PRINTED: 07/15/2013 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	<u>O. 0938-0391</u> E SURVEY PLETED
			A. BUILD	JING_			C
		345418	B. WNG				/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 GWANNANOA, NC 28778	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	(INJURY/DECLINE/Red) A facility must immediconsult with the reside known, notify the reside or an interested family accident involving the injury and has the pote intervention; a significal physical, mental, or post deterioration in health, status in either life three clinical complications); significantly (i.e., a new existing form of treatm consequences, or to contreatment); or a decision the resident from the fast 483.12(a). The facility must also pand, if known, the resident rights under Foregulations as specified this section. The facility must record the address and phone legal representative or the address and phone legal representative or the sased on record review facility failed to notify the facility failed to notify the facility failed to notify the consultations as the consultation of the sased on record review facility failed to notify the facility failed to notify the consultations.	ately inform the resident; ant's physician; and if dent's legal representative or member when there is an resident which results in an tential for requiring physician and change in the resident's eychosocial status (i.e., a mental, or psychosocial status (i.e., a mental, or psychosocial statening conditions or a need to alter treatment and to discontinue an ent due to adverse form of on to transfer or discharge acility as specified in an experience and there is a mental assignment as (2); or a change in ederal or State law or din paragraph (b)(1) of and periodically update number of the resident's interested family member.	F	157	The statements included are not admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain compliance with all federal anstate regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center allegation of compliance. All deficiencies have been or will be completed by the dates indicated. The Physician and R were notified of their fall durin the time of the survey for Resident # 3 and 6. How corrective action will be accomplished for those residents with the potential to affected by the same practice. On July 1, 2013, the prior Administrator completed all steeducation regarding notification of Medical Doctor (MD) and Responsible Party (RP) after a fall. An audit of all falls from 6/28/13 to 7/25/13 was completed on 7/25/13 to ensure notification of MD and RP.	fain d	7/26)
(Joans	1 Selles			Apministrator	_ 8	1/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined main other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 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 disclosuble 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requirite to continued program participation.

Event ID: 0U2311

Facility ID: 952947

AUG 0 2 2013

If continuation sheet Page

1 of 101

by:

STATEMENT	OF DESIGNATIONS	DIO TID GENTIOLS				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		345418	B. WING			06	C 5/28/2013
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	120/2010
ACHEVIII	LE UEAL TU OADE ADVE				984 HIGHWAY 70		
ASHEVIL	LE HEALTH CARE CENTI	ER		1	WANNANOA, NC 28778		
(V4) ID	SHIMMADY STA	ATEMENT OF DECIDIONS		_ 3	WANNANOA, NC 28/78		
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID	ıv.	PROVIDER'S PLAN OF CORRECTION	_	(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E ΔTF	COMPLETION DATE
					DEFICIENCY)		
F 157	Continued From page	1	F	157	Measures in place to ensure		
	responsible party follo	wing a fall for 2 of 3		101	practices will not occur. The		
	sampled residents rev	iewed with falls. (Residents		- 1	Administrator, Interim Director	or of	
	#3 and #6).	The state of the s			Nursing (IDON), Unit Manage	er	
	*				(UM) or designee will audit a		
	The findings included:				falls on the next business da		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				regarding notification of	y	
	The facility's policy for	Incident/Accident Reports			and the second s		
	in the Nursing Docume	entation manual with an			physician and responsible pa		
		/12 included the following			for a period of 2 weeks, wee		
	procedures:			1	x two weeks, then monthly x	2,	
		ian will immediately be			then quarterly x 3. The Staff		
	notified of the occurrer				Development Coordinator		
	*"A licensed nurse will	immediately notify the			(SDC)/DON/UM will ensure		
	responsible party of the	e occurrence."			annual and new nurse hire		
	Documentation and v	verification of the follow up			education on RP and MD		
	to the care and treatme	ent of the resident as well					
	as notification of the pr	nysician and responsible			notification.	¥00	
	party will be completed	in the Nurses Notes."			How the facility plans to mon	itor	
	1. Resident #3 was add	mitted to the facility on		- 1	and ensure correction is		
	03/13/13 with diagnose	es including Alzheimer's			achieved and sustained. The		
	type dementia with beh	asvioral disturbances			IDON or Unit Manager will		
	major depressive disor	der, generalized anxiety			present results of audits to		
	disorder, coronary arte	ry disease			Quality Assessment Commit	tee	
	hypothyroidism, and hy				monthly for 3 months, then		
		No Consideration Constitution			quarterly x 3 to show		
	The admission Minimur	n Data Set (MDS) dated			compliance with education a	nd	
- 1	03/20/13 coded her with	h severely impaired			allow for review and revision		
	cognitive skills, and req	uiring supervision with bed				п	
	mobility, transfers, and	walking.			needed.		
							- 1
	Review of an incident re	eport, written by Nurse #6,					
	revealed on 05/09/13 a	t 6:45 PM Resident #3					
	was observed on the flo	oor in her room on the side					- 1
10	of the bed, kneeling on	the floor mat with the					1
	alarm sounding. The in	cident report's section					
	relating to notifications t	o the physician and to the				1	- 1
1.0	responsible party were	left blank.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	I TIDI	E CONSTRUCTION		<u>IO. 0938-0391</u>
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				TE SURVEY MPLETED
		345418	B. WNG			0	C 3/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 -	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	at 11:53 PM revealed but gave no mention of doctor or the responsinate on 05/10/13 was gave no mention of an Interview with the Reg Administrator on 06/28 notifications should be incident report, in the replans. The care plan of notifications. Interview with Nurse ### revealed when a reside for filling out an incider was a spot on the form notification of the physical He stated that he called responsible party right injured. If there was not he made his progress rethe evening by the timeran out of time he pass (usually 11-7) to call or next day's first shift to refurther stated if he was	ogress note dated 05/09/13 the resident fell at 6:45 PM of any notification to the ble party. The only nursing timed at 3:41 PM and again y notifications. Jonal Nurse Consultant and	F	157			
1 1 1 2	document that notificati nursing notes. He also the policy for notification	stated he was not sure of n but he was trying to do a physician and responsible mitted to the facility on					

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPL	LE CONSTRUCTION		O. 0938-0391 E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	- 22				1PLETED
		345418	B. WNG				C
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06	5/28/2013
ASHEVIL	LE HEALTH CARE CENT	ER			1984 HIGHWAY 70		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	Г,	SWANNANOA, NC 28778		
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 157	Continued From page	3	_	457			
	type dementia with be		Г	157			
	major depressive diso	rder, generalized anxiety					
	disorder, coronary arte hypothyroidism, and h	ery disease, yperlipidemia.					
	The admission Minimu	ım Data Set (MDS) dated					
	03/20/13 coded her wi	th severely impaired					
	cognitive skills, and re-	quiring supervision with bed					
	as being steady with b	walking. She was coded alance at all times.					
	Review of an incident i	report, written by Nurse #6,					
	revealed that on 05/09	/13 at 8:45 PM Resident #6					
	the floor mat with no al	oor in her room sitting on arms sounding. The alarm					
	had been on but the co	ord was so long it didn't					
	disconnect and sound.	The incident report's ications to the physician					
	and to the responsible	party were left blank.					
	The corresponding pro	gress note dated 5/09/13					
	at 11:48 PM revealed to	hat Resident #6 was on					
	the floor at 8:45 PM. T documentation regarding	nere was no no notification of the					
	physician or the respon	sible party. The 2 nursing					
	notes on 05/10/13 at 3:	40 PM and again at 11:46					
	PM referred to the fall, indication that notification	nowever, there was no					
	physician or responsible						
	either.						
	Interview with the Region	onal Nurse Consultant and					
	Administrator on 06/28/	13 at 4:10 PM revealed					
13	notifications should be dincident report, in the pu	documented on the ursing notes or on the care					
	plans. The care plan di	d not address					1
	notifications.	10.0 / RESOURCE CONTROL OF THE CONTR					

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DATE PRODUCES	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345418	B. WING			C 6/28/2013
ASHEVIL	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	10	0/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
SS=D	Interview with Nurse # revealed when a resid for filling out an incide was a spot on the form notification of the phys He stated that he calle was injured. If there we until he made his nurs late or he ran out of tin next shift (usually 11-7 message for the next of notifications. He further assignment from another notification, he would of was made in the nursing was not sure of the pol was trying to do a better physician and responsional 483.13(c)(1)(ii)-(iii), (c)(INVESTIGATE/REPOF ALLEGATIONS/INDIVITATE facility must not en been found guilty of about a finding entered in registry concerning about of residents or misapproand report any knowled court of law against an indicate unfitness for secondary facility staff to the or licensing authorities. The facility must ensure nvolving mistreatment, ncluding injuries of unknowledging injurie	left on 06/28/13 at 6:54 PM lent fell he was responsible int report. He stated there in to complete regarding sician and responsible party. It dright away if the resident leas no injury, he may wait ling note. Then, if it was too line he passed it on to the line of the leave a liday's first shift to make the lear stated if he was left the liner shift to make the l	F 2	F225 How the corrective action accomplished for the reaffected. Resident #7 in was reported to the Stangency by the prior Administrator.	sident(s) ncident	7/26/

OLIVILI	TO FOR MEDICANE &	WEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		345418	B. WING				C 28/2013
NAME OF PE	ROVIDER OR SUPPLIER			CTO	DEET ADDRESS CITY OTATE TIP CODE	1 00/	20/2013
ACHEVILL	FUEAUTU CARE CEVE			1000	BEET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70		
ASHEVILI	LE HEALTH CARE CENT	EK			WANNANOA, NC 28778		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE	Ε	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(TE	DATE
F 225	Continued From page	E	_		How corrective action will be accomplished for those		
, 220			F	225	residents with the potential to b		
	to other officials in acc	ministrator of the facility and cordance with State law			affected by the same practice.	е	
		rocedures (including to the			All current Staff were in-service	d	
	State survey and certi	fication agency).			on Abuse and Neglect Policy	u	l)
		7-36 (T-950A			and reporting requirements by		
	The facility must have	evidence that all alleged			the prior administrator. The prior	or	
	violations are thorough	nly investigated, and must			Administrator and Interim	ו	
	prevent further potenti investigation is in prog	al abuse while the			Director of nursing (IDON) were	0	
	investigation is in prog	ress.			educated on reporting to other	5	
	The results of all inves	tigations must be reported			officials in accordance with		
	to the administrator or	his designated		-	State and Federal Regulations		
	representative and to	other officials in accordance			by the Nurse Consultant on		
	with State law (including	ng to the State survey and			June 28th. The new Interim		
		ithin 5 working days of the					
		ged violation is verified			DON (IDON) and prior		
	appropriate corrective	action must be taken.			Administrator were educated or	1	ı
					July 22, 2013 by the Nurse		
					Consultant to report injuries of		
		is not met as evidenced			unknown origin within 24 hours and submit the results of the		
	by:			İ	이 가 원인 위로 회장 경기가 그 경기에 가게 하게 되는 사무기를 위해를 취득하다.		
	Based on record revie	w and staff interviews, the			investigation by the 5 th working		
	unknown origin within	an allegation of an injury of 24 hours and submit by the			day. The Administrator will be		
	5th working day the inv	restigation for 1 of 3			responsible for completing the		
	residents sampled for a	abuse investigations			24 hour Report and 5 day		
	(Resident #7)				investigation report.		
	Tel 20 10 10 10 10 10 10 10 10 10 10 10 10 10				Measures in place to ensure		
	The findings included:				practices will not occur. Inciden		
	Resident #7 was admit	ted to the facility on			and Accident reports are	t	
	04/21/13 with diagnose				audited on the next business		
		neuropathy, chronic renal			day by IDON and reviewed by		
	insufficiency, right hip f	racture, chronic			Administrator, to ensure that		
100	obstructive pulmonary	disease, and			any injuries not explained are		
	gastroesophageal reflu	x disease.			investigated and reported as		
					needed. Staff who continue to		
			1	11 8			1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345418	B. WING			1	C /28/2013
ASHEVIL	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	720/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	note dated 05/01/13 at Administrator which in the right nare. The rebleeds all the time. A 05/02/13 at 3:08 PM visited a family conferd. This note stated the faresident's nosebleeds would often blow her making the bleed wors 05/05/13 at 2:25 PM significant value of the hospital peresident returned about note dated 05/06/13 at note stated the CT scatter appropriate changes. The family was "not pledicitium". The CT scatter family was "not pledicitium".	I record revealed a progress at 2:19 PM written by the oted a trickle of blood from sident stated she had nose progress note dated written by the Administrator ence was held this date. amily was aware of the and added that the resident nose with a nosebleed se. A progress note on stated Resident #7 had been the morning. A family terned about the resident's ent #7 subsequently was refamily request. The at 7:50 PM per the progress an of the head showed age. The note continued stating eased, that she is still with ean's impression noted in with small disease and age all changes. 05/07/13 at 3:45 PM was noted with frequent mount frank blood. At if the resident was noted to it of frank red blood with the had 'spit up'. Resident he blood coming up from the blood coming up from the blood coming up from the blood of the mouth. Envices was notified esident was transported to	F	225	turn in Incident and Accident Reports that are incomplete or fail to timely report allegations abuse will be re-educated and continued non-compliance will result in disciplinary action. How the facility plans to monitor and ensure correction is achieved and sustained. The IDON will report the results of the audit to the QA Committee for three months, then quarterly x 3 for compliance and revision as needed.	of or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	94 ACCESSES 240		CONSTRUCTION		E SURVEY PLETED
		345418	B. WNG				С
NAME OF PE	ROVIDER OR SUPPLIER	040410	B. WING	STR	EET ADDRESS, CITY, STATE, ZIP CODE	06	/28/2013
ASHEVILI	LE HEALTH CARE CENT			19	984 HIGHWAY 70 WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	Progress notes dated noted that at 6:35 PM, to the facility. Family her nose'. The progre results noting a fracturnew orders were noted. Review of the CT scar dated 05/07/13 at 5:07 impression "Possible straumatic irregularity owith soft tissue swellin. On 05/09/13 the physical indicated he was seeing her medications and deforehead and right eyes was on plavix and aspendications of abuse or mention the CT scan conose. Review of the abuse in 24 hour or 5 day report regarding the fractured. Interview with the Adme 9:35 AM revealed the forest removed.	05/07/13 at 10:12 PM In the resident was returned stated 'they found a crack in its so note included the CT are in the nasal bone. No incompleted at the hospital of PM included the subtle acute or old if the anterior nasal spine included the subtle acute or old if the anterior nasal spine included the subtle acute or old if the anterior nasal spine included the inclu		2225		ΠE	DATE
	find the root cause of the nurse who noted the in an incident report and a The Administrator state the red eye and determined the cause of the cause	he injury. She stated the jury should have filled out started an investigation. ed they had investigated nined it was from rubbing en tubing rolling on her but any investigation of the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	26 2600e		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		200-200-20	A. Boice	JING_			С
		345418	B. WNG	_		0	6/28/2013
17.1588 334 4	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 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)	3E	(X5) COMPLETION DATE
	resident had a fall at home. The Administrascan on 05/05/13 did and the one complete fractured nose. The Adwas no investigation of because the family stableeds at home. She nose caused the nose how or who made this provide any evidence. When asked if the new nose should have been of unknown origin, the unless the family was inhave happened at hom further stated that in the interview confirming Reat home she thought the and there was no need injury and therefore did agency as being investigated he recalled hear nose but could not recate the CT scan was in his came to the facility. He bruising he did not thin he did not have the CT him during this converse would say acute fracture to sure about the reporture stated he was not the restated he was not sure about the reporture the concluded the fracture for the stated he was not the stated he was not sure about the reporture the concluded the fracture for the stated he was not the stated he was not the concluded the fracture for the stated he was not t	and nose bleeds at alter acknowledged the CT not note a fractured nose of on 05/07/13 did show a diministrator stated there if the fractured nose atted the resident had nose further stated the fractured bleeds but could not say conclusion nor did she to support this conclusion. Ally diagnosed fractured in investigated as an injury Administrator stated yes in agreement that it could not not agreement that it could not	F	225			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345418	B. WING			1	C 5/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER	1	19	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778	1 00	1/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	contacted by phone we the hospital on 05/07/1 the hospital physician fractured nose. This fineard nothing more from fractured nose. On 06/28/13 at 1:42 P was conducted with Nowhen Resident #7 returns on 05/07/13 with nose. Nurse #11 states the findings and she saput in the physician's befacility at this time. Nur physician stated he did there were no new ord for injury of unknown of the physician, inform the physician, inform the absence pass it on in serecalled passing it on infurther explained that the administration would dishe did not fill out an inthis fracture and nor wor injury of unknown origin. On 06/28/13 at 2:12 P Nalso present at the hospification of sending Reswas for coughing up grathis family member states.	M a family member was ho acknowledged being at 13 and being informed by that Resident #7 had a amily member stated he om the facility about the M a telephone interview urse #11, who was working urned from the emergency the report of a fractured d the family told her about aw the CT report which she look as he was in the rese #11 stated the fanot see it as acute and ers. She then stated that rigin, she would report it to be unit manager and in his shift report. In this case she in shift report. Nurse #11 he unit manager brought horning meetings where secus it. Nurse #11 stated incident report regarding build she fill one out for an in. M another family member, potal on 05/07/13 when the covered, was interviewed illy stated that the facility's ident #7 to the hospital	F	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 4569 2050 00	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345418	B. WNG		-		C
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		984 HIGHWAY 70] 06	/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225 F 226 SS=D	and was a new develor On 06/28/13 at 6:08 P stated when he discover fractured nose he was reason for the fracture stated if he was the number would have filled or given it to the Adminis 483.13(c) DEVELOP/I ABUSE/NEGLECT, ETThe facility must develop policies and procedure mistreatment, neglect, and misappropriation of this REQUIREMENT by: Based on record revies	M interview with Nurse #2 vered Resident #7 had a surprised. Without any such as a fall, Nurse #2 urse responsible at the time, ut an incident report and trator to investigate. MPLMENT TC POLICIES op and implement written es that prohibit and abuse of residents of resident property. is not met as evidenced ws and staff interviews, the		2225	F226 How the corrective action will accomplished for the residen affected. Resident #7 incider was investigated and reporte to the State agency by the pradministrator. How corrective action will be accomplished for those residents with the potential to affected by the same practice	t(s) nt ed rior	7/26/13
	injury of unknown origi sampled for abuse investigation of the findings included: The findings included: The facility's policy "Dewith an effective date of the injuries of unknown originates as an allegation of abuse and must be repart of the injury in the injury in patient by a nurse aide	estigations. (Resident #7). estermination Guidelines" of 08/03/11 included: "2. gin should be handled the of mistreatment, neglect or orted to the State Survey onable cause to believe or has been inflected upon a or other Center staff." estigation and Reporting					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE	C. 0936-0391 E SURVEY PLETED
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		345418	B. WNG			06	/28/2013
12/12/20/20/20/20/20/20	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
(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
	included "3. The Adm Nursing will immediate investigation of the all report with 24 hours of allegation." Resident #7 was adm 04/21/13 with diagnost heart failure, diabetes insufficiency, right hip obstructive pulmonary gastroesophageal reflection of the right nare. The resident has a daministrator which not the right nare. The resident sall the time. A 05/02/13 at 3:08 PM with stated a family conferent in some stated the faresident's nosebleeds would often blow her making the bleed wors 05/05/13 at 2:25 PM styelling out throughout came in and was concomental status. Reside sent to the hospital per resident returned about note dated 05/06/13 at note stated the CT sca appropriate changes.	inistrator and/or Director of ely begin a thorough internal eged occurrence and will of knowledge of the litted to the facility on es including congestive, neuropathy, chronic renal fracture, chronic disease, and ux disease. I record revealed a progress to 2:19 PM written by the oted a trickle of blood from sident stated she had nose progress note dated written by the Administrator ence was held this date, mily was aware of the and added that the resident those with a nosebleed se. A progress note on tated Resident #7 had been the morning. A family erned about the resident's not #7 subsequently was a family request. The to 7:50 PM per the progress 6:17 AM. This progress no of the head showed age The note continued stating ased, that she is still with an's impression noted in with small isease and age	F	226	All current Staff were in-service by the Administrator on Abuse and Neglect Policy and reporting The Administrator ar Interim Director of nursing were educated on investigating and reporting to other officials in accordance with State and Federal Regulations by the Nurse Consultant on June 28, 2013. The new Interim DON was educated on July 22, 201 and given a copy of the policy and regulatory requirements be the Nurse Consultant on investigating and reporting injuries of unknown origin with 24 hours and submit the result of the investigation by the 5th working days. The Administrate will be responsible for completing the 24 hour Report and the 5 day Investigation Report. Measures in place to ensure practices will not occur. Incide and Accident reports are audited on the next business to IDON and reviewed by Administrator, to ensure that any injuries not explained are investigated for cause and reported to State authorities as indicated. Staff who continue is indicated. Staff who continues indicated.	and re	

