STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation (Event ID #VNY311) was conducted on 06/28/18 through 06/29/18. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. Tags F600 and F684 constituted substandard quality of care. Immediate jeopardy began on 05/29/18 and was removed on 06/29/18. An extended survey was completed.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, family, Physician, Nurse Practitioner, and Emergency Medical	F 600	Disclaimer: Submission of this plan of correction does	6/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/23/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600

Continued From page 1

Service interviews the facility neglected to stay with the resident, administer oxygen, and raise the head of the bed for a resident who was experiencing shortness of breath and assessed with a decreased oxygen saturation of 78 percent. The resident was sent to the emergency room for evaluation and treatment of pneumonia (Resident #1).

Immediate Jeopardy began on 05/29/18 when Nurse #1 neglected to raise the head of the bed and administer oxygen for Resident #1 who was experiencing shortness of breath and a decreased oxygen saturation of 78%. The resident was sent out to the emergency room for evaluation and treatment of pneumonia. Immediate Jeopardy was removed on 06/29/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective.

The findings included:

Resident #1 was admitted to the facility on 07/06/17 with diagnoses of heart failure, chronic obstructive pulmonary disease, respiratory failure, and high blood pressure.

Review of the Facility Standing Orders updated 08/2011 revealed the following for acute shortness of breath:

a. Elevate head of bead.

b. Check oxygen saturation on room air before

F 600

not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is submitted solely because it is required by the provision of federal and state law.
F600 Free from Abuse and Neglect
CFR(s): 483.12(a)(1)
(1) Plan for correcting specific area of concern identified, include the process that led to the concern:
Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1s change of condition including implementation of interventions for low oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in neglect, defined by CMS as Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (See 42 CFR Part 488.301.). Interview with LPN #1 states that nurse had instructed CNA #1 to get oxygen while he was completing documentation to send Resident #1 to hospital. Per LPN #1, he believed that Resident #1 was sitting on edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying O2 to resident. Interview with LPN #1 revealed that he understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1s change of condition. Resident #1s O2 saturation rate was 78% which justified supplemental oxygen and monitoring until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 2
application of oxygen.

c. Apply oxygen to get oxygen saturation to 90%.

d. Obtain and monitor vital signs (temperature, heart rate, respirations) and check oxygen saturation after application of oxygen.

e. Notify physician after above completed.

Review of the most recent quarterly Minimum Data Set (MDS) dated 04/17/17 revealed Resident #1 was severely cognitively impaired and required limited to extensive assistance with most activities of daily living. The MDS was not coded for oxygen use for Resident #1.

Review of the care plan dated 04/25/18 revealed Resident #1 had altered respiratory status/difficulty breathing related to emphysema and a history of pneumonia. The goal was for Resident #1 to maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date and his pulse oximetry will remain greater than 90% through the review date. The interventions included: Monitor for signs and symptoms of respiratory distress and report to MD as needed. Monitor pulse oximetry as needed.

Review of the nurse's notes dated 05/30/18 revealed the following note was written by Nurse #1 at 1:20 AM: Resident #1 was moaning intermittently and restless, he indicated left flank, side, pain when asked where he hurt. Resident #1 appeared to doze for short periods while sitting up and his oxygen saturation would drop, then

F 600

baseline O2 saturation rate is achieved
The plan to correct this identified concern includes the completion of a thorough investigation surrounding the event on 5/29/18, completion of a Root Cause Analysis to identify the variables that led to the process failure, house-wide education and in-service training to appropriate staff on areas for opportunity to include topics of abuse, neglect, abuse reporting, resident rights, Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plans. The facility will also implement monitoring measures and random audits spread over the course of the next 90 days to ensure compliance and efficacy of this plan. Lastly, all audit results will be shared with the facility Quality Assurance Performance Improvement team and the Medical Director no less than monthly for review. All negative audit results will be immediately brought before the QAPI team and Medical Director for immediate review and remedy.
(2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
On 6/28/18, the Director of Nursing immediately suspended LPN #1 pending investigation regarding neglect and failure to provide quality of care. If investigation is substantiated, facility will follow policy of terminating LPN #1s employment and reporting event to required agencies and licensing boards, as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 3

