbed table from the room and stated he would replace it with a newer one he had in storage.

An interview with the Administrator on 12/05/24 at 5:12 PM revealed he expected furniture to be in good repair or be replaced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 26	F 584		

15. Resident #13 was admitted to the facility on 09/08/17.

The quarterly Minimum Data Set (MDS) dated 09/27/24 coded Resident #13 with a moderately impaired cognition.

During an observation conducted on 12/02/24 at 12:01 PM, the toilet roll holder mounted on the wall for the shared bathroom of room 218 and room 220 was dysfunctional. The rod in the middle of the toilet roll holder to hold the toilet roll was missing. Three (3) opened and used toilet rolls were seen sitting on top of the water tank at the back of the commode.

An interview was conducted with Resident #13 on 12/02/24 at 12:03 PM. He stated the rod for the toilet roll holder had been missing for at least 3 months and it was very inconvenient for him. He added the opened toilet rolls sitting on top of the tank behind the commode might have fallen to the floor and been contaminated.

Subsequent observation conducted on 12/03/24 at 12:11 PM revealed the rod for the toilet roll holder remained missing.

During a joint observation conducted with the Housekeeper on 12/03/24 at 2:31 PM, the toilet roll holder remained dysfunctional without the toilet roll rod. Three (3) brand new unopened toilet rolls were seen sitting on top of the water tank behind the commode.

An interview was conducted with the Housekeeper on 12/03/24 at 2:32 PM. He stated part of his job was to replenish the toilet rolls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 27	F 584		

when cleaning the bathroom. He recalled when he brought toilet rolls to this bathroom last Friday, the rod for the toilet roll holder was still in place. He stated sometimes residents could have pulled the rod out and left it in the trash container.

An interview was conducted with the Maintenance Manager on 12/03/24 at 2:40 PM. He stated he checked the entire facility including residents' room and bathroom at least once every week. He recalled when he checked this shared bathroom last Friday, the rod for the toilet roll holder was still in place. He did not know when the rod was missing but stated it was important for the residents to have a functional toilet roll holder. He added he depended on residents and staff to report repair needs either verbally or through the work order. He typically checked the work orders at least once daily to ensure all repair needs were met in a timely manner.

An interview was conducted with Nurse Aide #5 (NA) on 12/03/24 at 2:51 PM. He stated he typically entered the bathroom a few times a week when he assisted residents using the toilet. He recalled the rod for the toilet roll holder was in the toilet last Friday when he assisted one of the 4 residents in this shared bathroom. He did not know when it was missing.

During an interview conducted on 12/03/24 at 3:05 PM, Nurse #3 explained she rarely entered residents' bathroom as personal and incontinence cares were mostly handled by the NAs. She expected NAs to report all repair needs to her so that she would notify the maintenance staff to fix them in a timely manner. She added it was important to keep the toilet roll holder in good repair to ensure sanitary and convenience.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 28 An interview was conducted with the Director of Nursing (DON) on 12/03/24 at 4:06 PM. She expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner. She added the maintenance staff should check repair needs on a regular basis and address the issues accordingly. It was her expectation for all the toilet roll holder to be in good repair all the time.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)	F 607		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 29 (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their abuse policy and procedure by not immediately reporting an allegation of resident-to-resident abuse to the Administrator for 1 of 5 sampled residents reviewed for abuse (Resident #11). Findings included: The facility policy titled, Abuse, Neglect and Exploitation revised 03/02/23, read in part: "all alleged violations will be reported to the Administrator within specified timeframes: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury." Resident #11 was admitted to the facility on 11/11/22. The quarterly Minimum Data Set (MDS) dated 04/26/24 assessed Resident #11 with intact cognition. Review of the staff progress notes for Resident #11 revealed an entry written by Nurse #4 on 04/08/24 at 6:49 AM with an effective date of 04/06/24 that read, "Resident reports that another male resident came to her room, touched her on the thighs at night and woke her up. Resident reassured of safety." There was no indication	F 607	The facility failed to follow their abuse policy and procedure by not immediately reporting an allegation of resident-to-resident abuse to the Administrator for 1 of 5 sampled residents reviewed for abuse (Resident #11). Investigation was already completed and unsubstantiated. Current facility residents are at risk of being affected by this deficient practice. The administrator completed a 100% audit of facility reportable investigations completed in the last 6 months to determine any late reporting. The audit was completed on ___12/17/2024_____. No concerns were noted. To ensure the deficient practice does not recur, the staff development coordinator (SDC) completed education with the current facility and agency staff on the abuse neglect and misappropriation policy and reporting requirements. Education completed on __12/27/2024_____. Newly hired facility and agency staff or staff not educated by 1/3/2025 will be educated upon hire or before working their next scheduled shift. The director of nursing or designee will audit 5 residents nursing progress notes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 30 that the Director of Nursing (DON) and/or Administrator were notified. Review of the initial report submitted by the facility to the State Agency noted an allegation type of resident abuse with an incident date of 04/08/24 and revealed Resident #11 reported a male resident came into her room, touched her on the thighs and then left the room. Further review revealed the facility was made aware of the allegation on 04/08/24 at 11:30 AM, the initial report was submitted to the State Agency via fax transmission on 04/08/24 at 12:40 PM and law enforcement was notified. During an interview on 12/02/24 at 11:09 AM, Resident #11 stated a few months ago a male resident came into her room and touched her on her breast and thighs, she yelled for help and kept kicking at him until he left the room. Resident #11 was unable to recall the exact date or time this occurred and stated she reported the incident to the nurse but could not recall the nurse's name. Resident #11 stated the male resident was transferred to another facility and she hasn't had any issues with other residents since. During a telephone interview on 12/06/24 at 10:40 AM, Nurse #4 revealed she used to work at the facility on an as needed basis and remembered Resident #11 but did not recall Resident #11 reporting a male resident had touched her inappropriately. When the progress note dated 04/08/24 with an effective date of 04/06/24 was read to Nurse #4, she stated if that was what she wrote then that was what Resident #11 had reported to her. Nurse #4 expressed she just didn't recall much regarding the incident since it	F 607	for the previous 72 hours to ensure no notation of reportable events weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completed By: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 31 was so long ago. Nurse #4 stated that although she did not document it in the progress note, she would have notified the DON or Administrator what Resident #11 had reported because she knew allegations of abuse was serious and should be reported immediately. During an interview on 12/06/24 at 10:50 AM, the DON reviewed the progress note written by Nurse #4 and confirmed the progress note was written on 04/08/24 with an effective date of 04/06/24. The DON stated she did not recall Nurse #4 notifying her on 04/06/24 to let her know what Resident #11 had alleged. During an interview on 12/06/24 at 10:58 AM, the Regional Director of Clinical Services (RDCS) revealed she was the Interim Administrator on 04/08/24 when Resident #11 reported a male resident touched her inappropriately and an investigation was immediately initiated. The RDCS stated she was made aware of the allegation on 04/08/24 at 11:30 AM and the initial report was submitted to the State Agency. The RDCS reviewed the progress note written by Nurse #4 on 04/08/24 with an effective of 04/06/24 and stated it seemed odd that the note was entered as a late entry because Nurse #4 was very good to call her and/or the DON to report any concerns. The RDCS stated that even if Nurse #4 entered the progress as a late entry in error, the time stamp of the note indicated it was written on 04/08/24 at 6:49 AM and Nurse #4 did not notify her until 11:30 AM. The RDCS stated Nurse #4 should have informed her or the DON of Resident #11's allegation as soon as it was reported.	F 607		
F 623 SS=E	Notice Requirements Before Transfer/Discharge	F 623		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 32 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 33	F 623		

under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 34 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Regional Ombudsman when residents discharged or transferred from the facility for 6 of 6 months (April 2024, July 2024, August 2024, September 2024, October 2024, and November 2024). Findings included: Review of the facility's Admission/Discharge report for the period 04/01/24 to 04/30/24 revealed there were 25 residents who were discharged home, transferred to the hospital, or transferred to another nursing facility. Review of the facility's Admission/Discharge report for the period 07/01/24 to 11/30/24 revealed there were 125 residents who were discharged home, transferred to the hospital, or transferred to another nursing facility.	F 623	The facility failed to notify the Regional Ombudsman when residents were discharged or transferred from the facility for 6 of 6 months (April 2024, July2024, August 2024, September 2024, October 2024, and November 2024). Discharges completed in November were documented and sent to the ombudsman on 12/9/2024. Residents discharging at the facility are at risk of being affected by the deficient practice. The Vice President of Clinical Operations (VPCO) completed an audit of the last 3 months of discharges and ensured the ombudsman was notified of discharges. This audit was completed 12/13/2024. To ensure the deficient practice does not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 35 During an interview on 12/06/24 at 3:52 PM, the Administrator stated he was unable to find any documentation that notifications of residents' discharges/transfers were sent to the Regional Ombudsman for the months of April 2024, July 2024, August 2024, September 2024, October 2024 or November 2024. He explained that the Admissions Director was the one who was previously responsible for sending the Regional Ombudsman monthly notification of resident discharges/transfers and they had been in the process of switching that responsibility over to the Social Worker (SW) but then both the Admissions Director and SW quit. The Administrator stated they have been actively interviewing candidates to fill the open positions and in the interim, he and the Director of Nursing had been trying to cover both positions and this process had just fell through the cracks.	F 623	recur, the VPCO completed education with the director of nursing and administrator on 12/30/2024. The newly hired social workers will be educated during orientation. The social worker will be responsible for notifying the ombudsman of facility discharges and in the event the social worker is unable to, the administrator will ensure the ombudsman is notified of facility discharges. The VPCO will audit monthly ombudsman notification of discharges monthly for 3 months. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completed By: 1/3/2025	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 36	F 636		

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 37 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the assessment period) (Residents #6, #16, #21, #28, #29, #47, #68, and #78) and failed to comprehensively complete the Care Area Assessment (CAA) for Resident #89 for 9 of 45 sampled residents. Findings included: 1. a. Resident #6 was admitted to the facility on 09/02/15. Review of Resident #6's electronic medical record revealed an annual MDS assessment with an ARD of 01/20/24 that was marked as completed on 02/26/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #6's annual MDS assessment with an ARD of 01/20/24 was not	F 636	The facility failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the assessment period) (Resident #'s 6, 16, 21, 28, 29, 47, 68, and 78) and failed to comprehensively complete the Care Area Assessment (CAA) for Resident #89 for 9 of 45 sampled residents. CAA's on identified residents was modified and resubmitted by 12/31/24 by MDS nurse. Current facility residents are at risk of being affected by this deficient practice. The Regional Director of Clinical Reimbursement (RDCR) completed an audit of CAA's completed over the past 30 days to ensure they were comprehensively completed and MDS was completed within 14 days of the ARD. The audit showed 4 concerns. The identified concerns were corrected by 1/3/2025. The audit was completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 38 completed within the regulatory time frame. b. Resident #16 was admitted to the facility on 07/02/13. Review of Resident #16's electronic medical record revealed an annual MDS assessment with an ARD of 01/26/24 that was marked as completed on 02/28/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #16's annual MDS assessment with an ARD of 01/26/24 was not completed within the regulatory time frame. c. Resident #21 was admitted to the facility on 06/05/24. Review of Resident #21's electronic medical record revealed an admission MDS assessment with an ARD of 06/10/24 that was marked completed 07/04/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #21's admission MDS assessment with an ARD of 06/10/24 was not completed within the regulatory time frame. d. Resident #28 was admitted 09/15/23. Review of Resident #28's electronic medical record revealed an annual MDS assessment with an ARD of 07/20/24 that was marked as completed on 08/21/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse	F 636	12/27/2024. To ensure this deficient practice does not recur the following has been completed: The RDCR educated the MDS licensed nursing staff and interdisciplinary team on comprehensively completing CAA's and completing MDS assessments with in 14 days of ARD, according to Resident Assessment Instrument (RAI) manual. Education was completed on 1/3/2025. Newly hired staff or staff not educated by 1/3/25 will be educated prior to working their next shift. The RDCR will audit 5 residents weekly for 4 weeks, 5 residents biweekly for 4 weeks, and 5 residents monthly for 1 month to ensure the last scheduled MDS was completed with comprehensive completion of CAA's as indicated and within 14 days of ARD. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completed By: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 39	F 636		

#3 all verified Resident #28's annual MDS assessment with an ARD of 07/20/24 was not completed within the regulatory time frame.

e. Resident #29 was admitted to the facility on 06/13/22.

Review of Resident #29's electronic medical record revealed an annual MDS assessment with an ARD of 04/11/24 that was marked as completed on 06/16/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #29's annual MDS assessment with an ARD of 04/11/24 was not completed within the regulatory time frame.

f. Resident #47 was admitted to the facility on 06/11/24.

Review of Resident #47's electronic medical record revealed an admission MDS assessment with an ARD of 06/14/24 that was marked as completed on 07/15/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #47's admission MDS assessment with an ARD of 06/14/24 was not completed within the regulatory time frame.

g. Resident #68 was admitted to the facility on 11/05/21.

Review of Resident #68's electronic medical record revealed an annual MDS assessment with an ARD of 06/22/24 that was marked as completed 07/19/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 40	F 636		

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #68's annual MDS assessment with an ARD of 06/22/24 was not completed within the regulatory time frame.

h. Resident #78 was admitted to the facility on 07/10/24.

Review of Resident #78's electronic medical record revealed an admission MDS assessment with an ARD of 07/12/24 that was marked as completed on 08/12/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #78's admission MDS assessment with an ARD of 07/12/24 was not completed within the regulatory time frame.

During a joint interview on 12/04/24 at 12:43 PM with MDS Nurse #2 and MDS Nurse #3 present, MDS Nurse #1 revealed both MDS Nurse #2 and MDS Nurse #3 just started at the facility in October 2024 and November 2024 respectively. MDS Nurse #1 explained that she floated between several facilities and had been working at this facility once a week to assist with completing MDS assessments. In addition, she stated MDS Nurses from other facilities had assisted when able to try and help get the MDS assessments caught up. MDS Nurse #1 stated MDS assessments fell behind primarily due to turnover in the MDS position as well as the MDS Nurses having to pick up the sections of the MDS assessment that were typically completed by other members of the Interdisciplinary Team due to turnover in those positions. MDS Nurse #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 41	F 636		

explained they had to complete all the sections of the MDS assessment which took a lot of time. She stated they would get caught up for a month or two, then the facility would get a lot of new admissions and MDS assessments would fall behind again. She stated all the MDS Nurses were working together and slowly getting MDS assessments caught back up.

