	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		TE SURVEY MPLETED	
	CONTRACTION	BERTH IS RIGHT COMBEN.	A. BUILDING			C	
		345285	B. WING		12/06/2024		
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD			
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE			
				HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	0			
F 000	investigation survey through 12/06/24. The compliance with the results of the second s	certification and complaint was conducted on 12/02/24 ne facility was found in requirement CFR 483.73, Iness. Event ID# MMG311.	F 00	0			
	survey was conducte 12/06/24. Event ID# intakes were investig NC00224170, NC002 NC00222510, NC002 NC00221930, NC002 NC00219872, NC002 NC00218945, NC002 NC00217995, NC002 NC00215994, NC002	complaint investigation d from 12/02/24 through MMG311. The following ated: NC00224517, 224110, NC00222814, 222526, NC00222515, 221635, NC00220844, 219799, NC00219461, 218552, NC00218337, 217979, NC00217390, 214976, NC00214000, 212250, and NC00212066.					
F 553 SS=D	22 of the 70 complai deficiency. Right to Participate ir CFR(s): 483.10(c)(2)		F 55	3		1/3/25	
	development and imp person-centered plan limited to: (i) The right to partici including the right to be included in the plan request meetings and revisions to the person (ii) The right to partic	to participate in the plementation of his or her of care, including but not pate in the planning process, identify individuals or roles to unning process, the right to d the right to request on-centered plan of care. ipate in establishing the putcomes of care, the type,					

Electronically Signed

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

12/31/2024

	-	ND HUMAN SERVICES			FOF	ED: 01/03/202 RM APPROVE O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		345285	B. WING		1:	2/06/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 553	other factors related plan of care. (iii) The right to be int changes to the plan of	to the effectiveness of the formed, in advance, of	F 553			
	included in the plan of (v) The right to see the					
	of the right to particip and shall support the planning process mu (i) Facilitate the inclu- resident representativ (ii) Include an assess strengths and needs. (iii) Incorporate the re- cultural preferences in This REQUIREMENT	sion of the resident and/or ve. ment of the resident's				
	interviews, the facility participate and provid 2 of 3 sampled reside #11).	iew, resident and staff / failed to invite residents to de input in care planning for ents (Residents #50 and		The facility failed to invite resid participate and provide input in planning for 2 of 3 sampled res (Residents #50 and #11). Care were scheduled for resident #5 and completed on 12/27/2024.	care idents Plans	
	07/06/23 with diagno chronic pain, chronic disorder, and anxiety The quarterly Minimu	ım Data Set (MDS) 9/13/24 revealed Resident		Current facility residents are at being affected by the deficient An audit of comprehensive min sets (MDS) that were complete last 30 days was completed by Regional Director of Clinical Reimbursement to ensure a ca was scheduled and residents w and able to participate and hav their plan of care. The audit wa	practice . imum data d over the the re meeting vere invited e input into	

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 2 of 119

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION		ATE SURVEY OMPLETED
			A. BOILDING			С
		345285	B. WING			12/06/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
ACCORD				200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SUNVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN(FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 553	Continued From page	a 2	F 55	53		
1 000		50's electronic medical	F J.	completed on 12/27/2024.	Concerns were	
		vidence she was invited to		identified and care plan me		
		tings to discuss and provide		scheduled and to be comp	-	
		lan of care following the		1/3/2025.		
		nual MDS assessment dated				
	-	erly MDS assessment		To ensure this deficient pra	actice does not	
	09/13/24.			reoccur the following have		
				place: The Regional Direct	tor of Clinical	
	The comprehensive of	care plan for Resident #50		Reimbursement educated	the	
	was last revised on 0	8/14/24.		Administrator, Director of N	Nursing, MDS	
				coordinators, and member		
	-	on 12/03/24 at 8:49 AM,		interdisciplinary team (IDT	·	
		she had not been invited to		process of inviting the resid		
		plan meeting scheduled		care plan meeting, the sch		
	since June 2024.			care plan meetings, and th		
				right to provide input into the		
	U U	12/4/24 at 2:28 PM and		Education completed on 1/	•	
		the Administrator revealed		staff in the IDT that is not e		
		W) was responsible for		1/3/2025 and newly hired I		
		care plan meeting schedule.		educated upon hire or prio	r to working	
	He explained the SW			their next shift.		
		nen, they had been actively			coldonto wh-	
		tes to fill the position. He the SW left employment, the		The RDCR will observe 5 r have had an MDS assessr		
	care plan meeting sc			weekly for 4 weeks, biwee		
		h the Interdisciplinary Team		and then monthly for 1 mo		
	had conducted sever			the resident has been had		
		leetings with residents in		scheduled, were invited, a	•	
		th the resident's Responsible		opportunity to participate in		
		r on the phone, they had not		care. The facility will monit	•	
		plan meetings in the		corrective actions to ensur		
		cord. The Administrator		deficient practice is correct		
		rtain if a care plan meeting		recur by reviewing informa		
	was held with Reside			during audits and reporting		
		nual MDS assessment dated		Assurance Performance In		
	-	MDS assessment dated		committee (QAPI) by the A		
		nistrator stated he would		monthly for three (3) month	ns. At that time	
	expect for care plan r	meetings to be completed		the QAPI committee will ev	aluate the	
	quarterly.			effectiveness of the interve	ntions to	

Facility ID: 923245

If continuation sheet Page 3 of 119

		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/03/2025 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	COM	E SURVEY PLETED
		345285	B. WING				C / 06/2024
	ROVIDER OR SUPPLIER	RSONVILLE		ST 20 H			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 553	 11/11/22 with diagnosheart failure, colostor disorder that causes post-traumatic stress depressive disorder. The quarterly Minimu assessment dated 05 #11 had moderate im The comprehensive of was last revised on 1 Review of Resident # record revealed no er attend a care plan meting her pl completion of the quadated 09/27/24. Review of the facility' Schedules provided to a care plan meeting of scheduled meetings is review revealed there meetings listed on the after 09/25/24. During an interview of Resident #11 did not participate in any care 	 admitted to the facility on ses that included congestive my status, epilepsy (brain seizures), chronic disorder, and major Im Data Set (MDS) 0/27/24 revealed Resident apairment in cognition. care plan for Resident #11 1/18/24. 411's electronic medical vidence she was invited to eeting to discuss and provide lan of care following the arterly MDS assessment 25 2024 Care Plan Meeting by the Administrator revealed was held with Resident #11's 6/26/24 with no other listed after that date. Further e were no care plan e schedule for any resident on 10/07/24 at 4:18 PM, recall being invited to 	F	553	determine if continued auditing or adjustments to the plan of correction a necessary. Completion Date: 1/3/2025	are	

Facility ID: 923245

If continuation sheet Page 4 of 119

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		0.45005			С	
		345285	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDE	RSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO	
F 553	Continued From pag	1e 4	F 553			
	-	V left employment on	F 330			
		hen, they had been actively				
	interviewing candida	tes to fill the position. He				
		the SW left employment, the				
		chedule had not been				
		h the Interdisciplinary Team ral initial 48-hour and				
		neetings with residents in				
	their rooms, along w	ith the resident's Responsible				
		er on the phone, they had not				
		e plan meetings in the ecord. The Administrator				
		ertain if a care plan meeting				
	was held with Reside					
		amily Member following the				
		arterly MDS assessment Administrator stated he				
		e plan meetings to be				
	completed quarterly.					
F 558	Reasonable Accomr	nodations Needs/Preferences	F 558	3	1/3/25	
SS=D	CFR(s): 483.10(e)(3)				
	§483.10(e)(3) The ri	ght to reside and receive				
	services in the facilit	y with reasonable				
	accommodation of re					
	preferences except	when to do so would or safety of the resident or				
	other residents.	or salety of the resident of				
		T is not met as evidenced				
	by:					
		on, record review, and		The facility failed to ensure a depend	dent	
		ent and staff, the facility failed ent resident could access a		resident could access a light switch located at the left side of her bed for	1 of 1	
	-	at the left side of her bed for 1		resident reviewed for accommodation		
	-	ed for accommodation of		needs (Resident #91). The access to	the	
	needs (Resident #97	1).		light switch was corrected upon		
	The findings include	d.		notification of need by the maintenan director on _12/6/2024	ce	

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 5 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/2025 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COME	E SURVEY PLETED
		345285	B. WING _				C / 06/2024
NAME OF P	ROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT HENDER	SONVILLE			10 HERITAGE CIRCLE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 558	Continued From page	5	F 5	558			
	05/13/24. The quarterly Minimu assessment dated 08 #91 had severe cogn coded Resident #91 v of lower extremity and inside the room for m attempted during the medical condition or s During an observation 1:09 PM, the switch f side of Resident #91' was attached with a or Resident #91 was un from the bed if needer An interview was con 12/02/24 at 1:13 PM. had been broken sind more than a month ag bed-bound and unable without assistance. It her as she could not had to rely on the sta all the time. Subsequent observat at 10:46 AM revealed fixture next to Reside inaccessible. An interview was con (NA) on 12/03/24 at 2 switch cord for Reside	 16/24 indicated Resident itive impairment. The MDS with impairment of one side d walking between locations ore than 10 feet was not assessment period due to safety concerns. n conducted on 12/02/24 at or the light fixture on the left s bed 5 feet from the floor cord 3 inches in length. able to reach the switch cord 			Current facility residents are at risk of being affected by this deficient practic The maintenance director completed a audit of each room throughout the fac to ensure that all residents had access a light switch. The audit was complete 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 a recur, the Administrator educated the maintenance director, maintenance assistant, and maintenance staff on ensuring all residents have access to switch to turn on and off the light in the room, and the residents right to accommodation of needs. This educar 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 onlir 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 fac and agency staff who are not educate by 1/3/25 will be educated upon hire of prior to working their next shift. The administrator or designee will aud resident rooms weekly, to ensure the resident has access to a light switch, a weeks. The facility will monitor the	an ility s to d not a eir tion / t ne to s ility ed or	

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 6 of 119

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345285			C 12/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		
ACCORD	IUS HEALTH AT HENDE	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE	
F 558	maintenance staff to switch on the wall ne switch on the light fix bed. He stated he sh maintenance staff to Resident #91 to have fixture at all time. During an interview of 2:58 PM, Nurse #3 of bedridden and unabi- stand up on her feet next to her bed. She that the switch cord of provided care for Re- weeks. During a joint observe Maintenance Manag he acknowledged the fixture was too short Resident #91, and it as possible. An interview was con Manager on 12/03/2 checked the entire fa #91's room and bath week. He did not kno broken and stated it #91 to have accessifi added he depended report repair needs of work order. He typica at least once daily to met in a timely many	fix it. Instead, he used the ear the entrance door to dure next to Resident #91's nould have notified the fix it as it was important for e full accessibility to her light conducted on 12/03/24 at confirmed Resident #91 was le to get up from her bed or to switch on the light fixture explained she did not notice was broken when she sident #91 in the past few vation conducted with the er on 12/03/24 at 2:40 PM, at the switch cord for the light and unreachable for needed to be fixed as soon nducted with the Maintenance 4 at 2:47 PM. He stated he acility including Resident room at least once every ow when the switch cord was was important for Resident bility to her light fixture. He on residents and staff to either verbally or through the ally checked the work orders o ensure all repair needs were her.	F 5	 corrective actions to ensure a deficient practice is corrected recur by reviewing informatic during audits and reporting to Assurance Performance Imp committee (QAPI) by the Admonthly for three (3) months the QAPI committee will eval effectiveness of the intervent determine if continued auditi adjustments to the plan of connecessary. Completion Date: 1/3/2025 	d and will not on collected o Quality rovement ministrator . At that time luate the tions to ng or	
ORM CMS-25	stand up on her feet next to her bed. She that the switch cord of provided care for Re weeks. During a joint observe Maintenance Manag he acknowledged that fixture was too short Resident #91, and it as possible. An interview was con Manager on 12/03/2 checked the entire fa #91's room and bath week. He did not kno broken and stated it #91 to have accessifi added he depended report repair needs of work order. He typic at least once daily to met in a timely mann An interview was con	to switch on the light fixture explained she did not notice was broken when she sident #91 in the past few vation conducted with the er on 12/03/24 at 2:40 PM, at the switch cord for the light and unreachable for needed to be fixed as soon nducted with the Maintenance 4 at 2:47 PM. He stated he acility including Resident room at least once every bw when the switch cord was was important for Resident bility to her light fixture. He on residents and staff to either verbally or through the ally checked the work orders o ensure all repair needs were her.	5311	necessary.	f continuation she	

Facility ID: 923245

If continuation sheet Page 7 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING			E SURVEY IPLETED
		345285	B. WING		12	C 2/06/2024
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	•	
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HERITAGE CIRCLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 558	expected the staff to I residents' living enviro needs to the mainten manner to accommod added the maintenan needs on a regular ba accordingly. It was he dependent residents control of the light fixt Request/Refuse/Dscr CFR(s): 483.10(c)(6) §483.10(c)(6) The rig discontinue treatment to participate in experi- formulate an advance §483.10(c)(8) Nothing construed as the right the provision of media services deemed med- inappropriate. §483.10(g)(12) The fa- requirements specifie subpart I (Advance D (i) These requirement inform and provide wir- resident's option, form (ii) This includes a wir- facility's policies to im- and applicable State (iii) Facilities are perm	be more attentive to onment, and to report repair ance department in a timely date residents' needs. She ce staff should check repair asis and address the issues er expectation for all the to have full access and ture all the time. Influe Trmnt;FormIte Adv Dir (8)(g)(12)(i)-(v) th to request, refuse, and/or t, to participate in or refuse rimental research, and to e directive. g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or acility must comply with the ed in 42 CFR part 489, irectives). ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. itten description of the aplement advance directives law. nitted to contract with other information but are still	F 558			1/3/25

Facility ID: 923245

If continuation sheet Page 8 of 119

CENTER		ND HUMAN SERVICES					RM APPROVE NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				TE SURVEY MPLETED
		345285	B. WING			1	C 2/06/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
4000DD				20	0 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HE	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 578	Continued From page	e 8	F 5	578			
1 0/0			1.5	0			
		ual is incapacitated at the d is unable to receive					
		a is unable to receive					
		ance directive, the facility					
		rective information to the					
		representative in accordance					
	with State law.	epresentative in accordance					
		relieved of its obligation to					
		on to the individual once he					
	or she is able to rece						
		s must be in place to provide					
		individual directly at the					
	appropriate time.	5					
		☐ is not met as evidenced					
	by:						
	Based on record rev	iew and staff interviews, the			The facility failed to maintain accura	te	
	facility failed to maint	ain accurate advanced			advanced directives throughout the		
	directives throughout	the medical record for 1 of 3			medical record for 1 of 3 residents		
	residents reviewed for	or advanced directives			reviewed for advanced directives		
	(Resident #65).				(Resident #65). Resident #65's care	plan	
					was corrected to show appropriate of	ode	
	Findings included:				status on 12/4/24.		
	Resident #65 was ad	mitted to the facility on			Current facility residents are at risk o	of	
	07/14/21.	-			being affected by the deficient practi		
					The minimum data set (MDS) coordi		
	Resident #65's advar	nced directive care plan,			completed an audit on current facility		
	initiated on 07/15/21,				residents to ensure the advanced		
	revision on 03/26/202	24 had Resident #65 Care			directives were correct throughout the		
	· ·	de. Care Plan Goal listed as:			medical record. The audit was comp		
		directives are in effect and			on 12/10/24. The audit was complete	ed	
		ctions will be carried out in			and 0 concerns were noted.		
		r advanced directives.					
		d: Allow resident if able to			The Staff Development Coordinator	_	
	discuss feelings rega				educated facility and contract license		
	Directives, An Advan				nurses including the MDS nurses, an		
	revoked or changed i				interdisciplinary team (IDT) on ensur	-	
		re Representative changes			the resident's advanced directives a	е	
	their mind about the i	medical care they want		1	accurate throughout the resident's		1

Facility ID: 923245

If continuation sheet Page 9 of 119

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CO	ONSTRUCTION	· · ·	ATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		CO	MPLETED
		345285	B. WING			С	
NAME OF PI	ROVIDER OR SUPPLIER	040200			EET ADDRESS, CITY, STATE, ZIP CODE		12/06/2024
					HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HEN	NDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 578	Continued From page	- 0		70			
1 576	-	and update MOST form as	F 57		medical record. The education was		
		ents and family wishes.			completed on 12/27/2024. Newly hire	ed.	
		ctives at least quarterly and			facility and contract licensed nurses		
		Health Care Representative			IDT members or facility and contract		
	will make all health ca	are decisions if the resident			licensed nurses including MDS nurse	es,	
	is incapacitated.				and IDT members not educated by		
	T I () N A ¹ (1/3/2025 will be educated upon hire		
		m Data Set (MDS) dated Resident #65 was severely			prior to working their next scheduled	shift.	
	cognitively impaired.	Resident #05 was severely			The Director of Nursing or designee	will	
					audit 5 resident s medical records w		
	Review of the Code E	Book revealed Resident			to ensure their advanced directives a	-	
		lical Orders for Scope of			accurate throughout medical record		
	Treatment (MOST) fo			weekly for 4 weeks, biweekly for 4 w			
	-	nce for a Do Not Resuscitate vent he had no pulse and			and then monthly for 1 month. The fa will monitor the corrective actions to	cility	
		he form was signed by			ensure that the deficient practice is		
	Resident #65's Resp	÷ •			corrected and will not recur by review	•	
	On the profile page o	f Resident #65's electronic			information collected during audits an reporting to Quality Assurance	nd	
		ent #65's code status was			Performance Improvement committe	e	
	listed as a "DNR".				(QAPI) by the Administrator monthly		
					three (3) months. At that time the QA		
		65's Physician orders,			committee will evaluate the effective	ness	
		ted 9/23/2024 for a Medical			of the interventions to determine if		
		Treatment (MOST) form			continued auditing or adjustments to	the	
		at indicated his preference for (DNR) status in the event			plan of correction are necessary.		
	he had no pulse and				Completion Date: 1/3/2025		
	During an interview of	n 12/04/2024 at 11:44am					
	-	esident's code status could					
		Book located at the desk					
		electronic medical record or					
		d new orders for advanced					
		ved by the nurse, the social					
		e the charts and care plan,					
	now it was completed	a by nursing.					

Facility ID: 923245

If continuation sheet Page 10 of 119

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/03/202 MAPPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	СОМ	E SURVEY PLETED
		345285	B. WING		C 12/06/2024	
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE .	
				200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 578	Continued From page	e 10	F 57	8		
	During an interview of Manager #1 stated no responsibility to make					
	face sheet and Code	were updated in the chart, Book, and the Minimum e updated the care plan.				
	MDS Coordinator #2 used to update advar resident's care plan b responsible to keep t Coordinator #2 verifie	out was not aware who was hem updated now. The MDS ed Resident #65's order for a ne Care Plan for Full code in				
	Director of Nursing (I received the order we needed to family and stated since the facili worker, the DON had keep advanced direc DON verified that Re Full Code did not ma					
	advanced directive st areas of the resident' stated it had been the responsibility to upda plans, but due to the	he would expect a resident's atus to match across all s chart. The Administrator				
F 580 SS=D		jury/Decline/Room, etc.)	F 58	0		1/3/25

Facility ID: 923245

If continuation sheet Page 11 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345285	B. WING				_ 06/2024
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT HENDER	SONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 580	CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications (C) A need to alter trea a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facili §483.15(c)(1)(ii). (ii) When making notified (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must arresident and the resident when there is- (A) A change in room as specified in §483.14 (B) A change in resider State law or regulation (e)(10) of this section (iv) The facility must arresident (iv) The facility must arresident (v) The facility must arresident ()(i)-(iv)(15) eation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident on there is- ving the resident which as the potential for requiring u; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial eatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and	F	580			

Facility ID: 923245

If continuation sheet Page 12 of 119

CENTERS FOR MEDICARE & MEI	IUMAN SERVICES				FORM	APPROVED . 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345285	B. WING_			(12/	C 06/2024
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			2	00 HERITAGE CIRCLE		
ACCORDIUS HEALTH AT HENDERSON	NVILLE		н	ENDERSONVILLE, NC 28791		
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 580Continued From page 12 representative(s).§483.10(g)(15)Admission to a composite that is a composite disting §483.5) must disclose in its physical configuration, locations that comprise th part, and must specify the room changes between it under §483.15(c)(9). This REQUIREMENT is by: Based on staff and Nurse interviews and record rev notify the Physician wher completed for 1 of 2 reside notification of change (Resident #38 was admitted 11/5/23 with diagnosis that Resident #38 had a phys urinalysis (UA) with culture urinary pain one time only ordered on 9/24/2024 and 9/25/2024.Review of the treatment at (TAR) for September 202 documented as completed Review of the lab results no results for the UA order Resident #38. A phone interview on 12/4	e distinct part. A facility ct part (as defined in its admission agreement including the various ne composite distinct e policies that apply to the different locations not met as evidenced e Practitioner (NP) view, the facility failed to n a urinalysis was not dents reviewed for esident #38). ed to the facility on at included bacteremia. ician's order for a re and sensitivity for y for one day. This was d marked completed on administration record 44 revealed the UA was ed on 9/25/2024. revealed that there were ered on 9/24/2024 for	F	580	The facility failed to notify the Physicia when a urinalysis was not completed for of 2 residents reviewed for notification of change (Resident #38). The medical director was notified of resident's refuse of urine specimen collection by Vice President of Clinical Operations on 12/4/2024 and resident #38 assessed to MD and new orders received. Current facility residents who have had order for urinalysis (UA) are at risk of being affected by the deficient practice 100% audit of UA's ordered in the last day was completed by 12/09/24 to ensu- the medical provider notified of result o refusal of testing. The audit was completed on and there were 0 concer- were noted. To ensure the deficient practice does n recur the Staff Development Coordinate (SDC) educated facility and contract licensed nurses on ensuring the reside urinalysis testing is completed and to notify medical provider of resident refus	or 1 of al oy an . A 30 ure r son r sot or or	

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 13 of 119

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	· · ·	E SURVEY PLETED
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G			
		345285	B. WING				C / 06/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	12	/00/2024
				200	0 HERITAGE CIRCLE		
ACCORD	US HEALTH AT HENDE	RSONVILLE		HE	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580	Continued From pag	e 13	F 58	80			
1 000	Nurse #6 revealed re		F JG	00	of testing. The education was comple	tod	
		cted the UA specimen for			of testing. The education was comple on 12/27/2024. Newly hired facility an		
F		5/2024 and placed it in the			contract licensed nurses or facility and		
		b to collect. She stated that if			contract licensed nurses not educated		
		n refrigerator too long the lab			1/3/2025 will be educated upon hire o		
		ld throw the specimen out			prior to working their next scheduled	shift.	
		er useable. She stated that					
		vere no results for the UA			The Director of Nursing or designee v		
		4. Nurse #6 indicated she here were no results for the			audit 5 resident's weekly to ensure the medical provider is notified of refusals		
		d not notified the Physician.			lab testing weekly for 4 weeks, biwee		
		a not notified the r hysiolari.			for 4 weeks, and then monthly for 1	i ti y	
	An interview on 12/0	6/2024 at 8:36 AM with the			month. The facility will monitor the		
	Nurse Practitioner (N	IP) revealed that she was not			corrective actions to ensure that the		
	notified that the Sept	ember UA did not have any			deficient practice is corrected and will	not	
		the laboratory and that she			recur by reviewing information collect	ed	
		ified if the staff were unable			during audits and reporting to Quality		
	to complete the UA c				Assurance Performance Improvemen		
		d that Resident #38 had not			committee (QAPI) by the Administrate monthly for three (3) months. At that t		
	UA not being comple	a negative outcome by the			the QAPI committee will evaluate the	inte	
		aeu.			effectiveness of the interventions to		
	An interview on12/06	6/2024 at 12:33 PM with the			determine if continued auditing or		
		DON) revealed that the			adjustments to the plan of correction	are	
		Nurse who collected the			necessary.		
		t fill out the requisition. She					
		found the specimen sooner			Completion Date: 1/3/2025		
	-	d have followed up with the					
		order for the UA and she					
	about the specimen.	up with the Nurse as well					
		laboratory test results, or					
		be communicated to the					
	Physician.						
	An interview on 12/0	6/24 at 3:54 PM with the					
		ed 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					

If continuation sheet Page 14 of 119

IATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		345285	B. WING		C 12/06/2024		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HERITAGE CIRCLE NDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET		
F 580	Continued From page	e 14	F 580				
	could make the decis not.	ion to order another lab or					
F 584 SS=E	Safe/Clean/Comforta	ble/Homelike Environment (7)	F 584		1/3/25		
The resid comfortal but not lir supports The facili §483.10(i homelike use his o possible. (i) This in receive c physical l independ (ii) The fa the protect	§483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir	ght to a safe, clean, elike environment, including siving treatment and					
	homelike environmen use his or her person	ide- clean, comfortable, and it, allowing the resident to al belongings to the extent					
	receive care and serv physical layout of the independence and do (ii) The facility shall e	ring that the resident can vices safely and that the facility maximizes resident bes not pose a safety risk. xercise reasonable care for resident's property from loss					
		eeping and maintenance o maintain a sanitary, orderly, ior;					
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are					
	§483.10(i)(4) Private resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequa levels in all areas;	te and comfortable lighting					