rise again once he roused. Adventitious, abnormal sounds heard over a patient's lungs and airways, lung sounds. The Family Nurse Practitioner (FNP) had ordered lab work, urinalysis with a culture and sensitivity, and a chest x-ray. Resident #1's family member, stated she wanted him sent to the emergency room (ER) for evaluation and treatment, stating she thought he was having a heart attack. The on-call FNP was contacted via telephone at 6:20 PM and agreed to have Resident #1 sent to the ER. The Director of Nursing (DON) was notified via telephone. Emergency Management System (EMS) was contacted via telephone for pickup. Resident #1 departed the facility at 6:45 PM. Vital signs were blood pressure - 104/67, pulse - 113, respirations - 28, temperature - 98.1 (orally), oxygen saturation 78% on room air. Nurse #1 contacted the ER at 11:00 PM and was informed that Resident #1 had been admitted to the hospital for pneumonia. The DON was notified via telephone at 11:10 PM.

Review of the Emergency Medical Services (EMS) run report dated 05/29/18 revealed they were called by the facility at 6:27 PM for transport of a resident having difficulty breathing to the emergency room (ER). The EMS report revealed they arrived at the facility at 6:41 PM and to Resident #1's bedside at 6:44 PM. They departed the facility for the ER at 7:04 PM and arrived at the hospital at 7:35 PM. The report further revealed when they arrived at the facility they found Resident #1 lying flat on his bed with adventitious lung sounds. His family member was at the bedside and stated he had some congestion lately but was worse today. They sat Resident #1 up in bed and he was able to pivot with assistance to the gurney. Physical exam

F 600

On 6/28/18, the Director of Nursing, Staff Development Coordinator, MDS nurse, and Assistant Director of Nursing created a timeline of events surrounding the 5/29/18 occurrence in order to successfully conduct a Root Cause Analysis of the process failure. Process failure was determined after reviewing timeline by DON and Administrator on 6/28/18. The failed process identified was that LPN #1 did not follow facility O2 protocols when he observed resident with 78% O2 saturation rate. At the time a low saturation rate was observed, LPN #1 should have placed resident on supplemental Oxygen, elevated head of bed, and remained with resident until resident could reach a baseline O2 saturation rate, which LPN #1 failed to do.

On 6/28/18, the Director of Nursing conducted 100% chart audit of other residents discharged from facility (either due to death or hospitalization) within the last 90 days to review for vital sign monitoring, change of condition, and following of standing orders. Area for opportunity was self identified in 1 of 15 residents with no negative outcomes noted as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discussed with IDT / Medical Director on 6/29/18.

On 6/28/18, the facility□s Staff Development Coordinator gathered the facility□s policies and procedures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 revealed lower extremity swelling, lung sounds full of fluid throughout, and skin was cool and clammy. Review of the oxygen saturation readings on the EMS report revealed the following: 6:57 PM - 69%, 6:59 PM - 73%, 7:00 pm - 89%, 7:07 PM - 80%, 7:17 - 92 %, 7:24 - 91%, and 7:32 PM - 93%. Oxygen via nasal cannula was applied at 7:01 PM and a CPAP, continuous positive airway pressure is a form of positive airway pressure ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are able to breathe spontaneously on their own, was applied at 7:03 PM. Review of the hospital discharge summary dated 05/30/18 revealed Resident #1 likely expired due to his severe pneumonia, which may have been a result of aspiration and was significantly affected by his congestive heart failure. Review of the death certificate for Resident #1 revealed he expired on 05/30/18 from pneumonia. An interview conducted on 06/28/18 at 12:10 PM with Nurse #2 stated she observed Resident #1 on 05/29/18 on the 7:00 AM to 3:00 PM shift and he was drowsier than usual and acting different. She stated she reported it to the FNP and she ordered lab work and a chest x-ray. Nurse #2 further stated she reported to Nurse #1 about Resident #1 being drowsier and acting different and that the FNP had ordered lab work and a chest x-ray earlier that day. An interview conducted on 06/28/18 at 1:39 PM with the Nurse Practitioner stated she saw Resident #1 on 05/29/18 at 11:15 AM per his	F 600	regarding abuse, neglect, abuse reporting, and resident rights and began 100% in-servicing of all staff on this topic with post test administered. Starting on 6/28/18, no staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 on abuse, neglect, abuse reporting, and resident rights. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employees respective department manager. This training included: (a) Resident Rights specific focus on ¿483.12 that The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the residents medical symptoms (b) Abuse - As defined by the Centers for Medicare and Medicaid Services, Abuse is the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 5

family member and Nurse #2's request due to being resistive to care and having an increase in agitation. She stated he was not congested or having shortness of breath (SOB) or difficulty breathing when she assessed him. She stated he had complaints of pain at the site of his broken rib and she ordered a chest x-ray per the family's request. She reported Nurse #1 called her that evening around 6:15 PM and reported Resident #1 was SOB and had a low oxygen saturation and she gave the order to send him to the ER for evaluation. She stated she was not informed Resident #1's oxygen saturation was 78% and would have expected staff to raise the head of the bed and provide oxygen per standing orders to bring his oxygen level back up.

