

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  04/01/2026
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications kept at bedside for 1 of 1 resident reviewed for self-administration (Resident #39). Findings included: Resident #39 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, coronary heart disease, hypertension, and heart failure. Review of Resident #39's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. Review of Resident #39's active physician orders included albuterol sulfate (bronchodilator) aerosol 90 micrograms (mcg) inhale 2 puffs every 4 hours as needed for dyspnea (shortness of breath) dated 3/16/26. There was no active order for the oxymetazoline hydrochloride (antihistamine) nasal spray. Review of Resident #39's medical records revealed no documentation Resident #39 was assessed to safely self-administer medications. During an observation and interview with Resident #39 on 03/29/26 at 12:16 PM, two inhalers of albuterol sulfate 90 mcg and two bottles of oxymetazoline hydrochloride nasal spray were observed in a plastic basket on the overbed table beside the bed. Resident #39 was in bed, and both medications were within his reach. Resident #39 stated he used the inhalers probably twice a week when short of breath and took 2 puffs and he used the nasal spray for congestion. An observation on 03/30/26 at 12:57 PM revealed the two inhalers of albuterol and the two bottles of oxymetazoline hydrochloride nasal spray remained in the basket on the overbed table within the reach of Resident #39 while he rested in bed. An interview was conducted on 03/31/26 at 4:07 PM with Nurse #3, the assigned nurse for Resident #39. Nurse #3 revealed she had administered the day shift medications to Resident #39 on 3/31/26 but she did not notice the inhalers or nasal spray bottles in the basket on the bedside table. Nurse #3 stated if she had noticed the medications, she would have removed them from the room and stored them on the medication cart. Nurse #3 stated she was not aware of any resident that self-administered medications. During an interview on 03/31/26 at 3:13 PM, the Director of Nursing (DON) explained if Resident #39 wanted to self-administer his inhaler and nasal spray a self-administer assessment should have been done and the inhaler and nasal spray should be stored securely. An observation on 03/31/26 at 3:16 PM with the DON revealed the two albuterol inhalers and two bottles of oxymetazoline hydrochloride nasal spray remained in the basket placed on the overbed table beside Resident #39. Resident #39 refused to share where he got the inhalers and nasal spray when asked by the DON. The DON explained to Resident #39 if he wanted to self-administer the inhaler and nasal spray she would need to ensure there was a physician's order for the medications and a self-administration assessment was needed to ensure he could safely administer the medication. Resident #39 confirmed he wanted to self-administer his albuterol inhaler and nasal spray. The DON removed both inhalers and nasal spray bottles from the room. During an interview on 04/01/26 at 2:09 PM, the Administrator stated Resident #39's ability to safely administer would need to be assessed if he wanted to self-administer the albuterol inhaler and nasal spray. The Administrator revealed the medications would need to be stored securely and not be left within reach of other residents.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, interviews with staff and Nurse Practitioner, the facility failed to follow a Nurse Practitioner order for the care of an intravenous (IV) access site for 1 of 1 resident who had a Peripherally Inserted Central Catheter (PICC) (Resident #85). Findings included: Hospital Discharge summary dated [DATE] revealed orders for Resident #85 to continue IV antibiotics for 38 days. A Nurse Practitioner order dated 03/20/26 revealed to change of the PICC line dressing every 7 days on Fridays. The Care Plan dated 03/21/26 revealed Resident #85 had a PICC line with an intervention of dressing change per order. The comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #85 is cognitively intact, received IV medication and had IV access in the form of a PICC. The medication administration record (MAR) revealed to change the PICC line dressing every Friday during dayshift with a start date of 03/27/26; it was left blank and not signed off as completed on 3/27/26. Review of progress notes dated 03/27/26 revealed no documentation as to why the dressing change did not occur. During an interview and observation on 03/29/26 at 2:19 PM of Resident #85 it was revealed that Resident #85 had a PICC line for IV antibiotic therapy. Observation of the IV access site revealed an intact dressing with corners curled up, no redness or drainage at the insertion site and a date of 03/18/26. During an interview conducted on 03/30/26 at 2:09 PM, Nurse #1 stated he had been assigned as the nurse for Resident #85 on 03/27/26. Nurse #1 revealed he was supposed to change the dressing on the PICC line as per the order, but he did not complete the task. During an interview conducted on 03/30/26 at 2:54 PM, the Assistant Director of Nursing (ADON) indicated that she had completed the PICC dressing change on 03/30/26. The ADON revealed the old dressing was dated 03/18/26. The ADON stated she expected the dressing to be changed on 03/27/26 and it was not changed. The ADON stated the dressing change was not completed as ordered. During an interview on 04/01/26 at 10:07 AM the Director of Nursing (DON) stated that dressing changes for IV access sites must be completed at least every seven days, with daily flushes ordered and the site monitored daily for signs of infection. The DON explained she would expect the nurse assigned to Resident #85 to assess the site and recognize that the dressing change was overdue. She emphasized that PICC line dressings must be changed every seven days to prevent infection. During an interview conducted with the Nurse Practitioner on 04/01/2026 at 9:32 AM, she indicated that she expected dressing changes to be performed every seven days. She explained that exceeding this timeframe increases the risk of infection.</p>		