If continuation sheet Page 15 of 119

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		345285	B. WING		12	2/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETIC DATE
F 584	Continued From page	e 15	F 58	4		
		lly certified after October 1,				
	1990 must maintain a temperature range of 71 to 81°F; and					
		maintenance of comfortable				
		「 is not met as evidenced				
	by:	ons and interviews with		The facility failed to accure on	avarbad	
		ne facility failed to secure an		The facility failed to secure an light fixture that was positioned		
		hat was positioned above a		resident's head to the wall (roo		
		e wall (room 318-B); ensure		ensure the overbed light worke	,	
		ked (room 318-B, 327-A,		318-B, 327-A, and 331-B); repl	•	
	-	he light bulbs in a fixture		light bulbs in a fixture above the		
	above the sink (room	#318); ensure the water		(room #318); ensure the water		
	temperature from a b			temperature from a bathroom s	ink was	
		too cool (room 319); ensure		comfortable and not too cool (re		
		vent was clean (Hall B		ensure the shower room air ver		
		e the overbed table and		clean (Hall B shower room); en		
		exposed sharp edges (room red bathroom toilet and floor		overbed table and dresser did r exposed sharp edges (room 22		
		ess a strong lingering odor		ensure a shared bathroom toile		
		om 224); ensure ceiling,		were clean and address a stror		
		oards, and overbed tables		odor resembling urine (room 22		
		od repair (rooms 227, 229-A,		ceiling, walls, flooring, baseboa		
	-	, and 330); provide a clean		overbed tables were clean and	in good	
		224); and ensure the toilet		repair (rooms 227, 229-A, 318,		
		place for a shared bathroom		327-A, and 330); provide a clea		
	· · · · · · · · · · · · · · · · · · ·	on 2 of 2 halls reviewed for		curtain (room 224); and ensure		
	environment (Halls A	and B).		paper holder was in place for a		
	Findings included:			bathroom (rooms 218 and 220) halls reviewed for environment	(Halls A	
	1. a. During an obse 12/02/24 at 3:51 PM	rvation and interview on of in room 318-B the		and B). Cited findings were rep 1/3/2025.	alleu by	
		in bed with an overbed light		Current facility residents are at	risk of	
		ove the head of the bed.		being affected by deficient prac		
		ed the overbed light did not		administrator and Maintenance		
		how long it had not. When		did a 100% audit of all resident		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 16 of 119

		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 01/03/2025 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345285	B. WING _			C 2/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, 2	•	
				200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HENDERSONVILLE, NC 287	'91	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETION DATE
F 584	U U	was pulled the fixture	F 5	identify further concern		
	 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 			cited areas of overbed water temperatures, air rooms, overbed tables of sharp edges and fun clean floors free of odo to walls, textured spack holes in plaster, privacy of cleaning, and toilet p Many areas of related of Repairs are to be comp ordered supplies arrive receipt of proof of order recruited assistance in necessary repairs withit time dependent upon ti receival. To ensure the deficient recur, the Vice Presider educated the maintena Environmental Services the maintenance assist residents with a safe ho environment. Newly hir directors and maintena maintenance staff who	vents in shower and dressers free ctioning properly, r and stains, stains ding on ceilings, y curtains in need baper holders. concerns identified. bleted when . Facility has ring. Facility has completing the n a reasonable me of order practice does not nt of Operations nce director, s Director, s Department, and cants on providing omelike ed maintenance nce assistants and	
	b. During an observa the lights above the s properly when turned	nterview with the er was conducted on		by 1/3/25 will be educa prior to working their ne The administrator or de resident rooms to ensu a safe homelike enviror weekly for 4 weeks, biv and then monthly for 1 will monitor the correcti ensure that the deficien corrected and will not re	ext shift. esignee will audit 5 re the resident has ment completed veekly for 4 weeks, month. The facility ve actions to nt practice is	

Facility ID: 923245

If continuation sheet Page 17 of 119

		MEDICAID SERVICES		n :			0.0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY	
							С	
		345285	B. WING			12/	06/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	DDE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE			00 HERITAGE CIRCLE ENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 584	Continued From page	e 17	F 58	84				
		ne lights above the sink in			information collected during audits and	ł		
1		rk and stated the bulbs			reporting to Quality Assurance			
		ne Maintenance Manager			Performance Improvement committee			
	the sink needed to be	aware the light bulbs above e replaced.			(QAPI) by the Administrator monthly for three (3) months. At that time the QAF			
					committee will evaluate the effectivene			
		tion on 12/02/24 at 3:51 PM			of the interventions to determine if			
	l i	18 had approximately three es where the textured			continued auditing or adjustments to the plan of correction are necessary.	ne		
	spackling was missin				plan of correction are necessary.			
		0			Completion Date: 1/3/2025			
	-	and observation on 12/04/24						
		ntenance Manager revealed e textured spackling needed						
		m 318. He revealed the						
	resident would need to repair the ceiling.	to be out of the room for him						
		tion on 12/02/24 at 10:41 AM oom 331-B did not work and hain was missing.						
		on 12/04/24 at 9:14 AM the						
		er revealed he was aware						
		oom 331-B did not work and e revealed the new light was						
		not find the purchase order						
	to show when and we (12/04/24).	ould order another one today						
	-	view on 12/03/24 at 9:01 AM 319 revealed the water in the warm enough.						
	Manager was conduc	ervation with Maintenance cted on 12/04/24 at 10:03 ce Manager tested the water						
	temperature from the	e bathroom sink in room 319 er. The temperature did not						

Facility ID: 923245

If continuation sheet Page 18 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/03/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345285	B. WING				C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY,	, STATE, ZIP CODE		
				200 HERITAGE CIRCLE			
ACCORDI	US HEALTH AT HENDER	SONVILLE		HENDERSONVILLE,	NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	9 18	F 58	84			
	The Maintenance Ma	r approximately 5 minutes. nager stated he was not perature was not getting					
	the ceiling in room 31	es by 4 inches where the					
	Manager was conduct AM. The Maintenance not aware the ceiling where the textured sp	ervation with Maintenance ted on 12/04/24 at 10:03 e Manager revealed he was in room 319 had damage backling was missing. He ay on textured spackling and g.					
	There were approxim where the textured sp Maintenance Manger						
	with the Floor Technic Two air vents located had a significant amo Floor Technician reve cleaning the air vents was done daily. He st air vent in Hall B show During an interview o Administrator he expe	n 12/06/24 at 3:52 PM, the acted overbed lights to work re to notify the Maintenance					

Facility ID: 923245

If continuation sheet Page 19 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 01/03/2025 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345285	B. WING		_		C 06/2024
NAME OF PF	ROVIDER OR SUPPLIER		- i	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NO	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	19	F 584	4			
	on 12/02/24 at 11:32 a missing wood to the to closest to the bed, lea corner. Additional observation 229-B on 12/03/24 at 7:42 AM, and 12/05/2 area of missing wood the side closest to the sharp corner. An interview with the 12/04/24 at 10:57 AM of the top of the dress missing wood resultin exposed. He stated h notify him of rough ed was busy working on Maintenance Director need to be replaced. An interview with the a	stated the dresser would					
	229-B on 12/02/24 rev	aced. the overbed table of room vealed an area of broken ne table leaving sharp edges					
	229-B on 12/03/24 at AM, and 12/05/24 at 7	ns of the dresser of room 8:55 AM, 12/04/24 at 7:42 7:34 AM revealed an area of top of the table leaving					

Facility ID: 923245

If continuation sheet Page 20 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345285	B. WING				C / 06/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	An interview with the 12/04/24 at 10:57 AM of the top of the overth having broken plastic being exposed. He si staff to notify him of ro- since he was busy wo The Maintenance Dire table would need to b An interview with the 5:12 PM revealed he good repair or be repl 8. a. An observation placed over the toilet room 224 on 12/02/24 large amount of brow brown stains to the ou brown discoloration w toilet. b. An observation of t placed over the toilet room 224 on 12/03/24 brown material on the the base of the toilet, extending from the ba bathroom door. An or resembling urine was c. An observation of t placed over the toilet room 224 on 12/04/24 seat was raised and r noted to the undersid discoloration was note and a dried yellow star	Maintenance Director on revealed he was not aware bed table in room 229-B resulting in sharp edges tated he relied on nursing bugh edges on furniture orking on other projects. ector stated the overbed e replaced. Administrator on 12/05/24 at expected furniture to be in faced. of the bedside commode in the shared bathroom of 4 at 11:11 AM revealed a n material on the seat, dried utside of the toilet bowl, and vas noted to the base of the he bedside commode in the shared bathroom of 4 at 2:07 PM revealed dried e seat, brown discoloration to and a dried yellow stain ase of the toilet almost to the verwhelming odor noted in the bathroom. he bedside commode in the shared bathroom of 4 at 7:32 AM revealed the multiple dried splatters were	F	584			

Facility ID: 923245

If continuation sheet Page 21 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345285	B. WING			12	C 2/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·		
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 584	the bathroom. d. An observation of t placed over the toilet room 224 on 12/05/24 seat was raised and o noted to the undersid discoloration was not and a dried yellow sta of the toilet almost to overwhelming odor re the bathroom. An interview with the on 12/05/24 at 8:13 A cleaning consisted of mopping, cleaning the the trash. She stated housekeepers to rour of times each shift, bu her staff and check al A follow-up interview Supervisor on 12/05/2 expected bathrooms An interview with the 5:12 PM revealed he bathrooms to be clean 9. An observation of room 224 on 12/02/22 circular brown stain. Additional observation curtain in room 224 o	esembling urine was noted in the bedside commode in the shared bathroom of 4 at 7:30 AM revealed the dried brown material was e of the lid, brown ed to the base of the toilet, ain extended from the base the bathroom door. An esembling urine was noted in Housekeeping Supervisor M revealed daily room dusting, sweeping, e bathroom, and removing 1 she had instructed her nd on this bathroom a couple ut she could not go behind I their work. with the Housekeeping 24 at 2:48 PM revealed she to be clean and free of odor. Administrator on 12/05/24 at expected resident n and free of odor. the room divider curtain in 4 at 11:12 AM revealed a hs of the room divider n 12/03/24 at 2:07 PM, and 12/05/24 at 7:30 AM	F	584				

If continuation sheet Page 22 of 119

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
-			A. BUILDI	ING _			
		345285	B. WING				C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		ŀ	HENDERSONVILLE, NC 28791		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	BATE
F 584	Continued From page	× 22		E01			
1 304	Continued From page	; 22	F	584	+		
	An interview with the	Housekeeping Supervisor					
	on 12/05/24 at 2:48 P						
		p cleaning schedule which					
		om divider curtains, but she					
		notify her if they noticed a					
		in before it was scheduled					
		d she would change it. She					
	stated she expected r	oom divider curtains to be					
		Administrator on 12/05/24 at					
		expected room divider					
	curtains to be clean.	•					
	10. An observation o	f the wall behind the bed in					
		/24 at 11:26 AM revealed					
	multiple dried brown s	stains.					
	Additional observation	ns of the wall behind the bed					
		03/24 at 8:56 AM, 12/04/24					
		5/24 at 7:33 AM revealed					
	multiple dried brown s	stains.					
	An interview with the	Housekeeping Supervisor					
	on 12/05/24 at 8:13 A	M revealed she had					
		p cleaning schedule which					
		Is, but she educated her					
	staff to go ahead and	-					
		d of waiting for the room to e stated she expected					
	resident room walls to						
		Administrator on 12/05/24 at					
	walls to be clean and	expected resident room free of stains					
	11. An observation of	f the floor beside the bed in					
		/24 at 11:26 AM revealed					
	multiple dried brown s	stains.					

If continuation sheet Page 23 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345285	B. WING _				C / 06/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			00 HERITAGE CIRCLE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	Continued From page	23	F	584			
	bed in room 229-A or	ns of the floor beside the 12/03/24 at 8:56 AM, and 12/05/24 at 7:33 AM d brown stains.					
	on 12/05/24 at 8:13 A cleaning consisted of	Housekeeping Supervisor M revealed daily room dusting, sweeping, e bathroom, and removing					
		with the Housekeeping 24 at 2:48 PM revealed she om floors to be clean.					
		Administrator on 12/05/24 at expected resident room					
		f the wall between 227-A 24 at 8:46 AM revealed stains.					
		ns of the wall between 227-A 24 at 7:36 AM, and 12/05/24 multiple dried stains.					
	on 12/05/24 at 8:13 A developed a new dee included cleaning wal staff to go ahead and noticed a stain instea	p cleaning schedule which ls, but she educated her clean the wall if they d of waiting for the room to e stated she expected					
		Administrator on 12/05/24 at expected resident room					

Facility ID: 923245

If continuation sheet Page 24 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SU COMPLET	
		345285	B. WING		_		C 06/2024
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		00 HERITAGE CIRCLE IENDERSONVILLE, NC	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	 11:57 AM revealed a plaster in the middle of door. An additional observation and the plaster in the middle of door. An additional observation and the plaster in the bathroom. An interview and tour Maintenance Director The Maintenance Director The Maintenance Director The Maintenance Director and the rooms yet are him when repairs were was not made aware bathroom door of room need to be patched, see to be patche	free of stains. f room 330 on 12/02/24 at circular hole with exposed of the wall by the bathroom ation of room 330 on revealed the condition of the door remained unchanged. was conducted with the on 12/04/24 at 10:40 AM. ector revealed he was in the n-to-room on each hall to needed but had not made it nd he relied on staff to notify e needed. He stated he of the hole in the wall by the m 330 and the hole would canded and painted. n 12/06/24 at 3:52 PM, the ected overbed lights to work re to notify the Maintenance were needed. n of room 327 on 12/03/24 he overbed light fixture eside the A bed did not turn ich chain was pulled. ms conducted on 12/04/24 at at 12:33 PM revealed the id not turn on when the light ed.	F 584		DEFICIENCY)		
		n 12/06/24 at 3:52 PM, the acted overbed lights to work					

Facility ID: 923245

If continuation sheet Page 25 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/03/2025 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345285	B. WING			_		C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER			:	200 HERITAGE CIRCLE			
Accordi					HENDERSONVILLE, NC	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Director when repairs b. An observation of 8:49 AM revealed the stay in a fixed position maximum height and a minimal amount of withe table surface. Additional observation 8:18 AM and 12/5/24 condition of the overb same. An interview and tour Maintenance Director The Maintenance Director The Maintenance Director make a list of repairs to all the rooms yet an him when repairs wer Maintenance Director the overbed light in ro stated it was one of th would need to be repair light fixture was order purchase order to sho would order another of Maintenance Director in room 327-A and co a fixed position when maximum height. He	re to notify the Maintenance were needed. room 327 on 12/03/24 at overbed table would not in when it was raised to the the table would lower when weight was placed on top of ins conducted on 12/04/24 at at 12:33 PM revealed the ed table remained the was conducted with the on 12/04/24 at 10:40 AM. ector revealed he was in the in-to-room on each hall to needed but had not made it and he relied on staff to notify e needed. The stated he was not aware bom 327-A did not work. He he older light fixtures and acced. He revealed a new ed but he could not find the bow when and stated he one today (12/4/24). The observed the overbed table nfirmed it would not stay in the table was raised to the removed the overbed table ated he would replace it with	F	584		DEFICIENCY)		
		Administrator on 12/05/24 at expected furniture to be in aced.						

Facility ID: 923245

If continuation sheet Page 26 of 119

	-	ID HUMAN SERVICES				FORM	MAPPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULT	TIPLE	E CONSTRUCTION		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					
		345285	B. WING				C 106/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	OMB NO. (X3) DATE S COMPL C C 12/0 CORECTION TON SHOULD BE THE APPROPRIATE	00/2024
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE		
					HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	26	F	584			
	15. Resident #13 wa 09/08/17.	s admitted to the facility on					
		m Data Set (MDS) dated dent #13 with a moderately					
	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.						
	12/02/24 at 12:03 PM toilet roll holder had b months and it was ve added the opened toi	ducted with Resident #13 on I. He stated the rod for the been missing for at least 3 ry inconvenient for him. He let rolls sitting on top of the node might have fallen to ntaminated.					
	-	ion conducted on 12/03/24 the rod for the toilet roll sing.					
	Housekeeper on 12/0 roll holder remained of toilet roll rod. Three (ation conducted with the 03/24 at 2:31 PM, the toilet dysfunctional without the (3) brand new unopened sitting on top of the water node.					
		ducted with the)3/24 at 2:32 PM. He stated replenish the toilet rolls					

If continuation sheet Page 27 of 119

	-	ID HUMAN SERVICES				FORM	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	F CONSTRUCTION		
	CORRECTION	IDENTIFICATION NUMBER:					
						(C
		345285	B. WING			12/	06/2024
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE					
					•		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX		E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIA		DATE
F 584	Continued From page	N 97		50			
F 304	Continued From page		F	584	4		
		throom. He recalled when to this bathroom last Friday					
	-	-					
						FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 12/06/2024 , ZIP CODE	
	the rod out and left it	in the trash container.					
	An interview was con	ducted with the Maintenance					
	, united and the second s						
		-					
		recalled when he checked this shared hroom last Friday, the rod for the toilet roll der was still in place. He did not know when rod was missing but stated it was important the residents to have a functional toilet roll der. He added he depended on residents and ff to report repair needs either verbally or bugh the work order. He typically checked the rk orders at least once daily to ensure all repair eds were met in a timely manner.					
			A. BUILDING COMPLETED C B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791				
					CONSTRUCTION (X3) DATE SURVEY COMPLETED C I2/06/2024 TREET ADDRESS, CITY, STATE, ZIP CODE TO HERITAGE CIRCLE ENDERSONVILLE, NC 28791 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE		
						OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 12/06/2024 E RRECTION I SHOULD BE (X3) DATE SURVEY COMPLETED	
		•					
	An interview was con	ducted with Nurse Aide #5					
	(NA) on 12/03/24 at 2	:51 PM. He stated he					
		-					
	know when it was mis	ssing.					
	During an interview of	onducted on 12/03/24 at					
	 Checked the ethroom 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.						
	-						
	-						
		-					

Facility ID: 923245

If continuation sheet Page 28 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	_	(X3) DATE COMF	
		345285	B. WING				06/2024
NAME OF P	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY,	, STATE, ZIP CODE		
ACCORD	US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	28	F 5	84			
F 607 SS=D	Nursing (DON) on 12, expected the staff to b residents' living enviro needs to the maintena manner. She added is should check repair n address the issues ac expectation for all the good repair all the tim Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facility implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95, §483.12(b)(4) Establis QAPI program require §483.12(b)(5) Ensure occurring in federally- facilities in accordanc Act. The policies and but are not limited to f §483.12(b)(5)(ii) Pos	onment, and to report repair ance department in a timely the maintenance staff eeds on a regular basis and coordingly. It was her toilet roll holder to be in ne. buse/Neglect Policies -(5)(ii)(iii) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures ch allegations, and training as required at sh coordination with the ed under §483.75.	F 64	07			1/3/25

Facility ID: 923245

If continuation sheet Page 29 of 119

		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/03/202 FORM APPROVEI MB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		3) DATE SURVEY COMPLETED
		345285	B. WING _				C 12/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	·		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				200	HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		HE	NDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	Continued From page	e 29	F 6	507			
	(3) of the Act.	0					
	retaliation, as defined (2) of the Act.	bhibiting and preventing at section 1150B(d)(1) and is not met as evidenced					
	Based on record rev facility failed to follow procedure by not imm allegation of resident	iew and staff interviews, the their abuse policy and nediately reporting an -to-resident abuse to the 5 sampled residents Resident #11).			The facility failed to follow their al policy and procedure by not immer reporting an allegation of resident-to-resident abuse to the Administrator for 1 of 5 sampled r reviewed for abuse (Resident #11 Investigation was already complet unsubstantiated.	ediately residents	5
	The facility policy title Exploitation revised 0 alleged violations will Administrator within s Immediately, but not allegation is made, if	ed, Abuse, Neglect and 03/02/23, read in part: "all be reported to the specified timeframes: a) later than 2 hours after the the events that cause the use or result in serious bodily			Current facility residents are at ris being affected by this deficient pra The administrator completed a 10 audit of facility reportable investig completed in the last 6 months to determine any late reporting. The was completed on12/17/2024 No concerns were noted.	actice.)0% ations audit	
	11/11/22. The quarterly Minimu	mitted to the facility on Im Data Set (MDS) dated lesident #11 with intact			To ensure the deficient practice de recur, the staff development coord (SDC) completed education with to current facility and agency staff or abuse neglect and misappropriation and reporting requirements. Educe completed on12/27/2024	dinator the n the on polic ation	
	#11 revealed an entry 04/08/24 at 6:49 AM 04/06/24 that read, "F male resident came t the thighs at night an	ogress notes for Resident y written by Nurse #4 on with an effective date of Resident reports that another o her room, touched her on d woke her up. Resident There was no indication			hired facility and agency staff or s educated by 1/3/2025 will be educ upon hire or before working their scheduled shift. The director of nursing or designed audit 5 residents nursing progress	taff not cated next ee will	

Facility ID: 923245

If continuation sheet Page 30 of 119

		MEDICAID SERVICES	(X2) MI II TIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		345285	B. WING		12/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACCORD	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETI
F 607	Continued From page	e 30	F 60	7	
	that the Director of N	ursing (DON) and/or		for the previous 72 hours to ensur	re no
	Administrator were no			notation of reportable events wee	kly for 4
		, , ,, ,, ,, ,,		weeks, biweekly for 4 weeks, and	
		eport submitted by the gency noted an allegation		monthly for 1 month. The facility we monitor the corrective actions to e	
		e with an incident date of		that the deficient practice is corrective	
		ed Resident #11 reported a		will not recur by reviewing information	
		nto her room, touched her		collected during audits and report	ing to
		n left the room. Further		Quality Assurance Performance	
		acility was made aware of 08/24 at 11:30 AM, the initial		Improvement committee (QAPI) b Administrator monthly for three (3	-
		to the State Agency via fax		months. At that time the QAPI cor	
		8/24 at 12:40 PM and law		will evaluate the effectiveness of t	
	enforcement was not			interventions to determine if conti	nued
				auditing or adjustments to the pla	n of
		on 12/02/24 at 11:09 AM,		correction are necessary.	
		a few months ago a male		Commission Dr. 1/2/2025	
		er room and touched her on s, she yelled for help and		Completed By: 1/3/2025	
	kept kicking at him ur				
		able to recall the exact date			
	or time this occurred	and stated she reported the			
		but could not recall the			
		lent #11 stated the male			
		red to another facility and successions with other residents			
	since.				
		nterview on 12/06/24 at 10:40			
		ed she used to work at the			
	-	led basis and remembered not recall Resident #11			
		dent had touched her			
		en the progress note dated			
		ctive date of 04/06/24 was			
		e stated if that was what she			
		vhat Resident #11 had			
		se #4 expressed she just			
	aidn't recall much reg	parding the incident since it			

If continuation sheet Page 31 of 119

		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 01/03/202 RM APPROVE NO. 0938-039
TATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		345285	B. WING		1	C 2/06/2024
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	
				200 HERITAGE CIRCLE		
ACCORDI	JS HEALTH AT HENDER	RSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 607	she did not documen would have notified the what Resident #11 has knew allegations of a should be reported in During an interview of DON reviewed the pr #4 and confirmed the on 04/08/24 with an e The DON stated she notifying her on 04/08 Resident #11 had alle During an interview of Regional Director of of revealed she was the 04/08/24 when Resid resident touched her investigation was imm RDCS stated she was allegation on 04/08/22 report was submitted RDCS reviewed the p Nurse #4 on 04/08/24 04/06/24 and stated if was entered as a late was very good to call report any concerns.	rse #4 stated that although t it in the progress note, she ne DON or Administrator ad reported because she buse was serious and nmediately. In 12/06/24 at 10:50 AM, the ogress note written by Nurse progress note was written effective date of 04/06/24. did not recall Nurse #4 S/24 to let her know what eged. In 12/06/24 at 10:58 AM, the Clinical Services (RDCS) e Interim Administrator on ent #11 reported a male inappropriately and an nediately initiated. The s made aware of the 4 at 11:30 AM and the initial to the State Agency. The progress note written by	F 60	07		
	written on 04/08/24 a not notify her until 11 Nurse #4 should have of Resident #11's alle reported.	of the note indicated it was t 6:49 AM and Nurse #4 did :30 AM. The RDCS stated e informed her or the DON egation as soon as it was				
F 623 SS=E	Notice Requirements	Before Transfer/Discharge	F 62	23		1/3/25

Facility ID: 923245

If continuation sheet Page 32 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345285	B. WING				C 06/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
					200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	CFR(s): 483.15(c)(3) - §483.15(c)(3) Notice Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and manner facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, the discharge required ur made by the facility ar resident is transferred (ii) Notice must be mat before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immediate under paragraph (c)(f)	(6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or oder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623	3		