During an interview on 12/04/24 at 1:06 PM, the Administrator stated MDS assessments were behind when he started his position in June 2024 and felt the breakdown was the result of a lot turnover in MDS staff. He explained since June 2024, they had a full-time MDS Nurse and a part-time MDS Nurse that both quit which put them further behind with getting MDS assessments completed. The Administrator stated with the MDS team he now had in place, he felt they would be able to get the MDS assessments caught up and stay caught up so that MDS assessments were completed within the regulatory timeframe.

2. Resident #89 was admitted to the facility on 10/26/23 with diagnosis including depression.

A review of the significant change in status Minimum Data Set (MDS) assessment dated 09/07/24 revealed Resident #89 was coded with a moderately impaired cognition. A review of Section V which consisted of care area assessment summary indicated the care area for psychotropic drug use was triggered for Resident #89. The facility did not provide any information in analysis of findings that described the nature of Resident 89's problems, possible causes and contributing factors, risk factors related to the care area, and reasons to proceed with care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 42 planning. During an interview conducted on 12/04/24 at 11:12 AM, the MDS Coordinator confirmed 1 of the 6 triggered care areas (psychotropic drug use) for Resident #89's MDS dated 09/07/24 were submitted without any pertinent information in analysis of findings in Section V. She explained she started her role as the MDS Coordinator about 2 months ago. Resident #89's MDS dated 09/07/24 was submitted by the former MDS Coordinator and she was unable to explain how it happened. She acknowledged that it was an error to submit a significant change in status MDS without the completion of analysis of findings for all the triggered areas. On 12/04/24 at 11:15 AM an interview was conducted with the Director of Nursing. She stated all the CAAs must be individualized and completed comprehensively. It was her expectation for the MDS Coordinators to complete the analysis of findings for all the triggered areas in Section V before submitting an MDS assessment. An attempt to conduct a phone interview with the former MDS Coordinator on 12/04/24 at 1:14 PM was unsuccessful. She did not return the call.	F 636		
F 638 SS=E	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	F 638		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 43 by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 14 of 45 sampled residents (Residents #6, #15, #16, #21, #28, #29, #42, #47, #48, #68, #78, #81, #83, and #85). Findings included: a. Resident #6 was admitted to the facility on 09/02/15. Review of Resident #6's electronic medical record revealed the following: -A quarterly MDS assessment with an ARD of 04/19/24 that was marked as completed on 06/29/24. -A quarterly MDS assessment with an ARD of 07/19/24 that was marked as completed on 08/21/24. -A quarterly MDS assessment with an ARD of 07/29/24 that was marked as completed on 08/21/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #6's quarterly MDS assessments with ARDs of 04/19/24, 07/19/24 and 07/29/24 were not completed within the regulatory time frame. b. Resident #15 was admitted to the facility on 01/25/23. Review of Resident #15's electronic medical	F 638	The facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, referring to the last day of the observation period) for 14 of 45 sampled residents (Residents #6, #15, #16, #21, #28, #29, #42, #47, #48, #68, #78, #81, #83, and #85). MDS assessments were completed and submitted on identified residents. Current facility residents are at risk of being affected by the deficient practice. The Regional Director of Clinical Reimbursement (RDCR) completed an audit of Quarterly Assessments due in the past 30 days to ensure they had been completed and submitted as scheduled. Concerns noted were addressed by 12/30/2024. The audit was completed on 12/27/2024. The following things have been put into place to ensure the deficient practice does not recur: The RDCR educated the MDS licensed nursing staff and interdisciplinary team on completing quarterly assessments within 14 days of the ARD date according to Resident Assessment Instrument (RAI) manual. Education was completed on 1/3/2025. Newly hired staff or staff not educated by 1/3/25 will be educated prior to working their next shift. The RDCR will audit 5 residents weekly for 4 weeks, 5 residents biweekly for 4 weeks, and 5 residents monthly for 1 month to ensure MDS assessments were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 44 record revealed the following: -A quarterly MDS assessment with an ARD of 01/22/24 that was marked as completed on 02/27/24. -A quarterly MDS assessment with an ARD of 02/23/24 that was marked as completed on 03/12/24. -A quarterly MDS assessment with an ARD of 04/05/24 that was marked as completed on 06/06/24. -A quarterly MDS assessment with an ARD of 07/06/24 that was marked as completed on 07/26/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #15's quarterly MDS assessments with ARDs of 01/22/24, 02/23/24, 04/05/24, and 07/06/24 were not completed within the regulatory time frame. c. Resident #16 was admitted to the facility on 07/02/13. Review of Resident #16's electronic medical record revealed the following: -A quarterly MDS assessment with an ARD of 04/26/24 that was marked as completed on 07/01/24. -A quarterly MDS assessment with an ARD of 07/27/24 that was marked as completed on 08/23/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #16's quarterly MDS assessments with ARDs of 04/26/24 and	F 638	completed within 14 days of ARD date. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 45	F 638		

07/27/24 were not completed within the regulatory time frame.

d. Resident #21 was admitted to the facility on 06/05/24.

Review of Resident #21's electronic medical record revealed a quarterly MDS assessment with an ARD of 09/10/24 that was marked as completed on 11/11/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #21's quarterly MDS assessment with an ARD of 09/10/24 was not completed within the regulatory time frame.

e. Resident #28 was admitted 09/15/23.

Review of Resident #28's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of 01/19/24 that was marked as completed on 02/26/24.
-A quarterly MDS assessment with an ARD of 04/19/24 that was marked as completed on 06/19/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #28's quarterly MDS assessments with ARDs of 01/19/24 and 04/19/24 were not completed within the regulatory time frame.

f. Resident #29 was admitted to the facility on 06/13/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 46	F 638		

Review of Resident #29's electronic medical record revealed a quarterly MDS assessment with an ARD of 07/17/24 that was marked as completed on 08/20/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #29's quarterly MDS assessment with an ARD of 07/17/24 was not completed within the regulatory time frame.

g. Resident #42 admitted to the facility on 07/23/19.

Review of Resident #42's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of 03/22/24 that was marked as completed on 05/12/24.
-A quarterly MDS assessment with an ARD of 06/05/24 that was marked as completed on 07/10/24.
-A quarterly MDS assessment with an ARD of 07/09/24 that was marked as completed on 07/31/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #42's quarterly MDS assessments with ARDs of 03/22/24, 06/05/24 and 07/09/24 were not completed within the regulatory time frame.

h. Resident #47 was admitted to the facility on 06/11/24.

Review of Resident #47's electronic medical record revealed a quarterly MDS assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 47	F 638		

with an ARD of 07/04/24 that was marked as completed on 07/24/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #47's quarterly MDS assessment with an ARD of 07/24/24 was not completed within the regulatory time frame.

i. Resident #48 was admitted to the facility on 02/20/20.

Review of Resident #48's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of 02/22/24 that was marked as completed on 03/10/24.
-A quarterly MDS assessment with an ARD of 04/12/24 that was marked as completed on 06/16/24.
-A quarterly MDS assessment with an ARD of 07/09/24 that was marked as completed on 07/31/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #48's quarterly MDS assessments with ARDs of 02/22/24, 04/12/24 and 07/09/24 were not completed within the regulatory time frame.

j. Resident #68 was admitted to the facility on 11/05/21.

Review of Resident #68's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 48	F 638		

03/07/24 that was marked as completed on 04/08/24.
-A quarterly MDS assessment with an ARD of 03/22/24 that was marked as completed on 05/15/24.
-A quarterly MDS assessment with an ARD of 07/17/24 that was marked as completed on 08/20/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #68's quarterly MDS assessments with ARDs of 03/07/24, 03/22/24 and 07/17/24 were not completed within the regulatory time frame.

k. Resident #78 was admitted to the facility on 07/10/24.

Review of Resident #78's electronic medical record revealed a quarterly MDS assessment with an ARD of 08/05/24 that was marked as completed on 09/11/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #78's admission MDS assessment with an ARD of 07/12/24 was not completed within the regulatory time frame.

l. Resident #81 was admitted to the facility on 09/27/23.

Review of Resident #81's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of 01/19/24 that was marked as completed on 02/22/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 49	F 638		

-A quarterly MDS assessment with an ARD of 04/19/24 that was marked as completed on 06/24/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #81's quarterly MDS assessments with ARDs of 01/19/24 and 04/19/24 were not completed within the regulatory time frame.

m. Resident #83 was admitted to the facility on 11/06/23.

Review of Resident #83's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of 03/06/24 that was marked as completed on 04/03/24.
-A quarterly MDS assessment with an ARD of 03/15/24 that was marked as completed on 05/09/24.
-A quarterly MDS assessment with an ARD of 06/14/24 that was marked as completed on 07/14/24.
-A quarterly MDS assessment with an ARD of 07/29/24 that was marked as completed on 08/23/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #83's quarterly MDS assessments with ARDs of 03/06/24, 03/15/24, 06/14/24 and 07/29/24 were not completed within the regulatory time frame.

n. Resident #85 was admitted to the facility on 10/20/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 50	F 638		

Review of Resident #85's electronic medical record revealed the following:

-A quarterly MDS assessment with an ARD of 05/04/24 that was marked as completed on 07/03/24.
-A quarterly MDS assessment with an ARD of 07/19/24 that was marked as completed on 08/21/24.

During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #85's quarterly MDS assessments with ARDs of 05/04/24 and 07/19/24 were not completed within the regulatory time frame.

During a joint interview on 12/04/24 at 12:43 PM with MDS Nurse #2 and MDS Nurse #3 present, MDS Nurse #1 revealed both MDS Nurse #2 and MDS Nurse #3 just started at the facility in October 2024 and November 2024 respectively. MDS Nurse #1 explained that she floated between several facilities and had been working at this facility once a week to assist with completing MDS assessments. In addition, she stated MDS Nurses from other facilities had assisted when able to try and help get the MDS assessments caught up. MDS Nurse #1 stated MDS assessments fell behind primarily due to turnover in the MDS position as well as the MDS Nurses having to pick up the sections of the MDS assessment that were typically completed by other members of the Interdisciplinary Team due to turnover in those positions. MDS Nurse #1 explained they had to complete all the sections of the MDS assessment which took a lot of time. She stated they would get caught up for a month