An interview conducted on 06/28/18 at 11:17 AM with Nurse Aide (NA) #1. NA #1 stated he was at the nurses desk on the East Hall the evening of 05/29/18 when the EMS arrived and told Nurse #1 they were there for Resident #1 and asked where his room was and if anyone was in the room with him, he heard the nurse say no and pointed in the direction of Resident #1's room. NA #1 stated he offered to take the EMS workers to Resident #1's room. He stated when they walked in the room Resident #1 was lying flat in bed and he could hear him trying to breathe, he sounded very congested and short of breath. NA #1 stated Resident #1 didn't have any oxygen on and there wasn't an oxygen concentrator or oxygen tank in the room. NA #1 further stated he was not assigned to Resident #1 that evening and had not seen him before taking EMS personnel to his room around 6:45 PM.

An interview was conducted on 06/28/18 at 12:05 PM with EMS Worker #1. She stated when they

F 600

well-being. Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

(c) Procedure If an employee suspects or witnesses abuse, they are to immediately protect the resident from abuse. Staff must intervene to assure the safety of the resident and other residents. The alleged perpetrator must be removed from the facility, and cannot be left unattended, to avoid any further contact with residents. The staff member will immediately report the incident or suspicions to their supervisor, Director of Nursing, or Administrator. Appropriate agencies will be notified by the Administrator within two hours of any suspected abuse, neglect, mistreatment or exploitation .

