

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/17/2025
NAME OF PROVIDER OR SUPPLIER  Accordius Health at Gastonia		STREET ADDRESS, CITY, STATE, ZIP CODE  416 N Highland Street Gastonia, NC 28052	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014</b></p> <p>Based on record review and staff interviews, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) prior to discharge from Medicare Part A skilled services for 3 of 3 residents reviewed for beneficiary notification review (Residents #57, #90 and #92).</p> <p>The Findings Included:</p> <p>1. Resident #57 was admitted to the facility on [DATE].</p> <p>Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #57's Responsible Party (RP) on 08/20/24 which indicated Resident #57's Medicare Part A coverage for skilled services would end on 08/23/24. Resident #57 remained in the facility.</p> <p>Review of Resident #57's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #57 or Resident #57's RP.</p> <p>During an interview on 01/16/25 at 11:16 AM, the Business Office Manager (BOM) revealed she issued SNF ABNs for residents covered under Medicare Part B. She stated the Social Worker (SW) issued NOMNC's and SNF ABNs for residents covered under Medicare Part A.</p> <p>During an interview on 01/16/25 at 11:24 AM, the SW confirmed she was responsible for issuing a NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #57 or his RP prior to Medicare Part A skilled services ending on 08/23/24.</p> <p>During an interview on 01/16/25 at 3:00 PM, the Administrator revealed the SW was responsible for issuing a NOMNC and/or SNF ABN to the resident or their RP when Medicare Part A services were ending. The Administrator expressed she had assumed the SW was aware to issue a SNF ABN in addition to a NOMNC when needed. The Administrator stated she would have expected for the SW to have issued both notices to Resident #57 or his RP as required.</p> <p>2. Resident #90 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #90's Responsible Party (RP) on 08/26/24 which indicated Resident #90's Medicare Part A coverage for skilled services would end on 08/28/24. Resident #90 remained in the facility until she discharged home on 10/11/24.</p> <p>Review of Resident #90's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #90 or Resident #90's RP.</p> <p>During an interview on 01/16/25 at 11:16 AM, the Business Office Manager (BOM) revealed she issued SNF ABNs for residents covered under Medicare Part B. She stated the Social Worker (SW) issued NOMNC's and SNF ABNs for residents covered under Medicare Part A.</p> <p>During an interview on 01/16/25 at 11:24 AM, the SW confirmed she was responsible for issuing a NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #90 or her RP prior to Medicare Part A skilled services ending on 08/28/24.</p> <p>During an interview on 01/16/25 at 3:00 PM, the Administrator revealed the SW was responsible for issuing a NOMNC and/or SNF-ABN to the resident or their RP when Medicare Part A services were ending. The Administrator expressed she had assumed the SW was aware to issue a SNF ABN in addition to a NOMNC when needed. The Administrator stated she would have expected for the SW to have issued both notices to Resident #90 or her RP as required.</p> <p>3. Resident #92 admitted to the facility on [DATE].</p> <p>Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #92 on 08/20/24 which indicated Resident #92's Medicare Part A coverage for skilled services would end on 08/22/24. Resident #92 remained in the facility until he discharged home on 09/09/24.</p> <p>Review of Resident #92's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #92.</p> <p>During an interview on 01/16/25 at 11:16 AM, the Business Office Manager (BOM) revealed she issued SNF ABNs for residents covered under Medicare Part B. She stated the Social Worker (SW) issued NOMNC's and SNF ABNs for residents covered under Medicare Part A.</p> <p>During an interview on 01/16/25 at 11:24 AM, the SW confirmed she was responsible for issuing a NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #92 prior to Medicare Part A skilled services ending on 08/22/24.</p> <p>During an interview on 01/16/25 at 3:00 PM, the Administrator revealed the SW was responsible for issuing a NOMNC and/or SNF-ABN to the resident or their RP when Medicare Part A services were ending. The Administrator expressed she had assumed the SW was aware to issue a SNF ABN in addition to a NOMNC when needed. The Administrator stated she would have expected the SW to have issued Resident #92 both notices as required.