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 51 or two, then the facility would get a lot of new admissions and MDS assessments would fall behind again. She stated all the MDS Nurses were working together and slowly getting MDS assessments caught back up. During an interview on 12/04/24 at 1:06 PM, the Administrator stated MDS assessments were behind when he started his position in June 2024 and felt the breakdown was the result of a lot turnover in MDS staff. He explained since June 2024, they had a full-time MDS Nurse and a part-time MDS Nurse that both quit which put them further behind with getting MDS assessments completed. The Administrator stated with the MDS team he now had in place, he felt they would be able to get the MDS assessments caught up and stay caught up so that MDS assessments were completed within the regulatory timeframe.	F 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 52 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge-return anticipated Minimum Data Set (MDS) assessment and entry tracking records within the regulated timeframes for 2 of 14 residents	F 640	The facility failed to complete a discharge-return anticipated Minimum Data Set (MDS) assessment and entry tracking records within the regulated timeframes for 2 of 14 residents reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 53 reviewed for resident assessments (Resident #47 and #83). Findings included: a. Resident #47 was admitted to the facility on 06/11/24. Review of Resident #47's electronic medical record revealed the following: A discharge-return anticipated MDS assessment dated 06/29/24 that was marked as completed on 07/23/24. An entry tracking record dated 07/02/24 that was marked as completed on 07/23/24. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #47's discharge-return anticipated MDS assessment dated 06/29/24 and entry tracking record dated 07/02/24 were not completed within the regulatory time frame. b. Resident #83 was admitted to the facility on 11/06/23. Review of Resident #83's electronic medical record revealed an entry-tracking record dated 11/06/23 that was marked as completed on 11/14/23. During a joint interview on 12/04/24 at 12:43 PM, MDS Nurse #1, MDS Nurse #2 and MDS Nurse #3 all verified Resident #83's entry tracking record dated 11/06/23 was not completed within the regulatory time frame.	F 640	for resident assessments (Resident #47 and #83). Identified assessments were transmitted if not already. Both assessments were submitted on 12/9/2024. Current facility residents are at risk of being affected by the deficient practice. The Regional Director of Clinical Reimbursement (RDCR) completed a 100% audit of the last 30 days of admissions and discharges to ensure they had discharge-return anticipated and discharge- return not anticipated MDS and entry tracking records within the regulated timeframes completed. Audit was completed by 12/27/2024. 0 concerns identified. Audit was completed by Regional Director of Clinical Reimbursement (RDCR). The following things have been put into place to ensure the deficient practice does not recur: The RDCR educated the MDS licensed nursing staff on completing discharge-return anticipated and discharge-not anticipated MDS and entry tracking records according to Resident Assessment Instrument (RAI) manual. Education was completed on 1/3/2025. Newly hired staff or staff not educated by 1/3/25 will be educated prior to working their next shift. The RDCR will audit 5 admissions/discharges weekly for 4 weeks, 5 admissions/discharges biweekly for 4 weeks, and 5 admissions/discharges monthly for 1 month to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 54 During a joint interview on 12/04/24 at 12:43 PM with MDS Nurse #2 and MDS Nurse #3 present, MDS Nurse #1 revealed both MDS Nurse #2 and MDS Nurse #3 just started at the facility in October 2024 and November 2024 respectively. MDS Nurse #1 explained that she floated between several facilities and had been working at this facility once a week to assist with completing MDS assessments. In addition, she stated MDS Nurses from other facilities had assisted when able to try and help get the MDS assessments caught up. MDS Nurse #1 stated MDS assessments fell behind primarily due to turnover in the MDS position as well as the MDS Nurses having to pick up the sections of the MDS assessment that were typically completed by other members of the Interdisciplinary Team due to turnover in those positions. MDS Nurse #1 explained they had to complete all the sections of the MDS assessment which took a lot of time. She stated they would get caught up for a month or two, then the facility would get a lot of new admissions and MDS assessments would fall behind again. She stated all the MDS Nurses were working together and slowly getting MDS assessments caught back up. During an interview on 12/04/24 at 1:06 PM, the Administrator stated MDS assessments were behind when he started his position in June 2024 and felt the breakdown was the result of a lot turnover in MDS staff. He explained since June 2024, they had a full-time MDS Nurse and a part-time MDS Nurse that both quit which put them further behind with getting MDS assessments completed. The Administrator stated with the MDS team he now had in place, he felt they would be able to get the MDS assessments caught up and stay caught up so	F 640	return-discharge anticipated and discharge-return not anticipated MDS and entry records were completed per RAI guidelines. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 55 that MDS assessments were completed within the regulatory timeframe.	F 640		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date and failed to develop comprehensive care plans that incorporated Level II PASRR determination for 2 of 3 sampled residents reviewed for PASRR (Resident #21 and #104). Findings included: 1. Resident #21 was admitted to the facility on	F 644	The facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date and failed to develop comprehensive care plans that incorporate Level II PASRR determination for 2 of 3 sampled residents reviewed for PASRR (Resident #21 and #104). PASRR screenings completed for Resident #21 and Resident #104 on 12/3/2024 and care plans put in place.	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 56 06/06/24 with diagnoses that included schizoaffective disorder and anxiety disorder. A PASRR Level II Determination Notification letter dated 06/04/24 for Resident #21 had an expiration date of 07/04/24. It was noted nursing facility placement was appropriate for a limited nursing facility stay lasting no more than thirty calendar days. A PASRR Level II Determination Notification letter dated 08/02/24 for Resident #21 had an expiration date of 10/31/24. It was noted nursing facility placement was appropriate for a 90 day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services to include mental health follow-up and rehab. Review of Resident #21's medical record revealed no evidence that a PASRR evaluation was requested or a new PASRR had been obtained prior to or after Resident #21's Level II PASRR expired on 10/31/24. Review of Resident #21's comprehensive care plan, last revised on 11/18/24, revealed no care plan that addressed his Level II PASRR determination. During an interview on 12/04/24 at 2:28 PM, the Administrator revealed the Social Worker (SW) was typically the person responsible for overseeing the PASRR process; however, the SW left employment on 10/24/24 and they have been actively interviewing candidates to fill the open position. The Administrator stated in the interim, the Regional Director of Clinical Services (RDCS) was the person handling Level II PASRR	F 644	All residents are at risk of being affected by this deficient practice. The Vice president of Clinical Operations (VPCO) completed a 100% audit on current facility residents to ensure they had PASRR's in place and appropriately care planned. The residents identified during the audit as needing a Level 2 PASRR screen or Level 1 PASRR screen was completed and appropriate care planning put in place. The audit and corrections were completed by 1/3/2025. The VCPO completed education with the administrator, director of nursing, and minimum data set nurses, and social worker on PASRR requirements and regulations of screenings and care planning requirements for residents with level 2 PASRR's.The social worker will be responsible for ensuring residents have active PASRR's and care plans in place as indicated. Education was completed by 1/3/2025. Newly hired staff and staff not educated prior to 1/3/25 will complete education upon hire or prior to working the next scheduled shift. The VPCO will audit 5 residents weekly for 4 weeks, 5 residents biweekly for 4 weeks, and 5 residents monthly for 1 month to ensure residents have an active appropriate PASRR and care plan in place. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 57 requests. During an interview on 12/04/24 at 2:57 PM, the RDCS revealed she was trying to stay on top of the PASRR process while the facility interviewed candidates to fill the open SW position. The RDCS was not aware that Resident #21's Level II PASRR had expired and stated she was now in the process of conducting an audit of all resident PASRRs. She stated Resident #21's expired PASRR was missed and a request for a PASRR review would need to be submitted. During a follow-up interview on 12/06/24 at 3:52 PM, the Administrator stated a care plan should have been developed to address Resident #21's Level II PASRR determination and due to the turnover in the SW position, it just fell by the wayside. 2. Resident #104 was admitted to the facility on 10/01/24 with multiple diagnoses that included schizophrenia, major depressive disorder and post-traumatic stress disorder. Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 12/03/24 revealed Resident #104 had a time-limited Levell II PASRR effective with an expiration date of 08/23/24. Further review revealed no evidence a PASRR evaluation was requested or a new PASRR had been obtained. Review of Resident #104's comprehensive care plan, last revised on 11/12/24, revealed no care plan that addressed the Level II PASRR determination.	F 644	committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 58 During an interview on 12/04/24 at 2:28 PM, the Administrator revealed the Social Worker (SW) was typically the person responsible for overseeing the PASRR process; however, the SW left employment on 10/24/24 and they have been actively interviewing candidates to fill the open position. The Administrator stated in the interim, the Regional Director of Clinical Services (RDCS) was the person handling Level II PASRR requests. During an interview on 12/04/24 at 2:57 PM, the RDCS revealed she was trying to stay on top of the PASRR process while the facility interviewed candidates to fill the open SW position. The RDCS was not aware that Resident #104's Level II PASRR had expired and stated she was now in the process of conducting an audit of all resident PASRRs. She stated Resident #104's expired PASRR was overlooked and a request for a PASRR review was submitted on 12/03/24. During a follow-up interview on 12/06/24 at 3:52 PM, the Administrator stated a care plan should have been developed to address Resident #104's Level II PASRR determination and due to the turnover in the SW position, it just fell by the wayside.	F 644		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable	F 660		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 59	F 660		

readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 60 to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge care plan that addressed the resident's discharge goals and post-discharge needs for residents who wished to discharge to the community for 2 of 3 sampled residents (Residents #50 and #70). Findings included:	F 660	The facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge care plan that addressed the resident's discharge goals and post-discharge needs for residents who wished to discharge to the community for 2 of 3 sampled residents (Residents #50 and #70). Residents #50 and 70 were interviewed to determine their discharge intentions whether to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 61 1. Resident #50 was admitted to the facility on 07/06/23 with diagnoses that included diabetes, chronic pain, chronic post-traumatic stress disorder, and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated 07/12/23 revealed Resident #50 had intact cognition. The MDS noted there was no active discharge plan in place and Resident #50 wanted to be asked about returning to the community on all MDS assessments. A Discharge Planning Review at Admission/Readmission assessment dated 08/25/23 noted Resident #50's discharge goal was to return to the community. Under the summary section it was noted in part that Resident #50 was approved for a Medicaid program that helped individuals residing in nursing homes transition back to their home in the community and with the assistance of the Medicaid program, appropriate referrals and appointments it would be feasible for Resident #50 to return to the community. A Discharge Planning Review at Admission/Readmission assessment dated 11/25/23 noted Resident #50's discharge goal was to return to the community. Under the summary section it was noted in part that Resident #50 had financial assistance from a Medicaid program that helped individuals residing in nursing homes transition back to their home in the community and she hoped to discharge within the next six (6) months. Review of Resident #50's comprehensive care plan, last reviewed/revised 08/14/24, revealed no discharge care plan.	F 660	remain in the facility long term or to discharge to the community by the Administrator. The Administrator then started working on their discharge planning and minimum data set (MDS) nurse initiated an appropriate care plan completed on 12/27/2024. Current facility residents are at risk of being affected by the deficient practice. The administrator audited current facility residents to ensure residents that have the desire to discharge to the community had a working discharge process in place and the residents were being incorporated into the planning process. The audit was completed on 1/3/25. Identified concerns were corrected by 1/3/2025. Effective 1/3/2025, the social worker will be responsible for discharge planning and care plan development discharge. To ensure this deficient practice does not recur the administrator educated the interdisciplinary team (IDT) on the Discharge Planning Process where the facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The education was completed by 1/3/2025. Newly hired IDT and IDT not educated by 1/3/2025 will be educated upon hire or prior to working their next scheduled shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 62 During interviews on 12/03/24 at 8:49 AM and 12/05/24 at 9:30 AM, Resident #50 revealed since admitting to the facility, her discharge goal was always to return back to the community when she was able. Resident #50 stated she was ready to discharge back to independent living and "had been for a while." She stated she had a housing assistance voucher when she first admitted to the facility but lost it in May 2024 when she didn't discharge as planned and was now back on the waiting list for another housing assistance voucher. Resident #50 stated she was also approved for financial assistance through a Medicaid program to help with returning back to independent living but with the facility not having a Social Worker, there had been no one to assist her with filling out the applications or setting up the appointments needed for her to discharge. Resident #50 stated the last time anything was mentioned about discharge planning was at her last care plan meeting in June 2024 and since then, no one had mentioned anything to her or asked her for input regarding her discharge goals and plans. During an interview on 12/05/24 at 9:00 AM, the MDS Nurse #2 revealed the facility currently did not have a Social Worker (SW) and typically, the SW would be the one responsible for developing a discharge care plan. MDS Nurse #2 was not sure who was responsible for developing discharge care plans until the SW position was filled. During interviews on 12/04/24 at 2:28 PM and 12/06/24 at 3:52 PM, the Administrator revealed that the SW typically handled the discharge planning process which included the development	F 660	The administrator will audit 5 residents weekly for 4 weeks, 5 residents biweekly for 4 weeks, and 5 residents monthly for 1 month to ensure residents have a discharge plan in place if indicated with an appropriate care plan in place for resident The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 63	F 660		

of a discharge care plan; however, the SW left employment on 10/24/24 and they have been actively interviewing candidates to fill the open position. He added they had just hired a new SW who would be starting within the next two weeks. The Administrator stated in the interim, both he and the Director of Nursing had been filling in to cover the SW position. The Administrator stated he has had frequent conversations with the Representative from the Medicaid program that had approved Resident #50 for assistance but he had not documented those conversations in Resident #50's medical record nor had he spoken with Resident #50 to keep her updated. The Administrator could not explain why a discharge care plan was not initially developed for Resident #50 and confirmed one should have been developed that incorporated Resident #50's discharge goals to return to the community and updated as her discharge plans progressed.

During a telephone interview on 12/06/24 at 8:16 AM, the Representative from the Medicaid program that assisted individuals residing in nursing homes transition back to their home in the community revealed Resident #50 was approved for assistance prior to the new company taking over management of the Medicaid program on 09/18/24. The Representative stated from what she could recall, Resident #50 was on the waiting list for housing.

2. Resident #70 was admitted to the facility on 08/21/24 with multiple diagnoses that included a chronic autoimmune disease that damages the central nervous system, history of falls and seizure disorder.

The admission Minimum Data Set (MDS) dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 64	F 660		

08/23/24 revealed Resident #70 had intact cognition. The MDS noted Resident #70's discharge goal was to return to the community and there was no current discharge plan in place.

Review of Resident #70's comprehensive care plan, last reviewed/revised on 09/20/24, revealed no discharge care plan.

During interviews on 12/02/24 at 12:07 PM and 12/05/24 at 4:15 PM, Resident #70 stated her desire was to discharge back to independent living and she was approved for a Medicaid program that helped individuals residing in nursing homes transition back to their home in the community but that was where the discharge planning stopped. Resident #70 stated the next step was to apply for housing but there was no one to help her with the process since the facility currently did not have a Social Worker (SW). Resident #70 stated since the SW left, no one had talked with her to discuss her discharge goals and she would like to move forward with her discharge plans.

During an interview on 12/05/24 at 9:00 AM, the MDS Nurse #2 revealed the facility currently did not have a Social Worker (SW) and typically, the SW would be the one responsible for developing a discharge care plan. MDS Nurse #2 was not sure who was responsible for developing discharge care plans until the SW position was filled.

During interviews on 12/04/24 at 2:28 PM and 12/06/24 at 3:52 PM, the Administrator revealed that the SW typically handled the discharge planning process which included the development of a discharge care plan; however, the SW left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 65	F 660		

employment on 10/24/24 and they have been actively interviewing candidates to fill the open position. He added they had just hired a new SW who would be starting within the next two weeks. The Administrator stated in the interim, both he and the Director of Nursing had been filling in to cover the SW position. The Administrator stated Resident #70 did not want to be at the facility and he has had many conversations with her explaining they could help get her transitioned to an Assisted Living Facility until she was able to return to the community but if they did that, she would lose the assistance she had been approved for through the Medicaid program. The Administrator stated he had not documented those conversations in Resident #70's medical record and could not explain why a discharge care plan was not initially developed for Resident #70. He stated one should have been developed that incorporated Resident #70's discharge goals to return to the community and updated as her discharge plans progressed.