If continuation sheet Page 33 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2025 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345285	B. WING		_		C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			2	00 HERITAGE CIRCLE			
ACCORDI	US HEALTH AT HENDER	SONVILLE	H	IENDERSONVILLE, NC	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten- notice specified in par must include the follow (i) The reason for trad (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of the protection and add developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilitt disorder or related dis email address and tel agency responsible for advocacy of individual	 a 33)(i)(A) of this section; or a resided in the facility for 30 at s of the notice. The written agraph (c)(3) of this section wing: asfer or discharge; of transfer or discharge; of transfer or discharge; of transfer or discharge; of transfer or discharge; of the resident is ged; a resident's appeal rights, ddress (mailing and email), and the entity which ts; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and the Office of the State budsman; v residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with ities established under Part tal Disabilities Assistance to 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental abilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy 	F 623				
		-					

Facility ID: 923245

If continuation sheet Page 34 of 119

			FORM APPROVED OMB NO. 0938-0391
	. ,		(X3) DATE SURVEY COMPLETED
345285	B. WING		C 12/06/2024
	•	STREET ADDRESS, CITY, STATE, ZIP	CODE
VILLE		200 HERITAGE CIRCLE	
		HENDERSONVILLE, NC 28791	
T BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
tice changes prior to scharge, the facility s of the notice as soon odated information vance of facility closure tre, the individual who is cility must provide the impending closure ty, the Office of the nbudsman, residents of nt representatives, as nsfer and adequate , as required at § not met as evidenced and staff interviews, the Regional Ombudsman d or transferred from ns (April 2024, July mber 2024, October 4). mission/Discharge /24 to 04/30/24 sidents who were rred to the hospital, or sing facility. mission/Discharge /24 to 11/30/24 esidents who were rred to the hospital, or	F	The facility failed to notify Ombudsman when reside discharged or transferred for 6 of 6 months (April 20 August 2024, September 2024, and November 202 completed in November v documented and sent to to on 12/9/2024. Residents discharging at risk of being affected by th practice. The Vice Presid Operations (VPCO) comp the last 3 months of disch ensured the ombudsman discharges. This audit wa 12/13/2024.	ents were from the facility 024, July2024, 2024, October 24). Discharges were the ombudsman the facility are at he deficient ent of Clinical oleted an audit of harges and was notified of as completed
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285 VILLE ENT OF DEFICIENCIES BT BE PRECEDED BY FULL ENTIFYING INFORMATION) the notice. tice changes prior to scharge, the facility s of the notice as soon odated information Vance of facility closure ure, the individual who is cility must provide the impending closure ty, the Office of the nbudsman, residents of nt representatives, as nsfer and adequate , as required at § not met as evidenced and staff interviews, the Regional Ombudsman d or transferred from ns (April 2024, July ember 2024, October 4). mission/Discharge /24 to 04/30/24 sidents who were tred to the hospital, or sing facility.	IDENTIFICATION NUMBER: A. BUILDI 345285 B. WING VILLE ID ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ID PREFI TAG PREFI TAG VILLE ID ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ID Vance of facility shore as soon bodated information PREFI TAG Vance of facility closure ure, the individual who is cility must provide the impending closure by, the Office of the mbudsman, residents of nt representatives, as nsfer and adequate , as required at § ID Not met as evidenced Ind staff interviews, the Regional Ombudsman d or transferred from ns (April 2024, July omber 2024, October 4). Ind staff interviews, the Regional Ombudsman d or transferred from ns (April 2024, July omber 2024, October 4). mission/Discharge /24 to 04/30/24 sidents who were red to the hospital, or sing facility. Ind staff interviews mission/Discharge /24 to 11/30/24 esidents who were red to the hospital, or	JDENTIFICATION NUMBER: A. BUILDING 345285 B. WING VILLE STREET ADDRESS, CITY, STATE, ZIF 200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791 ENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE AL CROSS-REFERENCED TO DEFICIE Ithe notice. F 623 the notice as soon vadated information F 623 vance of facility closure irre, the individual who is cility must provide the impending closure y, the Office of the budsman, residents of not met as evidenced The facility failed to notiff Ombudsman when reside discharged or transferred for 6 of 6 months (April 20 August 2024, September 2024, and November 202 completed in November 20 completed in Novembe

Facility ID: 923245

If continuation sheet Page 35 of 119

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	
		345285	B. WING		C 12/06/202	24
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
				200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMP	(X5) PLETIO DATE
F 623	Administrator stated documentation that in discharges/transfers Ombudsman for the 2024, August 2024, S 2024 or November 20 Admissions Director previously responsible Ombudsman monthly discharges/transfers process of switching Social Worker (SW) I Director and SW quit they have been active to fill the open position the Director of Nursin both positions and the through the cracks.	on 12/06/24 at 3:52 PM, the he was unable to find any outifications of residents' were sent to the Regional months of April 2024, July September 2024, October 024. He explained that the was the one who was le for sending the Regional <i>y</i> notification of resident and they had been in the that responsibility over to the but then both the Admissions . The Administrator stated ely interviewing candidates ons and in the interim, he and ng had been trying to cover is process had just fell	F 62	 recur, the VPCO completed educe with the director of nursing and administrator on 12/30/2024. The hired social workers will be educaduring orientation. The social work of be responsible for notifying the ombudsman of facility discharges the event the social worker is unat the administrator will ensure the ombudsman is notified of facility discharges. The VPCO will audit monthly ombudsman of discharges monthly months. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and recur by reviewing information conduring audits and reporting to Qu Assurance Performance Improve committee (QAPI) by the Administ monthly for three (3) months. At the QAPI committee will evaluate effectiveness of the interventions determine if continued auditing of adjustments to the plan of correct necessary. Completed By: 1/3/2025 	e newly ated ker will and in able to, budsman of for 3 he the d will not llected ality ment strator hat time the to	.5
SS=E	a comprehensive, ac	sessment duct initially and periodically				

Facility ID: 923245

If continuation sheet Page 36 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		345285	B. WING				C / 06/2024		
NAME OF P	ROVIDER OR SUPPLIER		ł	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 636	 §483.20(b) Comprehe §483.20(b)(1) Reside A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and d (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavid (vii) Psychological we (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutritid (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatment (xvi) Discharge planni (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The assinclude direct observation with the resident, as with the resident and nonlicent members on all shifts 	ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least emographic information	F	636	6				

Facility ID: 923245

If continuation sheet Page 37 of 119

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/202 MAPPROVE D. 0938-039	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		345285	B. WING			C 12/06/2024		
NAME OF PR	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				2	00 HERITAGE CIRCLE			
ACCORDI	US HEALTH AT HENDER	RSONVILLE		н	IENDERSONVILLE, NC 28791	I		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 636			F	636				
		dent in accordance with the						
	•	in paragraphs (b)(2)(i)						
	• • •	ction. The timeframes 43(b) of this chapter do not						
	apply to CAHs.							
		r days after admission,						
		ons in which there is no						
	-	the resident's physical or						
		or purposes of this section,						
		a return to the facility						
		y absence for hospitalization						
	or therapeutic leave.)							
	(iii)Not less than once	e every τ2 months. Γ is not met as evidenced						
	by:							
	-	iew and staff interviews, the			The facility failed to complete			
	facility failed to comp				comprehensive Minimum Data Set (N	∕IDS)		
		IDS) assessments within 14			assessments within 14 days of the			
		ent Reference Date (ARD,			Assessment Reference Date (ARD,			
		ay of the assessment period)			referring to the last day of the assess			
		#21, #28, #29, #47, #68, and			period) (Resident #'s 6, 16, 21, 28, 2			
		mprehensively complete the ent (CAA) for Resident #89			68, and 78) and failed to comprehener complete the Care Area Assessment	•		
	for 9 of 45 sampled re				(CAA) for Resident #89 for 9 of 45			
					sampled residents. CAA's on identifie	ed		
	Findings included:				residents was modified and resubmit by 12/31/24 by MDS nurse.			
	1. a. Resident #6 wa	as admitted to the facility on						
	09/02/15.				Current facility residents are at risk o			
	D · / D · · · · · ·				being affected by this deficient practi	ce.		
		#6's electronic medical			The Regional Director of Clinical	.		
	an ARD of 01/20/24 t	nnual MDS assessment with			Reimbursement (RDCR) completed a audit of CAA's completed over the pa			
	completed on 02/26/2				days to ensure they were	151 30		
		L I.			comprehensively completed and MD	S		
	During a joint intervie	ew on 12/04/24 at 12:43 PM,			was completed within 14 days of the			
		Nurse #2 and MDS Nurse			The audit showed 4 concerns. The			
	#3 all verified Reside				identified concerns were corrected by	y		
	assessment with an A	ARD of 01/20/24 was not			1/3/2025. The audit was completed of			

Facility ID: 923245

If continuation sheet Page 38 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/03/202 DRM APPROVE <u>NO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345285	B. WING				C 12/06/2024
NAME OF P	ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 636	Continued From page	e 38	E E	636			
		regulatory time frame.			12/27/2024.		
	07/02/13. Review of Resident # record revealed an ar an ARD of 01/26/24 t completed on 02/28/2 During a joint intervie MDS Nurse #1, MDS #3 all verified Reside assessment with an A completed within the c. Resident #21 was 06/05/24. Review of Resident # record revealed an ac with an ARD of 06/10 completed 07/04/24. During a joint intervie MDS Nurse #1, MDS #3 all verified Reside assessment with an A	24. w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #16's annual MDS ARD of 01/26/24 was not regulatory time frame. admitted to the facility on 221's electronic medical dmission MDS assessment /24 that was marked			To ensure this deficient practice door recur the following has been complet The RDCR educated the MDS licer nursing staff and interdisciplinary te comprehensively completing CAA's completing MDS assessments with days of ARD, according to Residen Assessment Instrument (RAI) manu Education was completed on 1/3/20 Newly hired staff or staff not educat 1/3/25 will be educated prior to work their next shift. The RDCR will audit 5 residents we for 4 weeks, 5 residents biweekly for weeks, and 5 residents monthly for month to ensure the last scheduled was completed with comprehensive completion of CAA's as indicated at within 14 days of ARD. The facility we monitor the corrective actions to en that the deficient practice is correct will not recur by reviewing informati collected during audits and reportin Quality Assurance Performance Improvement committee (QAPI) by Administrator monthly for three (3)	eted: ised am on and in 14 t jal. 025. ed by king eekly or 4 1 MDS end will sure ed and on g to the	
	d. Resident #28 was Review of Resident #	admitted 09/15/23. 28's electronic medical			months. At that time the QAPI com will evaluate the effectiveness of the interventions to determine if continu- auditing or adjustments to the plan	e ied	
		nnual MDS assessment with			correction are necessary.		
	completed on 08/21/2				Completed By: 1/3/2025		
		w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse					

Facility ID: 923245

If continuation sheet Page 39 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		LETED
		345285	B. WING				C 06/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 636	 #3 all verified Resider assessment with an A completed within the feet e. Resident #29 was 06/13/22. Review of Resident # record revealed an ar an ARD of 04/11/24 th completed on 06/16/2 During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed within the feet f. Resident #47 was a 06/11/24. Review of Resident # record revealed an ac with an ARD of 06/14, completed on 07/15/2 During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed on 07/15/2 During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed within the feet assessment with an A completed wit	ARD of 07/20/24 was not regulatory time frame. admitted to the facility on 29's electronic medical mual MDS assessment with hat was marked as 24. w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #29's annual MDS ARD of 04/11/24 was not regulatory time frame. admitted to the facility on 47's electronic medical dmission MDS assessment /24 that was marked as 24. w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #47's admission MDS Nurse nt #47's admission MDS ARD of 06/14/24 was not regulatory time frame. admitted to the facility on 68's electronic medical mual MDS assessment with	F	636			

Facility ID: 923245

If continuation sheet Page 40 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345285	B. WING				C 106/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		F	IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 636	Continued From page	∌ 40	F	636			
	During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed within the in- h. Resident #78 was 07/10/24. Review of Resident # record revealed an active with an ARD of 07/12, completed on 08/12/2 During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed within the in- During a joint intervier with MDS Nurse #1 reveal MDS Nurse #1 explai between several facilit at this facility once a to completing MDS asses stated MDS Nurses fr assisted when able to assessments caught MDS assessments fe	w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #68's annual MDS NRD of 06/22/24 was not regulatory time frame. admitted to the facility on 78's electronic medical dmission MDS assessment /24 that was marked as 24. w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #78's admission MDS NRD of 07/12/24 was not regulatory time frame. w on 12/04/24 at 12:43 PM nd MDS Nurse #3 present, led both MDS Nurse #2 and arted at the facility in wember 2024 respectively. ned that she floated ities and had been working					
	assessment that were other members of the	t up the sections of the MDS e typically completed by Interdisciplinary Team due ositions. MDS Nurse #1					

Facility ID: 923245

If continuation sheet Page 41 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF		
		345285	B. WING				06/2024	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 636	explained they had to the MDS assessment She stated they would or two, then the facilit admissions and MDS behind again. She st were working togethe assessments caught During an interview of Administrator stated N behind when he starte and felt the breakdow turnover in MDS staff 2024, they had a full- part-time MDS Nurse them further behind w assessments complei stated with the MDS the felt they would be assessments caught that MDS assessment the regulatory timefra 2. Resident #89 was 10/26/23 with diagnos A review of the signifi Minimum Data Set (M 09/07/24 revealed Re moderately impaired Section V which cons assessment summary psychotropic drug use #89. The facility did n analysis of findings th Resident 89's probler contributing factors, ri	 complete all the sections of which took a lot of time. d get caught up for a month y would get a lot of new assessments would fall ated all the MDS Nurses r and slowly getting MDS back up. n 12/04/24 at 1:06 PM, the MDS assessments were ed his position in June 2024 rn was the result of a lot. He explained since June time MDS Nurse and a that both quit which put vith getting MDS ted. The Administrator ream he now had in place, able to get the MDS up and stay caught up so ts were completed within me. admitted to the facility on sis including depression. cant change in status IDS) assessment dated sident #89 was coded with a cognition. A review of 	F	636				

Facility ID: 923245

If continuation sheet Page 42 of 119

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION				
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING				
		345285	B. WING		C 12/06/2024			
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CC	DDE			
	US HEALTH AT HENDE		2	00 HERITAGE CIRCLE				
			F	IENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE		
F 636	Continued From pag	ge 42	F 636					
	planning.							
		conducted on 12/04/24 at						
	the 6 triggered care	Coordinator confirmed 1 of areas (psychotropic drug						
		9's MDS dated 09/07/24 out any pertinent information						
	in analysis of finding	s in Section V. She explained						
she started her role as the MDS Coordinator about 2 months ago. Resident #89's MDS dated								
	-	tted by the former MDS						
	Coordinator and she	was unable to explain how it						
		nowledged that it was an error						
		nt change in status MDS on of analysis of findings for						
	all the triggered area							
		5 AM an interview was						
		Director of Nursing. She must be individualized and						
	completed compreh							
	expectation for the N	IDS Coordinators to						
		is of findings for all the						
	MDS assessment.	ection V before submitting an						
	· ·	ct a phone interview with the						
		nator on 12/04/24 at 1:14 PM						
F 638		She did not return the call. Least Every 3 Months	F 638		1/	3/25		
SS=E	-	Least Every 5 WORLINS	F 030		17	5/20		
	§483.20(c) Quarterly	y Review Assessment						
	A facility must asses	s a resident using the						
		rument specified by the State						
	and approved by CN once every 3 month	/IS not less frequently than s.						
	This REQUIREMEN	o.						

Facility ID: 923245

If continuation sheet Page 43 of 119

	ITH AND HUMAN SERVICES RE & MEDICAID SERVICES			FOF	ED: 01/03/2025 RM APPROVED IO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
	345285	B. WING _		C 12/06/2024		
NAME OF PROVIDER OR SUPPLI	ĒR		STREET ADDRESS, CITY, STATE, ZIP COD	θE		
ACCORDIUS HEALTH AT HE			200 HERITAGE CIRCLE			
ACCORDIOS REALTH AT HE	INDERSONVILLE		HENDERSONVILLE, NC 28791			
PREFIX (EACH DEF	ICIENCY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE	
	n page 43	F	538			
facility failed to Set (MDS) asse Assessment Re the last day of t sampled reside #28, #29, #42, i #85). Findings include a. Resident #6 09/02/15. Review of Resid record revealed -A quarterly MD 04/19/24 that w 06/29/24. -A quarterly MD 07/19/24 that w 08/21/24. -A quarterly MD 07/29/24 that w 08/21/24. -A quarterly MD 07/29/24 that w 08/21/24. During a joint in MDS Nurse #1, #3 all verified R assessments w and 07/29/24 w regulatory time	 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. -A quarterly MDS assessment with an ARD of 07/29/24 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. -A quarterly MDS assessment with an ARD of 07/29/24 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. -A quarterly MDS assessment with an ARD of 07/29/24 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 		The facility failed to complete Minimum Data Set (MDS) ass within 14 days of the Assess Reference Date (ARD, referri day of the observation period sampled residents (Residents #16, #21, #28, #29, #42, #47 #78, #81, #83, and #85). MDS assessments were completed submitted on identified reside Current facility residents are a being affected by the deficien The Regional Director of Clin Reimbursement (RDCR) com audit of Quarterly Assessmen past 30 days to ensure they h completed and submitted as Concerns noted were addres 12/30/2024. The audit was co 12/27/2024. The following things have bee place to ensure the deficient not recur: The RDCR educate licensed nursing staff and inte team on completing quarterly assessments within 14 days date according to Resident A: Instrument (RAI) manual. Edu completed on 1/3/2025. New or staff not educated by 1/3/2 educated prior to working the The RDCR will audit 5 reside for 4 weeks, 5 residents month month to ensure MDS assess	sessments ment ng to the last) for 14 of 45 s #6, #15, , #48, #68, S d and ents. at risk of at practice. ical ppleted an ats due in the had been scheduled. sed by ompleted on en put into practice does ed the MDS erdisciplinary of the ARD ssessment ucation was ly hired staff 25 will be ir next shift. nts weekly ekly for 4 hly for 1		

Facility ID: 923245

If continuation sheet Page 44 of 119

		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
					С
		345285	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO	12/06/2024
NAME OF P	ROVIDER OR SUPPLIER			200 HERITAGE CIRCLE	JE
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HENDERSONVILLE, NC 28791	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLE E APPROPRIATE DATE
F 638	Continued From page	e 44	F 6	38	
	record revealed the f	ollowing:		completed within 14 days of	
				The facility will monitor the c	
		sessment with an ARD of arked as completed on		actions to ensure that the de practice is corrected and will	
	02/27/24.			reviewing information collect	
		sessment with an ARD of		audits and reporting to Quali	
	02/23/24 that was ma 03/12/24.	arked as completed on		Performance Improvement c (QAPI) by the Administrator	
		sessment with an ARD of		three (3) months. At that time	-
		arked as completed on		committee will evaluate the e	
	06/06/24.	sessment with an ARD of		of the interventions to detern continued auditing or adjustr	
	· ·	arked as completed on		plan of correction are necess	
				Completion Date: 1/3/25	
		ew on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse			
		nt #15's quarterly MDS			
		RDs of 01/22/24, 02/23/24,			
	the regulatory time fra	24 were not completed within ame.			
	c. Resident #16 was 07/02/13.	admitted to the facility on			
	Review of Resident # record revealed the f	#16's electronic medical ollowing:			
		sessment with an ARD of arked as completed on			
	-A quarterly MDS ass	sessment with an ARD of arked as completed on			
	During a joint intervie MDS Nurse #1, MDS	ew on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #16's quarterly MDS RDs of 04/26/24 and			

If continuation sheet Page 45 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345285	B. WING _				C 06/2024	
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORD	US HEALTH AT HENDER	SONVILLE			00 HERITAGE CIRCLE ENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 638	 07/27/24 were not coltime frame. d. Resident #21 was 06/05/24. Review of Resident # record revealed a quawith an ARD of 09/10 completed on 11/11/2 During a joint intervie MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed within the e. Resident #28 was Review of Resident # record revealed the for -A quarterly MDS ass 01/19/24 that was ma 02/26/24. A quarterly MDS ass 04/19/24 that was ma 06/19/24. During a joint intervier MDS Nurse #1, MDS ass 04/19/24 that was ma 06/19/24. 	admitted to the facility on 21's electronic medical arterly MDS assessment /24 that was marked as /4. w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse int #21's quarterly MDS ARD of 09/10/24 was not regulatory time frame. admitted 09/15/23. 28's electronic medical ollowing: essment with an ARD of urked as completed on essment with an ARD of urked as completed on w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse int #28's quarterly MDS	F 6	538				

Facility ID: 923245

If continuation sheet Page 46 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE	SURVEY PLETED
		345285	B. WING				C / 06/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORD	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE		
_					HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 638	Review of Resident # record revealed a qua with an ARD of 07/17, completed on 08/20/2 During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessment with an A completed within the f g. Resident #42 adm 07/23/19. Review of Resident # record revealed the for -A quarterly MDS ass 03/22/24 that was ma 05/12/24. -A quarterly MDS ass 06/05/24 that was ma 07/10/24. -A quarterly MDS ass 07/09/24 that was ma 07/31/24. During a joint intervier MDS Nurse #1, MDS #3 all verified Resider assessments with AR and 07/09/24 were no regulatory time frame h. Resident #47 was 06/11/24. Review of Resident #	29's electronic medical arterly MDS assessment /24 that was marked as 4. w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse at #29's quarterly MDS RD of 07/17/24 was not regulatory time frame. itted to the facility on 42's electronic medical ollowing: essment with an ARD of rked as completed on essment with an ARD of rked as completed on essment with an ARD of rked as completed on w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse at #42's quarterly MDS Ds of 03/22/24, 06/05/24 at completed within the	F	638	8		

Facility ID: 923245

If continuation sheet Page 47 of 119

	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMF	LETED
		345285	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	343283	B. 11110	5	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	06/2024
					200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		ŀ	HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					,		
F 638	Continued From page	e 47	F	638	3		
	with an ARD of 07/04 completed on 07/24/2	/24 that was marked as 24.					
		w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse					
		nt #47's quarterly MDS					
		ARD of 07/24/24 was not regulatory time frame.					
	i. Resident #48 was a 02/20/20.	admitted to the facility on					
	Review of Resident # record revealed the fo	48's electronic medical bllowing:					
	02/22/24 that was ma	essment with an ARD of arked as completed on					
	04/12/24 that was ma	essment with an ARD of arked as completed on					
		essment with an ARD of arked as completed on					
	MDS Nurse #1, MDS #3 all verified Resider assessments with AR	w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #48's quarterly MDS Ds of 02/22/24, 04/12/24 ot completed within the s.					
	j. Resident #68 was a 11/05/21.	admitted to the facility on					
	Review of Resident # record revealed the fo	68's electronic medical bllowing:					
	-A quarterly MDS ass	essment with an ARD of					

Event ID: MMG311

If continuation sheet Page 48 of 119

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/03/2025 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345285	B. WING					C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP (CODE		
	US HEALTH AT HENDER				200 HERITAGE CIRCLE			
Accordi					HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE		(X5) COMPLETION DATE
F 638	Continued From page	e 48	F	638	3			
		irked as completed on			-			
	-A quarterly MDS ass	essment with an ARD of Irked as completed on						
	-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 07/10/24.	admitted to the facility on						
	record revealed a qua	78's electronic medical arterly MDS assessment /24 that was marked as /4.						
	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.							
	I. Resident #81 was 09/27/23.	admitted to the facility on						
	Review of Resident # record revealed the fe	81's electronic medical bllowing:						
		essment with an ARD of arked as completed on						

Facility ID: 923245

If continuation sheet Page 49 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345285	B. WING				C 106/2024	
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	DE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 638	 -A quarterly MDS ass 04/19/24 that was ma 06/24/24. During a joint intervie MDS Nurse #1, MDS #3 all verified Resider assessments with AR 04/19/24 were not co- time frame. m. Resident #83 was 11/06/23. Review of Resident # record revealed the for -A quarterly MDS ass 03/06/24 that was ma 04/03/24. -A quarterly MDS ass 03/15/24 that was ma 05/09/24. -A quarterly MDS ass 06/14/24 that was ma 05/09/24. -A quarterly MDS ass 06/14/24 that was ma 05/09/24. -A quarterly MDS ass 06/14/24 that was ma 07/14/24. -A quarterly MDS ass 07/29/24 that was ma 08/23/24. During a joint intervie MDS Nurse #1, MDS #3 all verified Resider assessments with AR 06/14/24 and 07/29/2 the regulatory time fractional contents. 	essment with an ARD of inked as completed on w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse int #81's quarterly MDS iDs of 01/19/24 and impleted within the regulatory as admitted to the facility on 83's electronic medical blowing: essment with an ARD of inked as completed on essment with an ARD of inked as completed on essment with an ARD of inked as completed on essment with an ARD of inked as completed on w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse int #83's quarterly MDS iDs of 03/06/24, 03/15/24, 4 were not completed within	F	638				