On 6/28/18, the facilitys Staff Development Coordinator gathered the facilitys policies and procedures regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. SDC, MDS, DON, and ADON began 100% in-service education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 arrived at the facility the nurse was at the desk and she told him they were there for Resident #1 for a respiratory distress call and he pointed down the hall, she asked if someone was with him and he said no, she told him she needed report and he continued to sit at the desk and do paperwork. She stated NA #1 told her he would take them to Resident #1's room, she reported when they walked into Resident #1's room he was lying flat in bed, with no oxygen on, and she could hear him trying to breathe. EMS Worker #1 stated there were no staff present in Resident #1's room when they arrived and she didn't see an oxygen tank or concentrator in the room. She further stated Resident #1's family member was in the room with him and she was crying, when she asked her why she told her she thought he was having a heart attack and he was going to die. An interview conducted on 06/28/18 at 12:15 PM with Nurse #1, who worked with Resident #1 on the 3:00 PM to 11:00 PM shift on 05/29/18, revealed he was in the middle of his medication pass and Resident #1's family member asked him to assess Resident #1 because he was having difficulty breathing and pain in his chest around 6:00 PM. Nurse #1 stated he went to Resident #1's room and assessed him while NA #2 obtained his vital signs. Nurse #1 stated Resident #1's oxygen saturation was 78% at that time. Nurse #1 stated the resident pointed to his ribs and not his heart when he asked him where his pain was but his family was insistent that he be sent to the ER. Nurse #1 stated he went to the nurse's desk to call the on-call provider for order's and start the transfer paperwork and thought he told NA #2 to put oxygen on Resident #1 per facility standing orders due to his oxygen saturation being 78% when the vital signs were	F 600	of all clinical staff (LPN, RN, CNA, contract therapy) on this topic with post test administered. Starting on 6/28/18, no clinical staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employees respective department manager. This training included: (a) MD Orders / Standing Orders Educated on process including explanation that there are hard copies orders for all residents in the narcotics book. When a nurse needs to implement a Standing order, facility requires nurse to place that order in the computer (EMR), and complete an E-Interact change of condition form along with that order, and to also document communication in the MD communication book. The expectation is that MD orders will be followed at all times. (b) Interventions for respiratory distress / low O2 levels facility processes include:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 checked but did not think about raising the head of the bed. Nurse #1 stated he called the FNP, DON and the EMS and started the paperwork for the transfer and he did not go back and assess Resident #1 due to trying to get the paperwork completed and did not go with the EMS to his room when they arrived because he wasn't finished with the paperwork. An interview conducted with the Director of Nursing revealed Nurse #1 called her on 05/29/18 and informed her he was sending Resident #1 to the ER per his family's request. She stated she was not informed Resident #1's oxygen saturation was 78%. She stated all nurses were trained on standing orders and there was a copy of the standing orders on every medication administration book and her expectation was for all nurses to follow the facility standing orders and raise the resident's head of bed and apply oxygen to get the oxygen saturation back to 90%. She further stated Nurse #1 should have followed the facility standing orders and administered oxygen and raised the head of the bed for Resident #1. An interview conducted on 06/28/18 3:16 PM with Resident #1's family member revealed she was with Resident #1 all day on 05/29/18 because he asked her to stay with him. She stated he complained of chest pain and the FNP saw him that day and ordered lab work and a chest x-ray to be done. The family member reported Resident #1 started having difficulty breathing that evening and she checked his oxygen saturation with her own machine and showed it to NA #2 who checked it with the facility machine. She stated NA #2's oxygen saturation reading was 78% around 6:00 PM and she reported it to Nurse #1. Resident #1's family member stated	F 600	Staff member is to be present if resident is noted to be in distress and have a low O2 saturation, Nurse will request that another staff member go and retrieve O2 concentrator or tank with tubing. Staff will follow protocol for administering Oxygen, and how to observe oxygen saturation by using Pulse Ox per protocol. Nurses will delegate to other staff to stay with resident once resident is stable. After resident is stable the nurse is to call MD for orders. Nurse will place all orders into the computer including orders implemented from Standing orders (ex: oxygen placement and settings. Refer to Order/care plan guide for items to include in orders). Nurse will then start completing the required paper work to transfer out if order received. Paperwork includes E-interact Change of Condition, and transfer form. If in an emergent situation arises and the nurse does not feel that the resident is stable, nurse will instruct another staff member to call 911 and help gather the required paperwork. Change of Condition / MD Notification / Resident Assessment With any change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8 Nurse #1 did not assess Resident #1 but he did come to the door of his room and ask her if she wanted him sent to the ER. She further stated she asked staff to give Resident #1 oxygen due to his shortness of breath and difficulty breathing but no one ever did until the EMS arrived around 6:30 PM and they provided oxygen for him. An interview conducted on 06/28/18 3:07 PM NA #2 revealed Resident #1's family member called her to his room on 05/29/18 around 6:00 PM and showed her the oxygen saturation reading she got on her own private machine and it was 75%. NA #2 stated she checked Resident #1's oxygen saturation with the facility machine and got a reading of 78% and immediately informed Nurse #1. She stated Nurse #1 assessed Resident #1 and she took oxygen into the room for him to put on Resident #1. She stated she didn't see Nurse #1 put the oxygen on Resident #1 and she didn't return to the room after she took the oxygen to the room. She further stated Resident #1 was lying flat in bed and he was having difficulty breathing. An interview conducted on 06/29/18 at 9:00 AM with the facility Physician revealed it was his expectation for a resident who was short of breath and had an oxygen saturation of 78% to have oxygen applied and the head of the bed raised per facility standing orders. He further stated the on-call provider should be called immediately. On 06/28/18 at 4:45 PM the Administrator and the DON were notified of Immediate Jeopardy. On 06/29/18 at 2:44 PM the facility provided an acceptable credible allegation of Immediate	F 600	of condition, vital signs need to be obtained appropriately, and frequently, vital signs should be taken at time of incident. If any abnormal VS, vitals need to be obtained at a minimum of every 4 hours until VS stable per baseline. Oxygen - the resident should not be left alone until O2 is at an acceptable level (at acceptable baseline) , continue to monitor. Blood pressure- if you have an abnormal blood pressure for the resident, you are to notify the MD immediately and obtain orders, continue to monitor. Pulse- if you have an abnormal pulse for the resident, you are to notify the MD immediately and obtain orders, continue to monitor. Respirations- encourage resident to purse lip breath. In through their nose out through their mouth. Slow, deep and steady. Temperature- Administer medications per standing orders, notify MD, and continue to monitor. Updating / Following of Care Plan It is the expectation of the facility that nursing staff will follow and / or update each resident s specific plan of care. On 6/28/18, the Staff Development Coordinator, Director of Nursing, MDS Nurse, and ADON began 100% in-service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 Jeopardy removal that included: (1) Plan for correcting specific area of concern identified, include the process that led to the concern: It was observed that on 05/29/2018 that LPN #1 failed to ensure the delivery of quality care and to prevent Resident #1 from experiencing neglect. The process breakdown that lead to the concern was as follows: " 5.28.18 (11:37pm) LPN #1 documented agitation and verbal aggression as well as insomnia. Zyprexa IM given. " 5.29.18 Patient seen by Nurse Practitioner related to increased agitation, insomnia, and flank pain. No documented fever, dyspnea, cough. Order for chest x-ray, urinalysis, CMP, and left rib x-ray given by nurse practitioner. Respiratory assessment by nurse practitioner shows poor compliance and diminished without wheezes, rales, or rhonchi. New orders for ibuprofen as requested for pain. " 5.29.18 (6:19pm) LPN #1 documented change of condition assessment related to shortness of breath, oxygen saturation of 78% on room air. Orders noted to send to emergency room. " 5.29.18 (6:35pm) LPN #1 completed transfer form. Oxygen was not documented as an intervention at this time. Per the transfer form to the hospital - - O2: 78%, Res: 28, Pulse: 113, B/P: 104/67. Pain eval conducted; rated as 4 of 10. Known d/x of COPD and CHF " Statements from EMS surrounding this event revealed that no staff member was present in room with Resident #1 and head of bed not elevated at time EMS arrived and that oxygen was not being administered 5.30.18 (01:22pm) LPN #1 documented nurses	F 600	education with nursing staff that the on-call nurse is to be notified immediately with any and all resident changes in condition. On 6/28/18, the Administrator / RVP reported the 5/29/18 event to the NC Department of Health and Human Services via Fax. The Administrator will proceed with required subsequent reporting protocol (5-day report, etc) as required. On 6/28/18, the Administrator / RVP began neglect investigation by having DON, ADON, SDC, MDS and Regional Nurse complete 100% interviews with interviewable residents (BIMS>8) to ensure they are free from abuse and neglect. No negative findings were noted during these interviews. On 6/28/18, the DON, ADON, SDC, MDS and Regional Nurse also completed 100% observation and skin assessments of non-interviewable residents (BIMS<8) to ensure there are no signs or symptoms of fear, neglect, or abuse. No negative findings were noted during these observations and skin assessments. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Starting on 6/29/18, each unit□s 24-hour report and available push reports will be reviewed daily (M-F) in clinical meeting to validate identified at-risk residents□ vitals are within normal limits, care plans are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 10