During a telephone interview on 12/06/24 at 8:16 AM, the Representative from the Medicaid program that assisted individuals residing in nursing homes transition back to their home in the community revealed Resident #70 was approved for assistance on 10/18/24. The Representative stated she met with Resident #70 and gave her an overview of the program, what she could expect and discussed her discharge needs. She stated Resident #70 mentioned she would need help with finding housing and she informed Resident #70 what documents she would need to obtain to apply for housing through the program. The Representative explained due to the volume of individuals in the program, they could provide the individual with the application if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 660	Continued From page 66 needed but they did not assist individuals with completing the applications. She stated they tried to empower them to do as much of it on their own or they could get assistance from facility staff.	F 660		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to have a qualified professional to direct the facility's activity program. This practice had the potential to affect all 106 residents at the facility. The findings included: On 12/3/24 at 2:13 PM an interview was conducted with the Assistant Activity Director (AD). She stated that she started working at the	F 680	The facility failed to have a qualified professional to direct the facility's activity program. This practice had the potential to affect all 106 residents at the facility. The facility hired a Certified Activities Director with a start date of 12/31/2024. Current facility residents were audited and reviewed on 12/20/24 by the Administrator to ensure residents have not been	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 680	Continued From page 67 facility on October 16th, 2024. She stated that there was an Activity Director (Admission Coordinator) when she started who left the beginning of November 2024. The Assistant Activity Director stated she had no training other than when the AD was working at the facility. The Assistant Activity Director could not give any details of any training the AD gave her. The Assistant Activity Director indicated she had no college degree. The Assistant Activity Director did not realize that the AD she was referring to was actually an acting AD. On 12/3/24 at 2:25 PM an interview was conducted with the Activity Assistant. She stated that she started working at the facility on 11/28/24. She had not had any training since working at the facility. She had no college degree. She had not taken any state training courses. She did have some prior experience working with adults with disabilities. On 12/5/24 at 10:33 AM an interview was conducted with the Administrator. The Administrator stated that from 8/7/24 till 8/20/24 the facility had an AD and an Activity Assistant. The AD left on 8/20/24 and the Activity Assistant left on 9/25/24. From 9/25/24 till 10/16/24 the department did not have an AD or an Activity Assistant. Since the facility no longer had these positions filled the Admission Coordinator took over as the acting AD and the evening receptionist took over the role as the Activity Assistant. The acting AD conducted activities during the weekday hours Monday through Friday and the evening/weekend receptionist did activities in the evenings and weekends. The plan was for the Admission Coordinator to remain the acting AD until an AD was hired, however the	F 680	affected by the facility not having a qualified activities professional. No concerns were noted during review. To ensure the deficient practice does not recur, the Vice President of Clinical Operations educated the Administrator on regulatory requirement for a facility to employee a qualified activities professional. This education was completed by 1/3/2025. The facility transferred a qualified activities professional from a sister facility to fill the role for the facility. This transfer was completed on 12/31/2024 . The administrator will audit 5 residents weekly for 4 weeks, 5 residents biweekly for 4 weeks, and 5 residents monthly for 1 month to ensure residents have no concerns regarding activities and their needs are being met. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 680	Continued From page 68 Admission Coordinator left his position the beginning of November. Prior to leaving his position the Admission Coordinator helped the newly hired Assistant Activity Director by explaining to her the activities that he had been doing with the residents. He continued to train and explain how activities were conducted until he left his position in November. The Administrator stated that neither the Admission Coordinator or evening receptionist had any formal training in regard to activities. The Administrator stated he was now conducting 2nd interviews for the AD position. The Administrator felt he may have an AD hired by this coming week. The Administrator was aware of the regulation and the need to have a qualified AD. The Administrator knew the facility was out of compliance due to not having an AD. The Administrator stated he had been actively trying to find a candidate for the position.	F 680		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director, Nurse Practitioner, and staff the facility failed to obtain a blood sugar as part of the change of condition assessment for a resident	F 684	The facility failed to obtain a blood sugar as part of the change of condition assessment for a resident with a current diagnosis of diabetes mellitus that was	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 69 with a current diagnosis of diabetes mellitus that was being treated with routine oral blood glucose lowering medication for 1 of 1 resident reviewed for a change of condition (Resident #205). The findings included: Resident #205 was admitted to the facility on 2/6/24 with diagnoses including diabetes mellitus, chronic kidney disease, and chronic systolic congestive heart failure. Review of the 5-day/discharge Minimum Data Set (MDS) assessment dated 2/10/24 revealed Resident #205's cognition was moderately impaired, and medications received included a hypoglycemic. The baseline care plan dated 2/7/24 identified Resident #205's level of consciousness as being alert and intact. A physician's order revealed glipizide-metformin (medication used to lower blood sugar levels) oral tablet 2.5-500 milligrams (mg) was started on 2/7/24 with directions to give 1 tablet by mouth two times a day. There was no physician order in place to check the blood sugar. A review of the Medication Administration Record (MAR) for February 2024 revealed glipizide-metformin oral tablet 2.5-500 mg was initialed by the nurse to indicate it was administered on 2/10/24 at 7:00 AM and at 4:00 PM. The SBAR (Situation Background Assessment Recommendation) progress note dated 2/10/24 at 3:08 PM was an evaluation of a change of	F 684	being treated with routine oral blood glucose lowering medication for 1 of 1 resident reviewed for a change of condition (Resident #205). Resident #205 had discharged prior to identified citation. Residents with a diagnosis of diabetes mellitus is at risk of being affected by deficient practice. The Director of Nursing (DON) completed an audit on 12/27/2024 of residents with a diagnosis of diabetes mellitus to ensure the residents had an order for blood glucose checks and reviewed each of those residents to ensure they were stable and not showing a change in condition. No concerns were noted during the audit. To ensure the deficient practice does not recur the Staff Development Coordinator (SDC) completed education with the facility and agency licensed nurses on signs and symptoms of hypoglycemia and how to respond to a change in condition in a resident with diagnosis of diabetes mellitus. Education completed by 1/3/2025. Newly hired facility and agency nurses and facility and agency nurses not educated by 1/3/25 will be educated upon hire or prior to working their next scheduled shift. The DON or designee will review 5 residents with a diagnosis of diabetes mellitus to ensure if a change of condition has occurred and the blood glucose was checked as indicated weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. The facility will monitor the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 70 condition for Resident #205. The SBAR was documented by Nurse #5 and noted Resident #205's relevant medical history background of diabetes mellitus and the physical assessment noted increased confusion and general weakness. Vital signs taken were blood pressure 130/72, pulse 76, respiratory rate 19, temperature 98.1, pulse oximetry 96% on room air. The SBAR document included guidance to check the blood sugar but was left blank to indicate it was not done. A progress note dated 2/10/24 at 5:15 PM was documented by Nurse #5 and revealed Resident #205 had returned to the facility after a couple of hours being out with her daughter. The daughter reported Resident #205 was depressed and agitated. Nurse #5 notified the on-call Medical Doctor (MD) and received a new order for lorazepam (medication used to treat anxiety). Nurse #5 informed the daughter of the new order who wanted Resident #205 seen by a MD. Nurse #5 offered to call emergency medical services for transport to the hospital. The daughter insisted she would drive Resident #205 to the hospital, and both left the facility. Nurse #5 noted Resident #205 left with the daughter in no apparent distress. A review of the emergency department note dated 2/10/24 at 5:30 PM revealed Resident #205 was brought in by her daughter for altered mental status. The daughter reported Resident #205 was confused and verbally agitated. The MD noted Resident #205 took glipizide and thought the reason for the admission was hypoglycemia. The physical exam revealed Resident #205's behavior was normal with no neurological deficit present and mental status as being alert. Vital signs were	F 684	corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 71	F 684		

as follows: blood pressure 93/67, pulse 97, temperature 98.1, respiratory rate 16, oxygen saturation 98%. The initial blood sugar obtained on 2/10/24 at 5:41 PM was 37 (reference range 70-111) then at 6:25 PM was 52, and 6:45 PM was 108, and 9:16 PM was high at 116. The hospital record revealed Resident #205 was treated with intravenous (IV) and oral glucose and the blood sugar significantly improved in the emergency department. Glipizide-metformin was discontinued with no blood sugar problems since admission and Resident #205 was discharged on 2/14/24 in stable condition.

During an interview on 12/12/24 at 9:04 PM Nurse #5 revealed what he saw and did for Resident #205 he documented on the SBAR, and progress note on 2/10/24. Nurse #5 confirmed he did not obtain a blood sugar as indicated on the SBAR and did not recall if he reported Resident #205 was taking oral hypoglycemic medications for diagnosis of diabetes mellitus to the on-call MD. Nurse #5 revealed he offered to call emergency medical services but Resident #205's daughter insisted she would take the resident and left the facility.

During an interview on 12/06/24 at 9:07 AM the Nurse Practitioner (NP) revealed she would expect Nurse #5 would obtain a blood sugar level as part of Resident #205's vital sign check. She explained when Resident #205 demonstrated altered mental status with diabetes mellitus as an active diagnosis and was taking oral hypoglycemic medication she would expect that information was provided to the on-call MD. The NP revealed checking the blood sugar level might have identified Resident #205 was hypoglycemic and a physician order could have been provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 72 to administer glucose and it appeared Resident #205 was alert and could have ate and drank something to increase the blood sugar level. An interview was conducted on 12/06/24 at 11:28 AM with the Medical Director. The Medical Director revealed when a resident presented with a change in mental status especially if diagnosed with diabetes mellitus and taking oral hypoglycemic medication, he would expect the blood sugar was checked. The Medical Director revealed it was an oversight by the nurse that the blood sugar was not checked and should be included as part of the assessment reported to the on-call MD for the provider to give informed guidance to the nurse. An interview was conducted on 12/06/24 at 12:17 PM with the Director of Nursing (DON). The DON revealed Nurse #5 did not check Resident #205's blood sugar due to there was no order in place. The DON revealed as a nurse she would have checked Resident 205's blood sugar as part of the assessment and reported the result to the on-call MD for guidance. During an interview on 12/06/24 at 4:47 PM the Administrator revealed he would expect Nurse #5 obtained a blood sugar level and include that information as part of the assessment reported to the on-call MD.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 73 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to ensure a Nurse Aide (NA #8) transferred a resident safely for 1 of 8 residents (Resident #4) reviewed for supervision to prevent accidents. Findings included: Resident #4 was admitted to the facility 12/12/15 with diagnoses including muscle spasm and lack of coordination. The quarterly Minimum Data Set (MDS) assessment dated 09/22/24 revealed Resident #4 had severely impaired cognitive skills for daily decision making and had impaired range of motion to one side of her upper extremities and impaired range of motion to both lower extremities. The MDS indicated Resident #4 was dependent for chair/bed transfers. Review of the activities of daily living (ADL) care plan last updated 09/20/24 revealed Resident #4 had an ADL self-care performance deficit and required a mechanical lift with 2-person assistance for transfers. Review of Resident #4's Kardex (a document that gives a brief overview of the care each resident requires) last updated 12/02/24 revealed she required a mechanical lift with 2-person assistance for transfers.	F 689	The facility failed to ensure a Nurse Aide (NA #8) transferred a resident safely for 1 of 8 residents (Resident #4) reviewed for supervision to prevent accidents. Nurse Aide #8 was immediately educated on utilizing the Kardex to obtain transfer status for residents by director of nursing (DON). Current facility residents are at risk of being affected by this deficient practice. The DON and minimum data set (MDS) nurse audited current facility residents to ensure they have a transfer status listed on the residents' Kardex. Residents who did not have a transfer status listed were that corrected at that time. Audit completed on 1/3/2025. To ensure the deficient practice does not recur the Staff Development Coordinator educated facility and agency nurse aides on accessing the Kardex and following the transfer status that is documented. Education completed on 1/3/2025. Newly hired facility and agency nurse aides and staff not educated by 1/3/25 will be educated upon hire or prior to working the next scheduled shift. The DON or designee will review 5 residents to ensure transfer status is listed on the Kardex and the nurse aide is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 74 A continuous observation on 12/02/24 from 11:28 AM through 11:34 AM revealed NA #8 picked Resident #4 under her arms and pivoted Resident #4 from the geriatric chair onto her bed. NA #8 failed to obtain assistance from a second staff member or use a mechanical lift to transfer Resident #4 from the chair to the bed. Review of NA #8's "Agency Orientation" documentation revealed she signed the document 09/18/24 acknowledging she received information on facility policies and processes and was to refer to the "Education Station" for any questions or call the Administrator or DON. An interview with NA #8 on 12/02/24 at 11:40 AM revealed she was an agency staff member who had been working in the facility for approximately a month. She stated she was told by another NA when she began employment that Resident #4 was a 1 person assist for transfers. An interview with Physical Therapist (PT) #1 on 12/02/24 at 2:22 PM revealed Resident #4 was not currently on therapy caseload, but she required 2 staff members and a mechanical lift for transfers. A follow-up interview with NA #8 on 12/02/24 at 2:44 PM revealed she obtained information regarding resident care, including transfer status, from other NAs or the resident's assigned nurse. She stated she did not receive any type of orientation when she was hired and did not know what a Kardex was or how to access it. An interview with the Director of Nursing (DON) on 12/02/24 at 2:49 PM revealed Resident #2 required use of a mechanical lift and the	F 689	following plan of care weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 75 assistance of 2 staff members for transfers and should not be manually transferred by 1 staff member. She stated information on resident transfer status could be located on the Kardex in the computer and all staff had access to the Kardex. The DON also stated an orientation book was located at each nurse's station which nursing staff could access if further information was needed for resident care and nurses were also available to answer any questions regarding resident care needs. She stated each nursing staff member had to sign a paper stating they received orientation upon hire. An interview with the Administrator on 12/05/24 at 5:31 PM revealed he expected staff to transfer residents as recommended by therapy or the Physician.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 76 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the resident and staff the facility failed to ensure the urinary catheter tubing was secured to the leg to prevent movement and trauma for 1 of 1 resident reviewed for urinary catheter (Resident #87). Findings included: Resident #87 was admitted to the facility on 07/14/23 with diagnosis including obstructive and reflux uropathy (obstruction of urine from bladder and a backwards flow). The quarterly Minimum Data Set assessment dated 09/05/24 revealed Resident #87's cognition was moderately impaired with no rejection of care behaviors during the lookback period. An indwelling urinary catheter was in place and setup or clean up assistance was needed for toileting	F 690	The facility failed to ensure the urinary catheter tubing was secured to the leg to prevent movement and trauma for 1 of 1 resident reviewed for urinary catheter (Resident #87). A catheter securement device was applied to Resident #87 upon identification of need by the Director of Nursing (DON). Current facility residents with indwelling catheters are at risk of being affected by the deficient practice. The DON completed an audit on residents with indwelling catheters to ensure a securement device was in place and if the resident refused the medical provider was notified and refusal was care planned. The audit was completed on 12/10/2024. To ensure the deficient practice does not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 77 hygiene. A review of Resident #87's current physician's order to secure the indwelling catheter tubing using an anchoring device to prevent movement and urethral traction every shift was initiated on 10/02/24. The care plan last revised on 11/19/24 identified Resident #87 had an indwelling catheter related to obstructive uropathy and was at risk of complications. Interventions included ensure the catheter was secured to the resident. The care plan identified Resident #87 had behaviors which included but not limited to yelling, cursing at staff, risk of refusing medications, treatments, and other interventions and noted showers were frequently refused. Interventions included encourage to build a rapport with caregivers with emphasis to show gratitude. Review of the Medication Administration Record (MAR) for November revealed the physician's order was transcribed with directions to secure the indwelling catheter tubing using an anchoring device to prevent movement and urethral traction every shift. Nurses initialed and checked each day, evening, and night shift from 11/01/24 through 11/30/24 to indicate the catheter tubing was secure. There were no refusals documented on the MAR to indicate Resident #87's anchoring device was not in place. Review of the MAR for December revealed the physician's order was transcribed with directions to secure the indwelling catheter tubing using an anchoring device to prevent movement and urethral traction every shift. Nurses initialed and checked each day, evening, and night shift from	F 690	recur, the staff development coordinator (SDC) educated facility and agency licensed nurses and nurse aides on ensuring a catheter securement device is in place for residents with indwelling catheters and document and notify medical provider of refusal. Education was completed by 1/3/2025. Newly hired facility and agency licensed nurses and nurse aides and ones not educated by 1/3/2025 will be educated upon hire or prior to working next shift. The DON or designee will review 5 residents with indwelling catheters to ensure the resident has a catheter securement device in place weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 78	F 690		

12/01/24 through 12/02/24 and 12/3/24 day shift to indicate the catheter tubing was secure. There were no refusals documented on the MAR to indicate Resident #87's anchoring device was not in place.