Facility ID: 923245

If continuation sheet Page 50 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY LETED	
		345285	B. WING				C 06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				2	200 HERITAGE CIRCLE			
ACCORDI	US HEALTH AT HENDER	SONVILLE		F	IENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 638	Continued From page	e 50	F	638				
	Review of Resident # record revealed the fo	85's electronic medical bllowing:						
	 -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. 							
	MDS Nurse #1, MDS #3 all verified Resider assessments with AR	w on 12/04/24 at 12:43 PM, Nurse #2 and MDS Nurse nt #85's quarterly MDS Ds of 05/04/24 and mpleted within the regulatory						
	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. get caught up for a month						

Facility ID: 923245

If continuation sheet Page 51 of 119

ATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		345285	B. WING			С
	ROVIDER OR SUPPLIER	545205		IREET ADDRESS, CITY, STATE, ZIP CODE		/06/2024
				00 HERITAGE CIRCLE	-	
ACCORDI	US HEALTH AT HENDE	RSONVILLE	н	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 638	Continued From pag	e 51	F 638			
		ty would get a lot of new	1 000			
		S assessments would fall				
		tated all the MDS Nurses				
		er and slowly getting MDS				
	assessments caught	back up.				
	During an interview o	on 12/04/24 at 1:06 PM, the				
		MDS assessments were				
		ted his position in June 2024 wn was the result of a lot				
		f. He explained since June				
		-time MDS Nurse and a				
	-	e that both quit which put				
	them further behind					
		eted. The Administrator team he now had in place,				
	he felt they would be	• •				
		up and stay caught up so				
		nts were completed within				
F 640	the regulatory timefra	ng Resident Assessments	F 640			1/3/25
SS=B			1 040			1/3/23
	§483.20(f) Automate	d data processing				
	requirement-					
		ng data. Within 7 days after resident's assessment, a				
		the following information for				
	each resident in the	facility:				
	(i) Admission assess (ii) Annual assessme					
		le in status assessments.				
	(iv) Quarterly review	assessments.				
		upon a resident's transfer,				
	reentry, discharge, a	nd death. e-sheet) information, if there				
		a chaot) information if there				

Facility ID: 923245

If continuation sheet Page 52 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345285	B. WING _				C 06/2024
NAME OF P	ROVIDER OR SUPPLIER		·	STR	REET ADDRESS, CITY, STATE, ZIP CODE	-	
	US HEALTH AT HENDER			200) HERITAGE CIRCLE		
ACCORDI	US REALTH AT HENDER	SONVILLE		HE	NDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 640	§483.20(f)(2) Transm after a facility complet a facility must be capa CMS System informa contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, at the CMS System, incl (i)Admission assessment (ii) Annual assessment (ii) Annual assessment (iii) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, ar (viii) Background (fac- initial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on record revi facility failed to complianticipated Minimum	itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to its and data dictionaries, dardized edits defined by ittal requirements. Within y completes a resident's must electronically transmit nd complete MDS data to uding the following: nent. it. e in status assessment. tion of prior full assessment. tion of prior quarterly upon a resident's transfer, nd death. e-sheet) information, for an MDS data on resident that nission assessment. trmat. The facility must y an alternate RAI approved t specified by the State and is not met as evidenced ew and staff interviews, the ete a discharge-return Data Set (MDS) y tracking records within the	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 review		

Facility ID: 923245

If continuation sheet Page 53 of 119

			(10)	D/ -			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	G			С
		345285	B. WING				
	ROVIDER OR SUPPLIER	0+0200			TREET ADDRESS, CITY, STATE, ZIP CODE	12	/06/2024
	NOVIDER OR GOI T EIER				00 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDEI	RSONVILLE			ENDERSONVILLE, NC 28791		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
F 640	Continued From pag	e 53	F 64	40			
	reviewed for resident	t assessments (Resident #47			for resident assessments (Resident #4	7	
	and #83).	-			and #83). Identified assessments were		
					transmitted if not already. Both		
	Findings included:				assessments were submitted on 12/9/2024.		
	a. Resident #47 was	s admitted to the facility on					
	06/11/24.				Current facility residents are at risk of		
					being affected by the deficient practice		
		#47's electronic medical			The Regional Director of Clinical		
	record revealed the f	following:			Reimbursement (RDCR) completed a		
	Δ discharge-return a	nticipated MDS assessment			100% audit of the last 30 days of admissions and discharges to ensure t	hev	
	-	was marked as completed on			had discharge-return anticipated and	licy	
	07/23/24.	•			discharge- return not anticipated MDS		
					and entry tracking records within the		
		ord dated 07/02/24 that was			regulated timeframes completed. Audit		
	marked as completed	d on 07/23/24.			was completed by 12/27/2024. 0 conce	erns	
	During a joint intervie	ew on 12/04/24 at 12:43 PM,			identified. Audit was completed by Regional Director of Clinical		
		S Nurse #2 and MDS Nurse			Reimbursement (RDCR).		
		ent #47's discharge-return					
	anticipated MDS ass	essment dated 06/29/24 and			The following things have been put into)	
		dated 07/02/24 were not			place to ensure the deficient practice d		
	completed within the	regulatory time frame.			not recur: The RDCR educated the MD	S	
	h Resident #92 was	s admitted to the facility on			licensed nursing staff on completing		
	11/06/23.	s aumitted to the lability off			discharge-return anticipated and discharge-not anticipated MDS and en	rv	
					tracking records according to Resident	-	
	Review of Resident #	#83's electronic medical			Assessment Instrument (RAI) manual.		
		ntry-tracking record dated			Education was completed on 1/3/2025.		
		arked as completed on			Newly hired staff or staff not educated	-	
	11/14/23.				1/3/25 will be educated prior to working)	
	During a joint intervie	ew on 12/04/24 at 12:43 PM,			their next shift.		
		S Nurse #2 and MDS Nurse			The RDCR will audit 5		
		ent #83's entry tracking			admissions/discharges weekly for 4		
		3 was not completed within			weeks, 5 admissions/discharges biwee	kly	
	the regulatory time fr	ame.			for 4 weeks, and 5 admissions/discharg	ges	
					monthly for 1 month to ensure		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 54 of 119

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DATE S	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLE	ETED
					C	
		345285	B. WING			6/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
				,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 640	Continued From page	e 54	F 64	10		
		w on 12/04/24 at 12:43 PM	10-	return-discharge anticipate	and and	
1		and MDS Nurse #3 present,		discharge-return not antici		
		led both MDS Nurse #2 and		entry records were comple		
	MDS Nurse #3 just s			guidelines. The facility will		
	-	ovember 2024 respectively.		corrective actions to ensur		
	MDS Nurse #1 expla	ined that she floated		deficient practice is correc	ted and will not	
		ities and had been working		recur by reviewing informa		
	at this facility once a			during audits and reporting		
		essments. In addition, she		Assurance Performance Ir		
		rom other facilities had		committee (QAPI) by the A		
		o try and help get the MDS up. MDS Nurse #1 stated		monthly for three (3) month the QAPI committee will ev		
	-	ell behind primarily due to		effectiveness of the interve		
		position as well as the MDS		determine if continued aud		
		c up the sections of the MDS		adjustments to the plan of	-	
	÷ .	e typically completed by		necessary.		
	other members of the	e Interdisciplinary Team due				
		ositions. MDS Nurse #1		Completion Date: 1/3/25		
		complete all the sections of				
		t which took a lot of time.				
		d get caught up for a month				
		ty would get a lot of new assessments would fall				
		ated all the MDS Nurses				
	•	er and slowly getting MDS				
	assessments caught					
	During an interview o	on 12/04/24 at 1:06 PM, the				
	-	MDS assessments were				
	behind when he start	ed his position in June 2024				
		n was the result of a lot				
		f. He explained since June				
		time MDS Nurse and a				
	-	that both quit which put				
	them further behind v	ted. The Administrator				
		team he now had in place,				
	he felt they would be	-				
	no for they would be	asis to got the MDO	1	1		

If continuation sheet Page 55 of 119

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING _		C 12/06/2024		
	ROVIDER OR SUPPLIER	RSONVILLE		STREET ADDRESS, CITY, STATE 200 HERITAGE CIRCLE HENDERSONVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) YE ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE CIENCY)		
F 640	that MDS assessments were completed within the regulatory timeframe.			540	4/0/05		
F 644 SS=D	CFR(s): 483.20(e)(1) §483.20(e) Coordinat A facility must coordin pre-admission screen (PASARR) program u of this part to the max avoid duplicative test includes: §483.20(e)(1)Incorpo from the PASARR lev PASARR evaluation n assessment, care pla care. §483.20(e)(2) Referri all residents with new serious mental disord related condition for la a significant change i This REQUIREMENT by: Based on record rev facility failed to reque Screening and Resid the expiration date ar comprehensive care Level II PASRR deter residents reviewed for #104). Findings included:	(2) tion. hate assessments with the hing and resident review under Medicaid in subpart C kimum extent practicable to ing and effort. Coordination rating the recommendations vel II determination and the report into a resident's inning, and transitions of ng all level II residents and vly evident or possible ler, intellectual disability, or a evel II resident review upon n status assessment. is not met as evidenced iew and staff interviews, the st a Preadmission ent Review (PASRR) before		The facility failed to re Preadmission Screeni Review (PASRR) befor date and failed to devo care plans that incorp PASRR determination residents reviewed for #21 and #104). PASF completed for Resider #104 on 12/3/2024 an place.	ng and Resident ore the expiration elop comprehensive orate Level II for 2 of 3 sampled PASRR (Resident RR screenings nt #21 and Resident		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 56 of 119

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
						С
		345285	B. WING		1	2/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 2875	91	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 644	Continued From page	e 56	F 64	4		
	06/06/24 with diagno			All residents are at risk	of being affected	
		der and anxiety disorder.		by this deficient practice		
				president of Clinical Ope		
	A PASRR Level II De dated 06/04/24 for Re	termination Notification letter		completed a 100% audi		
		/04/24. It was noted nursing		residents to ensure they place and appropriately		
		s appropriate for a limited		residents identified durir		
		asting no more than thirty		needing a Level 2 PASF	•	
	calendar days.			1 PASRR screen was co	ompleted and	
				appropriate care plannir		
		termination Notification letter		The audit and correction	is were completed	
	dated 08/02/24 for Re	/31/24. It was noted nursing		by 1/3/2025.		
		s appropriate for a 90 day		The VCPO completed e	ducation with the	
		ed services that consisted of		administrator, director o		
		provided by a Psychiatrist		minimum data set nurse	÷	
		vices to include mental		worker on PASRR requi		
	health follow-up and	rehab.		regulations of screening		
	Deview of Desident t	1211a madical record		planning requirements f		
	Review of Resident #	e that a PASRR evaluation		level 2 PASRR's.The so responsible for ensuring		
		ew PASRR had been		active PASRR's and car		
		fter Resident #21's Level II		as indicated. Education		
	PASRR expired on 1			1/3/2025. Newly hired s educated prior to 1/3/25	taff and staff not	
	Review of Resident #	21's comprehensive care		education upon hire or p	-	
		11/18/24, revealed no care		next scheduled shift.		
	plan that addressed I	his Level II PASRR				
	determination.			The VPCO will audit 5 refor 4 weeks, 5 residents		
	During an interview o	on 12/04/24 at 2:28 PM, the		weeks, and 5 residents	•	
		ed the Social Worker (SW)		month to ensure resider	-	
	was typically the pers			appropriate PASRR and	-	
		RR process; however, the		place. The facility will m		
		on 10/24/24 and they have		corrective actions to ens		
		ewing candidates to fill the Administrator stated in the		deficient practice is corr recur by reviewing infor		
		Director of Clinical Services		during audits and report		
		son handling Level II PASRR		Assurance Performance		

Facility ID: 923245

If continuation sheet Page 57 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/03/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345285	B. WING _				C 1 06/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			10 HERITAGE CIRCLE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 644	 RDCS revealed she w the PASRR process w candidates to fill the of RDCS was not aware PASRR had expired a the process of conduct PASRRs. She stated PASRRs. She stated PASRR was missed a review would need to During a follow-up inte PM, the Administrator have been developed Level II PASRR deter turnover in the SW pot wayside. Resident #104 was 10/01/24 with multiple schizophrenia, major post-traumatic stress Review of a North Ca Screening Tool (NC M provided by the facility Resident #104 had a effective with an expir Further review reveal evaluation was reque been obtained. Review of Resident # 	n 12/04/24 at 2:57 PM, the vas trying to stay on top of vhile the facility interviewed open SW position. The that Resident #21's Level II and stated she was now in cting an audit of all resident Resident #21's expired and a request for a PASRR be submitted. erview on 12/06/24 at 3:52 stated a care plan should to address Resident #21's mination and due to the osition, it just fell by the s admitted to the facility on e diagnoses that included depressive disorder and disorder. rolina Medicaid Uniform MUST) inquiry document y on 12/03/24 revealed time-limited Levell II PASRR ration date of 08/23/24. ed no evidence a PASRR had	F 6	44	committee (QAPI) by the Administrato monthly for three (3) months. At that the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction a necessary. Completion Date: 1/3/2025	me	

If continuation sheet Page 58 of 119

TEMENT C	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
J PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i			
		345285	B. WING		C 12/06/2024		
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
CCOPDI	US HEALTH AT HENDER			200 HERITAGE CIRCLE			
				HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETI HE APPROPRIATE DATE		
F 644	Continued From page	o 58	F 64				
1 011		on 12/04/24 at 2:28 PM, the	F 04	4			
		ed the Social Worker (SW)					
	was typically the pers	· · · · · · · · · · · · · · · · · · ·					
		RR process; however, the					
		on 10/24/24 and they have					
		ewing candidates to fill the Administrator stated in the					
		Director of Clinical Services					
		son handling Level II PASRR					
	requests.						
	During an interview o	on 12/04/24 at 2:57 PM, the					
		was trying to stay on top of					
	the PASRR process	while the facility interviewed					
		open SW position. The					
	-	e that Resident #104's Level d and stated she was now in					
	-	cting an audit of all resident					
		d Resident #104's expired					
	PASRR was overlook	ked and a request for a					
	PASRR review was s	submitted on 12/03/24.					
	During a follow-up int	terview on 12/06/24 at 3:52					
	÷ .	r stated a care plan should					
		d to address Resident #104's					
		rmination and due to the					
	wayside.	osition, it just fell by the					
F 660	Discharge Planning F		F 66	0	1/3/25		
SS=D	CFR(s): 483.21(c)(1)	(i)-(ix)					
	§483.21(c)(1) Discha	rge Planning Process					
		elop and implement an					
		lanning process that focuses					
		charge goals, the preparation					
		ive partners and effectively st-discharge care, and the					
	панынон шешто роз	si-discuarde care and the	1				

Facility ID: 923245

If continuation sheet Page 59 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		ECONSTRUCTION	(X3) DATE		
AND I LAN OF	OUNCEDHON	IDENTITION TO MODELY.	A. BUILDI	NG _			C	
		345285	B. WING				06/2024	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	SONVILLE						
		ATEMENT OF DEFICIENCIES			HENDERSONVILLE, NC 28791		(X5)	
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 660	process must be cons rights set forth at 483. (i) Ensure that the dis resident are identified development of a disc resident. (ii) Include regular re- identify changes that discharge plan. The d updated, as needed, t (iii) Involve the interdii by §483.21(b)(2)(ii), ir developing the dischar (iv) Consider caregive and the resident's or of person(s) capacity an required care, as part discharge needs. (v) Involve the resider representative in the of discharge plan and in resident representativ (vi) Address the resider treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indii to the community, the referrals to local conta appropriate entities m (B) Facilities must upo comprehensive care p appropriate, in respor from referrals to local appropriate entities.	cility's discharge planning sistent with the discharge .15(b) as applicable and- charge needs of each and result in the charge plan for each evaluation of residents to require modification of the lischarge plan must be to reflect these changes. sciplinary team, as defined in the ongoing process of arge plan. er/support person availability caregiver's/support id capability to perform to f the identification of the and resident development of the form the resident and we of the final plan. ent's goals of care and s. resident has been asked receiving information the community. cates an interest in returning facility must document any act agencies or other hade for this purpose. date a resident's olan and discharge plan, as hase to information received contact agencies or other	F	660				
	appropriate entities.	e community is determined						

If continuation sheet Page 60 of 119

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/202 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	Y	
		345285	B. WING		12/06/202	24	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDEI	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	(5) LETIOI ATE	
F 660	to not be feasible, the made the determinat (viii) For residents wh SNF or who are disc LTCH, assist residen representatives in se provider by using dat limited to SNF, HHA, patient assessment of measures, and data the data is available. the post-acute care se assessment data, dat data on resource use the resident's goals of preferences. (ix) Document, comp on the resident's need record, the evaluation needs and discharge evaluation must be d resident's representat information must be d resident's representation discharge plan to fact to avoid unnecessary discharge or transfer This REQUIREMENT by: Based on record rev interviews, the facility planning process in p resident in the develop plan that addressed f goals and post-disch	e facility must document who ion and why. no are transferred to another harged to a HHA, IRF, or ts and their resident electing a post-acute care ta that includes, but is not IRF, or LTCH standardized data, data on quality on resource use to the extent The facility must ensure that standardized patient ta on quality measures, and e is relevant and applicable to of care and treatment elete on a timely basis based eds, and include in the clinical n of the resident's discharge e plan. The results of the lisccussed with the resident or ative. All relevant resident incorporated into the cillitate its implementation and y delays in the resident's	F 66	0 The facility failed to have a disch planning process in place that incorporated the resident in the development of a discharge care addressed the resident's discharg and post-discharge needs for res who wished to discharge to the community for 2 of 3 sampled res (Residents #50 and #70). Reside and 70 were interviewed to deter their discharge intentions whethe	plan that ge goals idents sidents nts #50 mine		

Facility ID: 923245

If continuation sheet Page 61 of 119

CENTER	S FUR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345285	B. WING		С
	ROVIDER OR SUPPLIER	545285		STREET ADDRESS, CITY, STATE, ZIP CODE	12/06/2024
NAIVIE OF PI	ROVIDER OR SUPPLIER			200 HERITAGE CIRCLE	
CCORDI	US HEALTH AT HENDE	RSONVILLE		HENDERSONVILLE, NC 28791	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	D.17
F 660	Continued From pag	e 61	F 66	50	
		s admitted to the facility on		remain in the facility long term or to	0
		bses that included diabetes,		discharge to the community by the	
	-	post-traumatic stress		Administrator. The Administrator th	
	disorder, and anxiety			started working on their discharge	
				planning and minimum data set (M	IDS)
	The admission Minin	num Data Set (MDS)		nurse initiated an appropriate care	,
		7/12/23 revealed Resident		completed on 12/27/2024.	•
	#50 had intact cognit	tion. The MDS noted there			
		irge plan in place and		Current facility residents are at risl	< of
	Resident #50 wanted	to be asked about returning		being affected by the deficient practice	ctice.
	to the community on	all MDS assessments.		The administrator audited current	facility
	-			residents to ensure residents that	have
	A Discharge Plannin	g Review at		the desire to discharge to the com	munity
	Admission/Readmiss	sion assessment dated		had a working discharge process i	n place
	08/25/23 noted Resid	dent #50's discharge goal		and the residents were being inco	porated
	was to return to the o	community. Under the		into the planning process. The auc	lit was
	summary section it w	/as noted in part that		completed on 1/3/25. Identified co	ncerns
	Resident #50 was ap	pproved for a Medicaid		were corrected by 1/3/2025. Effect	live
	program that helped	individuals residing in		1/3/2025, the social worker will be	
		ition back to their home in		responsible for discharge planning	and
	the community and w	vith the assistance of the		care plan development discharge.	
		ppropriate referrals and			
		d be feasible for Resident		To ensure this deficient practice do	
	#50 to return to the c	community.		recur the administrator educated the	ne
				interdisciplinary team (IDT) on the	
	A Discharge Plannin	-		Discharge Planning Process when	
		sion assessment dated		facility must develop and impleme	
		dent #50's discharge goal		effective discharge planning proce	
		community. Under the		focuses on the resident's discharg	-
	-	vas noted in part that		the preparation of residents to be a	
		ancial assistance from a		partners and effectively transition t	
		at helped individuals residing		post-discharge care, and the reduc	CUON OT
		nsition back to their home in		factors leading to preventable	
	-	he hoped to discharge within		readmissions. The education was	
	the next six (6) mont	ns.		completed by 1/3/2025. Newly hire	
				and IDT not educated by 1/3/2025	
		#50's comprehensive care		educated upon hire or prior to wor	king
	discharge care plan.	evised 08/14/24, revealed no		their next scheduled shift.	

Facility ID: 923245

If continuation sheet Page 62 of 119

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLI	E CONSTRUCTION	(X3) DATE		
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _				
		345285	B. WING				06/2024	
NAME OF PI	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	RSONVILLE	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 660	12/05/24 at 9:30 AM, since admitting to the was always to return she was able. Reside ready to discharge ba "had been for a while housing assistance ve admitted to the facility when she didn't disch now back on the wait assistance voucher. was also approved fo through a Medicaid p back to independent I having a Social Work assist her with filling of setting up the appoint discharge. Resident anything was mention planning was at her la June 2024 and since anything to her or ask her discharge goals a During an interview o MDS Nurse #2 revea not have a Social Wo SW would be the one a discharge care plans filled. During interviews on	12/03/24 at 8:49 AM and Resident #50 revealed e facility, her discharge goal back to the community when ent #50 stated she was ack to independent living and ." She stated she had a oucher when she first y but lost it in May 2024 harge as planned and was ing list for another housing Resident #50 stated she or financial assistance rogram to help with returning living but with the facility not er, there had been no one to but the applications or tments needed for her to #50 stated the last time hed about discharge ast care plan meeting in then, no one had mentioned ked her for input regarding and plans. In 12/05/24 at 9:00 AM, the led the facility currently did orker (SW) and typically, the e responsible for developing h. MDS Nurse #2 was not	F	660		kly for 1 th an dent by nce pr Pl ess		
	that the SW typically	the Administrator revealed handled the discharge ch included the development						

If continuation sheet Page 63 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVE OMB NO. 0938-039			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345285	B. WING				C 06/2024		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE				
ACCORD	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 660	of a discharge care p employment on 10/24 actively interviewing of position. He added th who would be starting The Administrator sta and the Director of Ne cover the SW position he has had frequent of Representative from th had approved Reside had not documented Resident #50's medic with Resident #50 to Administrator could n care plan was not init #50 and confirmed or developed that incorp discharge goals to refund updated as her dischar During a telephone in AM, the Representation program that assisted nursing homes transit the community reveal approved for assistant company taking over Medicaid program on Representative stated Resident #50 was on 2. Resident #70 was 08/21/24 with multiple chronic autoimmune of central nervous syste seizure disorder.	lan; however, the SW left l/24 and they have been candidates to fill the open ney had just hired a new SW g within the next two weeks. ted in the interim, both he ursing had been filling in to a. The Administrator stated conversations with the the Medicaid program that ent #50 for assistance but he those conversations in cal record nor had he spoken keep her updated. The ot explain why a discharge ially developed for Resident he should have been borated Resident #50's turn to the community and arge plans progressed. terview on 12/06/24 at 8:16 ve from the Medicaid d individuals residing in tion back to their home in led Resident #50 was nee prior to the new management of the 09/18/24. The d from what she could recall, the waiting list for housing. admitted to the facility on e diagnoses that included a disease that damages the	F	660					

If continuation sheet Page 64 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345285	B. WING				06/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 660	and there was no curr Review of Resident # plan, last reviewed/re no discharge care pla During interviews on 12/05/24 at 4:15 PM, desire was to dischar living and she was ap program that helped i nursing homes transit the community but tha planning stopped. Re step was to apply for one to help her with th currently did not have Resident #70 stated s had talked with her to goals and she would her discharge plans. During an interview o MDS Nurse #2 reveal not have a Social Wo SW would be the one a discharge care plans filled. During interviews on 12/06/24 at 3:52 PM, that the SW typically planning process white	esident #70 had intact noted Resident #70's o return to the community rent discharge plan in place. 70's comprehensive care vised on 09/20/24, revealed in. 12/02/24 at 12:07 PM and Resident #70 stated her ge back to independent oproved for a Medicaid ndividuals residing in tion back to their home in at was where the discharge esident #70 stated the next housing but there was no ne process since the facility e a Social Worker (SW). since the SW left, no one o discuss her discharge like to move forward with n 12/05/24 at 9:00 AM, the led the facility currently did rker (SW) and typically, the responsible for developing 0. MDS Nurse #2 was not	F	660			