note related to change of condition and orders to send to hospital. Attending physician notified and sister aware and in room. Resident left facility at 6:45pm. At, 11:00pm facility was notified that resident was admitted to the hospital related to pneumonia (1) Plan for correcting specific area of concern identified, include the process that led to the concern:
It was observed that on 05/29/2018 that LPN #1 failed to ensure the delivery of quality care and to prevent Resident #1 from experiencing neglect. The process breakdown that lead to the concern was as follows:
" 5.28.18 (11:37pm) LPN #1 documented agitation and verbal aggression as well as insomnia. Zyprexa IM given.
" 5.29.18 Patient seen by Nurse Practitioner related to increased agitation, insomnia, and flank pain. No documented fever, dyspnea, cough. Order for chest x-ray, urinalysis, CMP, and left rib x-ray given by nurse practitioner. Respiratory assessment by nurse practitioner shows poor compliance and diminished without wheezes, rales, or rhonchi. New orders for ibuprofen as requested for pain.
" 5.29.18 (6:19pm) LPN #1 documented change of condition assessment related to shortness of breath, oxygen saturation of 78% on room air. Orders noted to send to emergency room.
" 5.29.18 (6:35pm) LPN #1 completed transfer form. Oxygen was not documented as an intervention at this time. Per the transfer form to the hospital - - O2: 78%, Res: 28, Pulse: 113, B/P: 104/67. Pain eval conducted; rated as 4 of 10. Known d/x of COPD and CHF
" Statements from EMS surrounding this event revealed that no staff member was present in room with Resident #1 and head of bed not

F 600

followed, code statuses honored, and appropriate O2 protocol is being followed as appropriate.

On 6/29/18, the Regional Nurse Consultant developed a monitoring flow sheet to check and validate at-risk residents as identified by the 24-hour report or available push report. This flow sheet includes assessment of abnormal vitals, honoring of code status and care plans, and oxygen protocol being followed as indicated. Starting 6/29/18, this flow sheet will be populated and reviewed daily (M-F) in morning clinical meeting to review and track at-risk residents over the previous 24 hours (72 hours if weekend).