During an observation and interviews on 12/03/24 at 1:41 PM Nurse Aide (NA) #7 provided catheter care for Resident #87 with the Staff Development Coordinator (SDC) in the room. An anchoring device to secure the tubing to the leg to prevent movement and trauma was not in place. NA #7 and the SDC revealed they were not aware the anchoring device was not in place and should be.

An interview was conducted on 12/03/24 at 1:41 PM with Resident #87. Resident #87 revealed he wanted the catheter tubing secured to his leg and stated the anchoring device was not routinely applied and he had not removed it.

During an observation on 12/03/24 at 2:06 PM the SDC applied an anchoring device to secure the catheter tubing to Resident#87's leg. Resident #87 was accepting of the care.

An interview was conducted on 12/03/24 at 2:49 PM with Nurse #8 who initialed the MAR on 12/2/24 and 12/3/24 day shift to indicate the catheter tubing was secure. Nurse #8 revealed when she initialed the MAR and checked Resident #87's securement device was in place. Nurse #8 revealed Resident #87 would remove the anchoring device.

During an interview on 12/06/24 at 8:55 AM the Nurse Practitioner (NP) revealed if there was a physician's order for the anchoring device and the nurses checked the MAR to indicate it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 79 secure she would expect it was in place. The NP revealed the anchoring device was used to help prevent trauma and she heard Resident #87 would remove it. An interview was conducted on 12/06/24 on 3:31 PM with the Director of Nursing (DON). The DON revealed if the nurses checked the MAR to indicate the anchoring device was in place she would expect it was. The DON revealed she was aware Resident #87 refused to wear the anchoring device.	F 690		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and Medical Director	F 712	The facility failed to ensure physician	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 80 (MD) and staff interviews, the facility failed to ensure physician visits were performed every 30 days for the first 90 days of admission for 4 of 4 sampled residents reviewed for physician visits (Residents #21, #31, #41, and #55). Findings included: a. Resident #21 was admitted to the facility on 06/05/24 with multiple diagnoses that included chronic obstructive pulmonary disease (trouble breathing), heart failure, and respiratory failure. The quarterly Minimum Data Set (MDS) dated 09/10/24 indicated Resident #21 had moderate impairment in cognition. Review of Resident 21's Electronic Medical Record (EMR) revealed he was seen by the Medical Doctor (MD) on 06/14/24 and 08/26/24 during the first ninety (90) days of his admission to the facility. b. Resident #31 was admitted to the facility on 06/06/24 with multiple diagnoses that included diabetes, chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues), heart failure, and chronic kidney disease. The quarterly Minimum Data Set (MDS) dated 10/07/24 indicated Resident #31 had intact cognition. Review of Resident #31's Electronic Medical Record (EMR) revealed he was seen by the Medical Doctor (MD) on 06/14/24 and 09/11/24 during the first ninety (90) days of his admission to the facility.	F 712	visits were performed every 30 days for the first 90 days of admission for 4 of 4 sampled residents reviewed for physician visits (Residents #21, #31, #41, and #55). Physician was notified by Director Of Nursing of residents that needed physician visits. Physician visited resident #21 on 12/15/2024, resident #31 on 12/4/2024, resident #41 on 12/11/2024, and resident #55 on 12/12/2024. Current residents with in their first 90 days of admission are at risk of being affected by this deficient practice. The Director of Nursing (DON) audited residents within their first 90 days of admission to ensure the medical provider had seen the resident every 30 days for the first 90 days. The Physician was notified of residents needing a physician visit and the visits were completed by 1/3/2025. Effective 1/3/2025 the DON and Assistant Director of Nursing (ADON) will be responsible for ensuring residents are visited by the physician every 30 days during the first 90 days of admission. The Staff Development Coordinator (SDC) educated the physician, DON, and ADON of the expectation and regulatory requirement of residents to have physician visits every 30 days for the first 90 days of admission. Newly hired physicians or physicians not educated by 1/3/2025 will be educated upon hire or prior to next facility visits. The DON or designee will review 5 residents within their first 90 days of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 81 c. Resident #41 was admitted to the facility on 07/18/24 with multiple diagnoses that included chronic obstructive pulmonary disease (trouble breathing), heart disease, diabetes, hypertension, and dementia. The quarterly Minimum Data Set (MDS) dated 08/15/24 indicated Resident #41 had moderate impairment in cognition. Review of Resident #41s Electronic Medical Record (EMR) revealed she was seen by the Medical Doctor (MD) on 08/17/24 during the first ninety (90) days of her admission to the facility. Following the MD visit on 08/17/24, Resident #41 was not seen again by the MD until 11/16/24. d. Resident #55 was admitted to the facility on 01/16/24 with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke), diabetes and depression. The quarterly Minimum Data Set (MDS) dated 08/30/24 indicated Resident #55 had intact cognition. Review of Resident #55's Electronic Medical Record (EMR) revealed he was seen by the Medical Doctor (MD) on 01/19/24 and 04/17/24 during the first ninety (90) days of his admission to the facility. During an interview on 12/05/24 at 11:15 AM, the Director of Nursing (DON) revealed Medical Records and the Social Worker were keeping track of regulatory visits for the MD but due to the turnover in both those positions, she had been	F 712	admission to ensure the physician has visited them every 30 days for the first 90 days weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 712	Continued From page 82 filling in with this process. The DON explained she provided the MD with a weekly report of all admission and discharges as well as a physician audit report for him to review to determine which residents needed to be seen. The DON stated it was not a foolproof system because if older visits were still showing up on the report as not completed, the newer admissions would not appear until the older visits were marked complete and regulatory visits would be overlooked. During a telephone interview on 12/06/24 at 11:29 AM, the MD stated the only progress notes of his visits to the facility were the ones documented in the resident's EMR. He stated that when he arrived at the facility, he was provided a list of all admissions that he reviewed to determine who was recently admitted and then saw those residents. The MD confirmed he was aware of the regulation regarding the frequency of visits and was not aware Residents #21, #31, #41, and #55 had not been seen as required following their admission to the facility. He explained the facility used to have a Medical Records staff member who kept track of when residents needed to be seen in order to remind him and it had helped him ensure regulatory visits were completed. The MD stated he tried keeping up with the regulatory visits due and if his progress notes were not documented in the resident's EMR, then there were none and the resident had not been seen.	F 712		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 83 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Consultant Pharmacist, Medical Director, resident and staff interviews, the facility failed to ensure antibiotic eye drops were received from the pharmacy as ordered which resulted in five (5) missed doses for 1 of 6 sampled residents reviewed for pharmacy services (Resident #11). Findings included:	F 755	The facility failed to ensure antibiotic eye drops were received from the pharmacy as ordered which resulted in five (5) missed doses for 1 of 6 sampled residents reviewed for pharmacy services (Resident #11). Residents eye drops were received and MD notified of delay and missed doses by the Director of Nursing (DON) on 12/05/2024. No new orders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 84 Resident #11 admitted to the facility on 11/11/22. Her cumulative diagnoses included chronic conjunctivitis. The Minimum Data Set (MDS) assessment dated 09/27/24 revealed Resident #11 had moderate impairment in cognition. A Physician Order Sheet dated 11/20/24 and signed by the Ophthalmologist read, "start Moxifloxacin eye drops - one drop twice a day, OD (right eye). Do not stop, continuous." Review of Resident #11's active physician orders revealed an order dated 11/21/24 for Moxifloxacin Hydrochloride (HCl) Ophthalmic Solution (antibiotic used to treat eye infections caused by bacteria) 0.5% - one drop in right eye two times a day for irritation. No stop date per Ophthalmology. A telephone attempt on 12/05/24 at 11:36 AM for an interview with the Ophthalmologist was unsuccessful. Review of Resident #11's Medication Administration Record (MAR) revealed the Moxifloxacin HCl eye drops were scheduled to be administered twice daily at 8:00 AM and 8:00 PM. Further review of the MAR revealed Resident #11 did not receive the 8:00 PM dose on 12/03/24, the 8:00 AM and 8:00 PM doses on 12/04/24, and the 8:00 AM and 8:00 PM doses on 12/05/24. During an interview on 12/04/24 at 8:55 AM, Nurse #7 revealed Resident #11 received her last dose of Moxifloxacin eye drops yesterday morning (12/03/24) and she put in a refill request	F 755	received. Current facility residents who are prescribed antibiotic eye drops are at risk of being affected by this deficient practice. Residents who are prescribed antibiotic eye drops were audited on 12/10/2024 by the DON to ensure their medication is available. No concerns noted during the audit. To ensure the deficient practice does not recur, the Staff Development Coordinator (SDC) educated current facility and agency licensed nurses on administering medications as ordered and in the event a medication is not available the medical provider must be notified and a hold order received. If medication is not received from pharmacy when ordered to notify the DON. Education completed by 1/3/2025. Newly hired facility and agency licensed nurses and licensed nurses not educated by 1/3/25 will be educated upon hire or prior to working their next scheduled shift. The DON or designee will review 5 residents to ensure their ordered medications are available and administered as ordered weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 85 with the pharmacy around 10:30 AM on 12/03/24. Nurse #7 explained she tried to put the refill request in as soon as possible to avoid any gap in administration but was told by the pharmacy the Moxifloxacin eye drops would be delivered to the facility around 2:00 AM and Resident #11 would miss the 8:00 PM scheduled dose on 12/03/24. Nurse #7 stated she was not sure why the Moxifloxacin eye drops were not delivered with the 2:00 AM shipment on 12/04/24. Nurse #7 stated she called the pharmacy again this morning (12/04/24) at 8:50 AM and was told the eye drops would be delivered today in the 3:00 PM shipment. During an observation and interview on 12/04/24 at 9:03 AM, Resident #11's right eye was red with no drainage observed. Resident #11 stated she did not get her Moxifloxacin eye drops at all yesterday (12/03/24) or this morning (12/04/24). Resident #11 stated she had missed 3 doses so far and was worried about not receiving the eye drops because she was scheduled to have eye surgery soon. Resident #11 stated the nurse thought the bottle was empty, tossed it away accidentally and they had to reorder the medication. During a follow-up interview on 12/04/24 at 4:33 PM, Nurse #7 stated when she checked the shipment from the pharmacy at 3:30 PM on 12/04/24 Resident #11's Moxifloxacin eye drops were not included in the shipment. Nurse #7 stated she called the pharmacy and they could not give her an explanation as to why Resident #11's eye drops were not sent as requested. During an observation and follow-up interview on 12/05/24 at 9:10 AM, Resident #11's right eye	F 755	the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 86	F 755		

was bright red with a small amount of drainage in the corner of the eye. Resident #11 stated it was not painful or itching. She stated she had still not received her eye drops as scheduled since 12/03/24.

During a telephone interview on 12/05/24 at 10:10 AM, the Consultant Pharmacist stated a refill request for Resident #11's Moxifloxacin eye drops was received on 12/03/24 at 8:45 AM and the facility was notified via an alert in the pharmacy system that it was too soon to refill but the medication could be refilled on 12/16/24 for the insurance to pay. The Pharmacist stated they did receive a Refill Too Soon Communication form this morning (12/05/24) at 6:36 AM indicating the facility would pay for the order to be refilled. The Pharmacist explained the cutoff time for the afternoon delivery was 6:30 AM and the cutoff time for the early morning delivery was 7:30 PM, Monday through Friday. The Consultant Pharmacist stated the other option would be for the facility to request the pharmacy to arrange for the medication to be filled at a backup pharmacy.

During an interview on 12/05/24 at 4:18 PM, Nurse #1 stated Resident #11's Moxifloxacin eye drops were not received in today's (12/05/24) afternoon shipment from the pharmacy. Nurse #1 stated she called the pharmacy and was told the order was not refilled because it was too soon and insurance would not pay. She stated the pharmacy mentioned something about a form that needed to be completed indicating the facility would pay for the medication to be refilled. When she spoke to the Director of Nursing (DON), the DON stated she had sent the form back to the pharmacy today and Resident #11's Moxifloxacin eye drops would be in the shipment expected to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 87	F 755		

arrive between 2:00 AM to 4:00 AM on 12/06/24. Nurse #1 confirmed Resident #11 had missed 5 doses of the scheduled Moxifloxacin eye drops due to the delay in the pharmacy refilling the order.

During an interview on 12/05/24 at 4:46 PM, the Director of Nursing (DON) stated she was notified around lunchtime on 12/04/24 that Resident #11 had missed the 8:00 AM dose of Moxifloxacin eye drops and the nurse had requested a refill from the pharmacy that was supposed to be delivered that afternoon. She stated she was not made aware that Resident #11 had also missed the 8:00 PM dose of the Moxifloxacin eye drops on 12/03/24. The DON stated she checked first thing this morning upon arriving to the facility and Resident #11's Moxifloxacin eye drops were not delivered from the pharmacy as expected. She stated she contacted the pharmacy, faxed the Refill Too Soon Communication form to the pharmacy at 5:57 AM and the Moxifloxacin eye drops should have been delivered in the 3:00 PM shipment but were not received. She stated per the pharmacy, Resident #11's Moxifloxacin eye drops would be delivered in the early morning shipment on 12/06/24. The DON stated the nurse should have notified her when Resident #11's Moxifloxacin eye drops were not delivered as expected after the refill request was submitted on 12/03/24 so that she could have followed up with the pharmacy sooner.