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37014</p> <p>Based on observations and staff interviews, the facility failed to maintain residents' wardrobe closets in good repair by not replacing knobs on the drawers which left exposed screws sticking out from the drawer that had the potential to cut residents when entering and exiting their rooms (rooms 202, 208, 215, 223, and 225); failed to ensure a resident's wardrobe closet had functioning drawers (room [ROOM NUMBER]); failed to maintain a clean and sanitary wheelchair (room [ROOM NUMBER]-A); and failed to ensure a call light cover was secured to the wall in a resident's bathroom to prevent it from coming loose when the cord was pulled to engage the call light (room [ROOM NUMBER]) for 8 of 31 rooms on 1 of 2 resident halls (200 hall) reviewed for environment.</p> <p>The findings included:</p> <p>1. a. Observations of room [ROOM NUMBER] on 01/14/25 at 8:44 AM, 01/15/24 at 9:02 AM, and 01/16/25 at 11:00 AM revealed a wardrobe closet located just inside the room door. The bottom drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.</p> <p>b. Observations of room [ROOM NUMBER] on 01/15/25 at 9:03 AM and 01/16/25 at 11:01 AM revealed a wardrobe closet located just inside the room door. The bottom drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.</p> <p>c. Observations of room [ROOM NUMBER] on 01/15/25 at 9:05 AM and 01/16/25 at 11:03 AM revealed a wardrobe closet located just inside the room door. The top drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The top drawer was approximately 2 feet from the floor.</p> <p>d. Observations of room [ROOM NUMBER] on 01/15/25 at 9:07 AM and 01/16/25 at 11:05 AM revealed a wardrobe closet located just inside the room door. Both the bottom and top drawers on the left side of the wardrobe closet were missing knobs and the end of the screws were sticking out approximately one inch. The top drawer was approximately 2 feet from the floor and the bottom drawer was approximately 1 foot from the floor.</p> <p>e. Observations of room [ROOM NUMBER] on 01/15/25 at 9:08 AM and 01/16/25 at 11:07 AM revealed a wardrobe closet located just inside the room door. The top drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The top drawer was approximately 2 feet from the floor.</p> <p>f. Observations of room [ROOM NUMBER] on 01/15/25 at 9:04 AM and 01/16/25 at 11:02 AM revealed a wardrobe closet located just inside the room door. The bottom two drawers had no knobs and both drawers were off track preventing them from opening and closing properly.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An environmental tour and interview was conducted on 01/17/25 at 9:39 AM with the Maintenance Director, which revealed the conditions of rooms 202, 208, 212, 215, 223, and 225 remained unchanged. The Maintenance Director acknowledged the exposed screws on the drawers of the wardrobe closets and the drawers not closing properly were safety concerns due to the potential for causing a skin tear or other injury and needed repaired. He explained he had replaced the left 2 knobs on the closet drawers in room [ROOM NUMBER] last week but was not sure why they were missing now and he was not aware of the missing knobs on the closet drawers in rooms 202, 208, 215 and 225. He explained the bottom 2 wardrobe closet drawers in room [ROOM NUMBER] were replacements and he had ordered new tracking for them to fit properly. The Maintenance Director stated he and the Department Managers made daily rounds to identify concerns but he also relied on floor staff to notify him when repairs were needed.</p> <p>During an interview on 01/17/25 at 11:37 AM, the Administrator stated the Department Managers conducted room rounds twice a day and they should be looking at the wardrobe closet drawers to ensure knobs were in place and were working properly. The Administrator stated the issues with the closet drawers in rooms 202, 208, 212, 215, 223 and 225 should have been identified during daily rounds and staff should have informed the Maintenance Director repairs were needed.</p> <p>2. Observations of the wheelchair in 227-A on 01/15/24 at 9:04 AM and 01/16/25 at 9:59 AM revealed dried, crusty debris on top and underneath the seat cushion and dried debris on the brake of the wheelchair.</p> <p>During an interview on 01/17/25 at 10:51 AM, the Environmental Services Director revealed her company was new to the facility as of last week and they were currently in the process of developing a schedule for cleaning and disinfecting resident wheelchairs. She stated that some of the resident wheelchairs were washed on Monday (01/13/25) and Tuesday (01/14/25) but she did not have documentation of the specific wheelchairs that were included.</p> <p>During an observation and follow-up interview on 01/17/25 at 11:27 AM, the Environmental Services Director confirmed the wheelchair in room [ROOM NUMBER]-A had dried, crusty debris on top and underneath the seat cushion and dried debris on the brake of the wheelchair. She acknowledged the wheelchair needed a good cleaning. The Environmental Services Director stated she was informed by the Administrator during the morning meeting on Monday (01/13/25) that some of the wheelchairs on the 2nd floor, where room [ROOM NUMBER]-A was located, needed to be cleaned but the Administrator had not provided specific room numbers or resident names.