Facility ID: 923245

If continuation sheet Page 65 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/03/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345285	B. WING			_		C 06/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		2	200 HERITAGE CIRCLE			
				ŀ	HENDERSONVILLE, NO	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 660	actively interviewing of position. He added the who would be starting The Administrator star and the Director of Nuc cover the SW position Resident #70 did not he has had many com- explaining they could an Assisted Living Far- return to the commun- would lose the assistar approved for through Administrator stated he those conversations in record and could not care plan was not initia #70. He stated one sis that incorporated Resis to return to the commun- discharge plans program During a telephone in AM, the Representative program that assisted nursing homes transit the community reveal approved for assistan Representative stated and gave her an over she could expect and needs. She stated Re- would need help with informed Resident #7 would need to obtain the program. The Re-	/24 and they have been candidates to fill the open ney had just hired a new SW within the next two weeks. ted in the interim, both he ursing had been filling in to a. The Administrator stated want to be at the facility and versations with her help get her transitioned to cility until she was able to ity but if they did that, she ance she had been the Medicaid program. The he had not documented in Resident #70's medical explain why a discharge ally developed for Resident hould have been developed ident #70's discharge goals unity and updated as her ressed. terview on 12/06/24 at 8:16 ve from the Medicaid individuals residing in ion back to their home in ed Resident #70 was	F	660		DEFICIENCY)		
	to the volume of indiv	-						

Facility ID: 923245

If continuation sheet Page 66 of 119

		MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345285	B. WING _		C 12/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 200 HERITAGE CIRCLE	CODE
ACCORDI	US HEALTH AT HENDE	RSONVILLE		HENDERSONVILLE, NC 28791	I
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 660	Continued From pag	e 66	F	660	
F 680 SS=C	,		Fe	580	1/3/25
	directed by a qualifie qualified therapeutic activities professiona (i) Is licensed or regis State in which practic (ii) Is: (A) Eligible for certific recreation specialist professional by a rec or after October 1, 19 (B) Has 2 years of e recreational program of which was full-time program; or (C) Is a qualified occ occupational therapy (D) Has completed a the State. This REQUIREMENT by: Based on staff interv have a qualified profe	stered, if applicable, by the cing; and cation as a therapeutic or as an activities cognized accrediting body on 290; or xperience in a social or within the last 5 years, one e in a therapeutic activities upational therapist or r assistant; or training course approved by T is not met as evidenced views, the facility failed to essional to direct the facility's is practice had the potential lents at the facility.		The facility failed to have professional to direct the program. This practice ha affect all 106 residents at facility hired a Certified A with a start date of 12/31/	facility's activity ad the potential to the facility. The ctivities Director

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 67 of 119

		MEDICAID SERVICES					IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			· /	E SURVEY IPLETED
		345285	B. WING				С
	ROVIDER OR SUPPLIER	545205			REET ADDRESS, CITY, STATE, ZIP CODE	12	2/06/2024
NAIVIE OF PI	ROVIDER OR SUPPLIER) HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE			NDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 680	Continued From page	e 67	F 6	80			
		oth, 2024. She stated that			affected by the facility not having a		
	there was an Activity				qualified activities professional. No		
	-	ne started who left the			concerns were noted during review.		
	, ,	per 2024. The Assistant			concerns were noted during review.		
		ed she had no training other			To ensure the deficient practice does n	ot	
	•	as working at the facility. The			recur, the Vice President of Clinical		
		ector could not give any			Operations educated the Administrator	on	
		the AD gave her. The			regulatory requirement for a facility to		
	, , ,	ector indicated she had no			employee a qualified activities		
		Assistant Activity Director did			professional. This education was		
		D she was referring to was			completed by 1/3/2025. The facility		
	actually an acting AD	-			transferred a qualified activities		
					professional from a sister facility to fill t	he	
	On 12/3/24 at 2:25 P	M an interview was			role for the facility. This transfer was		
	conducted with the A			completed on 12/31/2024 .			
	that she started work	ing at the facility on					
	11/28/24. She had n	ot had any training since			The administrator will audit 5 residents		
	working at the facility	 She had no college 			weekly for 4 weeks, 5 residents biweek	ly	
	degree. She had not	t taken any state training			for 4 weeks, and 5 residents monthly for	or 1	
	courses. She did hav	e some prior experience			month to ensure residents have no		
	working with adults w	vith disabilities.			concerns regarding activities and their		
					needs are being met. The facility will		
	On 12/5/24 at 10:33				monitor the corrective actions to ensure		
	conducted with the A				that the deficient practice is corrected a	and	
		that from 8/7/24 till 8/20/24			will not recur by reviewing information		
	-) and an Activity Assistant.			collected during audits and reporting to		
		24 and the Activity Assistant			Quality Assurance Performance		
		9/25/24 till 10/16/24 the			Improvement committee (QAPI) by the		
		ave an AD or an Activity			Administrator monthly for three (3)		
		facility no longer had these			months. At that time the QAPI committe	ee	
	•	Imission Coordinator took			will evaluate the effectiveness of the		
	over as the acting AD				interventions to determine if continued		
	-	r the role as the Activity AD conducted activities			auditing or adjustments to the plan of correction are necessary.		
	-	nours Monday through Friday			Concolion are necessary.		
	and the evening/wee				Completion Date: 1/3/2025		
		ngs and weekends. The plan			Completion Date. 1/3/2023		
		n Coordinator to remain the					
) was hired, however the					

Facility ID: 923245

If continuation sheet Page 68 of 119

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/03/202 FORM APPROVE OMB NO. 0938-039		
TATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING		C 12/06/2024		
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	JS HEALTH AT HENDER	RSONVILLE					
				ENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)			
F 680	F 680 Continued From page 68		F 680				
F 684 SS=D	position the Admission newly hired Assistant explaining to her the doing with the resider and explain how active he left his position in Administrator stated to Coordinator or evenir formal training in regar Administrator stated to interviews for the AD felt he may have an A week. The Administra- regulation and the ne The Administrator stated to compliance due to no Administrator stated to to find a candidate for Quality of Care CFR(s): 483.25	er. Prior to leaving his in Coordinator helped the Activity Director by activities that he had been ints. He continued to train vities were conducted until November. The that neither the Admission ing receptionist had any ard to activities. The he was now conducting 2nd position. The Administrator AD hired by this coming ator was aware of the red to have a qualified AD. ew the facility was out of the having an AD. The he had been actively trying r the position.	F 684		1/3/25		
	applies to all treatment facility residents. Base assessment of a resident that residents receive accordance with profe- practice, the compre- care plan, and the resident	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered					
	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			The facility failed to obtain a blood sug as part of the change of condition assessment for a resident with a curre diagnosis of diabetes mellitus that was	nt		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 69 of 119

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			I Y Y	E SURVEY IPLETED
	345285	B WING				С
	545205				12	2/06/2024
OVIDER OR SOFFLIER						
IS HEALTH AT HENDER	RSONVILLE					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULI) BE	(X5) COMPLETIO DATE
	- 60	E				
		FUC		a treated with routine oral blood		
				•	1	
	•					
			had	discharged prior to identified cita	ation.	
The findings included	l:			idente with a discussion of disk of		
Resident #205 was a	dmitted to the facility on			-		
	•					
congestive heart failu	ire.			0		
					an	
. ,					wina	
-	-			-	-	
hypoglycemic.						
The baseline care pla	an dated 2/7/24 identified		Тое	ensure the deficient practice does	s not	
	l of consciousness as being					
alert and intact.				<i>,</i> .		
A physician's order re	woolod alinizido motformin					
			U U			
				-		
two times a day. The	re was no physician order in		1/3/	2025. Newly hired facility and ag	-	
place to check the blo	ood sugar.					
A roution of the Marth	otion Administration Descard				upon	
			SUIR			
÷ ·	-		The	DON or designee will review 5		
-			resi	dents with a diagnosis of diabete		
PM.				-		
-	-			-		
), J	
	OVIDER OR SUPPLIER IS HEALTH AT HENDEF SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page with a current diagno was being treated with lowering medication f for a change of condit The findings included Resident #205 was a 2/6/24 with diagnose: chronic kidney diseas congestive heart failu Review of the 5-day/e (MDS) assessment d Resident #205's cogr impaired, and medica hypoglycemic. The baseline care pla Resident #205's leve alert and intact. A physician's order re (medication used to I tablet 2.5-500 milligra 2/7/24 with directions two times a day. The place to check the ble A review of the Medica (MAR) for February 2 glipizide-metformin o initialed by the nurse administered on 2/10 PM. The SBAR (Situation Recommendation) pr	JA5285 OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	A BUILDING 345285 B. WING	A BUILDING B WING SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY STATEMENT OF DEFICIENCIES ID ID	345285 B. WING DUDEE OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERTAGE CIRCLE HENDERSONVILLE IS HEALTH AT HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERTAGE CIRCLE HENDERSONVILLE, NC 28791 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISTE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX AG PROVIDERS FLAND OF CORRECTIVE (EACH DEFICIENCY MISTE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 69 IF 684 being treated with routine oral blood glucose lowering medication for 1 of 1 resident reviewed for a change of condition (Resident #205). F 684 D/2/24 with diagnoses included: Resident #205 was admitted to the facility on 28/2/4 with diagnoses including diabetes mellitus, chronic kidney disease, and chronic systolic congestive heart failure. Resident #205's cognition was moderately impaired, and medications received included a hypoglycemic. Resident #205's cognition was moderately impaired, and medications received included a hypoglycemic. To ensure the efficient practice does recur the Staff Development Coordin (SDC) completed facility and agency licensed nurses c signs and symptoms of hypoglycemi how to respond to a change in condition. No concerns so noted during the audit. The baseline care plan dated 2/7/24 identified Resident #205's level of consciousness as being alert and intact. To ensure the eficient practice does recur the Staff Development Coordin (SDC) completed building in abeter 2/7/24 with directions to give 1 tablet by mouth two times a day. Ther	345285 BUILTING 1 OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 20 HERTAGE CIRCLE 20 HERTAGE CIRCLE

Facility ID: 923245

If continuation sheet Page 70 of 119

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTI	PLE CONSTRUCTION	(X3) DATE SURVE	8-039 Y
	F CORRECTION	IDENTIFICATION NUMBER:	· · /	G	COMPLETED	1
					С	
		345285	B. WING		12/06/202	24
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
	IUS HEALTH AT HENDEI			200 HERITAGE CIRCLE		
ACCORD	IOS NEALTH AT HENDE	RSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPI THE APPROPRIATE DA	X5) PLETION ATE
F 684	Continued From page	e 70	F 6	84		
		nt #205. The SBAR was		corrective actions to ensure	e that the	
		e #5 and noted Resident		deficient practice is correct		
	-	cal history background of		recur by reviewing informat		
	diabetes mellitus and	the physical assessment		during audits and reporting	to Quality	
	noted increased conf	fusion and general		Assurance Performance Im	provement	
		s taken were blood pressure		committee (QAPI) by the A		
		piratory rate 19, temperature		monthly for three (3) month		
		96% on room air. The SBAR		the QAPI committee will ev		
	-	uidance to check the blood		effectiveness of the interve		
	-	ank to indicate it was not		determine if continued aud		
	done.			adjustments to the plan of	correction are	
	A progrado poto data	d 2/10/24 at 5:15 DM was		necessary.		
		d 2/10/24 at 5:15 PM was e #5 and revealed Resident		Completion Date: 1/3/2025		
		the facility after a couple of				
		her daughter. The daughter				
		205 was depressed and				
	agitated. Nurse #5 no	otified the on-call Medical				
	Doctor (MD) and rece	eived a new order for				
		on used to treat anxiety).				
		e daughter of the new order				
		t #205 seen by a MD. Nurse				
		ergency medical services for				
		ital. The daughter insisted				
		dent #205 to the hospital,				
		ity. Nurse #5 noted Resident ughter in no apparent				
	distress.					
	A review of the emer	gency department note				
) PM revealed Resident #205				
		r daughter for altered mental				
		reported Resident #205 was				
		y agitated. The MD noted				
	Resident #205 took g	glipizide and thought the				
		sion was hypoglycemia. The				
		led Resident #205's behavior				
		neurological deficit present				
	and mental status as	being alert. Vital signs were				

Facility ID: 923245

If continuation sheet Page 71 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 01/03/2025 FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION		X3) DATE S COMPL	SURVEY ETED
		345285	B. WING				C 12/0	;)6/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP COD	E.		
ACCORDI	US HEALTH AT HENDER	RSONVILLE			HERITAGE CIRCLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	E	(X5) COMPLETION DATE
F 684	temperature 98.1, res saturation 98%. The on 2/10/24 at 5:41 PM 70-111) then at 6:25 I was 108, and 9:16 PI hospital record revea treated with intravend the blood sugar signi emergency departmed discontinued with no admission and Resid 2/14/24 in stable cond During an interview of Nurse #5 revealed wil Resident #205 he doo progress note on 2/10 did not obtain a blood SBAR and did not red #205 was taking oral for diagnosis of diabe MD. Nurse #5 revealed emergency medical st daughter insisted she left the facility. During an interview of Nurse Practitioner (N expect Nurse #5 wou as part of Resident # explained when Resid altered mental status active diagnosis and hypoglycemic medica information was provided the status have identified Resid	ssure 93/67, pulse 97, spiratory rate 16, oxygen initial blood sugar obtained M was 37 (reference range PM was 52, and 6:45 PM M was high at 116. The led Resident #205 was ous (IV) and oral glucose and ficantly improved in the ent. Glipizide-metformin was blood sugar problems since ent #205 was discharged on dition. In 12/12/24 at 9:04 PM hat he saw and did for cumented on the SBAR, and 0/24. Nurse #5 confirmed he d sugar as indicated on the call if he reported Resident hypoglycemic medications etes mellitus to the on-call ed he offered to call services but Resident #205's a would take the resident and In 12/06/24 at 9:07 AM the P) revealed she would Id obtain a blood sugar level 205's vital sign check. She dent #205 demonstrated with diabetes mellitus as an	F	684				

Facility ID: 923245

If continuation sheet Page 72 of 119

	S FOR MEDICARE &					10.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			TE SURVEY MPLETED
			A. BUILDING	3		С
		345285	B. WING			2/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		2/00/2024
				200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDEI	RSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIO
F 684	Continued From pag	e 72	F 68	4		
		e and it appeared Resident				
	#205 was alert and could have ate and drank					
	something to increas	e the blood sugar level.				
	An interview was cor	nducted on 12/06/24 at 11:28				
		Director. The Medical				
	Director revealed wh	en a resident presented with				
		tatus especially if diagnosed				
	with diabetes mellitus					
		ation, he would expect the				
		cked. The Medical Director /ersight by the nurse that the				
		checked and should be				
		e assessment reported to				
		e provider to give informed				
	guidance to the nurse	e.				
	An interview was cor	nducted on 12/06/24 at 12:17				
	PM with the Director	of Nursing (DON). The DON				
		d not check Resident #205's				
	2	nere was no order in place.				
		s a nurse she would have				
		5's blood sugar as part of reported the result to the				
	on-call MD for guidar					
	During an interview o	on 12/06/24 at 4:47 PM the				
	-	ed he would expect Nurse #5				
		ar level and include that				
		f the assessment reported to				
	the on-call MD.		_			
F 689 SS=D	Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 68	9		1/3/25
	§483.25(d) Accidents	5.				
	The facility must ens	ure that -				
		sident environment remains				
	as free of accident ha	azards as is possible; and	1			1

Facility ID: 923245

If continuation sheet Page 73 of 119

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	IG	CO	MPLETED
		345285	B. WING _			C I 2/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT		
				200 HERITAGE CIRCL	E	
ACCORDI	US HEALTH AT HENDEI	RSONVILLE		HENDERSONVILLE	, NC 28791	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVI	DER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 689	Continued From pag	e 73	F	89		
	8/183 25(d)(2)Each r	esident receives adequate				
		stance devices to prevent				
	This REQUIREMEN	Γ is not met as evidenced				
	by: Based on observatio	ons, record review, and staff		The facility fail	led to ensure a Nurse Aide	
		failed to ensure a Nurse		-	erred a resident safely for 1	
	Aide (NA #8) transfe	rred a resident safely for 1 of		of 8 residents ((Resident #4) reviewed for	
	8 residents (Residen	t #4) reviewed for			prevent accidents. Nurse	
	supervision to prever	nt accidents.			nmediately educated on	
				-	rdex to obtain transfer	
	Findings included:			status for resid (DON).	ents by director of nursing	
		nitted to the facility 12/12/15				
	•	ding muscle spasm and lack			residents are at risk of	
	of coordination.				by this deficient practice.	
	-				minimum data set (MDS)	
	The quarterly Minimu				current facility residents to	
		9/22/24 revealed Resident #4 d cognitive skills for daily		-	ive a transfer status listed ts' Kardex. Residents who	
		had impaired range of			transfer status listed were	
	•	f her upper extremities and			at that time. Audit	
	impaired range of mo			completed on 2		
		S indicated Resident #4 was				
	dependent for chair/t	bed transfers.		To ensure the	deficient practice does not	
					Development Coordinator	
		es of daily living (ADL) care			ty and agency nurse aides	
		20/24 revealed Resident #4			he Kardex and following the	
		e performance deficit and			that is documented.	
	required a mechanic	•			pleted on 1/3/2025. Newly	
	assistance for transfe	513.			nd agency nurse aides and ted by 1/3/25 will be	
	Review of Resident #	#4's Kardex (a document that			hire or prior to working the	
		w of the care each resident		next scheduled	· •	
	•	d 12/02/24 revealed she				
	required a mechanic			The DON or de	esignee will review 5	
	assistance for transfe	-			sure transfer status is listed	
					and the nurse aide is	

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 74 of 119

PPLAN OF CORRECTION IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	1 Y	E SURVEY
	345285					C
	040200				1.	2/06/2024
	RSONVILLE	200 HERITAGE CIRCLE		00 HERITAGE CIRCLE		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETIOI DATE
		F 6	689			
				1		
	•			corrective actions to ensure that the		
failed to obtain assist	ance from a second staff					
					ed	
Resident #4 from the	chair to the bed.					
Review of NA #8's "A	gency Orientation"			•		
				the QAPI committee will evaluate the		
-						
	•			-	ro	
	Administrator of DON.				le	
An interview with NA	#8 on 12/02/24 at 11:40 AM			····· · ··· · ···· · ·················		
				Completion Date: 1/3/2025		
•	-					
-						
transfers.						
-						
	-					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I A continuous observa AM through 11:34 AM Resident #4 under he #4 from the geriatric of failed to obtain assist member or use a mee Resident #4 from the Review of NA #8's "A documentation revea document 09/18/24 a information on facility was to refer to the "E questions or call the A An interview with NA revealed she was an had been working in 1 a month. She stated when she began emp was a 1 person assis An interview with Phy 12/02/24 at 2:22 PM not currently on thera required 2 staff memil transfers. A follow-up interview 2:44 PM revealed she regarding resident ca from other NAs or the She stated she did no orientation when she what a Kardex was o An interview with the on 12/02/24 at 2:49 F	US HEALTH AT HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	OVIDER OR SUPPLIER US HEALTH AT HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFN TAG Continued From page 74 F 6 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 Residen	ROVIDER OR SUPPLIER S US HEALTH AT HENDERSONVILLE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 74 F 689 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" 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	IDENDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE US HEALTH AT HENDERSONVILLE 200 HERTAGE CIRCLE IDENDER SPLAN OF CORRECTIVE MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) IDENDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ATTORY OR LISC IDENTIFYING INFORMATION) Continued From page 74 F 689 A continuous observation on 12/02/24 from 11:28 AM through 11:34 AM revealed NA #8 picked 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" document 01/18/24 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 be was an agency staff member who had been working in the facility (PT) #1 on 12/02/24 at 2:22 PM revealed Resident #4 was a 1 person assist 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 %3 assigned nurse. She stated she was not 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 %3 assigned nurse. She stated she was inter 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	Control STREET ADDRESS, CITY, STATE, ZP CODE US HEALTH AT HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZP CODE US HEALTH AT HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX Continued From page 74 F 689 A continuous observation on 12/02/24 from 11:28 F 689 A through 11:34 AM revealed NA #8 picked Resident #4 under her arms and pivoted Resident #4 from the geriatric chair onto her bed. F 689 Review of NA #8's "Agency Orientation" document 09/18/24 acknowledging she received information on facility policies and processes and was to refer to the "Education Station" document 09/18/24 acknowledging she received information on call the Administrator or DON. F 689 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 of transfers. Completion Date: 1/3/2025 A follow-up interview with NA #8 on 12/02/24 at 2/24 PM revealed Resident #4 was not currently on therap caseload, but she required 2 staff members and a mechanical lift for transfers. Completion Date: 1/3/2025 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 #4 and was ta fard

	-	ND HUMAN SERVICES			FORM	: 01/03/202 APPROVE . 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345285	B. WING		_	,)6/2024
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE	
ACCORDI	US HEALTH AT HENDEF	RSONVILLE		HERITAGE CIRCLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689 F 690 SS=D	should not be manual member. She stated transfer status could the computer and all Kardex. The DON all book was located at e nursing staff could ac was needed for resid also available to answ resident care needs. staff member had to a received orientation u An interview with the 5:31 PM revealed he residents as recomm Physician. Bowel/Bladder Incom CFR(s): 483.25(e)(1) §483.25(e) Incontinent §483.25(e)(1) The fac resident who is contin admission receives s maintain continence of condition is or becom- not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent- indwelling catheter is resident's clinical con- catheterization was maintain and the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the statement of the s	members for transfers and illy transferred by 1 staff information on resident be located on the Kardex in staff had access to the so stated an orientation each nurse's station which cess if further information ent care and nurses were wer any questions regarding She stated each nursing sign a paper stating they upon hire. Administrator on 12/05/24 at expected staff to transfer ended by therapy or the tinence, Catheter, UTI -(3) nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is ain. esident with urinary on the resident's ssment, the facility must ters the facility without an not catheterized unless the adition demonstrates that	F 689			1/3/25

Facility ID: 923245

If continuation sheet Page 76 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	01/03/2025 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		345285	B. WING		C 12/0	6/2024
	ROVIDER OR SUPPLIER	RSONVILLE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 690	is assessed for remor as possible unless the demonstrates that ca and (iii) A resident who is receives appropriate prevent urinary tract if continence to the exter §483.25(e)(3) For a re- incontinence, based comprehensive assess ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on record rev- interviews with the re- failed to ensure the u- secured to the leg to trauma for 1 of 1 resident #87 Findings included: Resident #87 was ad 07/14/23 with diagnos- reflux uropathy (obstr- and a backwards flow The quarterly Minimu dated 09/05/24 revea- was moderately impa- behaviors during the indwelling urinary cat	 subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore ent possible. esident with fecal on the resident's assment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced iew, observation, and sident and staff the facility rinary catheter tubing was prevent movement and dent reviewed for urinary 87). mitted to the facility on sis including obstructive and ruction of urine from bladder <i>(</i>). m Data Set assessment led Resident #87's cognition ired with no rejection of care 	F 65	The facility failed to ensure the facility failed to ensure the focatheter tubing was secured to the prevent movement and trauma for the resident reviewed for urinary cate (Resident #87). A catheter secure device was applied to Resident at identification of need by the Diree Nursing (DON). Current facility residents with inconcatheters are at risk of being affect the deficient practice. The DON completed an audit on residents indwelling catheters to ensure a securement device was in place resident refused the medical pronotified and refusal was care plat The audit was completed on 12/To ensure the deficient practice.	he leg to or 1 of 1 heter rement #87 upon ctor of lwelling ected by with and if the vider was inned. 10/2024.	