During an interview on 12/05/24 at 5:49 PM, the Administrator stated the nurse should have immediately notified the DON when Resident #11's Moxifloxacin eye drops were not delivered after requesting a refill from the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 88 During an observation and follow-up interview on 12/06/24 at 8:20 AM, Resident #11's right eye was less red than it appeared on 12/05/24. Resident #11 confirmed the Moxifloxacin eye drops were delivered and she received a dose as scheduled this morning. During a telephone interview on 12/06/24 at 11:20 AM, the Medical Director stated he was made aware that Resident #11's Moxifloxacin eye drops had to be reordered. He stated Resident #11 was receiving the eye drops to treat conjunctivitis which caused redness to her eye with a small amount of drainage. The MD stated that while he wanted her to receive the eye drops as ordered, he did not feel there would be any negative outcome related to Resident #11 missing 5 doses.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and Medical Director, resident and staff interviews, the facility failed to prevent a significant medication error when they failed to administer antibiotic eye drops as prescribed by the physician. As a result, Resident #11 missed 5 doses of antibiotic eye drops. This affected 1 of 6 sampled residents reviewed for unnecessary medications (Resident #11). The findings included:	F 760	The facility failed to prevent a significant medication error when they failed to administer antibiotic eye drops as prescribed by the physician. As a result, Resident #11 missed 5 doses of antibiotic eye drops. This affected 1 of 6 sampled residents reviewed for unnecessary medications (Resident #11).). Residents eye drops were received and MD notified of delay and missed doses by the Director of Nursing (DON) on 12/06/2024. No new orders received.	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 89 Resident #11 admitted to the facility on 11/11/22. Her cumulative diagnoses included chronic conjunctivitis. A Family Nurse Practitioner progress note dated 08/19/24 revealed in part, Resident #11 had right eye conjunctivitis with chronic right eye redness and drainage that worsened intermittently. The FNP noted Resident #11 had been treated with multiple courses of antibiotic eye drops and the plan was to schedule an appointment with the Ophthalmologist for further management of ongoing symptoms. The Minimum Data Set (MDS) assessment dated 09/27/24 revealed Resident #11 had moderate impairment in cognition. A Physician Order Sheet dated 11/20/24 and signed by the Ophthalmologist read, "start Moxifloxacin eye drops - one drop twice a day, OD (right eye). Do not stop, continuous." A physician order dated 11/21/24 revealed Resident #11 was to receive Moxifloxacin Hydrochloride (HCl) Ophthalmic Solution (antibiotic used to treat eye infections caused by bacteria) 0.5% - one drop in right eye two times a day for irritation. Review of Resident #11's Medication Administration Record (MAR) revealed the Moxifloxacin HCl eye drops were scheduled to be administered twice daily at 8:00 AM and 8:00 PM. Further review of the MAR revealed Resident #11 did not receive the 8:00 PM dose on 12/03/24, the 8:00 AM and 8:00 PM doses on 12/04/24, and the 8:00 AM and 8:00 PM doses on 12/05/24.	F 760	Current facility residents who are prescribed antibiotic eye drops are at risk of being affected by this deficient practice. Residents who are prescribed antibiotic eye drops were audited on 12/10/2024 by the DON to ensure their medication is available. No concerns noted during the audit. To ensure the deficient practice does not recur, the Staff Development Coordinator (SDC) educated current facility and agency licensed nurses on administering medications as ordered and in the event a medication is not available the medical provider must be notified and a hold order received. If medication is not received from pharmacy when ordered to notify the DON. Education completed by 1/3/2025. Newly hired facility and agency licensed nurses and licensed nurses not educated by 1/3/25 will be educated upon hire or prior to working their next scheduled shift. The DON or designee will review 5 residents to ensure their ordered medications are available and administered as ordered weekly for 4 weeks, biweekly for 4 weeks, and monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 90 During an interview on 12/04/24 at 8:55 AM, Nurse #7 revealed Resident #11 received her last dose of Moxifloxacin eye drops yesterday morning (12/03/24) and she put in a refill request with the pharmacy around 10:30 AM on 12/03/24. Nurse #7 explained she tried to put the refill request in as soon as possible to avoid any gap in administration but was told by the pharmacy the Moxifloxacin eye drops would be delivered to the facility around 2:00 AM and Resident #11 would miss the 8:00 PM scheduled dose on 12/03/24. Nurse #7 stated she was not sure why the Moxifloxacin eye drops were not delivered with the 2:00 AM shipment on 12/04/24. Nurse #7 stated she called the pharmacy again this morning (12/04/24) at 8:50 AM and was told the eye drops would be delivered today in the 3:00 PM shipment. During an interview on 12/04/24 at 9:03 AM, Resident #11 stated she had missed 3 doses so far and was worried about not receiving the eye drops because she was scheduled to have eye surgery soon. Resident #11 stated the nurse thought the bottle was empty, tossed it away accidentally and they had to reorder the medication. During a follow-up interview on 12/04/24 at 4:33 PM, Nurse #7 stated when she checked the shipment from the pharmacy at 3:30 PM on 12/04/24 Resident #11's Moxifloxacin eye drops were not included in the shipment. Nurse #7 stated she called the pharmacy and they could not give her an explanation as to why Resident #11's eye drops were not sent as requested. During an interview on 12/05/24 at 4:18 PM, Nurse #1 stated Resident #11's Moxifloxacin eye	F 760	effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 91 drops were not received in today's (12/05/24) afternoon shipment from the pharmacy. Nurse #1 confirmed Resident #11 had missed 5 doses of the scheduled Moxifloxacin eye drops due to the delay in the pharmacy refilling the order. During an interview on 12/05/24 at 4:46 PM, the Director of Nursing (DON) stated the nurse should have notified her when Resident #11's Moxifloxacin eye drops were not delivered as expected after the refill request was submitted on 12/03/24 so that she could have followed up with the pharmacy sooner. During a telephone interview on 12/06/24 at 11:20 AM, the Medical Director stated he was made aware that Resident #11's Moxifloxacin eye drops had to be reordered. He stated Resident #11 was receiving the eye drops to treat conjunctivitis which caused redness to her eye with a small amount of drainage. The MD stated that while he wanted her to receive the eye drops as ordered, he did not feel there would be any negative outcome related to Resident #11 missing 5 doses. During an interview on 12/05/24 at 5:49 PM, the Administrator stated the nurse should have immediately notified the DON when Resident #11's Moxifloxacin eye drops were not delivered after requesting a refill from the pharmacy.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality	F 770		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 92 and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff and Nurse Practitioner (NP) interviews and record review, the facility failed to complete an ordered Urinalysis for 1 of 2 residents reviewed for laboratory services (Resident #38). The findings included: Resident #38 was admitted to the facility on 11/5/23 with a diagnosis that included bacteremia. Review of the quarterly minimum data set (MDS) dated 8/2/24 revealed that Resident #38 was cognitively intact. Resident #38 had a physician's order for a urinalysis (UA) with culture and sensitivity one time only for 1 day. This was ordered on 9/24/2024 and marked completed on 9/25/2024. Review of the treatment administration record (TAR) for September 2024 revealed the UA was documented as completed on 9/25/2024. Review of the lab results revealed that there were no results for the UA ordered on 9/24/2024 for Resident #38. A phone interview on 12/6/2024 at 9:54 AM with Nurse #6 revealed revealed that she had completed and collected the UA specimen for Resident #38 on 9/25/2024 and placed it in the	F 770	The facility failed to complete an ordered Urinalysis for 1 of 2 residents reviewed for laboratory services (Resident #38). The medical director was notified of resident□s refusal of urine specimen collection by Vice President of Clinical Operations on 12/4/2024 and resident #38 assessed by MD and new orders received. Current facility residents who have had an order for urinalysis (UA) are at risk of being affected by the deficient practice. A 100% audit of UA's ordered in the last 30 day was completed on 12/09/2024 to ensure the order was completed and the medical provider was notified of result or refusal of testing. The audit was completed and no additional concerns were noted. To ensure the deficient practice does not recur the Staff Development Coordinator SDC) educated facility and contract licensed nurses on ensuring the resident's urinalysis testing is completed as ordered and to notify medical provider of resident refusals of testing. The education was completed on 12/27/2024. Newly hired facility and contract licensed nurses and interdisciplinary team (IDT) members or facility and contract licensed nurses not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 93 refrigerator for the lab to collect. She stated that if the specimen is left in refrigerator too long the lab or an employee would throw the specimen out because it is no longer useable. She stated that could be why there were no results for the UA ordered on 9/24/2024. She stated that she was not sure what the process was for when that happened. An interview on 12/6/2024 at 8:36 AM with the Nurse Practitioner (NP) revealed that she was not notified that the September UA did not have any results returned from the laboratory and that she would want to be notified if the staff were unable to complete the UA or if it needed to be reordered. She stated that Resident #38 had not experienced harm or negative outcome by the UA not being completed. An interview on12/6/2024 at 12:33 PM with the Director of Nursing (DON) revealed when the nurse collects the specimen, she puts it in the refrigerator and fills out a requisition (a document that healthcare providers use to request specific laboratory tests for residents) that goes in the lab book. The lab comes in every morning and reviews the lab requisitions and pulls those specimens out of the refrigerator to go to the lab. She stated that she was the one who followed up with the lab book and made sure the requisitions had been marked off and if any had not been she would call the lab to inform them about any labs that were not collected. She stated that she had just found the specimen from Resident #38 's 9/24/2024 UA in the refrigerator. She stated that there was no requisition filled out for that specimen by the nurse. So that was why the UA was not collected with results. She further revealed that the breakdown was the Nurse who	F 770	educated by 1/3/2025 will be educated upon hire or prior to working their next scheduled shift. The Director of Nursing or designee will audit 5 resident's weekly to ensure lab orders are completed as ordered weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 94 collected the specimen did not fill out the requisition. She stated that if she had found the specimen sooner than 12/6/2024, she would have followed up with the NP to obtain a new order for the UA and she would have followed up with the Nurse as well about the specimen. An interview on 12/6/24 at 3:54 PM with the Administrator revealed that his expectation was that if a lab was ordered the nursing staff gather the sample and fill out all the applicable paperwork, so the sample got to the lab for analysis. He further revealed that he expected that if a lab order does not make it to the lab for whatever reason the NP would be notified so they could make the decision to order another lab or not.	F 770		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 95 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations of the meal service tray line, record review, and dietary staff, Registered Dietician (RD), and the Regional Director of Operations (RDO) interviews, the facility failed to provide all food items as specified by the approved menu and failed ensure residents received the correct portion sizes based on the approved menu. These practices had the potential to affect 77 residents receiving a regular diet, 18 residents receiving a mechanical soft diet (consisting of foods that are easy to swallow), and 8 residents receiving a puree diet (consisting of foods with a pudding-like texture). Findings included: 1. An observation of the lunch meal tray line on 12/02/24 at 12:32 PM revealed the shepherd's pie being served to residents receiving a regular or mechanical soft diet consisted of a layer of ground beef, a layer of mashed potatoes, and a layer of melted cheese. No additional serving of vegetables was provided. A review of the recipe with the Regional Director of Operations (RDO) and Dietary Manager on 12/02/24 at 12:33 PM revealed the recipe for 100 servings (resident census was 106 on 12/02/24) of shepherd's pie is as follows:	F 803	The facility failed to provide all food items as specified by the approved menu and failed to ensure residents received the correct portion sizes based on the approved menu. These practices had the potential to affect 77 residents receiving a regular diet, 18 residents receiving a mechanical soft diet (consisting of foods that are easy to swallow), and 8 residents receiving a puree diet (consisting of foods with a pudding-like texture). Current facility residents are at risk of being affected by the deficient practice. The Regional Director of Clinical Services completed an audit of all residents diets on 12/4/2024. Areas of concern that were noted during the audit were remedied on 12/6/2024. To ensure the deficient practice does not recur, the Vice President of Operations educated he Regional Director of Operations (RDO) for Culinary, Dietary Manager, and cooks on ensuring the residents are served the approved portions of the approved menu items and if a substitution is made it must be approved by the registered dietician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 96 (a). 18 pounds of 80/20 ground beef (b). one and one fourth quarts of chopped onions (c). one tablespoon of garlic powder (d). one tablespoon of black pepper (e). two and 3 fourths quarts of mashed potato flakes (f). two cups of margarine solids (g). two and a half gallons of frozen mixed vegetables In an interview with Cook #1 on 12/02/24 at 12:38 PM he confirmed he did not add mixed vegetables or onions to the shepherd's pie being served because they were unavailable. He stated the former RDO taught him how to make the shepherd's pie and it did not include mixed vegetables or onions. Cook #1 stated he did not inform the Dietary Manager he did not have mixed vegetables or onions for the recipe, and he followed guidance from the former RDO when preparing the shepherd's pie. A joint interview with the Dietary Manager and RDO on 12/02/24 at 12:41 PM reveled the shepherd's pie should have contained all the items called for in the recipe for all diet types or the Dietary Manager should have been notified so he could have obtained approval for appropriate substitutions. A telephone interview with the Registered Dietician (RD) on 12/04/24 at 4:26 PM revealed a contract company handled all aspects of food preparation, and she had "nothing to do with day-to-day kitchen operations". An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected dietary staff to	F 803	including approval of the portion size prior to serving. Education completed by 1/3/2025.Newly hired RDO's, Dietary Managers and cooks not educated by 1/3/2025 will be educated upon hire or before working their next scheduled shift. The Administrator or designee will observe meal tray line to ensure menu and nutritional accuracy weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 97	F 803		

follow approved recipes or notify their supervisor if the ingredients were unavailable, so an appropriate substitution could be provided.