		DELIVIOLO				OIMR M	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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NAME OF PR	ROVIDER OR SUPPLIER			STD	EET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E HEALTH CARE CENTI	≣R		100-110-110	984 HIGHWAY 70		
	SOCIATION CONTINUE BLV BOOKS STORE STORE CONTINUES			S	WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	10.46	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Progress notes dated revealed Resident #7 nose bleeds of small a approximately 1:00 PM have moderate amour grape sized clot that s stated she could feel ther throat and filling the Emergency Medical Scimmediately and the rethe emergency room for treatment. Progress notes dated noted that at 6:35 PM, to the facility. Family sher nose'. The progres results noting a fracturnew orders were noted. Review of the CT scandated 05/07/13 at 5:07 impression "Possible straumatic irregularity of with soft tissue swelling. On 05/09/13 the physicindicated he was seein her medications and deforehead and right eye was on plavix and aspindications of abuse or mention the CT scan onose. Review of the abuse in the service of the abuse in the content of the cont	05/07/13 at 3:45 PM was noted with frequent amount frank blood. At the resident was noted to at of frank red blood with the had 'spit up'. Resident the blood coming up from the blood coming up from the back of her mouth. the blood coming up from the back of her mouth. the vices was notified the blood coming up from the blood coming up from the back of her mouth. The revices was notified the resident was returned the resident was returned the resident was returned the resident was returned the included the CT the in the nasal bone. No the completed at the hospital the note of the anterior nasal spine the anterior nasal spine the anterior nasal spine the physician stated she the physician stated she trin and he saw no signs or the physician or fractured the vestigations revealed no	F	226	turn in Incident and Accident Reports that are incomplete or fail to timely report allegations will be educated and if continued will result in disciplinary action How the facility plans to monite and ensure correction is achieved and sustained. The IDON will report results of the audits to the QA committee for three months, then quarter x 3 for continued compliance and revision as indicated	or	
ļ	investigation regarding	the fractured nose found					

A. BUILDING COMPLETE 345418 B. WING 06/28/2	
345418 B. WING 06/28/2	28/2013
THE CHARLEST AND THE CH	F0/ V 10
ASHEVILLE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 Continued From page 13 on 05/07/13. Interview with the Administrator on 06/28/13 at 9.35 AM revealed the facility's investigation of an injury of unknown origin included attempting to find the root cause of the injury. She stated the nurse who noted the injury should have filled out an incident report and started an investigation. The Administrator stated they had investigated the red eye and determined it was from rubbing her eyes and the oxygen tubing rolling on her face. When asked about any investigation of the fractured nose, the Administrator stated the resident had a fall at home and nose bleeds at home. The Administrator stated the resident had a fall at home and nose bleeds at home. The Administrator stated the resident had a fall at home and nose bleeds at home. The Administrator stated there was no investigation of the fractured nose and the one completed on 05/07/13 did show a fractured nose. The Administrator stated there was no investigation of the fractured nose because the family stated the resident had nose bleeds at home. She further stated the fractured nose caused the nose bleeds but could not say how or who made this conclusion. When asked if the newly diagnosed fractured nose should have been investigated as an injury of unknown origin, the Administrator stated yes unless the family was in agreement that it could have happened at home. The Administrator further stated that in the context of the family interview confirming Resident #7 had nose bleeds at home she thought the reason was validated and there was no ned to investigate it as a new injury. On 06/28/13 at 12:38 PM Resident #7's physician was interviewed via telephone. The physician stated he recalled hearing about the fractured	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		O. 0938-0391 E SURVEY
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NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	5/28/2013
ASHEVIL	LE HEALTH CARE CENT	ER		1984 HIGHWAY 70 SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	nose but could not recithe CT scan was in his came to the facility. He bruising he did not thin he did not have the CT him during this converwould say acute fracture he concluded the fracture about the repifurther stated he was refractured nose and the about it. On 06/28/13 at 1:18 Pl contacted by phone with the hospital on 05/07/1 the hospital physician teractured nose. This far heard nothing more from fractured nose. On 06/28/13 at 1:42 PN was conducted with Nuwhen Resident #7 return room on 05/07/13 with nose. Nurse #11 stated the findings and she sain put in the physician's befacility at this time. Nurse physician stated he did there were no new order for injury of unknown or the physician, inform the absence pass it on in strecalled passing it on in further explained that the all new injuries to the missing the sain state of the mean recalled passing it on in further explained that the all new injuries to the missing the sain has a sain the physician of the mean recalled passing it on in further explained that the all new injuries to the missing the sain has a sain the physician of the mean recalled passing it on in further explained that the all new injuries to the missing the sain has a sain h	all if a nurse told him or if a folder to review when he e stated since he saw no hak it was acute. He stated a scan to review in front of sation but stated the scan are if it was acute. He stated ure was not recent but was porting requirements. He not concerned about the re was nothing to be done. Ma family member was no acknowledged being at 3 and being informed by that Resident #7 had a simily member stated he mem the facility about the. Ma telephone interview are #11, who was working and from the emergency the report of a fractured at the family told her about we who can be was in the see #11 stated the not see it as acute and eas. She then stated that igin, she would report it to be unit manager and in his nift report. Nurse #11 the unit manager brought.	F	226			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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200 21 200 200 200 200 200 200 200 200 2	ROVIDER OR SUPPLIER	ER		1	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 EWANNANOA, NC 28778	1 00	20/2013
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241 SS=D	she did not fill out an ithis fracture and nor vinjury of unknown origing. On 06/28/13 at 2:12 Falso present at the hofractured nose was disby telephone. The far reason for sending Rewas for coughing up on the CT and was a new develor on 06/28/13 at 6:08 Fatated when he disconfractured nose he was reason for the fractured stated if he was the number would have filled on given it to the Administ 483.15(a) DIGNITY AINDIVIDUALITY The facility must promise manner and in an envenhances each reside full recognition of his control of the process of the recognition of the facility staff failed to program the process of t	incident report regarding would she fill one out for an jin. PM another family member, spital on 05/07/13 when the scovered, was interviewed mily stated that the facility's esident #7 to the hospital grape sized blood clots. Stated the fractured nose did scan taken two days earlier opment. PM interview with Nurse #2 wered Resident #7 had a scurprised. Without any e, such as a fall, Nurse #2 were responsible at the time, ut an incident report and strator to investigate. ND RESPECT OF ote care for residents in a ironment that maintains or nt's dignity and respect in or her individuality. is not met as evidenced ews and staff interviews the romote dignity when they a demeaning way for 1 of (Resident #14).		226	F241 How the corrective action will be accomplished for the resident(affected. The Statement by the Nursing Instructor was investigated and unsubstantiated. The accuse Certified Nurse Assistant was suspended and counseled on dignity and respect.	s) e d	7/24/13

NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 241 Continued From page 16 Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included heart disease, high blood pressure, kidney disease, 10 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Administrator in-serviced All		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 241 Continued From page 16 Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included heart disease, high blood pressure, kidney disease, 1D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE DEFICIENCY) How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Administrator in-serviced All			245440					С
ASHEVILLE HEALTH CARE CENTER (X4) ID PREFIX TAG F 241 Continued From page 16 Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included heart disease, high blood pressure, kidney disease, and the facility on distance in the properties of the pressure of the	ME OF DD	DOVIDED OF CLIEBUIED	345418	B. WING	_		06/	/28/2013
F 241 Continued From page 16 Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included heart disease, high blood pressure, kidney disease,	SHEVILL	LE HEALTH CARE CENTI			1	984 HIGHWAY 70		
Resident #14 was admitted to the facility on 05/07/10 with diagnoses which included heart disease, high blood pressure, kidney disease,	REFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
diabetes, Alzheimer's disease and anxiety disorder. Staff on July 1, 2013 regarding Employee and Resident Handbook information on dignity and respect and the consequences of maintain resident dignity and respect and the consequences of maintain resident dignity and respect. In the finger at Resident #14 required extensive assistance from staff for activities of daily living but only required supervision by one staff for eating. Section E of the MDS for behaviors indicated Resident #14 rexibited no behaviors towards self or others. A review of a handwritten note dated 06/18/13 by a Nurse Aide (NA) Instructor indicated at 9:30 AM she observed NA #3 walk past the dining room and NA #3 stated to Resident #14 'your disgusting, that's disgusting; and you have the nerve to complain about other people touching your food." During an interview on 06/25/13 at 2:48 PM with the NA Instructor, she verified she was the Program Instructor for Nurse Aides in training and had students in the facility each week on Tuesday and Thursday. The NA Instructor explained she was standing in the hallway near the dining room on 06/18/13 at 9:30 AM and saw NA #3 point with her finger at Resident #14 and said you are disgusting, that's disgusting to take food off other resident's trays and you have the nerve to complain about other people touching your food.	i i i i i i i i i i i i i i i i i i i	Resident #14 was adm 05/07/10 with diagnos disease, high blood pr diabetes, Alzheimer's disorder. A review of the most re Data Set (MDS) dated Resident #14 had shor memory problems and in cognition for daily defurther indicated Resident gasistance from staff for but only required supe eating. Section E of the indicated Resident #14 towards self or others. A review of a handwritt a Nurse Aide (NA) Inst she observed NA #3 wand NA #3 stated to Redisgusting, that's disgunerve to complain about your food." During an interview on the NA Instructor, she was standing in the faciand Thursday. The NA was standing in the hal on 06/18/13 at 9:30 AM her finger at Resident #disgusting, that's disgusterident's trays and your standing that's disgusterident's trays and your standing that stays and your stays are stays and your stays are stays and your stays are stays	mitted to the facility on es which included heart ressure, kidney disease, disease and anxiety ecent annual Minimum 1 04/02/13 indicated rt term and long term It was moderately impaired ecision making. The MDS dent #14 required extensive for activities of daily living ervision by one staff for the MDS for behaviors the exhibited no behaviors ten note dated 06/18/13 by eructor indicated at 9:30 AM realk past the dining room esident #14 "your esting; and you have the fut other people touching 06/25/13 at 2:48 PM with verified she was the Nurse Aides in training and ility each week on Tuesday Instructor explained she llway near the dining room If and saw NA #3 point with full and said you are esting to take food off other unhave the nerve to	F		accomplished for those residents with the potential to be affected by the same practice. The Administrator in-serviced of Staff on July 1, 2013 regarding Employee and Resident Handbook information on dignicand respect and the consequences of maintain resident dignity and respect. Measures in place to ensure practices will not occur. Social Services (SS)/Discharge Planner(DP)/ will interview ten (10) residents that are able to respond to questions if they are treated with respect and dignity daily Mon-Fri for 2 weeks; weekly for 2 weeks; then monthly for 2 months investigating if they have been treated with dignity and respect The Administrator will also monitor the monthly Resident Council minutes for violations or dignity and respect. Any deviations will be immediately addressed by the Administrator. How the facility plans to monitor and ensure correction is achieved and sustained. The	All ty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345418	B. WNG _			C 06/28/2013	
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		00/20/2010	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		OULD BE	(X5) COMPLETION DATE	
06/18/13 and reported the note to the Director immediately. She staf NA students on Thursof the DON was no longer any information about the been investigated. During an interview on NA #3 she verified Respected for other resident trays that had already if that hadn't been passed explained Resident #14 lunch in the dining room the halls and grabbed if She confirmed Resider off the meal cart on the around 8:30 AM and significant with the she did not remember the NA Instructor's conductive During an interview on Administrator verified in NA instructor or investing Instructor heard NA #3 06/18/13 at 9:30 AM. So not interview NA#3 aboreported because she that. The Administrator	the handwritten note dated her observations and gave of Nursing (DON) ted when she returned with day 06/20/13 she was told for there and was not given whether the incident had 06/27/13 at 2:53 PM with sident #14 routinely tried to dis food and tried to eat off been eaten or from trays and to residents. She 4 usually ate breakfast and me and then she went down food off the meal carts. In the told Resident #14 you at supposed to touch other stated around 9:30 AM ted herself in her dining room. She stated anyone talking to her about occrns. 06/28/13 at 9:45 AM the she did not interview the gate what the NA say to Resident #14 on She also verified she did but what the NA Instructor thought the DON had done or stated an interview with lid have been done but it ther stated she had no	F2	results of Resident inter the QA committee for 3 then quarterly x 3 for recompliance and revision as needed.	month view of	ns, f	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 241 F 279 SS=D	would expect for there of the investigation the	given to her on the ne NA instructor and she e to be more detailed notes an there was. 1) DEVELOP		241 279	F279 How the corrective action will b	e	7/ 1.
	to develop, review and comprehensive plan of the facility must develop plan for each resident objectives and timetal medical, nursing, and	e results of the assessment d revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ed in the comprehensive			accomplished for the resident(s affected. The Care Plan for Resident #14 was updated to include behaviors of putting he hands in other resident's food. The care plan was updated for resident #8 to reflect the resident was no longer on restrictions. How corrective action will be	s) er	1/26/13
	to be furnished to atta highest practicable phrosychosocial well-being \$483.25; and any sense required under \$480.10, including the under \$483.10, including the under \$483.10(b)(4). This REQUIREMENT by: Based on observation interviews the facility interventions on a car from putting her hand	ng as required under vices that would otherwise 33.25 but are not provided exercise of rights under e right to refuse treatment is not met as evidenced as, record review and staff failed to include e plan to monitor a resident in other resident's food			accomplished for those residents with the potential to affected by the same practice. Resident Care Plans with behaviors were reviewed to ensure all interventions are current. The IDON/Unit Managers (UM) will be educat on updating the Care Plan by the Quality Improvement Nurs by 7/26/2013.	ed	
	plan to monitor a resid	nterventions on the care dent who was restricted 2 of 17 sampled residents.					