Facility ID: 923245

If continuation sheet Page 77 of 119

							<u>NO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			· · ·	TE SURVEY MPLETED
							С
		345285	B. WING			1	2/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDE	RSONVILLE			HERITAGE CIRCLE NDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	Continued From pag	e 77	F 69	90			
	hygiene.				recur, the staff development coordina (SDC) educated facility and agency	tor	
	A review of Resident			licensed nurses and nurse aides on			
	order to secure the in			ensuring a catheter securement device	e is		
	using an anchoring o			in place for residents with indwelling			
	and urethral traction			catheters and document and notify			
	10/02/24.				medical provider of refusal. Education was completed by 1/3/2025. Newly hi		
	The care plan last re	vised on 11/19/24 identified			facility and agency licensed nurses a		
		indwelling catheter related			nurse aides and ones not educated b		
		hy and was at risk of			1/3/2025 will be educated upon hire o	-	
		entions included ensure the			prior to working next shift.		
		d to the resident. The care					
	-	ent #87 had behaviors which			The DON or designee will review 5		
	included but not limit			residents with indwelling catheters to			
	-	cations, treatments, and nd noted showers were			ensure the resident has a catheter	r 1	
	frequently refused. In				securement device in place weekly fo weeks, biweekly for 4 weeks, and mo		
		rapport with caregivers with			for 1 month. The facility will monitor the		
	emphasis to show gr				corrective actions to ensure that the	10	
					deficient practice is corrected and wil	not	
	Review of the Medic	ation Administration Record			recur by reviewing information collect		
	(MAR) for November	r revealed the physician's			during audits and reporting to Quality		
		d with directions to secure			Assurance Performance Improvemen		
	•	er tubing using an anchoring			committee (QAPI) by the Administrate		
		ovement and urethral traction			monthly for three (3) months. At that the the QAPI committee will evaluate the	ime	
		nitialed and checked each ght shift from 11/01/24			effectiveness of the interventions to		
		indicate the catheter tubing			determine if continued auditing or		
		vere no refusals documented			adjustments to the plan of correction	are	
	on the MAR to indica	ate Resident #87's anchoring			necessary.		
	device was not in pla	-					
	Deview of the MARD				Completion Date: 1/3/2025		
		or December revealed the					
		s transcribed with directions ling catheter tubing using an					
		prevent movement and					
		ry shift. Nurses initialed and					
		evening, and night shift from					

Facility ID: 923245

If continuation sheet Page 78 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/03/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345285	B. WING			_		C 06/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	to indicate the cathete were no refusals docu indicate Resident #87 in place. During an observation at 1:41 PM Nurse Aid care for Resident #87 Coordinator (SDC) in device to secure the t movement and traum and the SDC revealed anchoring device was An interview was con PM with Resident #87 wanted the catheter to stated the anchoring applied and he had no During an observation SDC applied an anch catheter tubing to Res #87 was accepting of An interview was con PM with Nurse #8 wh 12/2/24 and 12/3/24 of catheter tubing was s when she initialed the Resident #87's secure Nurse #8 revealed Res the anchoring device. During an interview o Nurse Practitioner (N	2/24 and 12/3/24 day shift er tubing was secure. There umented on the MAR to "s anchoring device was not "and interviews on 12/03/24 e (NA) #7 provided catheter with the Staff Development the room. An anchoring ubing to the leg to prevent a was not in place. NA #7 d they were not aware the a not in place and should be. ducted on 12/03/24 at 1:41 Z. Resident #87 revealed he ubing secured to his leg and device was not routinely ot removed it. n on 12/03/24 at 2:06 PM the oring device to secure the sident#87's leg. Resident the care. ducted on 12/03/24 at 2:49 o initialed the MAR on day shift to indicate the ecure. Nurse #8 revealed e MAR and checked ement device was in place. esident #87 would remove	F	690				

Facility ID: 923245

If continuation sheet Page 79 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/03/2025 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345285	B. WING		_		C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		00 HERITAGE CIRCLE IENDERSONVILLE, NC	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 690	revealed the anchorin prevent trauma and s would remove it.	bect it was in place. The NP ng device was used to help he heard Resident #87	F 690				
F 712 SS=E	PM with the Director of revealed if the nurses indicate the anchoring would expect it was. T aware Resident #87 r anchoring device.	g device was in place she The DON revealed she was efused to wear the uency/Timeliness/Alt NPP	F 712				1/3/25
	physician at least onc	y of physician visits sidents must be seen by a e every 30 days for the first on, and at least once every					
		cian visit is considered ater than 10 days after the uired.					
	(c)(4) and (f) of this se	as provided in paragraphs ection, all required physician by the physician personally.					
	required visits in SNF alternate between per and visits by a physic practitioner or clinical accordance with para This REQUIREMENT by:	nurse specialist in graph (e) of this section. is not met as evidenced					
	Based on record revi	ew, and Medical Director		The facility failed to	o ensure physician		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 80 of 119

		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVI COMPLETED	
					С	
		345285	B. WING		12/06/20	24
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
ACCORDI	US HEALTH AT HENDEI	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 2879	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COM O THE APPROPRIATE	(X5) IPLETIO DATE
F 712	Continued From pag	e 80	F 71	12		
	-	iews, the facility failed to		visits were performed ev	erv 30 days for	
		its were performed every 30		the first 90 days of admis		
		lays of admission for 4 of 4		sampled residents review		
		eviewed for physician visits		visits (Residents #21, #3		
	(Residents #21, #31,			Physician was notified by		
				Nursing of residents that		
	Findings included:			physician visits. Physicia		
				#21 on 12/15/2024, resid		
		admitted to the facility on e diagnoses that included		12/4/2024, resident #41 and resident #55 on 12/1		
	-	ulmonary disease (trouble			2/2024.	
		unonally disease (nouble une, and respiratory failure.		Current residents with in	their first 90 days	
	breathing), heart lait			of admission are at risk of	-	
	The guarterly Minimu	ım Data Set (MDS) dated		by this deficient practice.		
		esident #21 had moderate		Nursing (DON) audited re		
	impairment in cogniti			their first 90 days of adm		
				the medical provider had	seen the	
		21's Electronic Medical		resident every 30 days fo		
		led he was seen by the		days. The Physician was		
		on 06/14/24 and 08/26/24		residents needing a phys		
		(90) days of his admission		visits were completed by		
	to the facility.			Effective 1/3/2025 the DO		
	h Resident #31 was	admitted to the facility on		Director of Nursing (ADC responsible for ensuring		
		e diagnoses that included		visited by the physician e		
	-	piratory failure with hypoxia		during the first 90 days o		
		in the body tissues), heart				
	failure, and chronic k	•		The Staff Development C	Coordinator	
		-		(SDC) educated the phys	sician, DON, and	
		ım Data Set (MDS) dated		ADON of the expectation	č	
		esident #31 had intact		requirement of residents		
	cognition.			physician visits every 30 90 days of admission. Ne	-	
	Review of Resident #	#31's Electronic Medical		physicians or physicians		
		led he was seen by the		1/3/2025 will be educated		
	. ,	on 06/14/24 and 09/11/24		prior to next facility visits	-	
		(90) days of his admission				
	to the facility.			The DON or designee wi		
				residents within their first	90 days of	

Facility ID: 923245

If continuation sheet Page 81 of 119

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		
		345285	B. WING			C 06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I	
ACCORDI	US HEALTH AT HENDEF	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 712	10		F 71	2 admission to ensure the physicia	an has	
	 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 			visited them every 30 days for the days weekly for 4 weeks, biweek weeks, and monthly for 1 monthe facility will monitor the corrective to ensure that the deficient practice corrected and will not recur by re-	e first 90 kly for 4 . The actions ice is	
	08/15/24 indicated Re impairment in cognition Review of Resident #	esident #41 had moderate on. 441s Electronic Medical		information collected during aud reporting to Quality Assurance Performance Improvement com (QAPI) by the Administrator mor	its and mittee hthly for	
	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.	on 08/17/24 during the first er admission to the facility. it on 08/17/24, Resident #41		three (3) months. At that time the committee will evaluate the effect of the interventions to determine continued auditing or adjustmen plan of correction are necessary	tiveness if ts to the	
	01/16/24 with diagnos (complete paralysis of hemiparesis (partial v	admitted to the facility on ses that included hemiplegia on one side of the body) and weakness on one side of the oral infarction (stroke), sion.		Completion Date: 1/3/2025		
	The quarterly Minimum Data Set (MDS) dated 08/30/24 indicated Resident #55 had intact cognition.					
	Record (EMR) reveal Medical Doctor (MD)	455's Electronic Medical led he was seen by the on 01/19/24 and 04/17/24 (90) days of his admission				
	Director of Nursing (Records and the Soc track of regulatory vis	on 12/05/24 at 11:15 AM, the DON) revealed Medical ial Worker were keeping sits for the MD but due to the e positions, she had been				

If continuation sheet Page 82 of 119

			0.00			O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING			С
		345285	B. WING			2/06/2024
	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CO		2/06/2024
	NO MEET ON OOT LEEK			200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDE	RSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETIO
F 712	Continued From pag	le 82	F 71	2		
		cess. The DON explained				
) with a weekly report of all				
		arges as well as a physician				
	-	o review to determine which				
w w co		be seen. The DON stated it system because if older visits				
		o on the report as not				
		er admissions would not				
		r visits were marked				
	complete and regula	tory visits would be				
	overlooked.					
	During a telephone i	nterview on 12/06/24 at 11:29				
		he only progress notes of his				
		ere the ones documented in				
		He stated that when he				
		, he was provided a list of all				
		eviewed to determine who d and then saw those				
		confirmed he was aware of				
		ling the frequency of visits				
		Residents #21, #31, #41, and				
		en as required following their				
		ility. He explained the facility				
		cal Records staff member en residents needed to be				
		ind him and it had helped him				
		sits were completed. The MD				
	stated he tried keepi	ng up with the regulatory				
	-	progress notes were not				
		esident's EMR, then there esident had not been seen.				
F 755		cedures/Pharmacist/Records	F 75	5		1/3/25
SS=D	CFR(s): 483.45(a)(b					110/20
	§483.45 Pharmacy \$	Services				
		vide routine and emergency				
	drugs and biological					

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 83 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/03/2025 RM APPROVED IO. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
		345285	B. WING		12/06/2024		
NAME OF PF	ROVIDER OR SUPPLIER	1	S	STREET ADDRESS, CITY, STATE, ZIP COD			
ACCORDI	US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 755	personnel to administ permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accur- dispensing, and admin biologicals) to meet th §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility. §483.45(b)(2) Establin receipt and disposition sufficient detail to enar reconciliation; and §483.45(b)(3) Determon order and that an accur is maintained and per This REQUIREMENT by: Based on observation Consultant Pharmacist and staff interviews, the antibiotic eye drops we pharmacy as ordered missed doses for 1 of	ment described in ty may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident. onsultation. The facility in the services of a licensed es consultation on all on of pharmacy services in shes a system of records of n of all controlled drugs in able an accurate hines that drug records are in oount of all controlled drugs riodically reconciled. T is not met as evidenced is, record review, and st, Medical Director, resident he facility failed to ensure vere received from the which resulted in five (5)	F 755	The facility failed to ensure a drops were received from the as ordered which resulted in f missed doses for 1 of 6 samp residents reviewed for pharm (Resident #11). Residents ey received and MD notified of d missed doses by the Director (DON) on 12/05/2024. No new	pharmacy five (5) oled acy services e drops were lelay and of Nursing		

Facility ID: 923245

If continuation sheet Page 84 of 119

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/03/2025 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345285	B. WING			1	C 2/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	US HEALTH AT HENDER			20	00 HERITAGE CIRCLE		
Accordi				H	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Continued From page	e 84	F 7	55			
		1 to the feature 14/14/00			received.		
		ed to the facility on 11/11/22. Noses included chronic			Current facility residents who are		
	conjunctivitis.			prescribed antibiotic eye drops are at of being affected by this deficient pra			
	The Minimum Data S	Set (MDS) assessment dated			Residents who are prescribed antibio		
		esident #11 had moderate			eye drops were audited on 12/10/202	•	
	impairment in cognition	on.			the DON to ensure their medication is		
	A Physician Order Sh	neet dated 11/20/24 and			available. No concerns noted during t audit.	ne	
	-	almologist read, "start					
		ps - one drop twice a day,			To ensure the deficient practice does		
	OD (right eye). Do n	-			recur, the Staff Development Coordin (SDC) educated current facility and		
		11's active physician orders			agency licensed nurses on administe	-	
	revealed an order da	ted 11/21/24 for Noride (HCI) Ophthalmic			medications as ordered and in the ev medication is not available the medic		
	-	sed to treat eye infections			provider must be notified and a hold of		
		0.5% - one drop in right eye			received. If medication is not received		
		ritation. No stop date per			from pharmacy when ordered to notif	y the	
	Ophthalmology.				DON. Education completed by 1/3/20		
					Newly hired facility and agency licens		
		on 12/05/24 at 11:36 AM for Ophthalmologist was			nurses and licensed nurses not educated upon hire		
	unsuccessful.				prior to working their next scheduled		
	Review of Resident #	11's Medication			The DON or designee will review 5		
		d (MAR) revealed the			residents to ensure their ordered		
	-	drops were scheduled to be			medications are available and		
		aily at 8:00 AM and 8:00 PM.			administered as ordered weekly for 4		
		MAR revealed Resident #11 00 PM dose on 12/03/24, the			weeks, biweekly for 4 weeks, and mo for 1 month. The facility will monitor the	-	
		I doses on 12/04/24, and the			corrective actions to ensure that the	10	
	8:00 AM and 8:00 PM				deficient practice is corrected and wil	not	
					recur by reviewing information collect	ed	
	-	on 12/04/24 at 8:55 AM,			during audits and reporting to Quality		
		esident #11 received her last			Assurance Performance Improvemen		
	dose of Moxifloxacin	eye drops yesterday nd she put in a refill request			committee (QAPI) by the Administrate monthly for three (3) months. At that		
	(12/03/24) a	na she parin a renn request					

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 85 of 119

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE (CONSTRUCTION	(X3) DATE	0. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G			PLETED
		345285	B. WING				C / 06/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	14	100/2024
				200	0 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE		HE	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 755	Continued From page	e 85	F 75	55			
1 100		ound 10:30 AM on 12/03/24.		55	the QAPI committee will evaluate the		
		she tried to put the refill			effectiveness of the interventions to		
	request in as soon as			determine if continued auditing or			
	administration but wa			adjustments to the plan of correction	are		
	-	ps would be delivered to the			necessary.		
	•	M and Resident #11 would					
		heduled dose on 12/03/24.			Completion Date: 1/3/2025		
		was not sure why the ps were not delivered with					
	-	nt on 12/04/24. Nurse #7					
	stated she called the						
		t 8:50 AM and was told the					
		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						
		loxacin eye drops at all					
	,	or this morning (12/04/24).					
		she had missed 3 doses so					
		about not receiving the eye					
		vas scheduled to have eye ent #11 stated the nurse					
	•••	is empty, tossed it away					
	accidentally and they						
	medication.						
		terview on 12/04/24 at 4:33					
		when she checked the					
		narmacy at 3:30 PM on					
		11's Moxifloxacin eye drops					
		the shipment. Nurse #7 pharmacy and they could					
		ination as to why Resident					
		e not sent as requested.					
	During an observatio	n and follow-up interview on					
	12/05/24 at 9:10 AM,	and ronow-up interview on					1

Facility ID: 923245

If continuation sheet Page 86 of 119

) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345285 NVILLE IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	A. BUILDING B. WING S	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE O HERITAGE CIRCLE HENDERSONVILLE, NC 28791 PROVIDER'S PLAN OF CORRECTION	(X3) DATE S COMPL C 12/0	ETED
NVILLE IENT OF DEFICIENCIES IST BE PRECEDED BY FULL	B. WING S 2 F ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
NVILLE IENT OF DEFICIENCIES IST BE PRECEDED BY FULL	ID PREFIX	100 HERITAGE CIRCLE HENDERSONVILLE, NC 28791	12/0	6/2024
IENT OF DEFICIENCIES ST BE PRECEDED BY FULL	ID PREFIX	100 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
IENT OF DEFICIENCIES ST BE PRECEDED BY FULL	ID PREFIX	HENDERSONVILLE, NC 28791		
IST BE PRECEDED BY FULL	PREFIX			
		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
all amount of drainage in esident #11 stated it was e stated she had still not s scheduled since view on 12/05/24 at 10:10 macist stated a refill 's Moxifloxacin eye drops 4 at 8:45 AM and the n alert in the pharmacy on to refill but the ed on 12/16/24 for the narmacist stated they did Communication form t 6:36 AM indicating the order to be refilled. The e cutoff time for the 30 AM and the cutoff g delivery was 7:30 PM, The Consultant her option would be for pharmacy to arrange for d at a backup pharmacy. 2/05/24 at 4:18 PM, t #11's Moxifloxacin eye in today's (12/05/24) the pharmacy. Nurse oharmacy and was told because it was too soon pay. She stated the	F 755			
	sident #11 stated it was e stated she had still not s scheduled since iew on 12/05/24 at 10:10 macist stated a refill s Moxifloxacin eye drops a t 8:45 AM and the alert in the pharmacy on to refill but the ed on 12/16/24 for the narmacist stated they did Communication form t 6:36 AM indicating the order to be refilled. The cutoff time for the 30 AM and the cutoff delivery was 7:30 PM, The Consultant er option would be for pharmacy to arrange for l at a backup pharmacy. 2/05/24 at 4:18 PM, s #11's Moxifloxacin eye n today's (12/05/24) the pharmacy. Nurse oharmacy and was told because it was too soon	sident #11 stated it was e stated she had still not s scheduled since iew on 12/05/24 at 10:10 macist stated a refill s Moxifloxacin eye drops at 8:45 AM and the alert in the pharmacy on to refill but the ed on 12/16/24 for the harmacist stated they did Communication form t 6:36 AM indicating the order to be refilled. The cutoff time for the 30 AM and the cutoff delivery was 7:30 PM, The Consultant her option would be for pharmacy to arrange for 1 at a backup pharmacy. 2/05/24 at 4:18 PM, #11's Moxifloxacin eye n today's (12/05/24) the pharmacy. Nurse oharmacy and was told because it was too soon pay. She stated the nething about a form ted indicating the facility tion to be refilled. When of Nursing (DON), the the form back to the	sident #11 stated it was a stated she had still not s scheduled since iew on 12/05/24 at 10:10 macist stated a refill s Moxifloxacin eye drops a 48:45 AM and the alert in the pharmacy on to refill but the ed on 12/16/24 for the marmacist stated they did Communication form t 6:36 AM indicating the order to be refilled. The cutoff time for the 30 AM and the cutoff i delivery was 7:30 PM, The Consultant ter option would be for pharmacy to arrange for I at a backup pharmacy. 2/05/24 at 4:18 PM, #11's Moxifloxacin eye in today's (12/05/24) the pharmacy and was told because it was too soon pay. She stated the nething about a form ted indicating the facility tion to be refilled. When of Nursing (DON), the the form back to the	sident #11 stated if was a stated she had still not a scheduled since iew on 12/05/24 at 10:10 macist stated a refill s Moxifloxacin eye drops a t 8:45 AM and the alert in the pharmacy on to refill but the ed on 12/16/24 for the narmacist stated they did Communication form t 6:36 AM indicating the order to be refilled. The cutoff time for the 30 AM and the cutoff of elivery was 7:30 PM, The Consultant ter option would be for pharmacy. to arrange for 1 at a backup pharmacy. //05/24 at 4:18 PM, #11's Moxifloxacin eye n today's (12/05/24) the pharmacy nurse sharmacy and was told because it was too soon pay. She stated the nething about a form ted indicating the facility tion to be refilled. When of Nursing (DON), the the form back to the

Facility ID: 923245

If continuation sheet Page 87 of 119

		D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 01/03/2025 APPROVED 0. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345285	B. WING				(12/0	06/2024
NAME OF PR	OVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE	, ZIP CODE		
ACCORDIL	JS HEALTH AT HENDER	SONVILLE			00 HERITAGE CIRCLE ENDERSONVILLE, NC 28	791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
	Nurse #1 confirmed R doses of the schedule due to the delay in the order. During an interview of Director of Nursing (D around lunchtime on had missed the 8:00 // drops and the nurse h the pharmacy that wa that afternoon. She s aware that Resident # 8:00 PM dose of the M 12/03/24. The DON s thing this morning upor Resident #11's Moxifie delivered from the pha stated she contacted Refill Too Soon Comm pharmacy at 5:57 AM drops should have be shipment but were no the pharmacy, Reside drops would be delive shipment on 12/06/24 nurse should have no #11's Moxifioxacin eye as expected after the on 12/03/24 so that sf with the pharmacy so	M to 4:00 AM on 12/06/24. Resident #11 had missed 5 ad Moxifloxacin eye drops a pharmacy refilling the an 12/05/24 at 4:46 PM, the ON) stated she was notified 12/04/24 that Resident #11 AM dose of Moxifloxacin eye had requested a refill from s supposed to be delivered tated she was not made the Aoxifloxacin eye drops on stated she checked first on arriving to the facility and oxacin eye drops were not armacy as expected. She the pharmacy, faxed the hunication form to the and the Moxifloxacin eye en delivered in the 3:00 PM t received. She stated per ent #11's Moxifloxacin eye red in the early morning . The DON stated the tified her when Resident e drops were not delivered refill request was submitted he could have followed up oner.	F 7	755				

If continuation sheet Page 88 of 119

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		OMB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345285	B. WING		C 12/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/06/2024	
ACCORDI	US HEALTH AT HENDEF	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 755	Continued From page	∋ 88	F 75	5		
	12/06/24 at 8:20 AM, was less red than it a Resident #11 confirm	n and follow-up interview on Resident #11's right eye ppeared on 12/05/24. ed the Moxifloxacin eye and she received a dose as ng.				
5 700	AM, the Medical Dire aware that Resident a had to be reordered. receiving the eye dro which caused redness amount of drainage. wanted her to receive he did not feel there w outcome related to R doses.	terview on 12/06/24 at 11:20 ctor stated he was made #11's Moxifloxacin eye drops He stated Resident #11 was ps to treat conjunctivitis s to her eye with a small The MD stated that while he the eye drops as ordered, would be any negative esident #11 missing 5			10/05	
F 760 SS=D		f Significant Med Errors	F 76		1/3/25	
	medication errors. This REQUIREMENT by:	nts are free of any significant				
	resident and staff interprevent a significant in failed to administer a prescribed by the phy	/sician. As a result,		The facility failed to prevent a significar medication error when they failed to administer antibiotic eye drops as prescribed by the physician. As a result Resident #11 missed 5 doses of antibio	, tic	
	drops. This affected	5 doses of antibiotic eye 1 of 6 sampled residents sary medications (Resident		eye drops. This affected 1 of 6 sampled residents reviewed for unnecessary medications (Resident #11).). Resident eye drops were received and MD notifie of delay and missed doses by the Direc	s	
	The findings included	•		of Nursing (DON) on 12/06/2024. No ne		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 89 of 119

		MEDICAID SERVICES				NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	TE SURVEY		
			D 14/11/0			С		
		345285	B. WING			2/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE			
ACCORDI	US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 2879 ⁻	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 760	Continued From page	89	F 76	50				
		d to the facility on 11/11/22.						
		oses included chronic		Current facility residents	who are			
	conjunctivitis.			prescribed antibiotic eye				
	-			of being affected by this	deficient practice.			
	-	itioner progress note dated		Residents who are preso				
		part, Resident #11 had right		eye drops were audited of	•			
		h chronic right eye redness		the DON to ensure their				
	•	rsened intermittently. The		available. No concerns n	oted during the			
		#11 had been treated with		audit.				
		ntibiotic eye drops and the an appointment with the		To ensure the deficient p	ractico doos not			
		urther management of		recur, the Staff Developm				
	ongoing symptoms.			(SDC) educated current				
	ongoing symptoms.			agency licensed nurses of				
	The Minimum Data S	et (MDS) assessment dated		medications as ordered a				
		sident #11 had moderate		medication is not availab				
	impairment in cognition	on.		provider must be notified	and a hold order			
				received. If medication is	not received			
		eet dated 11/20/24 and		from pharmacy when ord				
	signed by the Ophtha			DON. Education complet	•			
	• •	os - one drop twice a day,		Newly hired facility and a				
	OD (right eye). Do no	ot stop, continuous."		nurses and licensed nurs				
	A physician arder dat	$d \frac{11}{21} \frac{12}{24}$ revealed		by 1/3/25 will be educate				
	A physician order date Resident #11 was to r			prior to working their nex	a scheuuleu Shiit.			
	Hydrochloride (HCI) (The DON or designee wi	II review 5			
		at eye infections caused by		residents to ensure their				
		drop in right eye two times a		medications are available				
	day for irritation.			administered as ordered	weekly for 4			
				weeks, biweekly for 4 we				
	Review of Resident #			for 1 month. The facility v				
	Administration Record			corrective actions to ensu				
		drops were scheduled to be		deficient practice is corre				
		aily at 8:00 AM and 8:00 PM.		recur by reviewing inform				
		MAR revealed Resident #11		during audits and reportin				
		00 PM dose on 12/03/24, the 1 doses on 12/04/24, and the		Assurance Performance committee (QAPI) by the				
	8:00 AM and 8:00 PM			monthly for three (3) mor				
	0.00 AM and 0.00 FIV	1 40303 011 12/03/24.						