2. Review of the regular diet menu spreadsheet for breakfast on 12/03/24 is as follows:

(a). two slices of French toast
(b). one sausage patty
(c). six ounces of oatmeal

Review of the puree diet menu spreadsheet for breakfast on 12/03/24 is as follows:

(a). #10 scoop (equaling 3.2 ounces) of puree French toast
(b). #16 scoop (equaling 2 ounces) of puree sausage
(c). #6 scoop (equaling 5.3 ounces) of puree oatmeal

An observation of the steam table on 12/03/24 at 7:05 AM revealed grits, scrambled eggs, bacon, ground sausage, pureed eggs, and French toast had been prepared. Grits were served with a black spoodle (equaling 8 ounces), scrambled eggs were served with a green scoop (equaling 2.5 ounces), and bacon, sausage, and French toast were served with tongs.

A continuous observation of the breakfast meal tray line from 7:10 AM through 7:37 am revealed Cook #2 plated regular meal trays with one piece of French toast, one sausage patty or one piece of bacon (as an alternate), scrambled eggs, and grits. Cook #2 plated pureed meal trays with two scoops of pureed eggs and one scoop of grits.

An interview with Cook #2 on 12/03/24 at 9:52

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 98	F 803		

AM revealed he substituted grits for oatmeal and served one piece of bacon because he added scrambled eggs, and the eggs served as the primary protein. He stated he had approval to substitute grits for oatmeal and decided to serve eggs and bacon for residents receiving regular diets without seeking approval from the Dietary Manager. Cook #2 did not provide a reason why he did not seek approval for menu changes.

An interview with the Regional Director of Operations (RDO) on 12/03/24 at 10:40 AM revealed 2 slices of French toast, one sausage patty, and six ounces of oatmeal should have been served for residents on a regular diet, unless grits were approved as a substitute for oatmeal. She stated residents receiving a puree diet should have received pureed French toast, pureed sausage, and pureed oatmeal unless appropriate substitutions were approved. The RDO stated she was not sure why the approved menu was not followed.

An email from the Dietary Manager to the Registered Dietician (RD) dated 12/03/24 at 11:51 AM revealed the RD approved the substitution of grits for oatmeal and pureed eggs doubled with cheese could substitute for pureed French toast.

In a follow-up interview with Cook #2 on 12/04/24 at 12:28 PM he was unable to explain why only piece of French toast was served for the breakfast meal on 12/03/24 or why there was no pureed French toast or sausage. Cook #2 confirmed there was no cheese in the pureed eggs served in the breakfast meal on 12/03/24.

An interview with the Dietary Manager on 12/04/24 at 12:38 PM revealed he was not sure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 99 why only one slice of French toast was served for the breakfast meal on 12/03/24 or why there was no pureed French toast or pureed sausage. He stated substituting grits for oatmeal had been approved as a substitute by the Registered Dietician (RD), but otherwise the menu should have been followed. A telephone interview with the Registered Dietician (RD) on 12/04/24 at 4:26 PM revealed a contract company handled all aspects of food preparation, and she had "nothing to do with day-to-day kitchen operations". An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected menus to be followed, correct portion sizes to be served, and any substitutions made should be approved by the Registered Dietician (RD).	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews the facility failed to honor a resident's food preferences for 1 of 5 residents reviewed for food preferences	F 806	The facility failed to honor a resident's food preferences for 1 of 5 residents reviewed for food preferences (Resident #31). These practices had the potential to	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 100 (Resident #31). Findings included: Resident #31 was admitted to the facility 06/06/24. Review of Resident #31's Physician orders revealed an order dated 10/03/24 for a regular diet. The quarterly Minimum Data Set (MDS) assessment dated 10/07/24 revealed Resident #31 was cognitively intact and made himself understood and was able to understand others. Resident #31's nutrition care plan initiated 07/15/24 and last revised 12/03/24 revealed he was on a regular diet and desired double protein. Interventions included providing his diet as ordered and meeting his preferences. An interview with Resident #31 on 12/02/24 at 3:44 PM revealed he had asked the dietary department numerous times for large portions or at least double protein throughout his stay. He stated the last time he asked the Dietary Manager for large portions was on 12/01/24. Resident #31 stated he rarely received large portions. An observation of Resident #31 on 12/03/24 at 7:20 AM revealed he was sitting in the dining room eating breakfast. He stated he received one piece of French toast, one sausage patty, a scoop of grits, and a scoop of eggs for breakfast. Resident #31 stated that even though he was still eating, he was going to need more food to feel full. No mention of double portions was noted on Resident #31's meal ticket for the breakfast meal	F 806	affect 77 residents receiving a regular diet, 18 residents receiving a mechanical soft diet (consisting of foods that are easy to swallow), and 8 residents receiving a puree diet (consisting of foods with a pudding-like texture). Resident #31's preferences were updated in the dietary computer system, resident's order, and resident's care plan was updated when notified of identified issue. Current facility residents are at risk of being affected by the deficient practice. The Regional Director of Clinical Services completed an audit of all residents diets on 12/4/2024. Area of concerns that were noted during the audit were remedied on 12/6/2024. To ensure the deficient practice does not recur, the Vice President of Operations educated the Regional Director of Operations (RDO) for Culinary, Dietary Manager, and cooks on ensuring residents preferences are followed when serving meals. Education completed by 1/3/2025.Newly hired RDO's, Dietary Managers and cooks not educated by 1/3/2025 will be educated upon hire or before working their next scheduled shift. Effective 1/3/2025, the residents preferences will be reviewed upon admission, quarterly, and as needed by the dietary manager. The Administrator or designee will observe meal tray line to ensure menu and nutritional accuracy weekly for 4 weeks, biweekly for 4 weeks, and then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 101 on 12/03/24. On 12/03/24 at 7:22 AM the Dietary Manager was informed that Resident #31 was requesting additional breakfast food. The Dietary Manager stated Resident #31 would be provided with additional food when all other resident trays had been served. An interview with the Dietary Manager on 12/03/24 at 8:01 AM revealed he became aware of Resident #31's request for large portions on 12/01/24. He was unable to provide a reason why Resident #31 did not receive large portions for breakfast on 12/03/24 and stated he had not had time to add the request to his meal ticket. A follow-up interview with Resident #31 on 12/03/24 at 9:00 AM revealed he had not yet received any additional food and was still hungry. An additional follow-up interview with Resident #31 on 12/03/24 at 9:50 AM revealed the Dietary Manager did offer to make him an omelet (he was unable to recall the exact time, but it was after 9:00 AM), but he declined. Resident #31 stated he was still hungry, but he declined the omelet because he knew the Dietary Manager was busy and he did not want to inconvenience him. An interview with the Regional Director of Operations (RDO) on 12/03/24 at 10:40 AM revealed Resident #31 should have received additional food at the time he requested it, rather than having to wait until the tray line was finished. She stated Resident #31's preferences should have been honored. An interview with the Director of Nursing (DON)	F 806	monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 102 on 12/05/24 at 4:24 PM revealed Resident #31's care plan had probably not been updated recently because he had been to the hospital a couple of times and that was not necessarily an accurate reflection of his preferences. She stated she was not aware of any concerns from Resident #31 that he requested larger portion sizes but now that she was aware, she could address Resident #31's food preferences. An interview with the Administrator on 12/05/24 at 5:19 PM revealed he was not aware of any requests from Resident #31 to receive double portions, but he expected staff to honor residents' food preferences.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Registered Dietician (RD), and Nurse Practitioner (NP) interviews the facility failed to provide Resident #52 with a renal diet as ordered. This failure affected 1 of 3 residents reviewed for nutrition. Findings included:	F 808	The facility failed to provide Resident #52 with a renal diet as ordered. This failure affected 1 of 3 residents reviewed for nutrition. Resident #52's diet was corrected immediately upon notification by the dietary manager. Current facility residents are at risk of being affected by the deficient practice.	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 103 Resident #52 was admitted to the facility 09/11/24 with diagnoses including diabetes and dependence on renal dialysis. The admission Minimum Data Set (MDS) assessment dated 09/13/24 revealed Resident #52 was cognitively intact and received dialysis. Review of Resident #52's Physician orders revealed a diet order dated 09/17/24 for a regular renal diet and no potatoes, tomato sauce/soup, dried beans, cooked spinach, bananas, oranges/orange juice, raisins, cantaloupe, honey dew, star fruit, nuts, or chocolate. Resident #52's nutrition care plan last updated 11/13/24 revealed he was on a regular renal diet with thin liquids and interventions included providing his diet as ordered and weighing him as needed. An observation of Resident #52's meal ticket and breakfast tray on 12/04/24 at 7:49 AM revealed his breakfast meal tray ticket indicated he was to receive sausage and cheese breakfast bake, orange twist, a biscuit, orange juice, hot coffee or hot tea, whole milk, and oatmeal. Resident #52 actually received sausage and cheese breakfast bake, a biscuit, grits, and orange juice on his breakfast tray. An interview with Resident #52 on 12/04/24 at 7:51 AM revealed he wasn't supposed to receive orange juice, and he was served potatoes and tomato soup "all the time". An observation of Resident #52's lunch meal ticket on 12/04/24 at 12:11 PM revealed he was to receive pork roast, broccoli florets, red	F 808	The Regional Director of Clinical Services completed an audit of all residents diets on 12/4/2024. Area of concerns were noted during the audit were remedied on 12/6/2024. To ensure the deficient practice does not recur, the Vice President of Operations educated the Regional Director of Operations (RDO) for Culinary, Dietary Manager, and cooks on importance of following ordered diets and risks of not serving residents the diet that is ordered, when a communication form is delivered to the dietary department from nursing the dietary staff need to verify that the diet has updated in the computerized meal system. Education completed by 1/3/2025.Newly hired RDO□s, Dietary Managers and cooks not educated by 1/3/2025 will be educated upon hire or before working their next scheduled shift. Effective 1/3/2025, the electronic health record and computerized meal system were integrated, this will update diets in both systems if a change is ordered by the medical provider. The dietary manager will be responsible for ensuring the correct physician ordered diets are being served to the residents. The Administrator or designee will audit 5 residents diet orders and adherence to ordered diets weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 104 potatoes, a dinner roll, chocolate pudding, whole milk, and hot coffee or hot tea. Resident #52 actually received pork roast, broccoli, a dinner roll, potatoes, and chocolate pudding. A follow-up interview with Resident #52 on 12/04/24 at 12:15 PM revealed the only item he wanted to eat off his tray was chocolate pudding. Resident #52 declined to request alternate food from the kitchen. An interview with the Dietary Manager on 12/04/24 at 12:38 PM revealed he was not aware Resident #52 was on a renal diet and was not supposed to receive potatoes, tomato sauce/soup, dried beans, cooked spinach, bananas, oranges/orange juice, raisins, cantaloupe, honey dew, star fruit, nuts, or chocolate. He stated the computerized meal tracking system the facility used for diet orders was not printing the items Resident #52 was not supposed to receive on his meal tray ticket and he was not sure why. An interview with the Regional Director of Operations (RDO) on 12/02/24 at 1:14 PM revealed when Resident #52's diet order was changed on 09/17/24 it was entered into the computer in a way that did not list the items he was not supposed to receive on his meal tray. She explained that since the items like orange/orange juice, potatoes, bananas, tomato sauce/soup, cooked spinach, and other items were not listed on Resident #52's tray card as items he was not supposed to receive, dietary staff were not aware of his dietary restrictions. The RDO confirmed Resident #52 had not been receiving the correct diet since 09/17/24 and he should have received his diet as ordered.	F 808	during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 105 A telephone interview with the Registered Dietician (RD) on 12/04/24 at 4:31 PM revealed a renal diet consisted of foods containing lower sodium and lower potassium foods. She stated items to avoid on a renal diet included items such as orange juice, potatoes, and bananas. The RD stated since Resident #52 had an order for a renal diet, he should have received his diet as ordered. She stated she was not sure why the list of foods Resident #52 was not supposed to eat did not populate on his meal ticket. An interview with the Director of Nursing (DON) on 12/05/24 at 4:21 PM revealed she expected Resident #52 to receive a renal diet as ordered. An interview with the Administrator on 12/05/24 at 5:28 PM revealed he expected residents to receive their diet as ordered. A telephone interview with the Nurse Practitioner (NP) on 12/06/24 at 8:16 AM revealed she expected Resident #52 to receive his diet as ordered and should not be provided with food or drinks not approved for a renal diet.	F 808		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 106 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean floor in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer, 1 of 1 dry storage rooms, and 1 of 1 kitchen; label and date open food items and discard expired food in 1 of 1 walk-in cooler and 2 of 2 reach-in coolers; cover and date open food items in 1 of 1 walk-in freezer and 1 of 1 reach-in cooler; date milkshakes to identify their use-by date in 1 of 1 reach-in cooler; maintain clean shelves on 5 prep tables in 1 of 1 kitchen; discard expired bread in 1 of 1 kitchen; and maintain clean refrigerators and freezers in 2 of 2 nourishment rooms (200 hall and 300 hall). This failure had the potential to affect food served to residents. Findings included: 1. An initial observation of the walk-in cooler, walk-in freezer, walk-in storage, and kitchen floor on 12/02/24 at 9:42 AM revealed multiple dried yellow and brown stains on the floor of the walk-in cooler, multiple dried black stains on the walk-in freezer floor, scattered dried brown stains on the floor of the dry storage room and surveyor's shoes stuck to the floor, and multiple dried black stains scattered across the kitchen floor.	F 812	The facility failed to maintain a clean floor in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer, 1 of 1 dry storage rooms, and 1 of 1 kitchen; label and date open food items and discard expired food in 1 of 1 walk-in cooler and 2 of 2 reach-in coolers; cover and date open food items in 1 of 1 walk-in freezer and 1 of 1 reach-in cooler; date milkshakes to identify their use-by date in 1 of 1 reach-in cooler; maintain clean shelves on 5 prep tables in 1 of 1 kitchen; discard expired bread in 1 of 1 kitchen; and maintain clean refrigerators and freezers in 2 of 2 nourishment rooms (200 hall and 300 hall). This failure had the potential to affect food served to residents. The items cited were fixed on 12/6/2024. Current facility residents are at risk of being affected by the deficient practice. The Administrator and Registered Dietician completed an audit of the kitchen to include prep areas, coolers, storage, freezer and nourishment rooms on 12/20/2024. Area of concerns were noted during the audit and were remedied	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 107 An interview with the Dietary Manager on 12/02/24 at 9:52 AM revealed kitchen floors were usually cleaned once a week, but 2 dietary staff members were out sick and that contributed to the floors not being clean. An additional observation of the walk-in cooler, walk-in freezer, and kitchen floor on 12/04/24 at 12:32 PM revealed multiple dried yellow and brown stains on the floor of the walk-in cooler, multiple dried black stains on the walk-in freezer floor, scattered dried brown stains on the floor of the dry storage room, and multiple dried black stains scattered across the kitchen floor. An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected all floors in the kitchen to be clean and free of stains. 2. An initial observation of the walk-in cooler on 12/02/24 at 9:48 AM revealed a three quarters full box of pasteurized eggs with an expiration date of 08/17/24. An interview with the Dietary Manager on 12/02/24 at 9:52 AM revealed the pasteurized eggs were not used and he should have removed them from the cooler before they expired. An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected food to be used or discarded on or before the expiration date. 3. An initial observation of the walk-in freezer on 12/02/24 at 9:53 AM revealed the following: (a). a box of frozen biscuits sitting on a shelf that was open to air with an opened date of 10/31/24	F 812	by 12/31/2024. To ensure the deficient practice does not recur, the Vice President of Operations educated the Regional Director of Operations (RDO) for Culinary, Dietary Manager, cooks and aides on ensuring the kitchen and food storage areas remain clean and sanitary environment, ensuring food products are dated when opened and show their use by date, ensuring food items are thrown out when they are expired, and following the assigned cleaning schedule for the kitchen and food storage areas. Education completed by 1/3/2025.Newly hired RDO's, Dietary Managers cooks and aides not educated by 1/3/2025 will be educated upon hire or before working their next scheduled shift. The Administrator or designee will observe the kitchen and nourishment rooms weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 108	F 812		