</p> <p>During an interview on 01/17/25 at 11:37 AM, the Administrator revealed she was aware of the issue with resident wheelchairs not being cleaned regularly and explained there had been changes in the environmental services department. She stated she provided the Environmental Services Director with a list of resident wheelchairs that needed cleaned, which included the wheelchair in room [ROOM NUMBER]-A, and had also discussed with the Environmental Services Director to ensure the wheelchair in room [ROOM NUMBER]-A was checked daily and cleaned frequently. The Administrator stated she had been working with the Environmental Services Director on a process to ensure resident wheelchairs were cleaned routinely and a cleaning schedule was recently put into place.</p> <p>37538</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Observations of the bathroom in room [ROOM NUMBER] on 01/13/25 at 2:30 PM and 01/16/25 at 8:25 AM revealed when the call light switch was pulled the face plate cover came away from the wall and was not secured in place.</p> <p>An interview and observation was conducted with the Maintenance Director on 01/17/25 at 9:38 AM. The Maintenance Director observed in room [ROOM NUMBER] the call light in the bathroom did work when the switch was pulled but the face plate cover came away from the wall and was not secure. The Maintenance Director revealed Department Heads did daily rounds to check for environment issues and he tried to check call lights as part of his daily round. He revealed environment concerns identified were discussed with him during the morning meetings and staff could report concerns to him verbally or fill out a work order. The Maintenance Director stated he was not aware the face plate cover was not secured to the wall in the bathroom of room [ROOM NUMBER].</p> <p>During an interview on 01/17/25 at 5:32 PM the Administrator revealed Department Heads did daily room rounds to check for environment issues. The Administrator stated she was not aware the call light switch in the bathroom of room [ROOM NUMBER] was not secured to the wall.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>40200</p> <p>Based on record review and staff interviews, the facility failed to ensure Registered Nurse (RN) coverage was provided for at least 8 consecutive hours per day for 4 of the 91 days reviewed for RN Coverage (5/04/24, 5/18/24, 5/25/24, and 6/08/24).</p> <p>Findings included:</p> <p>The Payroll Based Journal (PBJ) report for third quarter of 2024 (April, May, and June) reported the facility without RN coverage for 8 consecutive hours per day for 5/04/24, 5/18/24, 5/25/24, and 6/08/24.</p> <p>a. Review of the daily staffing assignment sheet for Saturday, 5/04/24 revealed no RN assigned.</p> <p>Review of the timecard record for 5/04/24 revealed the former Director of Nursing (DON) had a clock in time of 6:45 AM and a clock out time of 3:15 PM.</p> <p>An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.</p> <p>An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former DON worked 5/04/24. She stated that since the former DON was a salaried employee and did not clock in and out. However, the Administrator added a clock in and out for the former DON to show the facility had RN coverage for 8 consecutive hours per day.</p> <p>An interview on 1/15/25 at 1:02 PM with the former DON revealed she was employed at the facility in May 2024. She stated she had never worked at the facility on the weekend and was not at the facility on 5/04/24.</p> <p>A follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.</p> <p>b. No daily staffing assignment sheet for Saturday, 5/18/24 was provided by the facility.</p> <p>Review of the timecard record for 5/18/24 revealed no RN had clocked in or out.</p> <p>An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.</p> <p>(continued on next page)</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former Assistant Director of Nursing (ADON) worked 5/18/24. She stated that since the former ADON was a salaried employee and did not clock in or out. The Administrator stated she should have added a clock in and out for the former ADON to show the facility had RN coverage for 8 consecutive hours per day, but she had not. No documentation was provided regarding the ADON working on 5/18/24.</p> <p>An interview on 1/15/25 at 4:29 PM with the former ADON revealed that she did not recall ever working a weekend day after she became the ADON on 5/01/24.</p> <p>During a follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.