Facility ID: 923245

If continuation sheet Page 90 of 119

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		345285	B. WING		12	C 2/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET		
F 760 Continued From page 90 During an interview on 12/04/24 at 8:55 AM			F 76) effectiveness of the interventions	s to		
	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.			determine if continued auditing o adjustments to the plan of correct necessary.			
	 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 		Completion Date: 1/3/2025				
	far and was worried a drops because she w surgery soon. Reside thought the bottle was accidentally and they medication.	about not receiving the eye as scheduled to have eye ent #11 stated the nurse s empty, tossed it away had to reorder the					
	PM, Nurse #7 stated shipment from the ph 12/04/24 Resident #1 were not included in t stated she called the	erview on 12/04/24 at 4:33 when she checked the armacy at 3:30 PM on 1's Moxifloxacin eye drops the shipment. Nurse #7 pharmacy and they could nation as to why Resident					

If continuation sheet Page 91 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345285	B. WING		_		C 06/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			00704		
			I	HENDERSONVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	Continued From page	91	F 760				
		ed in today's (12/05/24) om the pharmacy. Nurse					
	•	nt #11 had missed 5 doses					
	of the scheduled Mox	ifloxacin eye drops due to nacy refilling the order.					
	Director of Nursing (D should have notified h Moxifloxacin eye drop expected after the refi	ner when Resident #11's s were not delivered as ill request was submitted on					
	12/03/24 so that she of the pharmacy sooner.	could have followed up with					
	AM, the Medical Direct aware that Resident # had to be reordered. receiving the eye drop which caused redness amount of drainage.						
F 770 SS=D	Administrator stated the immediately notified the	he DON when Resident e drops were not delivered Il from the pharmacy.	F 770				1/3/25
	laboratory services to	ility must provide or obtain					

Facility ID: 923245

If continuation sheet Page 92 of 119

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		ATE SURVEY
			A. DOILDING			С
		345285	B. WING			12/06/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
	US HEALTH AT HENDER			200 HERITAGE CIRCLE		
ACCORD	05 HEALIN AI HENDEI	(SONVIELE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 770	Continued From page	e 92	F 77	'n		
	and timeliness of the					
		les its own laboratory				
		s must meet the applicable				
		pratories specified in part 493				
	of this chapter.	······································				
		Γ is not met as evidenced				
	by:					
	Based on staff and N	Nurse Practitioner (NP)		The facility failed to complete	an ordered	
		d review, the facility failed to		Urinalysis for 1 of 2 residents		
	complete an ordered	-		laboratory services (Resident		
	residents reviewed for	or laboratory services		medical director was notified		
	(Resident #38).			resident⊡s refusal of urine sp		
	-			collection by Vice President of		
	The findings included	1.		Operations on 12/4/2024 and assessed by MD and new ord		
	Resident #38 was ad	lmitted to the facility on		received.	1615	
		Resident #38 was admitted to the facility on 11/5/23 with a diagnosis that included bacteremia.		Teceived.		
				Current facility residents who	have had an	
	Review of the quarter	rly minimum data set (MDS)		order for urinalysis (UA) are a		
		d that Resident #38 was		being affected by the deficien		
	cognitively intact.			100% audit of UA's ordered in	•	
				day was completed on 12/09/		
	Resident #38 had a p	physician's order for a		ensure the order was comple		
		ulture and sensitivity one		medical provider was notified		
	time only for 1 day. T			refusal of testing. The audit w		
	9/24/2024 and marke	ed completed on 9/25/2024.		completed and no additional	concerns	
	Boviow of the treater	ont administration record		were noted.		
		ent administration record 2024 revealed the UA was		To ensure the deficient practic	na does not	
	documented as comp			recur the Staff Development (
				SDC) educated facility and co		
	Review of the lab res	ults revealed that there were		licensed nurses on ensuring t		
		ordered on 9/24/2024 for		urinalysis testing is completed		
	Resident #38.			and to notify medical provider		
				refusals of testing. The educa		
	A phone interview on	12/6/2024 at 9:54 AM with		completed on 12/27/2024. Ne	wly hired	
	Nurse #6 revealed re			facility and contract licensed		
		ted the UA specimen for		interdisciplinary team (IDT) m		
	Resident #38 on 9/25	5/2024 and placed it in the		facility and contract licensed	nurses not	

Facility ID: 923245

If continuation sheet Page 93 of 119

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CO	DNSTRUCTION	T	O. 0938-039
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:				· /	IPLETED
							С
		345285	B. WING			1:	2/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
ACCORD	US HEALTH AT HENDER			200 H	HERITAGE CIRCLE		
ACCORD		NOONVILLE		HEN	IDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 770	Continued From page	e 93	F 77	70			
		b to collect. She stated that if		e	educated by 1/3/2025 will be educated	b	
		n refrigerator too long the lab			upon hire or prior to working their next		
		d throw the specimen out		s	scheduled shift.		
		er useable. She stated that					
	•	vere no results for the UA			The Director of Nursing or designee w		
		4. She stated that she was			audit 5 resident's weekly to ensure lab		
		ocess was for when that			orders are completed as ordered week		
	happened.				or 4 weeks, biweekly for 4 weeks, and hen monthly for 1 month. The facility		
	An interview on 12/6/	/2024 at 8:36 AM with the			nonitor the corrective actions to ensu		
		IP) revealed that she was not			hat the deficient practice is corrected		
		ember UA did not have any			will not recur by reviewing information		
	-	results returned from the laboratory and that she			collected during audits and reporting t		
	would want to be not			Quality Assurance Performance			
	to complete the UA o			mprovement committee (QAPI) by the	e		
	reordered. She state			Administrator monthly for three (3)			
	experienced harm or			nonths. At that time the QAPI commit	tee		
	not being completed.			will evaluate the effectiveness of the			
	An interview on 12/6/	2024 at 12:33 PM with the			nterventions to determine if continuec auditing or adjustments to the plan of	1	
		DON) revealed when the			correction are necessary.		
		ecimen, she puts it in the			served on are neededary.		
		out a requisition (a document			Completion Date: 1/3/2025		
		ders use to request specific					
	laboratory tests for re	esidents) that goes in the lab					
		in every morning and					
	-	sitions and pulls those					
		refrigerator to go to the lab.					
		vas the one who followed up I made sure the requisitions					
		and if any had not been she					
		inform them about any labs					
		ed. She stated that she had					
	just found the specim	nen from Resident #38 's					
	9/24/2024 UA in the I	refrigerator. She stated that					
	there was no requisit						
		se. So that was why the UA					
		h results. She further					
	revealed that the bre	akdown was the Nurse who					

If continuation sheet Page 94 of 119

		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED //B NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3	3) DATE SURVEY COMPLETED C
		345285	B. WING			12/06/2024
	ROVIDER OR SUPPLIER	SONVILLE		STREET ADDRESS, CITY, STATE, ZIP (200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 770 F 803 SS=F	collected the specime requisition. She stated specimen sooner that followed up with the N the UA and she would Nurse as well about th An interview on 12/6/2 Administrator reveale that if a lab was order the sample and fill ou paperwork, so the sar analysis. He further re- that if a lab order doe whatever reason the l could make the decisi not. Menus Meet Residen CFR(s): 483.60(c)(1)- §483.60(c) Menus an Menus must- §483.60(c)(2) Be prep §483.60(c)(3) Be follo §483.60(c)(4) Reflect reasonable efforts, th	en did not fill out the d that if she had found the in 12/6/2024, she would have IP to obtain a new order for d have followed up with the he specimen. 24 at 3:54 PM with the d that his expectation was ed the nursing staff gather t all the applicable mple got to the lab for evealed that he expected s not make it to the lab for NP would be notified so they ion to order another lab or t Nds/Prep in Adv/Followed (7) d nutritional adequacy. en nutritional needs of ce with established national pared in advance; wed; , based on a facility's e religious, cultural and esident population, as well as esidents and resident	F 7			1/3/25

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 95 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/03/20 RM APPROVE NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				TE SURVEY MPLETED	
		345285	B. WING			1	C 2/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER	1		STI	REET ADDRESS, CITY, STATE, ZIP CODE	•		
ACCORDI	US HEALTH AT HENDEF	RSONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 803	Continued From page	e 95	F	803				
	 §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 							
					The facility failed to provide all for as specified by the approved me			
	Operations (RDO) int provide all food items approved menu and received the correct p approved menu. The potential to affect 77 diet, 18 residents rec	, record review, and dietary staff, Registered tician (RD), and the Regional Director of erations (RDO) interviews, the facility failed to vide all food items as specified by the roved menu and failed ensure residents eived the correct portion sizes based on the roved menu. These practices had the ential to affect 77 residents receiving a regular , 18 residents receiving a mechanical soft diet nsisting of foods that are easy to swallow),			failed to ensure residents receive correct portion sizes based on th approved menu. These practices potential to affect 77 residents re regular diet, 18 residents receivin mechanical soft diet (consisting of that are easy to swallow), and 8 receiving a puree diet (consisting with a pudding-like texture).	e s had the eceiving a ng a of foods residents		
	· -	ving a puree diet (consisting			Current facility residents are at ribeing affected by the deficient pr			
	Findings included:				The Regional Director of Clinical completed an audit of all resident	Services		
	12/02/24 at 12:32 PM being served to resid	the lunch meal tray line on I revealed the shepherd's pie ents receiving a regular or consisted of a layer of			on 12/4/2024. Areas of concern t noted during the audit were reme 12/6/2024.			
	ground beef, a layer	of mashed potatoes, and a see. No additional serving of			To ensure the deficient practice of recur, the Vice President of Oper educated he Regional Director of Operations (RDO) for Culinary, D	rations f		
	of Operations (RDO) 12/02/24 at 12:33 PM	e with the Regional Director and Dietary Manager on I revealed the recipe for 100 nsus was 106 on 12/02/24) s follows:			Manager, and cooks on ensuring residents are served the approve portions of the approved menu its if a substitution is made it must b approved by the registered dietic	the ed ems and e		

Facility ID: 923245

If continuation sheet Page 96 of 119

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SI COMPLE	JRVEY
	345285	B. WING			6/2024
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
 (a). 18 pounds of 80/2 (b). one and one fourfi (c). one tablespoon of (d). one tablespoon of (e). two and 3 fourths flakes (f). two cups of marga (g). two and a half gat vegetables In an interview with C PM he confirmed he of vegetables or onions served because they the former RDO tauglishepherd's pie and it vegetables or onions. inform the Dietary Ma mixed vegetables or or followed guidance fro preparing the shepher A joint interview with t RDO on 12/02/24 at 3 shepherd's pie should items called for in the the Dietary Manager and he could have obtained substitutions. A telephone interview Dietician (RD) on 12/0 contract company hard preparation, and she day-to-day kitchen op 	20 ground beef th quarts of chopped onions f garlic powder f black pepper quarts of mashed potato arine solids llons of frozen mixed ook #1 on 12/02/24 at 12:38 did not add mixed to the shepherd's pie being were unavailable. He stated nt him how to make the did not include mixed Cook #1 stated he did not nager he did not have onions for the recipe, and he m the former RDO when rd's pie. the Dietary Manager and 12:41 PM reveled the d have contained all the recipe for all diet types or should have been notified so ed approval for appropriate	F 8	including approval of the p to serving. Education com 1/3/2025.Newly hired RDC Managers and cooks not e 1/3/2025 will be educated before working their next s The Administrator or desig observe meal tray line to e and nutritional accuracy w weeks, biweekly for 4 wee monthly for 1 month. The f monitor the corrective activithat the deficient practice i will not recur by reviewing collected during audits and Quality Assurance Perform Improvement committee (C Administrator monthly for f months. At that time the Q will evaluate the effectiven interventions to determine auditing or adjustments to correction are necessary.	pleted by D's, Dietary educated by upon hire or scheduled shift. Inee will ensure menu eekly for 4 ks, and then facility will ons to ensure is corrected and information d reporting to nance QAPI) by the three (3) API committee ness of the if continued the plan of	
	DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER US HEALTH AT HENDER SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR I Continued From page (a). 18 pounds of 80/2 (b). one and one fourf (c). one tablespoon of (d). one tablespoon of (d). one tablespoon of (d). one tablespoon of (e). two and 3 fourths flakes (f). two cups of marga (g). two and a half gail vegetables In an interview with C PM he confirmed he of vegetables or onions served because they the former RDO taugh shepherd's pie and it vegetables or onions. inform the Dietary Ma mixed vegetables or of followed guidance fro preparing the shephe A joint interview with the RDO on 12/02/24 at 1 shepherd's pie should items called for in the the Dietary Manager she he could have obtained substitutions. A telephone interview Dietician (RD) on 12/0 contract company han preparation, and she day-to-day kitchen op An interview with the J	IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345285 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: (X2) MULTI A BUILDIN 345285 ROVIDER OR SUPPLIER US HEALTH AT HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 96 F 8 (a). 18 pounds of 80/20 ground beef (b). one and one fourth quarts of chopped onions (c). one tablespoon of garlic powder (c). one tablespoon of garlic powder (d). one tablespoon of garlic powder (c). one tablespoon of garlic powder (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 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. Cock #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 1	CPRECIENCIES (X1) PROVIDERSUPPLIENCULA (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING 345285 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP1 200 HEALTH AT HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZP1 US HEALTH AT HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZP1 (20, 0) TABEDRESONVILLE STREET ADDRESS, CITY, STATE, ZP1 (20, 0) TABEDRESONVILLE, NC 28791 PRETX (20, 0) TABEDRESON TO BESCONVILLE, NC 28791 PRETX (20, 0) TABEDRESON TO BESCONVILLE, NC 28791 PRETX (20, 0) TABEDRESON TO BESCONVILLE, NC 28791 PRETX (20, 0) TABESPOOT OF BLACK DEPERCIENCES PRETX (20, 0) TABESPOOT OF BLACK DEPERCIENCES PRETX (31, 18 pounds of 80/20 ground beef 10/3/2025 (1), ot tabEspoon of garlic powder (1) (1), ot tabEspoon of Jack pepper (2) (2), two and a half gallons of frozen mixed Vegetables (2), two and a h	premericitive (N1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER: (N2) NULTRE CONSTRUCTION A BULDING (N2) DATE SI COMPLE A BULDING (N2) DATE SI COMPLE A BULDING (N2) DATE SI COMPLE C ROWDER OR SUPPLIER 345285 INVIG C US HEALTH AT HENDERSONVILLE STREET ADDRESS, CITY, STATE, 2P CODE 200 HERITAGE CIRCLE HENDERSONVILLE, NC 28731 C ISLAMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FRECEDED BY FULL REQUILATORY OR LSC DENTIFYING INFORMATION) D PREX TAC PROVIDERS PLANOF CORRECTION (EACH ORRECTIVE ACTIONSHOLD BE (COSS REFERENCE) TO THE APPROPRIATE DEFICIENCY TO STRUCTIVE ACTIONSHOLD BE (COSS REFERENCE) TO THE APPROPRIATE DEFICIENCY Continued From page 96 F 803 Including approval of the portion size prior to serving. Education completed by 1/3/2025. Newly hired RDO'S, Diterry Managers and cooks not deducated by 1/3/2025. Newly hired RDO'S, Diterry Managers and cooks not deducated by 1/3/2025. Newly hired RDO'S, Diterry Managers and cooks not deducated by 1/3/2025 Newly hired RDO'S, Diterry Managers and cooks not deducated by 1/3/2025 Newly hired RDO'S, Diterry Managers and cooks not deducated by 1/3/2025 Will be educated upon hire or 1/3/2025 Will be educated upon hire o

If continuation sheet Page 97 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/03/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345285	B. WING			_		C 106/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	US HEALTH AT HENDER			2	200 HERITAGE CIRCLE			
ACCORDI	03 HEALTH AT HENDER	SONVILLE		ŀ	HENDERSONVILLE, NO	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803	Continued From page follow approved recip if the ingredients were appropriate substitution 2. Review of the regu for breakfast on 12/03 (a). two slices of Frem (b). one sausage patt (c). six ounces of oatr Review of the puree of breakfast on 12/03/24 (a). #10 scoop (equal French toast (b). #16 scoop (equal sausage (c). #6 scoop (equa	e 97 es or notify their supervisor e unavailable, so an on could be provided. ular diet menu spreadsheet 3/24 is as follows: ch toast y neal diet menu spreadsheet for is as follows: ing 3.2 ounces) of puree ing 2 ounces) of puree g 5.3 ounces) of puree steam table on 12/03/24 at s, scrambled eggs, bacon, eed eggs, and French toast Grits were served with a		803				
	eggs were served wit 2.5 ounces), and bac	ng 8 ounces), scrambled h a green scoop (equaling on, sausage, and French						
	tray line from 7:10 AM Cook #2 plated regula of French toast, one s of bacon (as an alterr grits. Cook #2 plated scoops of pureed egg	h tongs. tion of the breakfast meal 1 through 7:37 am revealed ar meal trays with one piece sausage patty or one piece hate), scrambled eggs, and pureed meal trays with two as and one scoop of grits.						

Facility ID: 923245

If continuation sheet Page 98 of 119

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 01/03/2025 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345285	B. WING			_		C 06/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
ACCORD	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803	AM revealed he subsiserved one piece of b scrambled eggs, and primary protein. He sisubstitute grits for oat eggs and bacon for re- diets without seeking Manager. Cook #2 di- he did not seek appro- An interview with the Operations (RDO) on revealed 2 slices of F patty, and six ounces been served for resid- unless grits were app oatmeal. She stated diet should have rece pureed sausage, and appropriate substitution RDO stated she was menu was not follower An email from the Die Registered Dietician (AM revealed the RD a grits for oatmeal and cheese could substitut In a follow-up intervie at 12:28 PM he was up piece of French toast of confirmed there was ne eggs served in the bro	ituted grits for oatmeal and acon because he added the eggs served as the tated he had approval to meal and decided to serve esidents receiving regular approval from the Dietary d not provide a reason why val for menu changes. Regional Director of 12/03/24 at 10:40 AM rench toast, one sausage of oatmeal should have ents on a regular diet, roved as a substitute for residents receiving a puree ived pureed French toast, pureed oatmeal unless ons were approved. The not sure why the approved d. tary Manager to the RD) dated 12/03/24 at 11:51 approved the substitution of oureed eggs doubled with te for pureed French toast. w with Cook #2 on 12/04/24 nable to explain why only was served for the 03/24 or why there was no or sausage. Cook #2 no cheese in the pureed eakfast meal on 12/03/24.	F	803				

Facility ID: 923245

If continuation sheet Page 99 of 119

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345285	B. WING				C 06/2024
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			00 HERITAGE CIRCLE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803 F 806 SS=D	why only one slice of the breakfast meal on no pureed French toa stated substituting gri approved as a substit Dietician (RD), but oth have been followed. A telephone interview Dietician (RD) on 12/0 contract company har preparation, and she day-to-day kitchen op An interview with the 5:19 PM revealed he followed, correct porti any substitutions mad the Registered Dietici Resident Allergies, Pr CFR(s): 483.60(d)(4)(0 §483.60(d) Food and Each resident receive §483.60(d)(5) Appeal nutritive value to resid food that is initially se different meal choice; This REQUIREMENT by: Based on observation resident and staff inte	French toast was served for 12/03/24 or why there was st or pureed sausage. He ts for oatmeal had been ute by the Registered herwise the menu should with the Registered 04/24 at 4:26 PM revealed a hadled all aspects of food had "nothing to do with erations". Administrator on 12/05/24 at expected menus to be on sizes to be served, and le should be approved by an (RD). eferences, Substitutes 5) drink is and the facility provides- nat accommodates resident a, and preferences; ing options of similar lents who choose not to eat rved or who request a is not met as evidenced h, record review, and rviews the facility failed to d preferences for 1 of 5		803	The facility failed to honor a resident's food preferences for 1 of 5 residents reviewed for food preferences (Resider #31). These practices had the potential	nt	1/3/25

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 100 of 119

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/2025 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345285	B. WING				C / 06/2024
NAME OF P	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	RSONVILLE			00 HERITAGE CIRCLE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	Continued From page	e 100	∫ F	806			
	(Resident #31).			000	affect 77 residents receiving a regular		
					diet, 18 residents receiving a mechan		
	Findings included:				soft diet (consisting of foods that are e		
					to swallow), and 8 residents receiving	а	
	Resident #31 was ad	lmitted to the facility			puree diet (consisting of foods with a		
	06/06/24.				pudding-like texture). Resident #31's preferences were updated in the dieta	ar\/	
	Review of Resident #	t31's Physician orders			computer system, resident's order, an	•	
		ted 10/03/24 for a regular			resident's care plan was updated whe		
	diet.	Ũ			notified of identified issue.		
	The quarterly Minimu	. ,			Current facility residents are at risk of		
		0/07/24 revealed Resident			being affected by the deficient practic		
		ntact and made himself able to understand others.			The Regional Director of Clinical Serv completed an audit of all residents die		
					on 12/4/2024. Area of concerns that v		
	Resident #31's nutriti	ion care plan initiated			noted during the audit were remedied		
		ised 12/03/24 revealed he			12/6/2024.		
		and desired double protein.					
		d providing his diet as			To ensure the deficient practice does		
	ordered and meeting	nis preterences.			recur, the Vice President of Operation educated the Regional Director of	IS	
	An interview with Red	sident #31 on 12/02/24 at			Operations (RDO) for Culinary, Dietar	v	
		had asked the dietary			Manager, and cooks on ensuring	3	
		is times for large portions or			residents preferences are followed wh	nen	
	at least double protei	n throughout his stay. He			serving meals. Education completed b		
		e asked the Dietary Manager			1/3/2025.Newly hired RDO's, Dietary		
		s on 12/01/24. Resident #31			Managers and cooks not educated by		
	stated he rarely recei	ived large portions.			1/3/2025 will be educated upon hire o		
	An observation of Re	sident #31 on 12/03/24 at			before working their next scheduled s Effective 1/3/2025, the residents	init.	
		was sitting in the dining			preferences will be reviewed upon		
		st. He stated he received			admission, quarterly, and as needed l	ру	
		toast, one sausage patty, a			the dietary manager.		
		scoop of eggs for breakfast.					
		that even though he was still			The Administrator or designee will		
		to need more food to feel			observe meal tray line to ensure men	u	
		ouble portions was noted on ticket for the breakfast meal			and nutritional accuracy weekly for 4 weeks, biweekly for 4 weeks, and the	n	
	Tresident #315 meal				weeks, biweekiy ioi 4 weeks, and the		

Facility ID: 923245

If continuation sheet Page 101 of 119

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		TE SURVEY
						С
		345285				2/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ACCORDI	US HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 806	on 12/03/24 at 7:22 A informed that Resider additional breakfast for stated Resident #31 a additional food when been served. An interview with the 12/03/24 at 8:01 AM of Resident #31's req 12/01/24. He was un why Resident #31 did for breakfast on 12/03 had time to add the ref A follow-up interview 12/03/24 at 9:00 AM received any addition An additional follow-u #31 on 12/03/24 at 9:00 AM received any addition An additional follow-u #31 on 12/03/24 at 9:00 Manager did offer to r unable to recall the et 9:00 AM), but he decl he was still hungry, b because he knew the and he did not want to An interview with the Operations (RDO) on revealed Resident #3 additional food at the than having to wait un	AM the Dietary Manager was Int #31 was requesting ood. The Dietary Manager would be provided with all other resident trays had Dietary Manager on revealed he became aware juest for large portions on lable to provide a reason a not receive large portions 3/24 and stated he had not equest to his meal ticket. with Resident #31 on revealed he had not yet hal food and was still hungry. Ip interview with Resident 50 AM revealed the Dietary make him an omelet (he was xact time, but it was after lined. Resident #31 stated ut he declined the omelet Dietary Manager was busy o inconvenience him.	F 80		to ensure prrected and prmation porting to ce PI) by the e (3) I committee s of the ontinued	

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345285	B. WING				C 06/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			00 HERITAGE CIRCLE ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 806 F 808 SS=D	care plan had probab because he had been times and that was no reflection of his prefer not aware of any cond that he requested large that she was aware, s #31's food preference An interview with the 5:19 PM revealed he requests from Reside portions, but he expect food preferences. Therapeutic Diet Press CFR(s): 483.60(e)(1)(§483.60(e)(1) Therapeut §483.60(e)(1) Therapeut §483.60(e)(2) The att delegate to a register task of prescribing a r therapeutic diet, to the law. This REQUIREMENT by: Based on observation Registered Dietician (M revealed Resident #31's ly not been updated recently to the hospital a couple of ot necessarily an accurate rences. She stated she was cerns from Resident #31 ger portion sizes but now she could address Resident es. Administrator on 12/05/24 at was not aware of any nt #31 to receive double cted staff to honor residents' scribed by Physician (2) tic Diets eutic diets must be ending physician. tending physician may ed or licensed dietitian the esident's diet, including a e extent allowed by State ' is not met as evidenced ns, record review, staff, RD), and Nurse Practitioner		806	The facility failed to provide Resident # with a renal diet as ordered. This failure		1/3/25
		cility failed to provide enal diet as ordered. This residents reviewed for			affected 1 of 3 residents reviewed for nutrition. Resident #52's diet was corrected immediately upon notification the dietary manager.	by	
	Findings included:				Current facility residents are at risk of being affected by the deficient practice.		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 103 of 119