(b). an undated 20-pound box of beef patties sitting on a shelf that was open to air
(c). an opened and undated bag of diced ham sitting on a shelf

An interview with the Dietary Manager on 12/02/24 at 9:53 AM revealed all items should be labeled, dated, and covered by the staff member placing the items in the freezer. He stated having 2 staff members out sick contributed to not having items labeled, dated, and covered.

An additional observation of the walk-in freezer on 12/04/24 at 12:32 PM revealed a box of frozen biscuits sitting on a shelf that was open to air with an opened date of 10/31/24.

An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected all food items to be labeled, dated, and covered appropriately.

4. An initial observation of the double door reach-in cooler on 12/02/24 at 9:54 AM revealed the following:

(a). both doors of the cooler had dried and smeared white/brown stains to the doors and vent of the cooler
(b). an unlabeled and undated bag of turkey sitting on a shelf
(c). a box of 39 fully thawed 4-ounce manufactured milkshakes with no label to indicate the date they were removed from the freezer or the expiration date
(d). 4 fully thawed 4-ounce manufactured milkshakes with no label to indicate the date they were removed from the freezer or the expiration date sitting on a shelf
(e). an opened and undated 46-ounce box of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 109	F 812		

thickened orange juice sitting on a shelf

An interview with the Dietary Manager on 12/03/24 at 8:01 AM revealed the reach-in cooler should be clean and all items should be labeled and dated, and it was all dietary staff members' responsibility to check for labels and dates on food and beverage items. He stated thawed manufactured milkshakes should have a date indicating when they were removed from the freezer and should be discarded after 14 days. The Dietary Manager stated having 2 staff members out sick contributed to the cooler not being clean and beverage items not being dated.

An additional observation of the double door reach-in cooler on 12:32 PM revealed both doors of the cooler had dried and smeared white/brown stains to the doors and vent of the cooler, and an opened and undated 46-ounce box of thickened orange was sitting on a shelf.

An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected all coolers to be clean, all opened food to be labeled and dated, and milkshakes to be dated when they were removed from the freezer and labeled with their expiration date.

5. An initial observation of the bottom shelves of 5 food preparation tables on 12/02/24 at 9:58 AM revealed the tables had scattered food crumbs and dried brown stains.

An interview with the Dietary Manager on 12/03/24 at 8:01 AM revealed the prep tables should be clean and free of debris and he stated having 2 staff members out sick contributed to the tables not being cleaned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 110	F 812		

An additional observation of the bottom shelves of 5 food preparation tables on 12/04/24 at 12:32 PM revealed the tables had scattered food crumbs and dried brown stains.

An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected food preparation tables to be clean and free of debris.

6. An initial observation of the single door reach-in cooler on 12/02/24 at 10:00 AM revealed the following:

(a). the outer door of the cooler had multiple dried and smeared white stains
(b). an opened and undated pack of sliced ham sitting on the shelf
(c). an opened and undated 5-pound bag of cheddar cheese sitting on the shelf
(d). an opened and undated bag of shredded lettuce with brown spots sitting on the shelf
(e). an undated 48-ounce pack of sliced ham open to air sitting on the shelf
(f). an opened and undated 40-ounce bag of cheddar cheese sitting on the shelf

An interview with the Dietary Manager on 12/03/24 at 8:01 AM revealed the cooler should be clean and all items should be labeled and dated when opened by the person placing the items in the cooler. He stated any food with signs of spoilage should be discarded and all food should be covered appropriately, and it was every staff member's responsibility to check for labeling and dating food. The Dietary Manager stated having 2 staff members out sick contributed to not having items labeled, dated, covered, and discarded when showing signs of spoilage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 111	F 812		

An additional observation of the single door reach-in cooler on 12/04/24 at 12:32 PM revealed the outer cooler door had multiple dried and smeared white stains.

An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected all coolers to be clean, all opened food to be labeled and dated, and any food with signs of spoilage to be discarded.

7. An observation of the bread rack in the kitchen on 12/02/24 at 10:04 AM revealed the following:

(a). 5 loaves of bread with a best-by date of 09/27/24
(b). 6 loaves of bread with a best-by date of 11/23/24
(c). 7 loaves of bread with a best-by date of 11/16/24
(d). 8 loaves of bread with a best-by date of 09/27/24

An interview with the Dietary Manager on 12/04/24 at 8:01 AM revealed all bread should be used or discarded by the best-by date and people had not been checking dates on the bread.

An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected all food items to be used or discarded on or before the best-by date.

8. (a). An observation of the 200-hall nourishment room refrigerator on 12/02/24 at 3:02 PM revealed dried yellow stains to the bottom of the refrigerator and the lowest shelf on the refrigerator door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 112 An interview with the Dietary Manager on 12/03/24 at 8:01 AM revealed it was the dietary department's responsibility to clean nourishment room refrigerators and freezers and having 2 staff members out sick contributed to the nourishment room refrigerators and freezers not being clean. An additional observation of the 200-hall nourishment room refrigerator on 12/03/24 at 8:38 AM and 12/05/24 at 7:42 AM revealed dried yellow stains to the bottom of the refrigerator and the lowest shelf on the refrigerator door. (b). An observation of the 300-hall nourishment room refrigerator on 12/04/24 at 12:46 PM revealed dried yellow stains to the bottom of the refrigerator and the lowest shelf on the refrigerator door. An observation of the 300-hall nourishment room freezer at the same date and time revealed dried red liquid to the bottom of the freezer. An additional observation of the 300-hall nourishment room refrigerator on 12/05/24 at 7:25 AM revealed dried yellow stains to the bottom of the refrigerator and the lowest shelf on the refrigerator door. An additional observation of the 300-hall freezer at the same date and time revealed dried red liquid to the bottom of the freezer. An interview with the Administrator on 12/05/24 at 5:19 PM revealed he expected nourishment room refrigerators and freezers to be clean and free of stains.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 842		1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 113 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 114 by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain a complete and accurate medical record when staff documented that they applied a splint when a splint was not applied. This occurred for 1 of 3 residents (Resident #73) reviewed for accurate medical records. The findings included: Resident #73 was admitted on 12/15/2021 with	F 842	The facility failed to maintain a complete and accurate medical record when staff documented that they applied a splint when a splint was not applied. This occurred for 1 of 3 residents (Resident #73) reviewed for accurate medical records. Splint was reevaluated for resident #73 and order updated. Splint order was discontinued due to no longer being the optimal treatment for the resident #37.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 115 diagnoses that included contracture of muscle, right hand. A physician's order dated 11/01/2023 read- Staff to don (apply) right hand splint, Place Pillow under right hip, all shifts to "access" for any skin irritation. Doff (remove) pm shift, every shift. An observation of Resident #73 on 12/02/2024 at 11:34am revealed Resident #73 did not have a splint in place to her right hand. During observation on 12/03/2024, Resident #73 was observed at 9:33am with no splint on right hand. A review of the Medication Administration Record (MAR) revealed it was documented by Nurse #2 on 12/02/2024 and 12/03/2024 that the splint was applied to Resident #73 ' s right hand. During an interview on 12/03/2024 at 10:11am, Nurse #2 stated the assigned nurse would apply the splint daily as Resident #73 would tolerate. Nurse #2 verified that Resident #73 was not wearing the splint on 12/3/24. Nurse #2 stated he may have clicked and signed by accident, but the splint was applied to Resident #73's right hand as tolerated. Nurse #2 verified at 10:12am the splint was documented as applied, and reviewed the order and verified the order did not read to apply splint as tolerated. Nurse #2 stated it could be documented on the MAR if a resident did not tolerate treatment. Nurse #2 was observed as the splint was applied to Resident #73 ' s right hand after Nurse #2 verified the order on the MAR. During an interview on 12/06/2024 at 2:41pm, the Director of Nursing (DON) stated if the MAR was	F 842	Current facility residents who have orders for splints are at risk of being affected by the deficient practice. The DON completed an audit on 12/27/2024 for residents with orders for splints to ensure the documentation related to splint application was correct. No concerns were noted during the audit. To ensure the deficient practice does not recur, the Staff Development Coordinator educated facility and agency licensed nurses and medication aides on documentation in the medical record is to be complete and accurate related to splint application. Education completed by 1/3/2025.Newly hired nurses and medication aides and staff not educated by 1/3/2025 will be educated upon hire or before working their next scheduled shift. The Director of Nursing or designee will audit 5 resident's with splint orders to ensure applied as ordered and documentation is accurate weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 116 documented a splint was applied, she expected the splint to be applied. The DON stated if a splint was not applied, she would expect a note written that explained why the splint was not applied. During an interview on 12/06/2024 the Administrator stated he expected if a splint was documented as applied then the splint should be on the resident.	F 842	correction are necessary. Completion Date: 1/3/2025	
F 914 SS=B	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the resident and staff the facility failed to install a privacy curtain and failed to ensure the privacy curtain extended around the bed for 2 of 9 rooms reviewed for environment (room #207-A and #304-A). Findings included: a. An observation on 12/03/24 at 2:06 PM revealed room 207 was a semi-private room shared by two residents. There was no ceiling mounting track in place to have a privacy curtain installed that extended around bed 207-A located by the door.	F 914	The facility failed to install a privacy curtain and failed to ensure the privacy curtain extended around the bed for 2 of 9 rooms reviewed for environment (room #207-A and #304-A). Room #207-A and #304-A had privacy curtains installed on 12/09/2024 by the maintenance director. Current facility residents are at risk of being affected by the deficient practice. The maintenance director completed an audit of all residents' rooms to ensure each bed in the rooms had a privacy curtain in place. The rooms noted to need privacy curtains were fixed on	1/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 914	Continued From page 117 An observation and interview on 12/03/24 at 2:06 PM Nurse Aide (NA) #7 revealed she was the assigned NA for room 207-A and did not notice there was no privacy curtain in place. During an observation and interview on 12/04/24 at 10:19 AM room 207-A continued to have no privacy curtain in place and no ceiling mounting track for it to be installed. The resident residing in room 207-A revealed he liked to crack the door open and wanted the privacy curtain placed to keep the hallway light from shining in his eyes. During an observation and interview on 12/04/24 at 10:19 AM the Maintenance Manager confirmed there was no mounting track in place for a privacy curtain to be installed in room 207-A. The Maintenance Manager revealed he was not aware there was no mounting track in place, and he would need to install one for a privacy curtain to be placed. b. During an observation on 12/04/24 at 12:09 PM room 304 was a semi-private room being shared by two residents. The privacy curtain for bed 304-A located by the door did not fully extend. The curtain got stuck in the mounting track where it started to curve around the bed. The resident revealed it was shared with nursing staff and maintenance the privacy curtain got stuck and she was told it would be fixed and gave leeway about how long it had been, but she wanted the curtain to work. An observation and interview was conducted on 12/04/24 at 1:16 PM with the Maintenance Manager. The Maintenance Manager observed the privacy curtain in room 304-A got stuck where	F 914	12/13/20324 by the maintenance director. To ensure the deficient practice does not recur, the Administrator and Staff Development Coordinator educated the facility and agency nurses, certified nursing assistants, maintenance director, housekeeping staff, and housekeeping director that all rooms and beds must always have clean functional privacy curtains. Education completed by 1/3/2025. Newly hired facility staff including facility and agency nurses, certified nursing assistants, maintenance director, housekeeping staff, and housekeeping director staff not educated by 1/3/2025, will be educated upon hire or prior to working their next scheduled shift. The maintenance director or designee will audit 5 resident rooms to ensure the privacy curtain in place, clean, and functional weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 1 month. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrator monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion Date: 1/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 914	Continued From page 118 the mounting track curved and did not extend all the way around the bed. The Maintenance Manager was not aware the privacy curtain did not fully extend and revealed the wheels that were attached into the mounting track were put in backwards causing it to get stuck. He revealed to fix it the privacy curtain it would need to be removed, and the wheels put back in the mounting track the correct way. During an interview on 12/06/24 at 4:05 PM the Administrator revealed he expected staff to report a missing privacy curtain and ensure the privacy curtain extended around the entire bed. The Administrator stated there were issues with staff communication and reporting environment issues that needed to be addressed.	F 914		