		I				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
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				s	WANNANOA, NC 28778		
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	(Residents #14 and # The findings included: 1. Resident #14 was 05/07/10 with diagnos esophageal reflux, thy disorder and Alzheime The most recent annua (MDS) dated 06/28/13 had short term and lon and was moderately in daily decision making. Resident #14 required person assistance with A review of care plans 04/10/13 indicated a proper plans of the proper plans of the proper plans of the proper plans of the Care plans did not listed to prevent Resident to The Care plans did not listed to prevent Resident puring an interview on NA #3 she explained R for other resident's food trays that have already trays that have already trays that haven't been used to be an occasion to reach for other resident women to reach	admitted to the facility on es which included roid disorder, anxiety or's disease. al Minimum Data Set indicated Resident #14 g term memory problems apaired in cognition for The MDS further indicated set up and one staff eating. with a revised date of roblem statement that ole to complete activity of endently related to and cognition. The oprovide meal set up and eat foods and drink fluids. have any interventions ent #14 from putting her so food. 06/27/13 at 2:53 PM with esident #14 tried to reach and tried to eat off the been eaten or resident's passed. She explained it all thing for Resident #14 ent's food but in the last 8 brse. She further ate breakfast and lunch	F	279	Measures in place to ensure practices will not occur. The IDON/Unit Managers (UM) waudit three (3) charts weekly during Nursing Management Meeting to ensure all interventions have been placin the Care Plan. Any variance will be monitored for patterns and trending. How the facility plans to moniand ensure correction is achieved and sustained. The IDON will report the results of the audits to the QA Committee monthly for 3 months, then quarterly x 3 for continued compliance/revision to the plan.	ed ces itor	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11 3M 52/07/29 1		E CONSTRUCTION		SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	came back to the hall the meal cart. During an interview of Unit Manager explains multidisciplinary procession that a result to put Resident #14's other resident's food of should be on there. Resident #14's current there were no interver plans to monitor Resident multing her hands in or During an interview or Administrator stated it interventions to prever reaching for other resist the care plan. 2. Resident #8 was as 07/01/11 with diagnoside depression, blood discaptive as troke. A review of the most repart of the most repart was cognindependent with transwheelchair in the facility indicated Resident #8 impairment on one side. A review of a facility do Concern Report dated Resident #8 had been	and tried to take food off 1 06/28/13 at 7:41 AM the ed care plans were a ess. He stated he commendation was made behavior for reaching for on the care plan and it The Unit Manager reviewed at care plans and confirmed attions listed on the care lent #14 to prevent her form other resident's food. 1 06/28/13 at 3:56 PM the awas her expectation for the att Resident #14 from dent's food to be listed on Idmitted to the facility on as that included seizures, orders, difficulty walking and excent (quarterly) Minimum 106/28/13 indicated attively intact and was fers and locomotion by yy. The MDS further and upper extremity excent titled "Service	F	279			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DAT	E SURVEY
		345418	B. WNG			0.6	C 5/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER	-	1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	12012013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	other residents. A review of care plans care plans with interver Resident #8 from the variety of a care plant there were no specific monitor Resident #8 from the facility. During an interview on Nurse Aide (NA) #1 he provided care for Resident had not been given regarding monitoring of explained he was not to restricted to the east unit when the went all over the build build have been given he went all over the build build have been given he went all over the build build have been given he went all over the build build have been given he went all over the build build have been given he went all over the build build have been given he went all over the build build have been given he went all over the build build have been given been give	previous interactions with revealed there were no entions listed to restrict west hall of the building. In dated 07/13/11 indicated interventions listed to om going to the west hall of the wes	F	279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	700 DE		CONSTRUCTION		SURVEY PLETED
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020300000000000000000000000000000000000	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		1	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280 SS=D	Unit Manager explain multidisciplinary proces remembered an incide Resident #8 and he was vending machine and to be monitored. He stocumented as an interview of the stocumented as during shift report the same more than the stocumented as an interview of the stocumented as during shift report the same more than the stocumented as an interview of the same more than the stocumented as an interview and the resident and the stocumented as an interview and the stocumented as an interview and the stocumented as an interview of the resident and the stocumented as an interview of the resident and the stocumented as an interview of the resident, and of the extent practice and the stocumented as an interview of the resident, and of the extent practice and the stocumented as an interview of the stocumented as an interview of the resident and the stocumented as an interview of the stocumented as a	an 06/28/13 at 7:41 AM the ed care plans were a ess. He explained he ent that occurred with vas then not to go past the onto the west unit and was stated this should have been ervention in the care plan aff would not know to an 06/28/13 at 3:56 PM the ed the monitoring of entervention that was shared ong the nurses and nurse out. She stated it should ed as an intervention on an so everyone would entering of Resident #8. (a) (2) RIGHT TO NING CARE-REVISE CP entering the state, to go care and treatment or reatment.		279	F280 How the corrective action will accomplished for the residen affected Care Plans were updated to ensure that current interventi for ADLS, fall, and Activities were in place for resident #3 and #6 by the Interdisciplinar Team (IDT).	t(s) ions	7/26/13

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	15 000000000000000000000000000000000000		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF D	ON/IDED OD SUDDUED	345418	B. WING	r -		06/	28/2013
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page and revised by a team each assessment. This REQUIREMENT by: Based on observation interviews, the facility plan interventions as a sampled residents. Rewere not revised for a falls or activities and Rewere not revised for fall of the fall of the problem of Resider had the goal of no fall of the problem of Resider had the goal of the problem o	of qualified persons after is not met as evidenced s, record reviews and staff failed to update the care changes occurred for 2 of 3 esident #3's care plans stivities of daily living skills, esident #6's care plans lls or activities. mitted to the facility on es including Alzheimer's navioral disturbances, der, generalized anxiety ry disease, //perlipidemia. 03/20/13 which addressed at #3 being at risk for falls related injury through next	TAG		How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nurses were educated on the documentation of interventions for falls, ADLs, and Activities of Care Plans by the Administrate and the Nurse Consultant with completion July 26, 2013. Measures in place to ensure practices will not occur. Care Plans have been updated with the intervention(s) for falls ADLs, and Activities. Nursing staff have been re-educated by IDON and the QI Nurse on falls and documentation of new interventions on July 23, 2013. How the facility plans to monitor and ensure correction is achieved and sustained. During weekly Risk meeting, the IDT will check care plans of each fall, ADLs, and Activities to ensure that care plans have been updated and RP and MD notification completed. Audit tool to be completed at that times.	oe s n or	
	pressure, promote ade for adverse reaction to resident to tell health c dizzy, off balance, wea	quate hydration, monitor			by the IDT and submitted to Administrator to be presented to the QA Committee for 3 months then quarterly x 3 for review an revision as needed to ensure compliance	s,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DAT	IO. 0938-0391 E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ΙE	(X5) COMPLETION DATE
	keep wheels on bed lo involvement in activitie and as needed. A care plan addressing activities of daily living dressing, etc) for Resinterventions for the reand dressed appropriate. A care plan addressing #3 to have decreased cognitive deficits included a staff to talk to resident staff to provide tactile as stimulation and visual and the plan added to the post fall assessment reapplicable interventions the fall and added to the interventions listed includes assistance and a bed as plan was not updated a of these interventions. Per an incident report, the resident #3 at that time sunroom. A self release Resident #3 at that time included a pharmacy coassistance, a restorative.	stive devices as needed, ocked, encourage es, vital signs as ordered grand the inability to complete tasks (transfers, walking, dent #3 included a goal and sident to be well groomed sident to be well groomed sident to be well groomed sident to be interventions for during care, and for activity estimulation, auditory stimulation, auditory stimulation. on 04/17/13 at 7:50 PM ne bed to the floor. The evealed a section that listed is initiated in response to e care plan. Post fall udded provide ambulation plarm for safety. The care at this time to include either this time to include either the eseat belt was placed on th	F	280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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5-5-7570 0-644-5-5	OVIDER OR SUPPLIER	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	20/2010
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F 280	unable to follow through determined she was a safer in a wheelchair. restorative nursing has ambulation. The care plan was up intervention of a self of Resident #3 removed care plan was update remind resident not to and to alert staff that the bed. The care platime to include the amprogram, the resident safety or a restorative Per an incident report Resident #3 was place then found on the flood buttocks. The nursing activated. Intervention assessment to be added pharmacy consult, amplan was not updated Per an incident report Resident #3 was observed in the pharmacy consult, programs was restorative to the pharmacy consult, programs assistance, restorative care plan was not updated car	gh with teaching. It was high risk for falls and was The discharge note stated ad been educated in dated on 05/01/13 with the releasing seat belt which at will. And on 05/06/13 the dot include a bed alarm to get up without assistance the resident has risen from answere not updated at this abulation restorative 's use of a wheelchair for a toileting program. If, on 05/08/13 at 3:00 PM ed in bed after lunch and for in her room sitting on her genote stated the alarm had ansper the post fall ded to the care plan included abulation assistance, and verbal cues. The care If, on 05/09/13 at 6:45 PM erved on the floor in her lee bed, kneeling on the floor unding. Interventions post a care plan included ovide ambulation et toileting, verbal cues. The	F	280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
	wheelchair in the sunr off. Resident #3 was r skin tear to her right e interventions included assessment, activities stimulation, redirect ar activity, relocate to hig involvement and educ calling for assistance. not updated with any a interventions for Resident #3 was obse her buttocks in the sun wheelchair. Post fall in management, activities stimulation, redirect an activities, relocate to hi involvement and educa using call bell for assis plan was not updated with specific interventions for Per an incident report, Resident #3 was witner self release lap belithe nurse aide could restaggered backwards aredness was noted to be Post fall assessment in for increased stimulation.	the floor in front of her from with her alarm going noted with bruising and a lbow. The post fall pain management and consult for increased and provide diversional the visibility area, family atteresident regarding. The activity care plan was additional or specific lent #3. on 05/14/13 at 10:00 AM reved sitting on the floor on aroom in front of the interventions included pain as consult for increased of provide diversional ligh visibility area, family after esident regarding tance. The activity care with any additional or or Resident #3. on 05/15/13 at 3:45 PM assed in the hall removing than and standing up. Before each her, Resident #3 and sat on the floor. Some auttocks and left elbow. Cluded activities consult in and redirect and provide the activity care plan was additional or specific ent #3.	F	280			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		(X3) DATE SURVEY COMPLETED					
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F 280	include the use of a la at all times when the included the use of a last all times when the included ambulation assistance diversional activities, area. There were no regarding any ambulation any changes to the included ambulation assistance diversional activities, area. There were no regarding any ambulation any changes to the included and the sunroom was lock hallway and contained dining and large winded wheelchair with a self place on 06/26/13 at \$10:49 AM. The seat believes around her wais residents in this room and the television was included a clip on alarm which alarm that was not turn on the seat which was pad was half hanging wheelchair. The seat believes around her wais herself to the hall and stopped an spoke to halarms. At 9:57 Nurse	ap buddy to the wheelchair resident is up. 4, on 06/25/13 at 6:05 PM allway and self released her ed to stand and slid to the attocks. The post fall interventions of provide end relocate to a high visible updates to the care plan atton assistance or program activity plan. ated in the upper end of the da large television, table for lows between the hall and and the standard belt in 2:59 AM, 10:23 AM and belt was noted to be very st. There were other at the time but no activities	F	280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345418	B. WNG_			06/	28/2013
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F 280	At this time, Nurse #1 not all being on and s #1 stated the facility hagitated her and she Nurse #1 if the seat b waist, Resident #3 go it. When asked about staff were to know who was, Nurse #1 stated communication when changed. Devices just the nurse aides would system they use for d On 06/27/13 at 3:52 F stated she will walk wo shuffled and her knees stated devices had incomply she removed, a chair To prevent falls, NA #1 close eye on Resident he bathroom before a send her to activities. On 06/28/13 at 2:50 F Resident #3 from falling do with her hands, to be beautiful, and took he NA #4 stated she was program and stated R On 06/28/13 at 3:42 F conducted with the Ac Nurse Consultant. The falls were discussed in stated the staff discussany changes in environment.	was informed of the alarms he attached them. Nurse had tried a lap buddy but that threw it on the floor. Per elt was too tight around her it very agitated and removed at the three alarms and how hat the current alarm usage there was a lack of devices are added or st showed up. She thought if know via the computer occumentation purposes. PM Nurse Aide (NA) #3 ith the resident but she is bothered her. NA #3 cluded a tab alarm which pad alarm and a lap strap. It is stated they tried to keep a total they are also to and after meals, and tried to the pad alarm and a lap strap. It is stated to prevent and after meals, and tried to the pad alarm and a lap strap. It is stated to prevent and after meals, and tried to the lap belt looked in with the NA to do charting. It is unaware of any ambulation desident #3 could not walk. PM an interview was diministrator and Regional the Administrator stated that an morning meetings. She used the specifics of the fall,	F	280			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22 19 2		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
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(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 280	they thought would provide the store plan. Per the administration on the progress and trials. So an ongoing intervention on the progress and trials. So an ongoing intervention was just to assist as intolleting was not necestable to removing the administrator country what specific interventing the progress and trials. The Administrator country what specific interventing the post fall assess that the second for the resident. On 06/28/13 at 6:32 Fourth with the MDS nurses a significant change and stated she thought should be second the second diagnoses included diagnoses included diagnoses included diagnoses included diagnoses included diagnoses. A care plan was deverable to removing her bed as bed without assistance resident to have no fall interventions included.	be left to the department gh and added to the care trator, the planned lost fall assessments were in the stated redirection was one, ambulation assistance recessary, restorative essarily a planned program. In all of the specific as to tions were initiated and department after. She could not say what ment intervention entailed or with what was to be provided. PM, a telephone interview tated this resident had a did could no longer walk. She is updated the care plan for mange. Inditited to the facility on cospitalized on 02/17/13 and lity on 03/11/13. Her elirium, dementia, llation, coronary artery obstructive pulmonary. Iloped 03/11/13 which the being at risk for falls due alarm and trying to get out of the The goal was for the	F	280					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	00.000000000000000000000000000000000000		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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	ROVIDER OR SUPPLIER	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	06/	/28/2013
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	to rise slowly to prevere pressure, promote addenvironment free of obtainvolvement in activitica and as needed, keep well fitting shoes and cambulating, assistive of call bell in place, keep resident, encourage from ask/encourage/assist in plan developed on 03/decreased socialization included interventions resident during care, postimulation, provide tax stimulation and visual. The care plan relating 03/22/13 with the additional belt at all times while the wheelchair. The resident #6 was in her belt, stood, fell and hit alarm on the seat belt of all assessment reveals applicable interventions the fall and added to the interventions included indiversional activity. The activity care plan.	onitoring for adverse ns, educating the resident nt a sudden drop in blood equate hydration, keep betacles, encourage es, vital signs as ordered wheels on bed locked, wear or nonskid socks when devices ad needed, keep most used items near equent rest periods, and resident to toilet. A care 21/13 for potential for n due to cognitive deficits for staff to talk with crovide items for sensory ctile stimulation, auditory stimulation. to falls was updated on tion of a removable seat he resident was in the ent was able to remove it. on 05/09/13 at 12:00 PM r room, unhooked her seat her head on the door. The did not sound. The post ed a section that listed is initiated in response to he care plan. Post fall redirect and provide ere was no change to the	F	280			
12	Resident #6 was obser room sitting on the floo	ved on the floor in her					

STATEMENT OF DEFICIENCIES	(1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	E CONSTRUCTION		<u>O. 0938-0391</u> E SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD				PLETED
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THE STATE OF THE S			s	WANNANOA, NC 28778		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
fall interventions include diversional activity. The activity care plan. Per an incident report or nurse aide observed the edge of the bed but coul in time to prevent her fro incident report noted the the alarm. The correspon 05/14/13 at 4:41 AM stat removed the alarm which history of doing and she or socks. The interventic assessment included recidiversional activities. The activity care plan. Per an incident report on staff heard Resident #6 c in the bathroom on her k. The mobility alarm was nand she had bare feet. The nursing note dated 05/19	ad been on but the cord connect and sound. Post of redirect and provide are was no change to the consideration of the direct and provide are resident sliding off the direct and provide and in the floor. The aresident had removed anding nursing note dated the resident had a recurrent was not wearing shoes ons listed on the post fall direct and provide are was no change to a 105/19/13 at 6:20 AM calling out and found her nees facing the toilet. The listed post fall redirect and provide are was no change to a 105/19/13 at 7:44 PM stated and and a forming on gabout her head and a forming on her elbow emergency room for	F	280			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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	belt alarm was repaired assessment interventing provide diversional acchange to the activity. The fall care plan was discontinue the resident to discontinue vital signification discontinue the assisting the reason of the "resolved." In additionable to alarm at all times with the care and a chair alarm resident was in the whole of 19/13 noting the reason of the alarm at all times with the care and a chair alarm resident was in the whole of 19/13. The activity to reflect any additional provide diversional act on 06/25/13. The activity to reflect any additional provide diversional act on 06/26/13 at 9:51 All observed with a tab/clip turn rail. On 06/26/13 at 9:54 All observed in the sunroularmed seat belt in plate the seat belt multiple times seat belt but provided runtil she was taken to the AM by the Administration or any activities going on 06/27/13 from 8:39 Resident #6 propelled from the survey of the seat belt was taken to the AM by the Administration or any activities going of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the seat belt was taken to the AM by the Administration of the the AM by t	d. The post fall ons was to redirect and tivities. There was no care plan. updated on 06/19/13 to nt education to rise slowly, ns as ordered and prn, to we devices as needed all e discontinuation due to the intervention of the seat was discontinued on ason was it was entered in was to be used when eelchair with a start date of care plan was not changed I interventions or plans to ivities. M Resident #6's bed was be type alarm on the right M, Resident #6 was m with a very loose ace, Resident #6 released mes sounding the alarm. me and refastened the diversional activities he activity room at 10:12 or. There was no television on at this time.	F	280			