</p> <p>c. The facility was unable to provide the daily nurse staffing assignment sheet for Saturday, 5/25/24.</p> <p>Review of the timecard record for 5/25/24 revealed the former ADON had a clock in time of 6:45 AM and a clock out time of 3:15 PM.</p> <p>An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.</p> <p>An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former ADON worked 5/25/24. She stated that since the former ADON was a salaried employee and did not clock in and out. However, the Administrator had added a clock in and out for the former ADON to show the facility had RN coverage for 8 consecutive hours per day.</p> <p>An interview on 1/15/25 at 4:29 PM with the former ADON revealed that she did not recall ever working a weekend day after she became the ADON on 5/01/24.</p> <p>A follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.</p> <p>d. No daily staffing assignment sheet for Saturday, 6/08/24 was provided by the facility.</p> <p>Review of the timecard record for 6/08/24 revealed the former DON had a clock in time of 6:45 AM and a clock out time of 3:15 PM.</p> <p>An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.</p> <p>An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former DON worked 6/08/24. She stated that since the former DON was a salaried employee and did not clock in and out. However, the Administrator stated she had added a clock in and out for the former DON to show the facility had RN coverage for 8 consecutive hours per day.</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview on 1/15/25 at 1:02 PM with the former DON revealed she was employed at the facility on 6/08/2024. She stated she had never worked at the facility on the weekend and was not at the facility on 6/08/24.</p> <p>During a follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>40200</p> <p>Based on record review and staff interviews, the facility failed to post complete and accurate daily licensed nurse staffing information for 19 of the 20 days reviewed 5/04/24, 5/18/24, 5/25/24, 6/08/24, and 1/01/25 through 1/16/25 for sufficient staffing and failed to maintain a posted staffing sheets for one day (5/25/24).</p> <p>Findings included:</p> <p>Reviews of posted staffing for 5/04/24, 5/18/24, 5/25/24, 6/08/24, and 1/01/25 through 1/16/25 revealed one day, 1/16/25, had been updated to accurately reflect the staffing.</p> <p>The facility was unable to provide a staffing sheet for 5/25/24.</p> <p>During an interview on 1/14/25 at 5:01 PM with the Scheduler, she stated she was responsible for the staff posting and that she was unaware of the requirement to adjust the posted staffing information to reflect the actual staff present. She stated that she completed the posted staffing sheets ahead of time based on the staff work schedule. She stated when she was off on the weekend or vacation, she completed the posted staffing sheets ahead of time and they were not adjusted to accurately reflect the actual staffing. The Scheduler was unable to locate the posted staffing sheet for 5/25/24.</p> <p>During an interview on 1/16/25 at 1:11 PM the Administrator, she stated she was aware of the requirement to adjust the posted staffing to accurately reflect the actual staff present. She also stated she was unaware this was not being done and that the Scheduler did not know that the posted staffing should be updated with the actual staff on each shift.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37014</p> <p>Based on record review, staff and Consultant Pharmacist interviews, the facility failed to follow the pharmacy recommendation to update a medication order to include indication for use for 1 of 5 residents reviewed for unnecessary medications (Residents #77).</p> <p>Findings included:</p> <p>Resident #77 admitted to the facility on [DATE] with diagnoses that included dementia, mood disturbance, anxiety disorder and major depressive disorder.</p> <p>An active physician's order dated 08/23/24 for Resident #77 read, Lamotrigine (mood stabilizer) 25 milligrams (mg) - give one tablet by mouth two times a day for There was no diagnosis included on the order indicating reason for use.</p> <p>The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had severe impairment in cognition.</p> <p>Review of a Pharmacist's Recommendation to Prescriber form dated 10/31/24 read, Resident #77 has an order for Lamotrigine 25 mg - give one tablet by mouth two times a day for Please update order directions to include indication for use. The bottom of the form where the provider would agree or disagree, provide comments and sign the form was blank.</p> <p>The Medication Administration Records (MARs) for October 2024, November 2024, December 2024, and January 2025 revealed Resident #77 received Lamotrigine 25 mg twice daily as ordered.