TATE A			()(0) 100			
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	· · ·	DATE SURVEY COMPLETED
			A. DOILDING			С
		345285	B. WING			12/06/2024
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
	JS HEALTH AT HENDER			200 HERITAGE CIRCLE		
ACCORDI	JS REALTH AT HENDER	GONVILLE		HENDERSONVILLE, NC 2879	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 808	Continued From page	e 103	F 80	18		
		mitted to the facility 09/11/24		The Regional Director of	Clinical Services	
	with diagnoses includ			completed an audit of all		
	dependence on renal	5		on 12/4/2024. Area of co		
				noted during the audit we	ere remedied on	
	The admission Minim	. ,		12/6/2024.		
		0/13/24 revealed Resident ntact and received dialysis.		To oncure the deficient n	ractica daga pat	
	#52 was cognitively in			To ensure the deficient p recur, the Vice President		
	Review of Resident #	52's Physician orders		educated the Regional D		
		dated 09/17/24 for a regular		Operations (RDO) for Cu		
		atoes, tomato sauce/soup,		Manager, and cooks on i		
	dried beans, cooked	-		following ordered diets a		
		, raisins, cantaloupe, honey		serving residents the die		
	dew, star fruit, nuts, c	or chocolate.		when a communication for		
	Resident #52's putriti	on care plan last updated		to the dietary department dietary staff need to verif	-	
		was on a regular renal diet		has updated in the comp		
	with thin liquids and in			system. Education comp		
		ordered and weighing him as		1/3/2025.Newly hired RD		
	needed.			Managers and cooks not	•	
				1/3/2025 will be educated		
		sident #52's meal ticket and		before working their next		
		04/24 at 7:49 AM revealed ay ticket indicated he was to		Effective 1/3/2025, the el		
		cheese breakfast bake,		record and computerized were integrated, this will	•	
		t, orange juice, hot coffee or		both systems if a change		
	U	nd oatmeal. Resident #52		medical provider. The die		
		sage and cheese breakfast		be responsible for ensuri		
	-	and orange juice on his		physician ordered diets a	are being served	
	breakfast tray.			to the residents.		
	An interview with Res	sident #52 on 12/04/24 at		The Administrator or des	ignee will audit 5	
		wasn't supposed to receive		residents diet orders and	-	
	orange juice, and he	was served potatoes and		ordered diets weekly for		
	tomato soup "all the t	ime".		biweekly for 4 weeks, an		
	A 1 4-			for 1 month. The facility		
		sident #52's lunch meal		corrective actions to ensu		
	licket on 12/04/24 at	12:11 PM revealed he was		deficient practice is corre	ected and Will not	

Facility ID: 923245

If continuation sheet Page 104 of 119

	S FOR MEDICARE &		0.00			NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	ATE SURVEY
						С
		345285	B. WING			12/06/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
ACCORDI	JS HEALTH AT HENDER	RSONVILLE		200 HERITAGE CIRCLE		
				HENDERSONVILLE, NC 2	8791	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 808	Continued From page	e 104	F 80)8		
		II, chocolate pudding, whole	1.00	during audits and rep	porting to Quality	
	•	or hot tea. Resident #52		Assurance Performa		
		k roast, broccoli, a dinner		committee (QAPI) by	-	
	roll, potatoes, and ch	ocolate pudding.		monthly for three (3)	months. At that time	
				the QAPI committee		
		with Resident #52 on		effectiveness of the in		
		I revealed the only item he		determine if continue	-	
wanted to eat off his tray was chocolate pudding. Resident #52 declined to request alternate food	, ,		adjustments to the pl necessary.	an of correction are		
	from the kitchen.			Completion Date: 1/3	8/2025	
	An interview with the	Dietary Manager on				
		I revealed he was not aware				
	Resident #52 was on	a renal diet and was not				
	supposed to receive	-				
	•	ans, cooked spinach,				
	bananas, oranges/ora					
	cantaloupe, honey de	ew, star fruit, nuts, or I the computerized meal				
		acility used for diet orders				
	•••	tems Resident #52 was not				
		on his meal tray ticket and				
	he was not sure why					
	An interview with the	Regional Director of				
	,	n 12/02/24 at 1:14 PM				
		ent #52's diet order was				
	0	it was entered into the				
		at did not list the items he receive on his meal tray.				
	She explained that si	-				
	-	potatoes, bananas, tomato				
		spinach, and other items				
	•	sident #52's tray card as				
	-	posed to receive, dietary				
		of his dietary restrictions.				
	-	Resident #52 had not been				
	receiving the correct	diet since 09/17/24 and he				

If continuation sheet Page 105 of 119

	MENT OF HEALTH AN					FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION) DATE SURVEY COMPLETED
		345285	B. WING			C 12/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
ACCORD	US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 808	Continued From page	9 105	F 8	308		
F 812 SS=F	renal diet consisted o sodium and lower pot items to avoid on a re as orange juice, potat stated since Resident renal diet, he should h ordered. She stated s of foods Resident #52 did not populate on hi An interview with the on 12/05/24 at 4:21 P Resident #52 to recei An interview with the 5:28 PM revealed he receive their diet as o A telephone interview (NP) on 12/06/24 at 8 expected Resident #5 ordered and should n drinks not approved ff Food Procurement,St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for	04/24 at 4:31 PM revealed a f foods containing lower assium foods. She stated inal diet included items such idees, and bananas. The RD #52 had an order for a have received his diet as she was not sure why the list 2 was not supposed to eat is meal ticket. Director of Nursing (DON) M revealed she expected ve a renal diet as ordered. Administrator on 12/05/24 at expected residents to rdered. with the Nurse Practitioner 16 AM revealed she 22 to receive his diet as ot be provided with food or for a renal diet. ore/Prepare/Serve-Sanitary 2) y requirements. re food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State	F8	112		1/3/25

Facility ID: 923245

If continuation sheet Page 106 of 119

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/202 MAPPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	CONSTRUCTION	Сом	E SURVEY PLETED	
		345285	B. WING _				C 2/ 06/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER			20	0 HERITAGE CIRCLE		
Accordi				H	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 106	F	312			
		es not prohibit or prevent		512			
		roduce grown in facility					
		ompliance with applicable					
	safe growing and foo						
		es not preclude residents					
	from consuming food	s not procured by the facility.					
	8483 60(i)(2) - Store	prepare, distribute and					
		ance with professional					
	standards for food se	•					
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		ons and staff interviews the			The facility failed to maintain a clean		
		ain a clean floor in 1 of 1 walk-in freezer, 1 of 1 dry			in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer, 1 of 1 dry storage rooms, and		
		of 1 kitchen; label and date			1 kitchen; label and date open food it		
		discard expired food in 1 of			and discard expired food in 1 of 1 wa		
	1 walk-in cooler and	2 of 2 reach-in coolers; cover			cooler and 2 of 2 reach-in coolers; co		
		tems in 1 of 1 walk-in freezer			and date open food items in 1 of 1 wa		
		ooler; date milkshakes to			freezer and 1 of 1 reach-in cooler; da		
		date in 1 of 1 reach-in cooler;			milkshakes to identify their use-by da		
		es on 5 prep tables in 1 of 1 red bread in 1 of 1 kitchen;			1 of 1 reach-in cooler; maintain clean shelves on 5 prep tables in 1 of 1 kito		
		efrigerators and freezers in 2			discard expired bread in 1 of 1 kitche		
		ms (200 hall and 300 hall).			and maintain clean refrigerators and	,	
		otential to affect food served			freezers in 2 of 2 nourishment rooms	•	
	to residents.				hall and 300 hall). This failure had the	e	
	Finalizata in du da d				potential to affect food served to		
	Findings included:				residents. The items cited were fixed 12/6/2024.	on	
		ion of the walk-in cooler,				-	
		in storage, and kitchen floor			Current facility residents are at risk of		
		AM revealed multiple dried			being affected by the deficient practic	æ.	
	-	ins on the floor of the walk-in black stains on the walk-in			The Administrator and Registered Dietician completed an audit of the		
		ed dried brown stains on the			kitchen to include prep areas, coolers	6.	
		je room and surveyor's			storage, freezer and nourishment roc		
		oor, and multiple dried black			on 12/20/2024. Area of concerns wer		
	stains scattered acro	-			noted during the audit and were reme	edied	

Facility ID: 923245

If continuation sheet Page 107 of 119

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/2025 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345285	B. WING				C / 06/2024
NAME OF PF	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	00 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		н	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 812	Continued From page	e 107	F 8	12			
	1 0		_		by 12/31/2024.		
	An interview with the	Dietary Manager on			,		
		revealed kitchen floors were			To ensure the deficient practice does	not	
		a week, but 2 dietary staff			recur, the Vice President of Operation	s	
		ck and that contributed to			educated the Regional Director of		
	the floors not being c	lean.			Operations (RDO) for Culinary, Dietar	•	
	An additional abaany	ation of the walk-in cooler,			Manager, cooks and aides on ensurin the kitchen and food storage areas	g	
		kitchen floor on 12/04/24 at			remain clean and sanitary environmer	nt	
		nultiple dried yellow and			ensuring food products are dated whe		
		loor of the walk-in cooler,			opened and show their use by date,		
		tains on the walk-in freezer			ensuring food items are thrown out wh	nen	
	floor, scattered dried	brown stains on the floor of			they are expired, and following the		
		, and multiple dried black			assigned cleaning schedule for the		
	stains scattered acros	ss the kitchen floor.			kitchen and food storage areas. Educ completed by 1/3/2025.Newly hired	ation	
		Administrator on 12/05/24 at			RDO's, Dietary Managers cooks and		
		expected all floors in the			aides not educated by 1/3/2025 will be	9	
	kitchen to be clean a	nd free of stains.			educated upon hire or before working their next scheduled shift.		
	2 An initial observat	ion of the walk-in cooler on			their next scheduled shift.		
		revealed a three quarters full			The Administrator or designee will		
		ggs with an expiration date of			observe the kitchen and nourishment		
	08/17/24.	,ge a exp. a.e a.e. e.			rooms weekly for 4 weeks, biweekly for	or 4	
					weeks, and then monthly for 1 month.		
	An interview with the				facility will monitor the corrective action		
		revealed the pasteurized			to ensure that the deficient practice is		
		and he should have removed			corrected and will not recur by reviewi	0	
	them from the cooler	before they expired.			information collected during audits and	d	
	An interview del 4	Administrator or 40/05/04 -1			reporting to Quality Assurance		
		Administrator on 12/05/24 at expected food to be used or			Performance Improvement committee (QAPI) by the Administrator monthly for		
		re the expiration date.			three (3) months. At that time the QAF		
		e ale expiration date.			committee will evaluate the effectiven		
	3. An initial observat	ion of the walk-in freezer on			of the interventions to determine if		
		revealed the following:			continued auditing or adjustments to t	he	
		5			plan of correction are necessary.		
		is suite sitting on a shalf that			•		1
	(a). a box of frozen bi	iscuits sitting on a shelf that		I	Completion Date: 1/3/2025		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 108 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345285	B. WING				06/2024
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 812	 (b). an undated 20-pc sitting on a shelf that (c). an opened and un sitting on a shelf An interview with the 12/02/24 at 9:53 AM plabeled, dated, and coplacing the items in the 2 staff members out as having items labeled, An additional observation 12/04/24 at 12:32 biscuits sitting on a sharen opened date of 10 An interview with the 5:19 PM revealed he be labeled, dated, and 4. An initial observation reach-in cooler on 12/2 the following: (a). both doors of the smeared white/brown of the cooler (b). an unlabeled and sitting on a shelf (c). a box of 39 fully the manufactured milkshare with no law were removed from the sitting on a shelf 	bund box of beef patties was open to air indated bag of diced ham Dietary Manager on revealed all items should be overed by the staff member he freezer. He stated having sick contributed to not dated, and covered. Attion of the walk-in freezer PM revealed a box of frozen helf that was open to air with /31/24. Administrator on 12/05/24 at expected all food items to d covered appropriately. on of the double door /02/24 at 9:54 AM revealed cooler had dried and stains to the doors and vent undated bag of turkey hawed 4-ounce akes with no label to indicate moved from the freezer or punce manufactured bel to indicate the date they he freezer or the expiration	F	812			
	date sitting on a shelf	-					

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 109 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345285	B. WING				06/2024
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	thickened orange juic An interview with the 12/03/24 at 8:01 AM is should be clean and a and dated, and it was responsibility to check food and beverage ite manufactured milksha indicating when they freezer and should be The Dietary Manager members out sick cor being clean and bever An additional observat reach-in cooler on 12 of the cooler had drie stains to the doors ar opened and undated orange was sitting on An interview with the 5:19 PM revealed he clean, all opened food and milkshakes to be removed from the free expiration date. 5. An initial observation 5 food preparation tal	Dietary Manager on revealed the reach-in cooler all items should be labeled a all dietary staff members' k for labels and dates on ems. He stated thawed akes should have a date were removed from the e discarded after 14 days. stated having 2 staff ntributed to the cooler not erage items not being dated. ation of the double door :32 PM revealed both doors d and smeared white/brown ad vent of the cooler, and an 46-ounce box of thickened	F	812			
	should be clean and f	Dietary Manager on revealed the prep tables free of debris and he stated ers out sick contributed to					

Facility ID: 923245

If continuation sheet Page 110 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345285	B. WING				C /06/2024
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 812	Continued From page	9 110	F	812	2		
	of 5 food preparation PM revealed the table crumbs and dried bro An interview with the 5:19 PM revealed he tables to be clean and 6. An initial observation	wn stains. Administrator on 12/05/24 at expected food preparation d free of debris.					
	 (a). the outer door of and smeared white sti (b). an opened and un sitting on the shelf (c). an opened and un cheddar cheese sittin (d). an opened and un lettuce with brown spi (e). an undated 48-out open to air sitting on the 	ndated pack of sliced ham ndated 5-pound bag of g on the shelf indated bag of shredded ots sitting on the shelf ince pack of sliced ham the shelf idated 40-ounce bag of					
	be clean and all items dated when opened b items in the cooler. H of spoilage should be should be covered ap staff member's respon and dating food. The having 2 staff member not having items labe	Dietary Manager on revealed the cooler should a should be labeled and by the person placing the le stated any food with signs discarded and all food opropriately, and it was every nsibility to check for labeling Dietary Manager stated ers out sick contributed to led, dated, covered, and ving signs of spoilage.					

If continuation sheet Page 111 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345285	B. WING				C /06/2024
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT HENDER	SONVILLE			00 HERITAGE CIRCLE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From page	e 111	F	812			
	reach-in cooler on 12	ation of the single door /04/24 at 12:32 PM revealed had multiple dried and					
	5:19 PM revealed he	Administrator on 12/05/24 at expected all coolers to be d to be labeled and dated, ns of spoilage to be					
		the bread rack in the kitchen AM revealed the following:					
	09/27/24	with a best-by date of					
	11/23/24	with a best-by date of with a best-by date of					
	11/16/24	with a best-by date of					
	used or discarded by	Dietary Manager on revealed all bread should be the best-by date and people g dates on the bread.					
	5:19 PM revealed he	Administrator on 12/05/24 at expected all food items to on or before the best-by					
	room refrigerator on 1	stains to the bottom of the					

If continuation sheet Page 112 of 119

	-	ID HUMAN SERVICES				FORM	APPROVED
			()(0) 10111 T				0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	
			A. BUILDIN	NG			~
		345285	B. WING				C
		545205			TREET ADDRESS, CITY, STATE, ZIP CODE	12/	06/2024
NAME OF Pr	ROVIDER OR SUPPLIER						
ACCORDI	US HEALTH AT HENDER	SONVILLE					
			HENDERSONVILLE, NC 28791				
(X4) ID			ID	,	PROVIDER'S PLAN OF CORRECTION	-	(X5) COMPLETION
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 812	Continued From page	e 112	F8	312			
	1 5						
	An interview with the	Dietary Manager on					
		revealed it was the dietary					
		sibility to clean nourishment					
		d freezers and having 2 staff					
	members out sick cor	ntributed to the nourishment					
	room refrigerators and	d freezers not being clean.					
	An additional observa						
		frigerator on 12/03/24 at					
		4 at 7:42 AM revealed dried ottom of the refrigerator and					
	the lowest shelf on th	0					
	(b). An observation of	f the 300-hall nourishment					
	room refrigerator on 1						
	revealed dried yellow	stains to the bottom of the					
	refrigerator and the lo						
	-	observation of the 300-hall					
		ezer at the same date and					
		ed liquid to the bottom of the					
	freezer.						
	An additional observa	ation of the 300-hall					
		frigerator on 12/05/24 at					
		ed yellow stains to the					
		ator and the lowest shelf on					
	-	An additional observation of					
	the 300-hall freezer a	t the same date and time					
	revealed dried red liq	uid to the bottom of the					
	freezer.						
	An interview with the	Administrator on 10/05/04 st					
		Administrator on 12/05/24 at expected nourishment room					
		zers to be clean and free of					
	stains.						
F 842		dentifiable Information	F8	342			1/3/25
SS=D	CFR(s): 483.20(f)(5),						
			1				

Facility ID: 923245

If continuation sheet Page 113 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345285	B. WING				06/2024	
NAME OF PF	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	SONVILLE			200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	9 113	F	842	2			
	 (i) A facility may not reresident-identifiable to (ii) The facility may reresident-identifiable to accordance with a conagrees not to use or cexcept to the extent the do so. §483.70(h) Medical resident area (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(h)(2) The face all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitted with 45 CFR 164.506 (iv) For public health and and and enforcement purp purposes, research purp medical examiners, further and the second procession of the second processic tre	lease information that is o an agent only in intract under which the agent disclose the information he facility itself is permitted ecords. ordance with accepted is and practices, the facility al records on each resident ented; e; and ganized cility must keep confidential he in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert						
	accordance with a con agrees not to use or of except to the extent the to do so. §483.70(h) Medical res §483.70(h)(1) In accor- professional standard must maintain medical that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically or §483.70(h)(2) The fac all information contain regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research pr medical examiners, fu	ntract under which the agent disclose the information he facility itself is permitted ecords. ordance with accepted is and practices, the facility al records on each resident ented; e; and ganized cility must keep confidential hed in the resident's records, h or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners,						

If continuation sheet Page 114 of 119

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345285	B. WING				C 06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>		
				2	200 HERITAGE CIRCLE			
ACCORDI	US HEALTH AT HENDER	SONVILLE		H	HENDERSONVILLE, NC 28791	:8791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 842	§483.70(h)(3) The fac record information ag unauthorized use. §483.70(h)(4) Medica for- (i) The period of time (ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(h)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensiv provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on observatio interviews, the facility complete and accurat documented that they splint was not applied	with 45 CFR 164.512. cility must safeguard medical ainst loss, destruction, or al records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches are law. edical record must contain- on to identify the resident; cident's assessments; ve plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed as notes; and ogy and other diagnostic equired under §483.50. ' is not met as evidenced n, record review and staff	F	842		ff		
	The findings included Resident #73 was add	: mitted on 12/15/2021 with			order was discontinued due to no longe being the optimal treatment for the resident #37.			

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 115 of 119

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				RM APPROVE
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345285	B. WING		1	C 2/06/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
				200 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HEND	ERSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 842	Continued From pa	aae 115	F 84	2		
-	-	uded contracture of muscle,		-		
	right hand.			Current facility residents wh	o have orders	
	ingine naria.			for splints are at risk of bein		
	A physician's order	dated 11/01/2023 read- Staff		the deficient practice. The D		
		hand splint, Place Pillow		completed an audit on 12/2		
		shifts to "access" for any skin		residents with orders for spl		
	• •	ove) pm shift, every shift.		the documentation related to		
				application was correct. No	•	
		Resident #73 on 12/02/2024 at Resident #73 did not have a		were noted during the audit		
	splint in place to he			To ensure the deficient prac	tice does not	
				recur, the Staff Developmen		
	During observation	on 12/03/2024, Resident #73		educated facility and agence		
		33am with no splint on right		nurses and medication aide		
	hand.			documentation in the medic	al record is to	
				be complete and accurate re	elated to splint	
	A review of the Med	dication Administration Record		application. Education comp	pleted by	
	(MAR) revealed it v	vas documented by Nurse #2		1/3/2025.Newly hired nurse	s and	
		12/03/2024 that the splint was		medication aides and staff r	ot educated	
	applied to Resident	t #73 ' s right hand.		by 1/3/2025 will be educated	d upon hire or	
				before working their next sc	heduled shift.	
	During an interview	/ on 12/03/2024 at 10:11am,		-		
	Nurse #2 stated the	e assigned nurse would apply		The Director of Nursing or d	esignee will	
		Resident #73 would tolerate.		audit 5 resident's with splint		
		nat Resident #73 was not		ensure applied as ordered a		
		on 12/3/24. Nurse #2 stated he		documentation is accurate v	•	
		nd signed by accident, but the		weeks, biweekly for 4 weeks		
		o Resident #73's right hand as		monthly for 1 month. The fa		
		verified at 10:12am the splint		monitor the corrective action		
		s applied, and reviewed the		that the deficient practice is		
		he order did not read to apply		will not recur by reviewing ir		
	•	Nurse #2 stated it could be		collected during audits and		
		MAR if a resident did not		Quality Assurance Performa		
		Nurse #2 was observed as the		Improvement committee (Q		
		o Resident #73 ' s right hand		Administrator monthly for th	.,	
	aiter Nurse #2 Verit	fied the order on the MAR.		months. At that time the QA		
	During on interview	(on 12/06/2024 of 2:44 mm the		will evaluate the effectivene		
	-	on 12/06/2024 at 2:41pm, the		interventions to determine if		
		(DON) stated if the MAR was		auditing or adjustments to the		

Facility ID: 923245

If continuation sheet Page 116 of 119

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (PPROVE	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
		345285	B. WING		C 12/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	RSONVILLE	200 HERITAGE CIRCLE				
				HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 842	Continued From page	e 116	F 842				
	documented a splint	was applied, she expected d. The DON stated if a splint		correction are necessary.			
		would expect a note written e splint was not applied.		Completion Date: 1/3/2025			
		n 12/06/2024 the he expected if a splint was ed then the splint should be					
F 914 SS=B	Bedrooms Assure Fu CFR(s): 483.90(e)(1)	-	F 914	L .	1,	/3/25	
		designed or equipped to acy for each resident;					
	March 31, 1992, exce bed must have ceiling extend around the be	acilities initially certified after ept in private rooms, each g suspended curtains, which ed to provide total visual n with adjacent walls and					
	curtains. This REQUIREMENT by:	is not met as evidenced					
	Based on record rev interviews with the re failed to install a priva ensure the privacy cu	iew, observations, and sident and staff the facility acy curtain and failed to irtain extended around the reviewed for environment i04-A).		The facility failed to install a private curtain and failed to ensure the pri curtain extended around the bed for rooms reviewed for environment (r #207-A and #304-A). Room #207- #304-A had privacy curtains install 12/09/2024 by the maintenance dir	vacy or 2 of 9 room A and led on		
	Findings included:			Current facility residents are at risk			
	shared by two reside mounting track in pla	12/03/24 at 2:06 PM as a semi-private room nts. There was no ceiling ce to have a privacy curtain ed around bed 207-A located		being affected by the deficient prac The maintenance director complet audit of all residents' rooms to ens each bed in the rooms had a priva curtain in place. The rooms noted privacy curtains were fixed on	ctice. ed an ure cy		

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 117 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/03/2025 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345285	B. WING			C 12/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	00 HERITAGE CIRCLE		
ACCORDI	US HEALTH AT HENDER	SONVILLE		н	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 914	Continued From page	e 117	F	914	12/13/20324 by the maintenance direc	tor	
	An observation and ir	nterview on 12/03/24 at 2:06			12/15/20324 by the maintenance direc		
	PM Nurse Aide (NA) assigned NA for room there was no privacy During an observation at 10:19 AM room 20 privacy curtain in place track for it to be instal room 207-A revealed open and wanted the keep the hallway light During an observation at 10:19 AM the Main there was no mountir curtain to be installed Maintenance Manage aware there was no m he would need to instal to be placed. b. During an observation 304-A located by the The curtain got stuck it started to curve aro revealed it was share maintenance the privi-	#7 revealed she was the a 207-A and did not notice curtain in place. an and interview on 12/04/24 7-A continued to have no be and no ceiling mounting lled. The resident residing in he liked to crack the door privacy curtain placed to t from shining in his eyes. an and interview on 12/04/24 thenance Manager confirmed ing track in place for a privacy			To ensure the deficient practice does r recur, the Administrator and Staff Development Coordinator educated th facility and agency nurses, certified nursing assistants, maintenance direct 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, maintenar director, housekeeping staff, and housekeeping director staff not educat by 1/3/2025, will be educated upon hir prior to working their next scheduled s The maintenance director or designee audit 5 resident rooms to ensure the privacy curtain in place, clean, and functional weekly for 4 weeks, biweekl 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 recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Administrato monthly for three (3) months. At that ti the QAPI committee will evaluate the	e tor, g ace e or hift. will y not ed	
	12/04/24 at 1:16 PM Manager. The Mainte	nterview was conducted on with the Maintenance enance Manager observed room 304-A got stuck where			effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction a necessary. Completion Date: 1/3/2025	ire	

Event ID: MMG311

Facility ID: 923245

If continuation sheet Page 118 of 119

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/03/2025 MAPPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345285	B. WING		_		C 06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
ACCORDI	US HEALTH AT HENDER	SONVILLE		200 HERITAGE CIRCLE HENDERSONVILLE, NC	28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 914	the way around the be Manager was not awa not fully extend and re were attached into the backwards causing it fix it the privacy curta removed, and the who mounting track the co During an interview o Administrator reveale a missing privacy curt curtain extended arou Administrator stated t	rved and did not extend all ed. The Maintenance are the privacy curtain did evealed the wheels that e mounting track were put in to get stuck. He revealed to in it would need to be eels put back in the prect way. n 12/06/24 at 4:05 PM the d he expected staff to report tain and ensure the privacy und the entire bed. The here were issues with staff eporting environment issues	F 914					

If continuation sheet Page 119 of 119