STATEMENT AND PLAN C	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DAT	E SURVEY PLETED
		345418	B. WNG_				С
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIF 1984 HIGHWAY 70 SWANNANOA, NC 28778	CODE] 06	1/28/2013
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	(NA) #3 revealed Resalarmed seat belt. Nadepartment gave her tried to hide the belt. It resident had never be stand and pivot. NA # to some music groups eye on her the best th Interview on 06/27/13 revealed interventions #6 from falling include keeping an eye on her resident liked to talk. Interview with NA #4 or revealed she gave Reshe liked to do things where the prevent falls. NA #4 storedirect. On 06/28/13 at 3:42 Pl conducted with the Add Nurse Consultant. The falls were discussed in the staff discuss the spechanges in environment added any options or in would prevent falls. Ar would be left to the depthrough and add to the administrator, the plant post fall assessments where stated redirection winterventions, ambulatic assist as necessary, re	at 3:59 PM with Nurse Aide sident #6 often removed her A #3 stated activity laundry to fold and staff According to NA #3 the sen ambulatory but can 3 stated Resident #6 will go and staff try to keep an ey can. at 5:24 PM with NA #5 sused to prevent Resident dher alarmed seat belt and r. He further stated the solution of the fall and the fal	F 2	80			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1,020,000,000,000,000		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	040410	B. WINO	STR	EET ADDRESS, CITY, STATE, ZIP CODE	06	/28/2013
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312 SS=E	that any department h would be up to the de the care plan. The Ad specific as to what specific as to what specific as to what specific and implement after discussing each the alarm was meant not specific to a press could not say what ear intervention entailed on what was to be provided 483.25(a)(3) ADL CARDEPENDENT RESIDED A resident who is unatted ally living receives the	pead wanted to implement partment head to place on ministrator could not be ecific interventions were need by each department fall. She also stated that for any type of an alarm and ure type or clip type. She ch post fall assessment r how staff were to know ed for the resident.		3312	F312 How the corrective action will be accomplished for the resident(s affected. Resident # 3, #6, #17 were given showers by 6/27/13 How corrective action will be accomplished for those	s) ,	7/26/13
	by: Based on record reviet facility failed to provide twice a week for 3 of 3 (Resident #3, #6, #17) The findings included: 1. Resident #6 was ad	mitted to the facility on spitalized on 02/17/13 and yon 03/11/13. Her lirium, dementia, ation, coronary artery			residents with the potential to be affected by the same practice. Shower schedules were updated to ensure showers are twice a week. CNA's were given a shower sheet to indicate the days and shifts responsible for the showers. If the patient refuses, they must get a nurse to verify refusal and the nurse will place a note in the progress note regarding the refusal. Residents will be asked upon admission their choice for how often they would like to shower.	е	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345418	B. WNG			5-57-60	C
FIE 28 30	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		1 06	/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	The admission Minimu 03/18/13 coded her as cognitive skills, having behaviors and rejectine extensive assistance wand bathing. A care plan was devel address the inability of activities of daily living included to assist the reweek. Review of the ADL Danursing assistants, reveceive a shower from (6 days) and from 06/2 days). On 06/26/13 at 2:08 Planton of the showers were not gettistaffing. She further streported to her that stase has told the nurse can and Nurse #1 tried what resident would be skip. Nurse Aide (NA) # 3 st PM that staffing has be or so. She stated if she completed then they the and make up the show until the next shower difficult to the stafficult of the stafficult to the stafficult to the showers were difficult to the stafficult to the s	um data Set (MDS) dated is having severely impaired goverbal and physical ing care and requiring with bed mobility, transfers disped on 03/22/13 to if Resident #6 to complete in (ADL) tasks. Interventions resident to shower twice a completed by realed Resident #3 did not in 05/31/13 through 06/05/13 in 21/13 through 06/26/13 (6) M, Nurse #1 stated ing completed due to short tated when it has been affican't complete showers, aides to do the best they in the prioritize what care and it is most important not to in the prioritize what care and it is most important not to it is a care in the prioritize what care and it is most important not to it is a care in the prioritize what care and it is most important not to it is a care in the prioritize what care and it is a care in the	F		Measures in place to ensure practices will not occur. CNA's were educated on ADL documentation and notification of refusals by patients by the prior administrator and completed on 7/26/13. The 3-11 Supervisor will collect the Daily Shower sheets and ensure that all patients received their shower. If a refusal is documented on the sheet, the supervisor is to check and ensure that a progress note was documented by the nurse. Deviations may result in disciplinary action. Manager on Duty (MOD) will monitor showers completion on their assignment checklist. How the facility plans to monitor and ensure correction is achieved and sustained. Shower sheets and MOD checklist are to be given to the prior Administrator to be reviewed weekly and submitted to the QA Committee for 3 months, then quarterly x 3 for review and revision as needed to ensure compliance.	re s	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION 345418 NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 312 Continued From page 36 to the nurses who stated that a bed bath was acceptable. On 06/28/13 at 10:10 AM, NA #4 stated due to short staffing, showers were not always completed twice a week. Staff tried to make a		N. BOILD				С	
NAME OF P	BOVIDED OF STIPPLIED	345418	B. WNG			06	/28/2013
ASHEVIL	LE HEALTH CARE CENTE			19	REET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778		
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	to the nurses who state acceptable. On 06/28/13 at 10:10 a short staffing, showers completed twice a week missed shower up the Interview with the adm 4:55 PM revealed if an shower for some reason ask he resident if it wouthen ext day or pass it complete. She further showers were not bein 2. Resident #3 was ad 03/13/13 with diagnose type dementia with behmajor depressive disordisorder, coronary arte hypothyroidism, and hy The admission Minimum 03/20/13 coded her with cognitive skills, and required mobility, transfers, and physical help with bathin A care plan was develoaddressed her inability daily living (ADL) tasks assist the resident to show the state of the ADL Data nursing assistants, reversided to show the state of the ADL Data nursing assistants, reversided to show the state of the ADL Data nursing assistants, reversided to show the state of the ADL Data nursing assistants, reversided to the state of the ADL Data nursing assistants, reversided to the state of the ADL Data nursing assistants, reversided to the state of the state of the ADL Data nursing assistants, reversided to the state of the state of the state of the the state of the s	AM, NA #4 stated due to were not always ex. Staff tried to make a next day as able. inistrator on 06/28/13 at nurse aide could not do a son, the nurse aide should all be alright to make it up off to the next shift to stated she was unaware given as scheduled. Imitted to the facility on as including Alzheimer's navioral disturbances, der, generalized anxiety ry disease, perlipidemia. Im Data Set (MDS) dated in severely impaired uiring supervision with bed walking and requiring ng. ped on 03/26/13 which to complete activities of a Report, completed by aled Resident #3 did not /02/13 through 04/07/13	F	312	DEPICIENCY)		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TANGET STATE OF THE STATE OF TH		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF D	DOMBER OF SUPERIOR	345418	B. WNG			2000	06/28/2013	
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	O4/21/13 (6 days). On 06/26/13 at 2:08 P showers were not gett staffing. She further streported to her that stashe has told the nurse can and Nurse #1 ties what resident would be skip. Nurse Aide (NA) # 3 st PM that staffing has be or so. She stated if she completed then they the and make up the show until the next shower defined to due to staffing. She stated in acceptable. On 06/28/13 at 10:10 A short staffing, showers completed twice a weel missed shower up the relative with the admit 4:55 PM revealed if a nice shower for some reason ask he resident if it woutthe next day or pass it of the shower day or pass it of the shower shower shower day or pass it of the shower shower shower shower day or pass it of the shower show	M, Nurse #1 stated ing completed due to short tated when it has been aff can't complete showers, aides to do the best they to prioritize what care and a most important not to ated on 06/27/13 at 2:53 ten short for the last month owers cannot be y to give good bed baths er on the next day or wait ay. If 3 at 5:31 PM stated that complete as scheduled ated that staff report this to that a bed bath was M, NA #4 stated due to were not always constructed. Staff tried to make a next day as able. Inistrator on 06/28/13 at turse aide could not do a not, the nurse aide should lid be alright to make it upoff to the next shift to stated she was unaware	F	3312				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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5011 491.9	ROVIDER OR SUPPLIER	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
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F 312	3. Resident #17 was a 03/19/13 with diagnos sclerosis, osteoporosi depression. The most recent quart 06/28/13 indicated Reintact for daily decision extensive assistance of dependent on staff for A review of care plans problem statement that to complete tasks rela goals indicated Reside and dressed approprial living tasks will be added to 604/03/13. The plan were listed in parpersonal hygiene and and assist resident to A review of a shower staff was scheduled for Friday of each week of 3:00 PM and 11:00 PM. A review of The ADL Enursing assistants, review a shower from (5 days), from 05/08/13 thand from 06/23/13 through an observation Resident #17 was lying an observation Resident #17 was lying	admitted to the facility on sees which included multiple is, muscle weakness and sees which included multiple is, muscle weakness and sees which included multiple is, muscle weakness and sees which included with 17 was cognitively in making and required with hygiene and was totally in bathing. So dated 04/01/13 indicated a lat Resident #17 was unable seed to personal care. The lent #17 will be well groomed ately and activities of daily diressed through next review approaches on the care in to provide assistance with grooming needs as needed shower twice a week. Schedule indicated Resident in a shower on Tuesday and on second shift between which in our of the second shift between which is second shift between which	F	312			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	70.70.00.00.00.00.00.00		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	had her hair washed sexplained she missed evening. She further swould get a shower or shift on Tuesday night. During an interview or NA #10 she confirmed second shift shower so Resident #17 told her had a shower since last first time she had hear Resident #17 had to be 2 staff when she went. During an interview on NA #5 he explained the Tuesday evening that confirmed that it was Festated Resident #17's them last night but the He further stated once nearly impossible to car Resident #17 should her Tuesday evening and report. He stated Resident #17 should her showers. During an interview on NA #11 she explained shower last Saturday ber shower on Friday, hour to 45 minutes to get the shower of the shower or shower or shower or shower or shower to get the shower or sh	s a sour odor. 10 06/27/13 at 9:52 AM he hasn't had a shower or since last Saturday. She her shower last Friday stated she was told she in the 3:00 PM to 11:00 PM but she didn't get it. 10 06/27/13 at 10:24 AM with I Resident #17 was on the chedule. She stated this morning that she hadn't set Saturday but that was the red that. NA #10 explained the transferred with a lift with for her shower. 10 06/27/13 at 5:40 PM with ere was a shower on did not get done and Resident #17's shower. He shower was then passed to be youldn't get it done either. In a shower got behind it was eatch up. NA #5 stated ave gotten her shower on we discussed it in our shift dent #17 required a lift ides when she received her we cause she had missed She stated it took a half	F	312			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			TE SURVEY MPLETED
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SS=D	and shower her. During an interview or Administrator stated it resident's should get a a shower. She further missed the NA's should find out when they war accommodate the resistated the NA's should nurse when a resident' 483.25(c) TREATMEN PREVENT/HEAL PRE Based on the compreh resident, the facility must who enters the facility must who enters the facility of does not develop pressindividual's clinical conthey were unavoidable pressure sores receive services to promote he prevent new sores from This REQUIREMENT by: Based on observations interview the facility fail pressure wound as orderesidents (Resident #5) The findings included: Resident #5 was admitt 05/01/13 with diagnoses peri-rectal cellulitis, would appress of the state of	in 06/28/13 at 3:56 PM the swas her expectation that a shower when they wanted it as shower was lid talk with the resident and ident's needs. She further it also communicate with the shower was missed. IT/SVCS TO ESSURE SORES Inensive assessment of a just ensure that a resident without pressure sores sure sores unless the idition demonstrates that it; and a resident having its necessary treatment and eating, prevent infection and in developing. It is not met as evidenced It is, record review and staff led to assess and treat a lered for 1 of 3 sampled it.		312	F314 How the corrective action will accomplished for the resident affected. Resident # 5 Chart was assessed, treatment provided as ordered, and documentation updated How corrective action will be accomplished for those residents with the potential to affected by the same practice. Current Nursing staff was educated on wound assessments, and documentation by the QI Nurse to the same of the potential to affected by the same practice. Current Nursing staff was educated on wound assessments, and documentation by the QI Nurse to the same of the provided by the QI Nurse to the provided by the QI Nurse to the same compliance with the most current physician orders. Wound assessment, Treatments, and skin assessments will be included all New Nurse orientation.	be see	7/26/13

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94 (25)5554 (25)707 (5	ROVIDER OR SUPPLIER			19	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778	06	/28/2013
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	address a Stage 3 sac care plan indicated ba applied to thighs/butto keep it away from the The sacral wound was packed with silver algi and secured with a tra daily. Additional intervalternating pressure a reduction and wound area on the right poste a Stage 2 diabetic ulce. A review of the skin ar records for Resident # titled Ulcer and Wound completed on 05/01/13 had multiple (15 - 20) sleft buttocks and left ulvaried in size from 10 No specific measurem open area except the I as 11.4 cm long X 2.0 intact blisters with no carea was described as measurements between Additional measureme follows: 05/18/13 - 4.4 cm long serosanguinous draina granulation and epithelindicated; the peri-wou 06/05/13 - 4.2 cm long deep with serosanguin wound bed had granula no blisters were indicated.	cral pressure ulcer. The arrier cream was to be acks daily and to be sure to transparent film dressing. In the covered with saline, mate, covered with foam ansparent film dressing entions included a Group 2 ir mattress for pressure consult as indicated. The erior thigh was described as er. Individual wound assessment and wound assessment and record which was and noted that resident estage II ulcers on right and apper lateral thigh which centimeters (cm) to 30 cm. ents were listed for each eft thigh which was listed cm wide and described as drainage; the peri-wound and intact. There were not any en 05/01/13 and 05/18/13. Ints of the left thigh were as the continuation and the continuation and epithelial tissue, ted. In the continuation of the continuation and epithelial tissue, ted. In the continuation of	F	314			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	wound bed had granu the peri-wound area wool/18/13 - 34.0 cm lor deep with serosanguir wound bed had granu was red/inflamed. An ulcer and wound rethe right inner buttock wide X 0.2 cm deep with drainage and wound be granulation tissue; the red/inflamed. There we between 05/08/13 and measurements of the follows: 05/23/13 - 6.2 cm long deep 06/05/13 - the area to buttocks was describe and the measurement forward under the left when the location descrum. An ulcer and wound rethe left inner cheek (but cm wide with eschar a red/inflamed. There we between 05/08/13 and measurements of the I follows: 05/23/13 - 7.2 cm long 06/05/13 - 10.5 cm lond deep with serosanguin wound bed had eschar peri-wound was red/inflamed.	lation and epithelial tissue; vas red/inflamed. Ing X 4.0 cm wide X 0.1 cm hous drainage and the lation tissue; the peri-wound ecord dated 05/08/13 listed is: 6.2 cm long X 4.0 cm ith serosanguinous hed had slough and peri-wound was here not any measurements and 105/23/13. Additional right inner buttocks were as as a X 4.0 cm wide X 0.2 cm the right and left inner does not any measurements as were listed from that date inner buttock until 06/18/13 cription was changed to hold to cord dated 05/8/13 listed attock): 7.2 cm long X 5.3 and the peri-wound was here not any measurements 05/23/13. Additional her inner buttock were as a X 5.3 cm wide X 0 deep g X 10.3 cm wide X 0 deep g X 10.3 cm wide X 2.5 cm ous drainage and the rand slough; the	F	314			

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100000 to 1000	ROVIDER OR SUPPLIER	ER		198	ET ADDRESS, CITY, STATE, ZIP CODE 4 HIGHWAY 70 ANNANOA, NC 28778	1 0	6/28/2013
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	deep with serosanguing wound bed had eschaperi-wound was red/in 06/18/13 9.0 cm long deep with serosanguing 30% of the wound bed the wound bed had graperi-wound area was a Additional record reviet physician's orders: 05/23/13 Doxycycline antibiotic, twice a day buttocks. 05/24/13 Wound clinic possible. 05/28/13 Change wour follows: xeroform and covaseline impregnated grantifungal medication, 06/06/13 Bactrim Doubtwice a day for 10 days 06/12/13 0.25% Dakin's X 4 gauze to sacral ulcometer a day for 2 weeks; Center in 2 weeks. 06/13/13 Diflucan 100 record for the form of th	nous drainage and the ar and slough; the affamed. X 9.0 cm wide X 2.8 cm nous and purulent drainage; dead had slough and 70% of anulation tissue; the red/inflamed. We revealed the following 100 milligrams (mg), an for 10 days for cellulitis of consult as soon as a cover with viscopaste (a gauze); Diflucan, an 200 mg daily for 14 days. Sele Strength, an antibiotic, and solution wet to dry with 4 er twice a day for 2 weeks; to right posterior thigh follow up with Wound and daily for 14 days. In graph of the days of the days of the selection on her buttock dead the area appeared to be a was possibly from shear as due to a pressure area.	F	314			