</p> <p>During a phone interview on 01/16/25 at 2:03 PM, the Consultant Pharmacist revealed as part of her monthly medication reviews, she checked to ensure medications had a clinical indication for use and if they did not, she submitted a recommendation to the facility. She confirmed that she submitted a recommendation to the facility on [DATE] to add an indication of use to Resident #77's Lamotrigine medication order. She explained she was out of work November 2024 and December 2024 and the Pharmacists who covered in her absence likely had not known to follow up on the recommendation. The Consultant Pharmacist indicated it was her expectation for the facility to have addressed the recommendation for Resident #77 within 30 days, before the next monthly medication review.</p> <p>During an interview on 01/16/25 at 11:55 AM, the Director of Nursing (DON) revealed she had started back at the facility in December 2024 and since then, the Unit Manager was the person responsible for reviewing and following-up on pharmacy recommendations and then sending them back to her when completed. The DON stated prior to December 2024, she was not sure who was following-up on pharmacy recommendations. The DON confirmed the pharmacy recommendation dated 10/31/24 for Resident #77 had not been addressed and a diagnosis had not been added to the physician order for Lamotrigine as requested.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/17/2025
NAME OF PROVIDER OR SUPPLIER  Accordius Health at Gastonia		STREET ADDRESS, CITY, STATE, ZIP CODE  416 N Highland Street Gastonia, NC 28052	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/16/25 at 3:00 PM, the Administrator revealed she thought the former DON would have been the person following-up to make sure pharmacy recommendations were completed. The Administrator stated she expected pharmacy recommendations to be addressed when provided to the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39037</p> <p>Based on observations and staff interviews the facility failed to maintain a clean floor in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer, and 1 of 1 kitchen; label and date open food items and discard food with signs of spoilage or use-by date in 1 of 1 walk-in cooler; restrain facial hair during food preparation; and label and date food items in 2 of 2 nourishment room refrigerators and freezer (first and second floor nourishment rooms).</p> <p>Findings included:</p> <p>1. An initial tour of the walk-in cooler, walk-in freezer, and kitchen on 01/13/25 at 11:10 AM revealed multiple dried white stains and debris scattered on the floor of the walk-in cooler, dried brown stains and scattered debris on the floor of the walk-in freezer, and a dried blue substance to the kitchen floor near the 3 compartment sink, 2 plastic drinking cups on the floor under the dish machine, and a large amount of black debris on the floor under the sink near the dish machine.</p> <p>An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed the walk-in cooler, walk-in freezer, and kitchen were mopped daily and she expected the floors to be clean.</p> <p>An additional observation of the walk-in cooler, walk-in freezer, and kitchen floor on 01/15/25 at 11:10 AM revealed multiple dried white stains and debris scattered on the floor of the walk-in cooler, dried brown stains and scattered debris on the floor of the walk-in freezer, and a dried blue substance to the kitchen floor near the 3 compartment sink, 2 plastic drinking cups on the floor under the dish machine, and a large amount of black debris on the floor under the sink near the dish machine.</p> <p>An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected floors of the walk-in cooler, walk-in freezer, and kitchen to be clean and free of debris.</p> <p>2. An initial observation of the walk-in cooler on 01/13/25 at 11:15 AM revealed an undated bowl of salad, 3 opened and undated packs of sliced cheese, a bag of shredded lettuce with brown discoloration with an opened date of 01/02/25, a metal pan of tomato soup with a date of 01/07/25, and an opened and undated 46-ounce box of thickened orange juice sitting on a shelf.</p> <p>An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed all food and beverage items should be dated when opened and cooks were responsible for making sure all items were dated on a daily basis. She stated any food with signs of spoilage should be discarded and the tomato soup should have been discarded 3 days after being placed in the cooler.</p> <p>An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected all food and beverage items to be dated when opened, food with signs of spoilage should be discarded, and food items should be used or discarded according to use-by policies.