AND PLAN O	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
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E V S	with Doxycycline 100 On 05/28/13 Resident assess her buttock with the wound was improon an air mattress. On 06/04/13 Resident assessment of sacral assessment of sacral assessed as slowly in felt the resident needed due to incontinence a contamination of the without the felt the resident needed due to incontinence a contamination of the without the plant was that Resident of sacral wound. The buttock wound was oppurulent drainage was had a wound on the leplan was that Resident both buttocks and was wound center as soon debridement. The plant Santyl for chemical defend viscopaste to her place her on Bactrim Effor 10 days. A review of the May are Administration (TAR) in revealed the following on Resident #5's extra protective cream discopaste strips twice	The plan was to treat her mg BID for 10 days. It #5 was seen again to ound and the note indicated wing and the resident was to #5 was seen for wound. The area was inproving and the physician ed an indwelling catheter and the need to minimize wound and promote wound to #5 was seen for evaluation mote indicated the right pen and had eschar. No is noted. The resident also eff hip. The assessment and to #5 had a decubitus to is to be referred to the as possible for med treatment was to use bridement of the decubitus left leg. He also planned to bouble Strength twice daily and June 2013 Treatment ecords for Resident #5 documentation: Doump was documented as bed beginning 05/28/13. It buttocks covered with daily was documented as scontinued 06/06/13 -	F	314					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	twice daily was documented discontinued 06/0 documented as done of 5:00 PM, on 05/30/13 documented as done of 06/03/13, on 06/04/13 documented as done of 06/06/13. Santyl ointment to coccibeginning 06/06/13 thronly documented as done and discontinued 06/25/documented as done and 06/15/13, on 06/18/13 at 9:00 AM, on 06/22/13 at 9:00 PM. Irrigate sacral wound walginate, cover with foa dressing daily was documented as documented as documented as documented as done and 9:00 PM. Irrigate sacral wound walginate, cover with foa dressing daily was documented as	vered with viscopaste strips cented as started 05/28/13 6/13 but was not on 05/28/13, on 05/29/13 at at 9:00 AM; it was not at all from 05/31/13 through at 9:00 AM; and it was not at all on 06/05/13 or cyx daily was documented ough 06/12/13 but was one on 06/09/13 and apply twice daily topical ented as started 06/12/13 6/13 but was not tall on 06/13/13 through at 9:00 PM, on 06/21/13 at at 9:00 AM or on 06/23/13 with saline, pack with silver m, secure with transparent umented beginning	F	314				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	40 000000000		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778			06/28/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE		
	Review of records from & Hyperbaric Center Non 06/11/13 indicated a sacral decubitus who approximately 1 months of the X 7.5 cm X 4.5 cm wound as having a lar serosanguinous and non pressure ulcer bed had tissue and the skin and erythematous. The record treatment was to apply and 4 X 4 gauze twice resident was to be seen weeks. The note also in flap was removed with obtained. The area was pressure and the wound confirmation that the resident was to be seen weeks. The pressure area was assessed as being An observation on 06/47 providing treatment the sacrum revealed not over the wound when the treatment. Nurse #7 as when the dressing came came off earlier when so pressure ulcer was on the buttocks and extended area was approximately by 10 cm wide with a dicm. Subcutaneous tissubloody drainage present.	m the local Wound Healing Note of Initial Examination resident was evaluated for ich had been present for h. The area measured 9.0 . The note described the ge amount of nalodorous exudate. The dexposed subcutaneous bund the pressure ulcer was commendation for 1/4 % Dakin's wet to dry daily for 2 weeks and the en again at the Clinic in 2 andicated a large necrotic forceps and a culture was as assessed as being due to a clinic requested esident was on a Group 2 anation on the duration of it's a on Resident #5's thigh go due to diabetes. 26/13 at 2:35 PM of Nurse to the pressure ulcer on orderssing was in place the nurse started the ked Nurse Aide (NA)#7 are off and the NA stated it is the changed her. The the inner aspect of both across the sacrum. The 1/4 10 centimeters(cm) long epth of approximately 3 are was visible & there was	F	314					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER LE HEALTH CARE CENTE	ΕR		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	6/28/2013
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	#7 revealed the reside incontinence care about bowel movement and fulcer came off then. SI nurse but thought the distated they are expected dressing is off. She stated they are the treatment of the dressing in Resident #5's sacrum informed by the NAs they were provided Nurse #7 stated that she the NAs to notify her they have been didn't notify as off because she king to do the treatment. Supposed to notify the mooff. An interview on 06/26/1 #1 revealed the nurses treatments as ordered for their expensitioning the resident the treatment. Nurse #1 mattress was not placed until 05/24/13. Nurse #1 measurements weren't in they should be.	ant was provided ut 1:00 PM after she had a the dressing to the sacral he stated she didn't tell the other NA might have. She ed to notify the nurse if the sted the resident had wel movement between the dressing was changed at 3 at 3:05 PM with Nurse not being in place to revealed she had not been at the dressing came offing incontinence care. He would have expected at the dressing was off. If at 3:10 PM with NA #7 fy the nurse the dressing new the nurse was coming the stated she was nurse if the dressing was 3 at 3:35 PM with Nurse weren't doing the or Resident #5 because As to assist with the so the nurse could do stated a specialty on Resident #5's bed	F	314			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			102275.0	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	0/20/2013	
ASHEVIL	LE HEALTH CARE CENT	ER			84 HIGHWAY 70 NANNANOA, NC 28778			
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	#2 revealed the nurse all the treatments as y medications. Nurse #2 the medications often aren't consistently get because there isn't en An interview on 06/27/physician about Resid he was asked to see the assess skin breakdow stated he saw the resid asked staff to get an all He stated he examined the buttocks on 05/28/getting better. He stated on Resident #5's butto the area was much wo had eschar and he refe Wound Clinic as soon adebridement. The physe expectation for measur wounds and he stated measuring and monitor. An interview on 06/28/Regional Nurse Consulfor assessment of open open wounds should be assessment should incle wound. When asked if the measurements of Resid stated the facility was undescribed in the stated his wounds to be assessed week whether they were are the stated the stated his wounds to be assessed week whether they were are the stated the stated they were the stated the stated his wounds to be assessed week whether they were the stated the stated they were the stated they were the stated they were they were they are the stated they were they were they are th	s are responsible for doing yell as administering takes all shift so the nurses ting the treatments done ough time. 13 at 5:30 PM with the ent #5's wounds revealed the resident on 05/23/13 to non the buttocks. He dent again on 05/25/13 and ir mattress for the resident. It dent again on 05/25/13 and ir mattress for the resident. It dent again on 06/06/13 and rese; at that point the wound exerced the resident to the as possible for sician was asked about his ring and monitoring of the nurses should be ring the areas. 13 at 11:15 AM with the lant about the expectation in wounds revealed that all the assessed weekly and the lant about the expectation of the there were any additional dent # 5's wounds, he nable to locate any wound expectation was for all and measured every adduct opressure or not.	F	314				
F 323	483.25(h) FREE OF AC	CIDENT	F 32	23			Thola	

SERVICES OF WESTONIE & WESTONIE SERVICES					OMR MO	<i>J.</i> 0938-0391		
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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	OUR HANDY OF			Γ,				
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					DEFICIENCY)		0.7-201000000	
							1 1	
F 323	Continued From page	50	F	323	F323		7/26/10	
SS=E				020	How the corrective action will b		12913	
	TIVES INDOVOOT LINVI	SION/DEVICES			accomplished for the resident(s			
	The facility must ensu	ro that the resident				')		
		as free of accident hazards			affected. Resident # 3 will be			
	as is possible; and ea				screened by therapy for			
		and assistance devices to			appropriate positioning device			
	prevent accidents.	and assistance devices to			usage and for a Toileting Plan			
	provone addiagonto.				before and after meals, as well			
					as Activities in place for	=		
					Resident #3.			
					resident #5.			
	This REQUIREMENT	is not met as evidenced			Desident #6 east helt clarm we			
	by:				Resident #6 seat belt alarm wa	IS		
	Based on observation	s, record reviews, and staff			checked and worked; and the		7	
	interviews, the facility				alarm cord was checked for			
	reasons for falls and ir				appropriate length and type as			
	interventions to prever	nt further falls for 3 of 3			described on the Care Plan an	d		
		lesidents #3, #6 and #17).			was attached to the resident			
					and functional. Residents #3			
	The findings included:				and #6 were each assessed fo	r		
						'		
	 Resident #3 was ac 	lmitted to the facility on			appropriate intervention which			
		es including Alzheimer's			were added to the care plan.			
	type dementia with bel				How corrective action will be			
	major depressive disor	der, generalized anxiety			accomplished for those			
	disorder, coronary arte	ry disease,			residents with the potential to b	e		
	hypothyroidism, and hy	/perlipidemia.			affected by the same practice.	-		
	The admin to Mr.	D 1 0 1/4/DC:			Nursing and Administrative Sta	ff		
		m Data Set (MDS) dated						
	03/20/13 coded her will				will be re-educated by the QI			
		quiring supervision with bed			Nurse by 7/26/13.on devices		1	
	as being stoods with h	walking. She was coded			and the device list. The			
	had wandering haber	alance at all times. She			Interdisciplinary Team (IDT), th	е	- 1	
	than daily. She was as	ors 4 to 6 days, but less			Administrator, and newly hired		I	
	than daily. She was co prior to admission or si				employees will be educated on		- 1	
	The Care Area Assess				devices and the device list.		- 1	
				1	as noos and the device list.		1	
	oorzor io stated Reside	nt #3 was at risk for fall						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
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	LE HEALTH CARE CENT	ER	1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	related injuries due to medication and sever resulting in poor safety stated a care plan wor fall related injuries. A care plan developed the problem of Reside had the goal of no fall review. Interventions used items near reside rest periods, ask/enco toilet, keep call bell in rise slowly to prevent a pressure, promote add for adverse reaction to resident to tell health of dizzy, off balance, weafree of potential obstactor nonskid socks, assiskeep wheels on bed lo involvement in activitie and as needed. Physical therapy was sher exhibiting a shuffling Review of the incident following falls: *04/17/13 at 7:50 PM the medication, heard a local sitting on the floor with door. It was noted Response to the incident following falls:	ther use of psychotropic e cognitive impairment y awareness. The CAA and be developed to prevent in a being at risk for falls related injury through next included keeping most ent, encourage frequent urage/assist resident to place, educate resident to place, educate resident to equate hydration, monitor medications, educate are professionals if feeling alk, etc., keep environment eles, wear well fitting shoes estive devices as needed, cked, encourage s, vital signs as ordered tarted on 04/04/13 due to g gait with ambulation. Teports revealed the me nurse was passing and bang and found resident ther head resting on the ident #3 was resting in all assessment revealed a	F 323	Measures in place to ensure practices will not occur. A device list for all residents will be provided to the Nursing an Administrative Staff for daily auditing of devices. All reside with devices have been review for appropriateness, type, and the care plan updated. The device list will be updated as needed during fall review. The Interdisciplinary Team (IDT) at the Administrator will review falls during Stand-Up on the next business day to determine the cause of the fall. IDON/UN will update the device list and the care plan. Any deviations will be addressed at that time. How the facility plans to monitiand ensure correction is achieved and sustained. The IDON/ Administrator will report results to the QA Committee monthly x 3, then quarterly x 3 for continue compliance or revisions to the plan as needed.	nts w d end ne nt	

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AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	safety. The nursing no 10:04 PM noted a presapplied for safety. *04/19/13 at 6:15 AM and was observed sittle her wheelchair. A self placed on Resident #3 interventions included provide ambulation astoileting program, and evidence in the medical program or toileting program or toil	esistance, bed alarm for otes dated 04/17/13 at source sensitive alarm was she was in the sunroom ing on the floor in front of release seat belt was at that time. Post fall a pharmacy consult, sistance, a restorative verbal cues. There was no al record that an ambulation ogram was initiated. IDS dated 04/25/13 coded rely impaired cognitive iors, and requiring with bed mobility, transfers, with ambulation. It was addy but able to stabilize en walking and turning ff assistance to stabilize ted to standing position, and surface to surface that she had falls since ding one with no injury and The CAA dated 04/30/13 or fall related injuries due pic medications and sever sulting in poor safety falls and had declined shuffling gait and had wheelchair for safety as to use her walker.	F	323				
	05/01/13 due to severe	cognition and being						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DAT	TE SURVEY MPLETED	
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PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG	333	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	determined she was he safer in a wheelchair. restorative nursing har ambulation. There was medical record of a reprogram for Resident: The care plan was upointervention of a self received as self received and to alert staff that the bed. Resident #3 continued following incident repointervention of a self received and to alert staff that the bed. Resident #3 continued following incident repointerventions and the room sitting on her but nursing note dated 05/6 staff left resident her be on and staff later walked floor by the doorway ar Interventions per the peadded to the care plan consult, ambulation assistileting and verbal cue of a restorative toileting *05/09/13 at 6:45 PM Roon the floor in her room.	gh with teaching. It was igh risk for falls and was. The discharge note stated dobeen educated in its no evidence in the storative ambulation #3. Idated on 05/01/13 with the eleasing seat belt which at will. And on 05/06/13 the idea to include a bed alarm to get up without assistance he resident has risen form It fall as evidenced by the ents: Resident #3 was placed in the found on the floor in her tocks. The accompanying 108/13 7-3 PM stated when the educated alarm was active and and her alarm going off. The post fall assessment to be included pharmacy sistance, restorative is. There was no evidence in program. Resident #3 was observed on the side of the bed, at with the alarm sounding. The provide is added to the care of consult, provide	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ann		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	verbal cues. There we restorative toileting provided in the post fall intervention management and asset for increased stimulating diversional activity, religious family involvement and regarding calling for as evidence of any change Resident #3. The activity of the post fall intervention management and regarding calling for as evidence of any change Resident #3. The activity of the post family involvement and regarding calling for as evidence of any change Resident #3. The activity of the post family involvement and one 1:1 each day. *05/14/13 at 10:00 AM sitting on the floor on him front of the wheelchalling increased stimulation, rediversional activities, rearea, family involvement regarding using call believed. *05/15/13 at 3:45 PM Rim the hall removing her standing up. Before the her, Resident #3 stagget.	as no evidence of a ogram. I resident was found on the eelchair in the sunroom ff. Resident #3 was noted in tear to her right elbow. Ons included pain essment, activities consult on, redirect and provide ocate to high visibility area, if educate resident esistance. There was no es in the activity plan for vity participation record for 2/13 showed no activities involving Resident esident #3 observed er buttocks in the sunroom ent, activities consult for edirect and provide elocate to high visibility at and educate resident if for assistance. Resident #3 was witnessed self release lap belt and enurse aide could reach ered backwards and sat on is was noted to buttocks assessment included reased stimulation and	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DAT	(X3) DATE SURVEY COMPLETED	
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0.0000000000000000000000000000000000000	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		984 HIGHWAY 70	1 06	6/28/2013
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	The care plan was up include the use of a last at all times when he reserved was provided. There was nothing do for Resident #3 for 7 of Between 06/01/13 and days without any document of the post fall assessment of provide ambulation and provide diversional the resident to a high whose dated 06/25/13 are sident's fall was with oriented resident. The sunroom was local hallway and contained dining and large windouthe sunroom. Resident wheelchair with a self replace on 06/26/13 at 9:10:49 AM. The seat be loose around her waist residents in this room and the television was On 06/27/13 at 8:36 AM.	dated on 05/17/13 to up buddy to the wheelchair esident is up. participation record for 11/13 revealed she discriptions activities less than daily, cumented by activity staff lays during this period. If 06/25/13 there were 10 umented activities. Resident was in the hallway seat belt and attempted to poor, sitting on her buttocks, ent included interventions assistance, redirections all activities, and to relocate visible area. The nursing at 6:24 PM noted the essed by another alert and ted in the upper end of the allarge television, table for was between the hall and the table table to the sease alarmed belt in 59 AM, 10:23 AM and elt was noted to be very. There were other the time but no activities	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	NAME OF PE	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 084 HIGHWAY 70 WANNANOA, NC 28778	0	6/28/2013	
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	saali oo rik da C wa baa aa sa ##	a clip on alarm which was alarm that was not turn on the seat which was pad was half hanging of wheelchair. The seat beloose around her waist herself to the hall and stopped an spoke to he alarms. At 9:57 AM, Nother medication cart as a medications. At this time of the alarms not all being them. Nurse #1 stated buddy but that agitated the floor. Per Nurse #1 around her waist, Reside and removed it. Nurse seen Resident #3 actual wheelchair still attached Nurse #1 also stated Restronger. When asked a stronger. When a stronger a stronger and the	in her wheelchair. She had was not clipped, a seat belt hed on and a pressure pad on. A dycem (non skid) but of the cushion in her elt was noted to be very. The resident wheeled sat until while various staffer but never checked her lurse #1 took her to sit by she administered he, Nurse #1 was informed ing on and she attached the facility had tried a lapher and she threw it on if the seat belt is too tight lent #3 got very agitated #1 further stated she had hally stand and walk with the divia the belt 3 - 4 times. Sesident #3 had gotten about the three alarms how what the current eleft stated there was a when devices were added set showed up on the ne nurse aides would system they use for se. Nurse Aide (NA) #3 will uffles and her knees devices have included moved, a chair pad to prevent falls, NA #3 a close eye on Resident the bathroom before and	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	VI 200 000 000 000 000		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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-	(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
		On 06/28/13 at 2:50 Pl Resident #3 from fallin do with her hands, tell beautiful, and take her NA #4 stated she was program and stated Re and she never tried to and she never tried to an on 06/28/13 at 3:42 Ph conducted with the Adr Nurse Consultant. The falls were discussed in the staff discuss the sp changes in environment added any options or in would prevent falls. An would be left to the depthrough and the department interventions to the care administrator, the plantment post fall assessments where She stated redirection vinterventions, ambulation assist as necessary, respected and interventions and ctivities wo activity director would known as not working this date did not return calls. There was no evidence ambulation program was discharge summary. The oileting program initiate was not changed and incompare the summary and incompared the summary. The oileting program initiate was not changed and incompared to the summary and incompared to the summary. The oileting program initiate was not changed and incompared to the summary and incompared to the summary.	M NA #4 stated to prevent g, she gave her things to her the lap belt looked with the NA to do charting. Unaware of any ambulation esident #3 could not walk ambulate with her. M an interview was ministrator and Regional e Administrator stated that morning meetings. That recifics of the fall, any at and each department reterventions they think reterventions they think reterventions they think reterventions on the red interventions on the red interventions on the red interventions was just to reogram. The be specific as to what uld refer to and stated the now. The activity director the (last day of survey) and that a restorative is initiated per the therapy here was no evidence of a d. The activity care plan	F	323			

CTATEMEN		I SERVICES				OMB N	O. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A BUILD		LE CONSTRUCTION		E SURVEY PLETED
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	#3. 2. Resident #6 was an 02/13/13, then was ho readmitted to the facili diagnoses included dedepression, atrial fibrill disease, and chronic or disease. A care plan was developed addressed Resident #6 to removing her bed all bed without assistance resident to have no fall Interventions included health care professions balance, weak, etc, more reactions to medication to rise slowly to prevent pressure, promote ade environment free of obsinvolvement in activities and as needed, keep well fitting shoes and of ambulating, assistive deall bell in place, keep in resident, encourage free ask/encourage/assist resident #6 fell on 03/11 could not locate the incinotes did not have any there was an entry date indication this as a late	dmitted to the facility on spitalized on 02/17/13 and ty on 03/11/13. Her lirium, dementia, fation, coronary artery obstructive pulmonary oped 03/11/13 which is being at risk for falls due arm and trying to get out of the related injuries. The goal was for the related injuries. The goal was for the related injuries, educating resident to tell fals if feeling dizzy, off onitoring for adverse is, educating the resident to a sudden drop in blood quate hydration, keep stacles, encourage is, vital signs as ordered theels on bed locked, wear or nonskid socks when evices ad needed, keep most used items near quent rest periods, and esident to toilet. king log revealed 4/13. The administrator dent report. The nursing incident noted, however	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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1	ROVIDER OR SUPPLIER LE HEALTH CARE CENTE	ER	-	19	EET ADDRESS, CITY, STATE, ZIP CODE 84 HIGHWAY 70 NANNANOA, NC 28778	1 06	5/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	03/18/13 coded her as cognitive skills, having behaviors and rejecting extensive assistance wand walking only once needed. It was also coonce since admission. The fall Care Area Ass 03/22/13 stated Reside related injuries duet to and balance. She required for transfers and used and had a history of fall proceed with a care plate of the care plan relating to 03/22/13 with the addit belt at all times while the wheelchair. The residence of the care plan relating to 05/09/13 at 12:00 PM room, unhooked her se her head on the door. It is did not sound. The post a section that listed application of the care plan. Post fall integrated in response to care plan. Post fall integrated in the cand provide diversional nothing documented related in the cound.	am data Set (MDS) dated a having severely impaired a verbal and physical g care and requiring with bed mobility, transfers or twice with assistance ided that she had fallen sessment (CAA) dated ent #6 was at risk for fall her decreased strength uired extensive assistance psychotropic medications lls. The plan was to an. Ito falls was updated on ion of a removable seat her resident was in the ent was able to remove it. Resident #6 was in her eat belt, stood, fell and hit The alarm on the seat belt at fall assessment revealed blicable interventions the fall and added to the enventions included redirect	F	323			
	with no alarms sounding	g. The alarm had been on					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11 25 14000000 RA	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345418	B. WNG				28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE		(X5) COMPLETION DATE
F 323	but the cord was so to sound. Post fall internand provide diversion indication if the alarm cord was shortened. Review of the activity revealed there were in Resident #6 on 05/09 change of activity interesident sliding off the not reach the resident hitting the floor. The irresident had removed corresponding nursing 4:41 AM stated the realarm which she had and she was not wear interventions listed on included redirect and activities. *05/19/13 at 6:20 AM calling out and found I knees facing the toilet not clipped to her cloth The corresponding nur at 7:44 PM stated the the bed where she applisted post fall intervention and provide diversions. *06/06/13 at 7:45 AM the sunroom lying on the about her head and right and provide diversions.	ang it didn't disconnect and ventions included redirect al activity. There was no was changed out or if the participation record to documented activities for //13 through 05/11/13 and no rventions. a nurse aide observed the edge of the bed but could in time to prevent her from neident report noted the the alarm. The gonet dated 05/14/13 at sident had removed the arecurrent history of doinging shoes or socks. The the post fall assessment provide diversional staff heard Resident #6 the in the bathroom on her are in the bathroom	F	323			

CENTER	TO TOT WEDIONIL G	WEDIOAID SERVICES				OMB M	0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 44		CONSTRUCTION	СОМ	E SURVEY PLETED
		345418	B. WING			2007	C 5/28/2013
	ROVIDER OR SUPPLIER	ER	•	19	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	report mentioned the repaired. The post fa was to redirect and properties. The fall care plan was discontinue the reside to discontinue vital signification discontinue vital signification discontinue the assist noting the reason of the "resolved." In addition belt alarm at all times 06/19/13 noting the referror and a chair alarm resident was in the whole of 25/13. On 06/26/13 at 9:51 A observed with a tab/of turn rail. On 06/26/13 at 9:54 A observed in the sunror alarmed seat belt in plot the seat belt multiple to Staff responded each located in the upper election of the properties of the position	seat belt alarm was all assessment interventions rovide diversional activities. s updated on 06/19/13 to ent education to rise slowly, gns as ordered and prn, to tive devices as needed all he discontinuation due to in the intervention of the seat was discontinued on eason was it was entered in m was to be used when heelchair with a start date of AM Resident #6's bed was lip type alarm on the right AM, Resident #6 was som with a very loose lace, Resident #6 released times sounding the alarm. time. The sunroom was ind of the hallway and vision, table for dining and en the hall and the sunroom. Aide (NA) #3 revealed loved her alarmed seat belt department will give her	F	323			

STATEMENT	OF DECIDIENDIS	LEDIO, IID CERTIFICE				OMB	NO. 0938-0391
AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		ATE SURVEY IMPLETED
525		345418	B. WNG				C 06/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 184 HIGHWAY 70 WANNANOA, NC 28778		5072072070
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	Interview with NA #5 r to prevent Resident #6 alarmed seat belt and #% further stated the revealed she gave Reshe liked to do things prevent falls. NA #4 s to redirect. On 06/28/13 at 3:42 Pl conducted with the Ad Nurse Consultant. The falls were discussed in the staff discuss the sp changes in environmer added any options or in would prevent falls. Ar would be left to the depthrough and add to the administrator, the plant post fall assessments with She stated redirection interventions. She furtidistinct difference regardinterventions of alarms, there was an alarm on intervention that any desimplement would be upplace on the care plan. The plant post fall assessments with the same alarm on the care plan. The plant post fall assessments with the same alarm on the care plan. The plant post fall assessments with the same alarm on the care plan. The plant post fall assessments with the care plan. The plant place on the care plan activity director to know the plant pl	revealed interventions used from falling included her keeping an eye on her. NA resident liked to talk. In 06/28/13 at 2:54 PM sident #6 laundry to fold as with her hands in order to tated Resident #6 was hard M an interview was ministrator and Regional e Administrator stated that morning meetings. That becifics of the fall, any and each department interventions they think by thing that was discussed partment head to follow care plan. Per the med interventions on the were in progress and trials. Was an ongoing her stated there was reding care planned. She stated as long as	F 39	323			
SS=E F	PER CARE PLANS	-					1/26/12

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ION NUMBER:		ECONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
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		345418	B. WNG			C 06/28/2013		
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
	The facility must have provide nursing and remaintain the highest pand psychosocial well-determined by resident individual plans of care. The facility must provid numbers of each of the personnel on a 24-hou care to all residents in care plans: Except when waived usection, licensed nurse personnel. Except when waived usection, the facility must nurse to serve as a chaduty. This REQUIREMENT by:	sufficient nursing staff to elated services to attain or racticable physical, mental, being of each resident, as t assessments and e. de services by sufficient e following types of accordance with resident ender paragraph (c) of this es and other nursing ender paragraph (c) of this est designate a licensed arge nurse on each tour of elated services to attain the ender paragraph (c) of this est designate a licensed arge nurse on each tour of	F 3		F353 How the corrective action will be accomplished for the resident for appropriate positioning, device and appropriate transfers. Resident #6 devices were audited for appropriateness are functionality. Resident #3, #6, and #17 were showered on 6/27/13 How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Staffing for each unit is scheduled to meet the needs of residents on each shift. Any resident needs will be	es ad	7/24/13	
	interview, the facility fai to provide showers for a supervision of residents of 3 residents with accid pressure sores for 1 of	to prevent accidents for 3			addressed immediately during leadership rounds to ensure staff is providing the necessary care to the residents. Observation by the leadership team will be done five x a weel x 2 weeks, weekly x 2 monthly 2, then quarterly x 3. Staffing	<		
(Resident #5 was adm 05/01/13 with diagnose: peri-rectal cellulitis, wou	nitted to the facility on s which included unds to buttocks, morbid			deviations noted will be addressed at that time. Nursing Administration have been reeducated on staffing for the	9		

CENTE	TO FOR THE ALTH A	ND HUMAN SERVICES			PRINTED: 07/15/2013
CENTE	ERS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVED
SIMIEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF		345418	B. WING		С
NAME OF F	PROVIDER OR SUPPLIER			SIDELI ADDOLOG	06/28/2013
ASHEVIL	LE HEALTH CARE CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANGA, NO. 2007	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	105	SWANNANOA, NC 28778	
TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE COURTE
I a w b a ir	obesity, diabetes mellit and anemia. An admission Minimum completed on 05/08/13 #5 as cognitively intact. The MDS indicated the extensive assistance of toilet use, personal hygi was totally dependent or resident was non-ambul observation period. The Resident #5 was frequerand always incontinent of was assessed as having skin damage and 9 Stag MDS indicated the follow place: a pressure reducin nutrition or hydration integrare, and applications of The Care Area Assessments.	Data Set (MDS) was and assessed Resident for daily decision making. resident required 2 staff with bed mobility, ene and dressing and in staff for bathing. The atory during the MDS also indicated intly incontinent of urine of bowel. The resident moisture associated in a 2 pressure ulcers. The ring interventions were in ing device for chair, rivention, pressure ulcer ointments/medication. Lent (CAA) Summary indicated Resident #5 in the Stage 2 ulcers on the sat risk for developing mited mobility and in bladder. The decision	F3	facility and the protocol to foll	ow ns et.
A br wi in sk pc ke as	care plan dated 05/03/1 reakdown and multiple S hich were present on ad	3 addressed skin tage 2 pressure ulcers mission. Interventions ered by physician, keep h turning and		How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator will report results of audits to the QA Committee monthly for three months, then quarterly x three for tracking and trending.	

STATEMENT	OF DEFICIENCIES	(V4) PROVIDER/OURD ISSUE	5221 201			OIMB M	O. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		345418	B. WING			80 97	C 5/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	care plan indicated ba applied to thighs/butto keep it away from the The sacral wound was packed with silver algi and secured with a tra daily. Additional interval alternating pressure ai reduction and wound carea on the right poste a Stage 2 diabetic ulce. A review of the skin an records for Resident # titled Ulcer and Wound completed on 05/01/13 had multiple (15 - 20) selft buttocks and left upvaried in size from 10 c No specific measuremopen area except the last 11.4 cm long X 2.0 c intact blisters with no darea was described as measurements betwee Additional measurement done on 05/18/13. An ulcer and wound recond the right inner buttocks wide X 0.2 cm deep with drainage and wound be granulation tissue; the parallel in the right inner buttocks wide X 0.2 cm deep with drainage and wound be granulation tissue; the parallel in the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks wide X 0.2 cm deep with the right inner buttocks with th	rised on 06/13/13 to cral pressure ulcer. The crier cream was to be cks daily and to be sure to transparent film dressing. To be irrigated with saline, nate, covered with foam insparent film dressing entions included a Group 2 ir mattress for pressure consult as indicated. The erior thigh was described as er. Indicated a document of the erior thigh was described as er. Indicated that resident is tage II ulcers on right and oper lateral thigh which centimeters (cm) to 30 cm. ents were listed for each eff thigh which was listed cm wide and described as rainage; the peri-wound intact. There were not any in 05/01/13 and 05/18/13. Into of the left thigh were 15/13, 06/11/13 and 15/13, 06/11/13	F	353			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 30		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
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ASHEVIL	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	6/28/2013
(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 APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	measurements of the done on 05/23/13 and An ulcer and wound re the left inner cheek (bit cm wide with eschar a red/inflamed. There will between 05/08/13 and measurements of the lon 05/23/13, 06/05/13. A review of the May ar Administration (TAR) revealed the following An air mattress with a being on Resident #5's Extra protective cream viscopaste strips twice started 05/01/13 and dithere were 35 instance documented as done. Xeroform dressing cover twice daily was documented as done of 5:00 PM, on 05/30/13 and documented as done at 06/03/13, on 06/04/13 and documented as done at 06/03/13, on 06/04/13 and documented as done at 06/06/13.	right inner buttocks were 06/05/13. ecord dated 05/8/13 listed uttock): 7.2 cm long X 5.3 and the peri-wound was ere not any measurements 05/23/13. Additional left inner buttock were done 06/11/13 and 06/18/13. and June 2013 Treatment ecords for Resident #5 documentation: pump was documented as a bed beginning 05/28/13. to buttocks covered with daily was documented as iscontinued 06/06/13 - is when it was not ered with viscopaste strips ented as started 05/28/13 at at 9:00 AM; it was not at all from 05/31/13 through at 9:00 AM; and it was not at all on 06/05/13 or	F	353			

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245442					С
NAME OF P	ROVIDER OR SUPPLIER	345418	B. WNG	\equiv		06	3/28/2013
ASHEVIL	LE HEALTH CARE CENT			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 GWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Dakin's 0.25% solution for wound was docume and discontinued 06/2 documented as done a 06/15/13, on 06/18/13 9:00 AM, on 06/22/13 at 9:00 PM. Irrigate sacral wound walginate, cover with for dressing daily was documented as do	n apply twice daily topical ented as started 06/12/13 5/13 but was not at all on 06/13/13 through at 9:00 PM, on 06/21/13 at at 9:00 AM or on 06/23/13 with saline, pack with silver am, secure with transparent umented beginning mattress for stage 3 cumented as started on	F	353			
	#1 revealed the nurses treatments as ordered there weren't enough N repositioning the reside the treatment. Nurse #1 mattress was not place until 05/24/13. Nurse #1 measurements weren't they should be. An interview on 06/26/11 #2 revealed the nurses all the treatments as we medications. Nurse #2 streatments as we medications. Nurse #2 streatments as we medications.	weren't doing the for Resident #5 because IAs to assist with ont so the nurse could do I stated a specialty don Resident #5's bed I also stated wound being done every week as 3 at 5:02 PM with Nurse are responsible for doing the stated just administering stated just administering lakes all shift so the nurses ag the treatments done up time.					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY PLETED
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NAME OF D		345418	B. WNG			06	/28/2013
ASHEVIL	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778			
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	physician about Resid he was asked to see to assess skin breakdow stated he saw the residuasked staff to get an a He stated he examined the buttocks on 05/28/getting better. He stated on Resident #5's butto the area was much wo had eschar and he refe Wound Clinic as soon debridement. The physic expectation for measur wounds and he stated measuring and monitor. An interview on 06/28/Regional Nurse Consultor assessment of oper open wounds should be assessment should inclined wound. When asked if measurements of Residuated the facility was us measurements done be 05/23/13. He stated his wounds to be assessed.	ent #5's wounds revealed the resident on 05/23/13 to n on the buttocks. He dent again on 05/25/13 and ir mattress for the resident. d Resident #5's wound on 13 and thought it was ad he looked at the wound cks again on 06/06/13 and rese; at that point the wound erred the resident to the as possible for sician was asked about his ring and monitoring of the nurses should be ring the areas. 13 at 11:15 AM with the litant about the expectation in wounds revealed that all the assessed weekly and the lude measurements of the lude measurements of the latent # 5's wounds, he mable to locate any wound exween 05/08/13 and expectation was for all and measured every the due to pressure or not.	F	353			
1	major depressive disord disorder, coronary arter	er, generalized anxiety y disease,					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIP	LE CONSTRUCTION		J. 0938-0391
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	1907 0000000000				E SURVEY PLETED
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
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E 050							
F 353	Continued From page		F	353	3		
	hypothyroidism, and h	iyperlipidemia.					
		um Data Set (MDS) dated					
	03/20/13 coded her w						
	mobility, transfers, and	quiring supervision with bed d walking. She was coded					
	as being steady with b	palance at all times. She					
	than daily. She was c	ors 4 to 6 days, but less oded as having no falls					
	prior to admission or s	ince admission.					
	The Care Area Assess						
		ent #3 was at risk for fall her use of psychotropic					
	medication and severe	cognitive impairment					
	resulting in poor safety	awareness. The CAA					
	fall related injuries.	nd be developed to prevent					
	A care plan developed	03/20/13 which addressed					
	the problem of Resider	nt #3 being at risk for falls					
	review. Interventions i	related injury through next					
	used items near reside	ent, encourage frequent					
	rest periods, ask/encou	urage/assist resident to place, educate resident to					
	rise slowly to prevent a	sudden dropping blood					
	pressure, promote ade	quate hydration, monitor					
	for adverse reaction to	medications, educate are professionals if feeling					
	dizzy, off balance, wea	k, etc., keep environment					
	free of potential obstac	les, wear well fitting shoes					
	keep wheels on bed lo	stive devices as needed,					
	involvement in activities	s, vital signs as ordered					
	and as needed.						
	Physical therapy was s	tarted on 04/04/13 due to					
	her exhibiting a shufflin	g gait with ambulation.					
						1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		345418	B. WING			1	С
NAME OF PE	ROVIDER OR SUPPLIER	040410	B. WING			06	/28/2013
ASHEVILI	LE HEALTH CARE CENTI			19	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	7000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	Continued From page	70	F	353			
	Review of the incident following falls:	reports revealed the					
	medication, heard a lo sitting on the floor with door. It was noted Re bed earlier. Post fall in provide ambulation as safety. The nursing no	the nurse was passing and bang and found resident her head resting on the sident #3 was resting in terventions listed included sistance, bed alarm for otes dated 04/17/13 at ssure sensitive alarm was					
	and was observed sitti her wheelchair. A self placed on Resident #3 interventions included provide ambulation ass toileting program, and	at that time. Post fall a pharmacy consult, sistance, a restorative verbal cues. There was no al record that an ambulation					
	Resident #3 with sever skills, having no behavextensive assistance wand limited assistance noted she was not steatherself without help wharound but needed state when moving from seatmoving on and off toiled transfers. She had 2 falphysically resulting in a	iors, and requiring with bed mobility, transfers, with ambulation. It was ady but able to stabilize en walking and turning ff assistance to stabilize ted to standing position, t and surface to surface Ils and had declined shuffling gait and had wheelchair for safety as					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345418	B. WNG				С
	ROVIDER OR SUPPLIER	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 06	6/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
	05/01/13 due to seven unable to follow through determined she was hafer in a wheelchair. restorative nursing had ambulation. There was medical record of a resprogram for Resident #3 continued following incident reportant following incident follo	paraged Resident #3 on e cognition and being gh with teaching. It was igh risk for falls and was The discharge note stated di been educated in s no evidence in the storative ambulation #3. to fall as evidenced by the rts: Resident #3 was placed in en found on the floor in her tocks. Interventions per the be added to the care plan insult, ambulation toileting and verbal cues. e of a restorative toileting Resident #3 was observed in on the side of the bed, at with the alarm sounding. be be added to the care y consult, provide restorative toileting, is no evidence of a gram. resident was found on the elchair in the sunroom f. Resident #3 was noted tear to her right elbow.	F	353			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 2001000000		E CONSTRUCTION	(X3) DAT	IO. 0938-0391 TE SURVEY MPLETED
		345418	B. WNG			00	C 6/ 28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTE			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	072012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES 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)	E ATE	(X5) COMPLETION DATE
	for increased stimulation diversional activity, rel family involvement and regarding calling for as *05/14/13 at 10:00 AM sitting on the floor on hin front of the wheelche included pain manager increased stimulation, diversional activities, rearea, family involveme regarding using call be *05/15/13 at 3:45 PM F in the hall removing he standing up. Before the her, Resident #3 stagg the floor. Some redness and left elbow. Post fa activities consult for incredirect and provide diversional to the floor. The post fall assessment of provide ambulation a and provide diversional the resident to a high vioriented resident witness.	on, redirect and provide ocate to high visibility area, dieducate resident esistance. Resident #3 observed her buttocks in the sunroom air. Post fall interventions ment, activities consult for redirect and provide elocate to high visibility nt and educate resident ll for assistance. Resident #3 was witnessed in self release lap belt and enurse aide could reach ered backwards and sat on se was noted to buttocks ll assessment included breased stimulation and versional activities. Resident was in the hallway eat belt and attempted to or, sitting on her buttocks. In tincluded interventions activities, and to relocate sible area. An alert seed this fall. Red in the upper end of the alarge television, table for vs between the hall and #3 was observed in a glease alarmed belt in	F	353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/15/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING

			A. BOILD				
		345418	B. WNG				C
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI			STREET 1984	ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 70 NNANOA, NC 28778	06	/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	: TE	(X5) COMPLETIC DATE
	10:49 AM. The seat beloose around her wais residents in this room and the television was On 06/26/13 at 2:08 Per were not enough staff ambulate which was a Restorative nursing was floor nurse aides but the todo restorative ambulate of the todo restorative ambulate which was a Restorative nursing was floor nurse aides but the todo restorative ambulate of the last twice a weekends, there was dentire hall of 32 reside. On 06/27/13 at 2:53 Per been lots of turn over it Lately she had been where the last couple of wides the best she can to prevent falls, NA #3 close eye on Resident the bathroom before an send her to activities. On 06/28/13 at 10:10 A often just 1 to 2 nurse a don't have time to do e watching for this reside. On 06/28/13 at 3:42 Per conducted with the Adri Nurse Consultant. The	t. There were other at the time but no activities off. M, Nurse #1 stated there to help Resident #3 II the resident wanted to do. as supposed to be done by here was not enough aides lation. M, Nurse Aide (NA) #1 month, mostly on only one nurse aide for the nots. M NA #3 stated there have in the last month or so. orking on this all by herself eekends. She stated she to care for the residents. It is stated they tried to keep a #3, routinely take her to and after meals, and tried to had after meals, and tried to werything including in twho is high risk for falls. M an interview was ininistrator and Regional Administrator stated that morning meetings. That ecifics of the fall, any	F	353			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		345418	B. WNG				C
Apple Market and Apple	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 84 HIGHWAY 70 VANNANOA, NC 28778	1 06	6/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	would prevent falls. A would be left to the de through and the depart the care plan. Per the interventions on the progress and trials. San ongoing intervention was just to assist as not to t	interventions they think anything that was discussed epartment head to follow rement heads would add to a administrator, the planned lost fall assessments were in the stated redirection was ans, ambulation assistance eccessary, restorative essarily a planned program. Id not be specific as to ties would refer to and ctor would know. The lot working this date (last not return calls. The that a restorative has initiated per the therapy of the er was no evidence of a ted. The activity care plan	F	353			
	3. Resident #6 was ac 02/13/13, then was hos readmitted to the facilit diagnoses included de depression, atrial fibrill disease, and chronic o disease.	lirium, dementia, ation, coronary artery					
	to removing her bed ala bed without assistance resident to have no fall	being at risk for falls due arm and trying to get out of . The goal was for the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
		345418	B. WING				C
63040402.40.0046	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI			STF	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	Ubi	28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	health care profession balance, weak, etc, m reactions to medicatio to rise slowly to preve pressure, promote add environment free of of involvement in activitic and as needed, keep well fitting shoes and ambulating, assistive call bell in place, keep resident, encourage frask/encourage/assist Review of the Falls transk-encourage/assist Review of the Falls transk-encourage frask-encourage/assist Review of the Falls transk-encourage frask-encourage/assist The admission thave any there was an entry data indication this as a late no verbal complaints on the 7-3 shift. The admission Minimum 03/18/13 coded her as cognitive skills, having behaviors and rejecting extensive assistance wand walking only once needed. It was also conce since admission. The care plan relating 03/22/13 with the additional times while to the second concession of the second concession.	nals if feeling dizzy, off nonitoring for adverse ons, educating the resident ent a sudden drop in blood lequate hydration, keep bstacles, encourage es, vital signs as ordered wheels on bed locked, wear or nonskid socks when devices ad needed, keep or most used items near requent rest periods, and resident to toilet. acking log revealed 8/14/13. The administrator incident report. The nursing by incident noted, however ated 03/15/13 at 3:02 AM are entry that the resident had of injuries related to the fall of injuries related to the fall of care and requiring with bed mobility, transfers ever or twice with assistance or twice with assistance or twice with assistance or the falls was updated on ition of a removable seat the resident was in the dent was able to remove it.	F	353			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY
		345418	B. WNG			1	C 5/28/2013
0.073-1117-120-1420-1420-1420	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER		19	REET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 SWANNANOA, NC 28778	1	TECHNO IC
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	3200775	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	BE	(X5) COMPLETION DATE
	*05/09/13 at 12:00 PM room, unhooked her sher head on the door. did not sound. Post faredirect and provide dwas nothing documen which did not sound. *05/09/13 at 8:45 PM on the floor in her room with no alarms sounding but the cord was so losound. Post fall intervand provide diversional *05/14/13 at 3:30 AM are sident sliding off the not reach the resident hitting the floor. The ir resident had removed interventions listed on included redirect and practivities.	M Resident #6 was in her seat belt, stood, fell and hit. The alarm on the seat belt all interventions included diversional activity. There inted related to the alarm. Resident #6 was observed in sitting on the floor mat ing. The alarm had been on ong it didn't disconnect and ventions included redirect all activity. In a nurse aide observed the edge of the bed but could in time to prevent her from incident report noted the the alarm. The the post fall assessment provide diversional. In the mobility alarm was along and she had bare feet.	F	353	DETIGENOT)		
	*06/06/13 at 7:45 AM F the sunroom lying on h about her head and rigi	rversional activities. Resident #6 was found in her back and complaining with elbow. A bruise was and she was sent tot he eatment. The incident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 100		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF PE	ROVIDER OR SUPPLIER	345418	B. WING		DEST ADDRESS SITE OF THE SITE OF THE	06/	28/2013
	E HEALTH CARE CENT	ER			REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	was to redirect and procession of the fall care plan was discontinue the reside to discontinue vital significant of the fall care plan was discontinue vital significant of the fall care and th	Il assessment interventions rovide diversional activities. Is updated on 06/19/13 to ent education to rise slowly, gns as ordered and prn, to ive devices as needed all the discontinuation due to in the intervention of the seat was discontinued on eason was it was entered in meelchair with a start date of the MM, Resident #6 was om with a very loose lace, Resident #6 released times sounding the alarm. It ime. The sunroom was not of the hallway and vision, table for dining and en the hall and the sunroom. Aide (NA) #3 on 06/27/13 at sident #6 often removed her he stated that there had it couple of months and she fon this unit. She stated	F	353			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345418	B. WNG			1	29/2042
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	067.	28/2013
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	don't have time to do watching for this residual watching for this residual interview with NA #4 revealed she gave Reshe liked to do things prevent falls. NA #4 sto redirect and short supervision for this re On 06/28/13 at 3:42 Fooducted with the Ad Nurse Consultant. The falls were discussed in the staff discuss the schanges in environment added any options or would prevent falls. A would be left to the dethrough and added to administrator, the plangost fall assessments She stated redirection interventions. She fundistinct difference reginterventions of alarm there was an alarm or intervention that any of interve	e aide on this wing and often everything including lent who is high risk for falls. on 06/28/13 at 2:54 PM esident #6 laundry to fold as with her hands in order to stated Resident #6 was hard staffing resulted in a lack of sident. Of M an interview was diministrator and Regional are Administrator stated that an morning meetings. That pecifics of the fall, any ent and each department interventions they think any thing that was discussed epartment head to follow the care plan. Per the med interventions on the were in progress and trials. It was an ongoing ther stated there was	F	353			

The second secon	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	201 201		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345418	B. WING				C /28/2013
47848 0000 7004 70000	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		1984 HIGHWAY 70		20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	readmitted to the facili diagnoses included de depression, atrial fibril disease, and chronic odisease. The admission Minimu 03/18/13 coded her as cognitive skills, having behaviors and rejecting	espitalized on 02/17/13 and ty on 03/11/13. Her slirium, dementia, lation, coronary artery obstructive pulmonary sim data Set (MDS) dated a having severely impaired verbal and physical g care and requiring with bed mobility, transfers	F	353			
	activities of daily living included to assist the rweek. Review of the ADL Dainursing assistants, rev	Resident #6 to complete (ADL) tasks. Interventions esident to shower twice a ta Report, completed by ealed Resident #3 did not					
		05/31/13 through 06/05/13 1/13 through 06/26/13 (6					
	staffing. She further st reported to her that sta she has told the nurse	ng completed due to short ated when it has been ff can't complete showers, aides to do the best they to prioritize what care and					
		ated on 06/27/13 at 2:53 en short for the last month owers cannot be					

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
		345418	B. WING				C 6/28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER	·	198	ET ADDRESS, CITY, STATE, ZIP CODE 4 HIGHWAY 70 VANNANOA, NC 28778	1 0	0/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	2000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	completed then they to and make up the show until the next shower of the next shower of the next shower of the nurses who stated acceptable. On 06/28/13 at 10:10 of short staffing, showers completed twice a week missed shower up the linterview with the admit 4:55 PM revealed if a right shower for some reason ask the resident if it would the next day or pass it complete. She further showers were not being 5. Resident #3 was ad 03/13/13 with diagnose type dementia with behing in depressive disorder, coronary arter hypothyroidism, and hy the admission Minimum 03/20/13 coded her with cognitive skills, and required the next has a completed to the next disorder, coronary arter hypothyroidism, and hy the admission Minimum 03/20/13 coded her with cognitive skills, and required the next has a care plan was developed the staff of the next disorder with the next disorder, coronary arter hypothyroidism, and hypothyroidism,	ry to give good bed baths ver on the next day or wait day. 7/13 at 5:31 PM stated that occuplete as scheduled tated that staff report this to that a bed bath was AM, NA #4 stated due to severe not always ex. Staff try to make a next day as able. Inistrator on 06/28/13 at nurse aide could not do a son, the nurse aide should huld be alright to make it up off to the next shift to stated she was unaware griven as scheduled. Inited to the facility on as including Alzheimer's avioral disturbances, der, generalized anxiety by disease, perlipidemia. In Data Set (MDS) dated in severely impaired uiring supervision with bed walking and requiring ng.	F	353			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		CONSTRUCTION	(X3) DATE SU COMPLET C 06/28/	NO. 0938-0391 TE SURVEY MPLETED
		345418	B. WNG			١,	
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER	•	19	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778	_10	0/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
i si	Review of the ADL Da nursing assistants, rev receive a shower on 0- (6 days) and again from 04/21/13 (6 days). On 06/26/13 at 2:08 Pl showers were not getti staffing. She further st reported to her that sta she has told the nurse can and Nurse #1 tries what resident would be skip. Nurse Aide (NA) # 3 sta PM that staffing has be or so. She stated if she completed then they try and make up the shower duntil the next shower days and the nurses who stated to staffing. She stated in the completed than they try and make up the shower are difficult to a due to staffing. She stated in the nurses who stated the nurses who stated the nurses who stated the completed twice a week missed shower up the nurterview with the administration.	s. Interventions included to shower twice a week. Ita Report, completed by realed Resident #3 did not 4/02/13 through 04/07/13 m 04/16/13 through M, Nurse #1 stated ng completed due to short ated when it has been ff can't complete showers, aides to do the best they to prioritize what care and most important not to ated on 06/27/13 at 2:53 en short for the last month owers cannot be to give good bed baths er on the next day or wait ay. 13 at 5:31 PM stated that complete as scheduled ated that staff report this to that a bed bath was M, NA #4 stated due to were not always staff try to make a ext day as able.	F	353			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	21 Section 100 (100)		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345418	B. WNG			06/	28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353	shower for some reas ask he resident if it we the next day or pass it complete. She further showers were not bein 6. Resident #17 was a 03/19/13 with diagnos sclerosis, osteoporosi depression. The most recent quart 06/28/13 indicated Reintact and required exhygiene and was total bathing. A review of care plans problem statement that to complete tasks rela goals indicated Reside and dressed approprialiving tasks will be add date of 04/03/13. The plan were listed in parpersonal hygiene and and assist resident to A review of a shower significant with the statement to a shower significant with the shower signific	on, the nurse aide should build be alright to make it up to off to the next shift to restated she was unawareing given as scheduled. Admitted to the facility on sees which included multiples, muscle weakness and terly Minimum Data dated sident #17 was cognitively tensive assistance with ly dependent on staff for at Resident #17 was unable ted to personal care. The ent #17 will be well groomed ately and activities of daily dressed through next review approaches on the care to provide assistance with grooming needs as needed shower twice a week. Schedule indicated Resident on a shower on Tuesday and on second shift between M. on 06/27/13 at 9:51 AM g in bed in her room. She on, her hair was uncombed	F	353			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345418	B. WNG				C
	ROVIDER OR SUPPLIER LE HEALTH CARE CENTI			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 06	/28/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
	During an interview or Resident #17 stated shad her hair washed sexplained she missed evening. She further swould get a shower or shift on Tuesday night Resident #17 explaine Vice-Chairman of the had discussed resident getting showers at the there was not enough residents as scheduled. During an interview on NA #5 he stated somet and they can't get all the second shift shower so that once a shower got impossible to catch up. #17's shower was not obecause they were overeverything done. During an interview on NA #11 explained she get shower last Saturday be on Friday. She stated shower last Saturday be on Friday. She stated is baths if a shower was mocouldn't get them all do During an interview on Administrator stated it we resident's should get as a shower. She further smissed the NA's should find out when they want	the hasn't had a shower or since last Saturday. She her shower last Friday stated she was told she to the 3:00 PM to 11:00 PM but she didn't get it. d she was the Resident Council and they to concerns about not council meetings and felt staff to provide showers to d. 1. 06/27/13 at 5:40 PM with times staffing was an issue the showers done on the shedule. He further stated to behind it was nearly he explained Resident done on Tuesday night exwhelmed to get 1. 06/27/13 at 6:03 PM with gave Resident #17 her ecause she didn't get one she did try to give bed nissed but sometimes they ne. 1. 06/28/13 at 3:56 PM the was her expectation that shower when they wanted	F	353			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		345418	B. WNG			C 06/28/2013	
ASHEVIL	ROVIDER OR SUPPLIER LE HEALTH CARE CENT		1 3	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		0/20/2013	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	stated the NA's should nurse when a residen 483.60(a),(b) PHARM ACCURATE PROCED. The facility must providrugs and biologicals them under an agreen §483.75(h) of this part unlicensed personnel law permits, but only usupervision of a licens. A facility must provide (including procedures acquiring, receiving, diadministering of all druthe needs of each resident the needs of each resident alicensed pharmacist on all aspects of the preservices in the facility. This REQUIREMENT by: Based on observations interview, the facility failemergency supply of neavailable for 6 of 6 med which resulted in medicinessiden.	d also communicate with the it's shower was missed. ACEUTICAL SVC - DURES, RPH de routine and emergency to its residents, or obtain ment described in it. The facility may permit to administer drugs if State under the general fied nurse. pharmaceutical services that assure the accurate ispensing, and ags and biologicals) to meet dent. by or obtain the services of who provides consultation rovision of pharmacy is not met as evidenced s, record review and staff illed to maintain an arcotic medications dication carts in the facility cations which were dent being administered to indings included:	F 353	Fior	t(s) is tics ant. ish be	7/26/13	