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Accordius Health at Gastonia		STREET ADDRESS, CITY, STATE, ZIP CODE  416 N Highland Street Gastonia, NC 28052	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. An observation of [NAME] #1 on 01/13/25 at 11:35 AM revealed he was preparing food for the lunch meal and did not have a restraint in place to cover his facial hair. [NAME] #1 had a partial beard with varying lengths of hair covering mainly his chin and the surrounding skin.</p> <p>In an interview with [NAME] #1 on 01/13/25 at 11:35 AM he confirmed he was not wearing a restraint for his facial hair and stated he was not sure if the kitchen stocked restraints for facial hair.</p> <p>An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed she had ordered beard guards but had not received them. She stated all employees with facial hair should have a beard guard in place when preparing and serving food.</p> <p>An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected all dietary staff with facial hair to have a beard guard in place when preparing and serving food.</p> <p>4. (a). An observation of the first-floor nourishment room refrigerator on 01/14/25 at 8:39 AM revealed an undated 46-ounce box of thickened apple juice sitting on a shelf.</p> <p>(b). An observation of the second-floor nourishment room on 01/14/25 at 8:44 AM revealed the following:</p> <ul style="list-style-type: none"> <li>(1) an unlabeled and undated bag of meatballs sitting in the door of the refrigerator</li> <li>(2) an unlabeled and undated bag of pizza slices sitting in the door of the refrigerator</li> <li>(3) an unlabeled and undated half empty thawed milkshake sitting on a shelf in the refrigerator</li> <li>(4) an unlabeled and undated pitcher of brown liquid sitting on a shelf in the refrigerator</li> <li>(5) an undated 12-ounce can of soda sitting on a shelf in the freezer</li> <li>(6) 2 unlabeled and undated 16.9-ounce bottles of water sitting in the door of the freezer</li> </ul> <p>An interview with the Dietary Manager on 01/15/25 at 11:35 AM revealed the dietary department was responsible for ensuring all items in the nourishment room refrigerators and freezers were labeled and dated on a daily basis. She stated dietary staff would check to ensure all items were labeled and dated but nursing staff would place unlabeled and undated items in the refrigerators or freezers after dietary staff checked for dates and labels.</p> <p>An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected all items in nourishment room refrigerators and freezers to be labeled and dated.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>39037</p> <p>Based on observations and staff interviews the facility failed to ensure the area surrounding dumpsters remained free of garbage and debris and failed to close the doors to the dumpsters that contained waste for 3 of 3 dumpsters reviewed. These failures had the potential to attract pests and rodents.</p> <p>Findings included:</p> <p>An observation of the dumpster area with [NAME] #1 on 01/13/25 at 11:25 AM revealed the side doors of all 3 dumpsters were open and the door on top of the middle dumpster was open, with multiple cardboard boxes hanging out the top of the dumpster. Further observation of the dumpster area revealed there were 3 gloves, a plastic drinking cup, pieces of tape, a straw, and various condiment packets scattered on the ground around the dumpster area.</p> <p>An interview with [NAME] #1 on 01/13/25 at 11:25 AM revealed he was not sure who was responsible for cleaning the dumpster area and ensuring dumpster lids were closed.</p> <p>An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed the maintenance department was responsible for cleaning the dumpster area.</p> <p>An interview with the Housekeeping Director on 01/17/25 at 8:26 AM revealed floor technicians and the maintenance department split keeping the dumpster area clean. She stated the dumpster area was supposed to be checked daily for cleanliness and that dumpster lids were closed.</p> <p>An interview with the Maintenance Director on 01/16/25 at 8:30 AM revealed he and the floor technicians were responsible for ensuring the dumpster area was clean and dumpster lids were closed on a daily basis. He stated he had not had an opportunity to check the dumpster area the morning of 01/13/25.</p> <p>An interview with Floor Technician #1 on 01/17/25 at 8:33 AM revealed he and the Maintenance Director were responsible for ensuring the dumpster area was clean and dumpster lids were closed on a daily basis. He stated he had not had an opportunity to check the dumpster area the morning of 01/13/25.</p> <p>An interview with the Administrator on 01/16/25 at 4:05 PM revealed all dumpster lids should be shut and the area around the dumpsters should be clean and free of debris. She stated the housekeeping department was responsible for ensuring the dumpster area was clean.</p>