1.2	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD				
		345418	B. WNG			06/2	28/2013
NAME OF PR	OVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
V C II E / II I	E HEALTH CARE CENT	EP		19	984 HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	EK		SI	WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	(mg), which was disprevealed a total of 10 Resident # 27 betwee a. On 06/15/13 at 2:0 administered to Resid hydrocodone/acetam was dispensed for Resident # 27 one hydrocodone/acetam was dispensed for Resid hydrocodone/acetam hydrocodone/acetam hydrocodone/acetam hydrocodone/acetam w	the inophen 10/325 milligrams ensed for Resident #19, doses were administered to en 06/15/13 and 06/18/13. 0 PM Nurse # 7 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 0 PM Nurse # 7 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 0 PM Nurse # 7 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 0 PM Nurse # 8 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 00 AM Nurse # 9 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 00 AM Nurse # 9 administered tablet of inophen 10/325 mg which esident # 18. 00 AM Nurse # 9 administered tablet of inophen 10/325 mg which esident # 18. 00 PM Nurse # 7 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 00 PM Nurse # 7 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 00 PM Nurse # 8 dent # 27 one tablet of inophen 10/325 mg which esident # 18. 00 PM Nurse # 8 dent # 27 one tablet of inophen 10/325 mg which	F	425	month. The residents Narcot Administration sheets will be reviewed weekly by the Unit Manager to ensure an ample supply of medications. Measures in place to ensure practices will not occur. IDO to inventory Pyxis narcotics of Monday mornings and Thurs evening to routinely replenish the Pyxis. If nurses go to the Pyxis and find that the medication needed is not present then they are to immediately notify the physici on call to either obtain a prescription for a different narcotic that is available for a one time use and/or a prescription to obtain medicate from a back-up pharmacy. How the facility plans to monit and ensure correction is achieved and sustained. IDON will copy the inventory sheet and submit it to the Administrator weekly. Nurses will complete a Communication Form for the IDON when	N on day n an	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9 8	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345418	B. WING_			C 06/28/2013	
900 900 00 00 00 00 00 00 00 00 00 00 00	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		00/20/2010	
(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 COR ((EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	to Resident # 27 one hydrocodone/acetami was dispensed for Re j. On 06/18/13 at 9:00 to Resident # 27 one hydrocodone/acetami was dispensed for Re A review of the Contro Record for the hydrocodone/acetami was dispensed for Re A review of the Contro Record for the hydrocodone/acetami was dispensed for the that indicated 10 table Resident # 18. 2. A review of the Controlled I was dispensed for Re # 6 administered one 05/14/13 at 5:00 PM. locate the Controlled I for the oxycodone 5mg Resident # 26. 3. A review of the Controlled I for the oxycodone 5mg Resident # 26. 3. A review of the Controlled I for the oxycodone 5mg Resident # 26. 4. A review of the Controlled I for the oxycodone 9 mg which was dispensed for Resident Was dispensed for R	tablet of nophen 10/325 mg which sident # 18. PM Nurse # 3 administered tablet of nophen 10/325 mg which sident # 18. Diled Medication Utilization odone/acetaminophen sidispensed for Resident # of reveal any documentation reveal any documentation reveal any documentation reveal any documentation record graph which sident # 18, revealed Nurse tablet to Resident # 26 on The facility was unable to Medication Utilization record record graph which relorazepam 0.5 mg, which relorazepam 1 mg, which relorazepam 1 mg, which relorazepam 1	F 4	medications are low to refills of the Pyxis. Bot Inventory Sheet and Communication sheets submitted to the Admin weekly for a period of the months, then quarterly Results will be address the QA committee months, then quarterly for compliance and revineeded.	h the are to be istrator hree x 3. ed with this for reerly x 3.	pe	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	STON WILDICANE &	VIEDICAID SERVICES				T	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10.000000000000000000000000000000000000		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING			06/	28/2013
		345416	b. viiivo			067.	20/2013
	OVIDER OR SUPPLIER E HEALTH CARE CENT	ER		1	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778		
			-				(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page 05/23/13 at 4:30 PM. Medication Utilization hydrocodone/acetami was dispensed for Reany documentation the was replaced to Residual to the was dispensed for Residual to the was dispensed for Reference of the was dispensed for the was dispensed for Residual to the was dispensed to Residual to the was dispensed to Residual to the was dispensed to Residual to the was dispensed for Residual to	A review of the Controlled record for the inophen 5/500 mg, which esident # 28, did not reveal that indicated the medication dent # 21. Introlled Medication the lorazepam 0.5 mg, which esident # 22, revealed Nurse blet to Resident # 25 on the Controlled to record for the lorazepam spensed for Resident # 25 reveal any documentation dication was replaced to the zolpidem 5 mg, which esident # 23, revealed a total instered to Resident # 12. On PM Nurse # 10 dent # 12 one tablet of was dispensed for Resident # 10 PM Nurse # 6 dent # 12 one tablet of was dispensed for Resident was dispensed for Resident # 10 PM Nurse # 6 dent # 12 one tablet of was dispensed for Resident # 10 PM Nurse # 6 dent # 12 one tablet of was dispensed for Resident # 10 PM Nurse # 6 dent # 12 one tablet of was dispensed for Resident # 12 one tablet of was dispensed for Resident # 12 on 06/12/13, did not ation that indicated the deced to Resident # 23.		425			
	7. A review of the Co Utilization record for	ntrolled Medication the lorazepam 0.5 mg, which					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		- A - A	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345418	B. WNG			C	
	COVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1984 HIGHWAY 70 SWANNANOA, NC 28778		06/28/2013	
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 425	was dispensed for Re of 2 doses was admir a. On 05/10/13 at 2:0 administered to Residerazepam 0.5 mg who Resident # 24. b. On 05/13/13 at 8:0 administered to Residerazepam 0.5 mg who Resident # 24. The facility was unab Medication Utilization 0.5 mg which was dispensed for Re of 3 doses was admirated to Residerazepam 0.5 mg who Resident # 25. b. On 06/20/13 at 6:0 administered to Residerazepam 0.5 mg who Resident # 25. c. On 06/20/13 at 10:1 administered to Resident # 25. c.	esident # 24, revealed a total nistered to Resident # 29. 0 PM Nurse # 5 dent # 29 one tablet of nich was dispensed for 0 PM Nurse # 5 dent # 29 one tablet of nich was dispensed for le to locate the Controlled a Record for the lorazepam spensed for Resident # 29. Introlled Medication the lorazepam 0.5 mg, which esident # 25, revealed a total nistered to Resident # 30. 0 PM Nurse # 6 dent # 30 one tablet of nich was dispensed for 10 PM Nurse # 6 dent # 30 one tablet of nich was dispensed for	F	125			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345418	B. WNG				C 5/28/2013	
ASHEVIL	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	1 00	0/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	a. On 05/28/13 at 10:4 administered to Resid vicodin 500 mg which Resident # 39. b. On 05/30/13 at 9:00 to Resident #34 one to which was dispensed of the Controlled Medithe vicodin 500 mg who Resident # 39 on 05/3 documentation that increplaced to Resident # 10. A review of the Coutilization record for the hydrocodone-acetamin dispensed for Resident administered 1 tablet to 06/02/13 at 8:45 PM. Medication Utilization in hydrocodone-acetamin dispensed for Resident # 11. A review of the Coutilization Record for the hydrocodone-acetamin dispensed for Resident # 11. A review of the Coutilization Record for the hydrocodone/acetamin dispensed for Resident # 11. A review of the Coutilization Record for the hydrocodone/acetamin dispensed for Resident # 11. A review of the Coutilization Record for the hydrocodone/acetamin dispensed for Resident # 11. A review of the Coutilization Record for the hydrocodone/acetamin dispensed for Resident # 11. A review of the Coutilization Record for the hydrocodone/acetamin dispensed to Resident # 11. A review of the Coutilization Record for the hydrocodone/acetamin dispensed to Resident # 12. On 05/06/13 at 4:00 to Resident # 135 one ta hydrocodone/acetamin dispensed to Resident	ent # 34 one tablet of was dispensed for D PM Nurse #6 administered ablet of vicodin 500 mg for Resident # 39. A review cation Utilization record for nich was dispensed for 0/13, did not reveal any dicated that 2 tablets were #39. Introlled Medication need nophen 325 mg, which was at #8, revealed Nurse #3 or Resident #41 on A review of the Controlled record for the nophen 325 mg, which was at #41, did not reveal any dicated medication was 8. Introlled Medication need nophen 325 mg, which was at #41, did not reveal any dicated medication was 8. Introlled Medication need nophen 325 mg, which was at #36, revealed a total of 2 need to Resident #35 no5/10/13 and a total of 2 need to Resident #2 between need nophen 325 mg which was 1 need to 1 need to 1 need nophen 325 mg which was 2 need to Resident #2 between 2 need to Resident #2 between 325 mg which was 325 m	F	425				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WNG				C /28/2013
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			19	REET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	to Resident #35 one thydrocodone/acetamidispensed to Resident c. On 05/23/13 at 5:00 one tablet of hydrocodomy which was dispensed. On 05/24/13 at 10:0 administered one table hydrocodone/acetamidispensed to Residen A review of the Controrecord for the hydrocomy which was dispensed to Resident A review of the Controrecord for the hydrocomy which was dispensed to Resident 4 tablets #36. 12. A review of the Control of the Control of the hydrocodone/acetamine was dispensed for the total of the control of the total of the t	ablet of nophen 325 mg which was t #36. DPM Nurse #6 administered done/acetaminophen 325 sed to Resident #2. DO AM Nurse #1 et of nophen 325 mg which was t #2. Dilled Medication Utilization done/acetaminophen 325 sed for Resident #36 on all any documentation that is were replaced to Resident was the ensed for Resident #13, ministered 2 tablets to 5/13 at 7:30 PM. The locate the Controlled Record for the oxycodone with was dispensed for the oxycodone on the ensed for the oxycodone on the ensed for the oxycodone on the locate the Controlled Record for the oxycodone on the locate the Controlled Record for the oxycodone on the locate the Controlled Record for the oxycodone on the locate the Controlled Record for the oxycodone on the locate the Controlled Record for the oxycodone on the locate the Resident #30. PM Nurse #10 ent #30 one tablet of locate the H34. PM Nurse #10	F	425			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A 2000 (40) (40)		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A BUILD	IING_			
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300000000000000000000000000000000000000	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	was dispensed for Re Controlled Medication hydrocodone/acetam was dispensed for Re not reveal any docum medication was replated. A review of the Cutilization record for twas dispensed for Re #1 administered 1 tat 06/26/13 at 9:00 AM. Medication Utilization 1mg which was dispensed for Re indicated the medicate Resident #33. 15. A review of the Cutilization record for twas dispensed for Re of 2 doses were adm a. On 06/23/13 at 5:3 administered to Resident #3. b. On 06/24/13 at 7:0 administered to Residerated to Residerated the Medication Utilization 0.5 mg who Resident #3. A review Medication Utilization 0.5 mg, which was di 06/24/13, did not revindicated that 2 table #3.	inophen 10/325 mg which esident #34. A review of the inophen 10/325 mg, which esident # 34 on 06/19/13, did inentation that indicated the ced to Resident #34. Controlled Medication the lorazepam 1 mg, which esident #33, revealed Nurse olet to Resident #32 on A review of the Controlled incord for the lorazepam ensed for Resident #33 on eal any documentation that the lorazepam 0.5 mg, which esident #3, revealed a total inistered to Resident #6. O AM Nurse #12 dent #6 one tablet of nich was dispensed for	F	425			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	COVIDER OR SUPPLIER		b. Wild	1	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778	06/2	28/2013
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	was dispensed for Re Nurse#11 administers Resident # 40 or mg which was dispen 06/18/13 at 8:00 PM. Medication Utilization 0.5 mg which was dis 06/18/13, did not reveindicated the medicat Resident #32. 17. A review of the C Utilization record for I was dispensed for Re #7 administered 1 tab 06/19/13 at 2:00 PM. Medication Utilization 0.5 mg which was dis 06/19/13, did not reveindicated the medicat Resident #31. A review of the facility narcotic medications hydrocodone/acetamilevel of 11, lorazepan 12, oxycodone 5 mg with facility did not have hy 10/325 mg or zolpide emergency supply of review of the docume submitted for refills in 04/15/13 which indicated ordered - the form did were in stock at that the	clonazepam 0.5 mg, which esident # 32, revealed ed 1 tablet to ne tablet of clonazepam 0.5 sed for Resident# 32 on A review of the Controlled record for theclonazepam pensed for Resident # 32 on eal any documentation that ion was replaced to controlled Medication orazepam 0.5 mg, which esident #31, revealed Nurse elet to Resident #43 on A review of the Controlled record for the lorazepam pensed for Resident #31 on eal any documentation that ion was replaced to controlled record for the lorazepam pensed for Resident #31 on eal any documentation that ion was replaced to controlled the supply included inophen 5/500 mg with a par level of 7. The ydrocodone/acetaminophen m 5 mg available in the narcotic medications. A	F	425			

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	200 - 2000 - 100		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _		С		
		345418	B. WNG			06/2	8/2013	
CONTACT STATEMENT CONTACT OF THE STATEMENT OF THE STATEME	OVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 425	ordered - the form did were in stock at that 106/13/13 indicated th 0.5 mg in stock and 2 had 2 hydrocodone/a stock and 9 were ord oxycodone 5 mg in s order form dated 06/2 had no lorazepam 0. ordered; the facility hydrocodone/acetam and 9 were ordered; 5 mg in stock and 7 records for the facilit narcotic medications. An interview on 06/2 #3 revealed there has she would have to be stated she would set and the Pharmacy we next day. Nurse #3 make a note on the Utilization record so An interview on 06/2 #4 revealed there we resident would run of would borrow the meresident. She stated document on the Corecord the name of the medication was adm. An interview on 06/2 Medical Director reveany problem with get and 2 high pro	In not indicate how many time. An order form dated be facility had no lorazepam in were ordered; the facility had no lock and 7 were ordered. An 26/13 indicated the facility for my in stock and 11 were ad 2 linophen 5/500 mg in stock the facility had no oxycodone were ordered. No additional y's stock of emergency was available. 5/13 at 4:51 PM with Nurse we been occasions where ordered and an extra pill the further stated she would controlled Medication there would be a record of it. 6/13 at 11:03 AM with Nurse are occasions when a little of medication and she edication from another in those instances she would ntrolled Medication Utilization the resident to whom the	F	425				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ER	1984	T ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 70 ANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	EC 22/4/2021		
F 425	was good to notify hin needing refills of narc could order a refill of the An interview on 06/26 #1 revealed there was getting medication refistated it sometimes to medications. An interview on 06/27 Regional Nurse Consaware of any problem from the pharmacy. However, and the stated he was not with emergency narcoavailable. He stated he when a nurse asked he medication for a resident he told the nurse medication but she neresident's medication. An interview on 06/27 #5 revealed she recall 0.5 mg to Resident #2 and on 05/13/13 at 8:0 dispensed for Resider wasn't any lorazepam emergency supply so and requested permis which was dispensed stated Resident #29 we threatening to leave so give her medication as	n when residents were otic medications so he he medication. /13 at 2:19 PM with Nurse is an on-going problem with ills from the pharmacy. She wok 2 weeks to get /13 at 9:26 AM with the ultant revealed he was not with getting medications in estated the Director of ble for ordering narcotic cility's emergency supply, aware there was a problem with medications not being in erecalled one incident with about borrowing a pain ent from another resident she could borrow the medications the pharmacy. /13 at 11:05 AM with Nurse led administering lorazepam in 9 on 05/10/13 at 2:00 PM	F 425				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED			
		345418	B. WING			06/2	28/2013
	OVIDER OR SUPPLIER	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 984 HIGHWAY 70 WANNANOA, NC 28778		
(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 425	medication from one resident, she stated spermissible as long are and consented. Nurse medications are frequence facility's emergency seems and consented. Nurse medications are frequence facility's emergency seems and consented. Nurse medications are frequence facility's emergency seems and the facility of the facili	resident for another he was told it was is the doctor was informed a #5 stated narcotic rently not available in the upply. 7/13 at 5:25 PM with the aled he did not feel it was other the nurses could edication to a resident for another resident. He any instances of a nurse permission to give a which was dispensed for stated he didn't think it was 8/13 at 4:20 PM with Nurse inclear about the facility's ing medication to one in dispensed for another here were instances when he cotic medications to a in dispensed for another sometimes took a week to ad and that sometimes it ill order from the physician his. 8/13 at 5:20 PM with the d it was considered best	F	425			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345418	B. WING			С	
2020	ROVIDER OR SUPPLIER LE HEALTH CARE CENT			TREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778	<u> </u>	6/28/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 441 SS=D	Regional Nurse Cons aware until a few days medications for the erre-ordered as needed facility 2 days a week reported a problem to 483.65 INFECTION C SPREAD, LINENS The facility must established infection Control Prog safe, sanitary and conto help prevent the de of disease and infection (a) Infection Control P The facility must estable Program under which (1) Investigates, controin the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infection determines that a resid prevent the spread of i isolate the resident. (2) The facility must procommunicable disease from direct contact will direct contact will transfer.	d. /13 at 5:20 PM with the ultant revealed he was not a ago that narcotic nergency kit were not being. He stated he was in the and none of the nurses had him. ONTROL, PREVENT Dish and maintain an ram designed to provide a anfortable environment and velopment and transmission on. rogram Dish an Infection Control it - Dish, and prevents infections edures, such as isolation, in individual resident; and of incidents and corrective etions. of Infection Control Program Jent needs isolation to infection, the facility must on infected skin lesions in residents or their food, if	F 424	F441 How the corrective action w	nt(s) and 13 e to be ee. ated 72 ors bags en ply asure	7/26/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 CA 10				(3) DATE SURVEY COMPLETED	
		345418	B. WING			C 06/28/2013		
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 441	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	441	administrator and completed July 1, 2013 How the facility plans to moniand ensure correction is achieved and sustained. The Supply clerk will do weekly tubing changes and supplyine each device with a new bag is storage per policy. The Leadership Team will audit Oxygen and nebulizer storag 3x per week for 2 weeks; then monthly for 2 months. The ID will report results of audit to to QA Committee monthly for 3 months, then quarterly x 3 to ensure compliance or revision to the plan.	g for le n OON the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	40.000000000000000000000000000000000000	(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE	3) DATE SURVEY COMPLETED	
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		345418	B. WNG	_		06	/28/2013	
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER				1	REET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		D BE COMPLETION		
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	441				

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CTATCHENE	OF DEFINITION	I DIE/ IID GERVIGES				OMB	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRI		CONSTRUCTION		ATE SURVEY OMPLETED
		345418	B. WING				C 06/28/2013
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778			00/20/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG			D BE	(X5) COMPLETION DATE
	D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		345418	B. WNG	s		C	
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		TREET ADDRESS, CITY, STATE, ZIP CODE 1984 HIGHWAY 70 SWANNANOA, NC 28778		6/28/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	covered with a plastic staff saw the mouth ping or get a bag and covered buring an interview on Regional Nurse Consupolicy was to use a platice when not in use. clip on the back of the staff could attach the minimal piece should be still be and not be left exposed saw the mouth piece with get a plastic bag from the staff could attach the minimal piece with the mouth piece with the mou	resident rooms should be bag when not in use and if ece uncovered they should r it. 06/28/13 at 5:15 PM the alltant stated the facility estic bag to store the mouth. He explained there was a nebulizer machine where mouth piece but the mouth covered with a plastic bag d. He further stated if staff as uncovered they should the supply room and cover a bag was not available.	F 44				