Starting on 6/29/18, the DON, ADON, SDC, MDS, Regional Nurse, or designated nurse manager will conduct (3) random audits of patient charts to review vitals, code status changes, incident reports, orders, change of condition and required notifications therein, as well as care plans 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to monitor delivery of quality care and to ensure resident is free from neglect. Any noted issues from audits will be discussed with the IDT and QA committee and addressed immediately.

Starting on 6/30/18, the DON, ADON, SDC, MDS, Regional Nurse, Manager on Duty, or designated nurse will conduct random abuse post-tests with (3) staff each shift daily x 2 weeks, then (3) staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 11

elevated at time EMS arrived and that oxygen was not being administered

" 5.30.18 (01:22pm) LPN #1 documented nurses note related to change of condition and orders to send to hospital. Attending physician notified and sister aware and in room. Resident left facility at 6:45pm. At, 11:00pm facility was notified that resident was admitted to the hospital related to pneumonia.

" 6.28.18 (08:00) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/29/18. Facility was cited with F600 for neglect.

Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for low oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in neglect, defined by CMS as "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." (See 42 CFR Part 488.301.). Interview with LPN #1 states that nurse had instructed CNA #1 to "get oxygen" while he was completing documentation to send Resident #1 to hospital. Per LPN #1, he believed that Resident #1 was sitting on edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying O2 to resident. Interview with LPN #1 revealed that he understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1's change of condition. Resident #1's O2 saturation rate was 78% which justified supplemental oxygen and monitoring until baseline O2 saturation rate is achieved

The plan to correct this identified concern includes the completion of a thorough

F 600

each shift 2x per week x 4 weeks, then (3) staff each shift 1x per week x 4weeks with score of 100% to ensure staff are well informed of facility abuse / neglect policies and protocols. Any noted issues from post-tests will be discussed with IDT and QA committee and addressed immediately.

Starting on 6/30/18, the DON, ADON, SDC , MDS, Regional Nurse, Manager on Duty, or designated nurse manager with conduct (3) random resident interviews with residents with BIMS > 8 and (3) random resident skin assessments / observations for residents with BIMS < 8 daily x 2 weeks, then 3x per week x 4 weeks, then weekly x 4 weeks to ensure residents are free from abuse and neglect. Any noted issues from interviews / skin assessments will be discussed with IDT and QA committee and addressed immediately.

Starting 6/29/18, the Inter Disciplinary Team and Medical Director will attend QAPI meeting to review the efficacy of the aforementioned plan weekly x 4 weeks, then bi-weekly x 1 month, then monthly thereafter to ensure continued compliance with the requirements of participation. The IDT includes the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Activities Director, Business Office Manager, Admissions Coordinator, Staff Development Coordinator, Housekeeping Director, Maintenance Director, MDS Nurse, Dietary Director, Medical Director, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12 investigation surrounding the event on 5/29/18, completion of a Root Cause Analysis to identify the variables that led to the process failure, house-wide education and in-service training to appropriate staff on areas for opportunity to include topics of abuse, neglect, abuse reporting, resident rights, Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plans. The facility will also implement monitoring measures and random audits spread over the course of the next 90 days to ensure compliance and efficacy of this plan. Lastly, all audit results will be shared with the facility Quality Assurance Performance Improvement team and the Medical Director no less than monthly for review. All negative audit results will be immediately brought before the QAPI team and Medical Director for immediate review and remedy. (2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: " On 6/28/18, the Director of Nursing immediately suspended LPN #1 pending investigation regarding neglect and failure to provide quality of care. If investigation is substantiated, facility will follow policy of terminating LPN #1's employment and reporting event to required agencies and licensing boards, as appropriate. On 6/28/18, the Director of Nursing, Staff Development Coordinator, MDS nurse, and Assistant Director of Nursing created a timeline of events surrounding the 5/29/18 occurrence in order to successfully conduct a Root Cause Analysis of the process failure. Process failure was determined after reviewing timeline by DON	F 600	Pharmacist. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

and Administrator on 6/28/18. The failed process identified was that LPN #1 did not follow facility O2 protocols when he observed resident with 78% O2 saturation rate. At the time a low saturation rate was observed, LPN #1 should have placed resident on supplemental Oxygen, elevated head of bed, and remained with resident until resident could reach a baseline O2 saturation rate, which LPN #1 failed to do.

" On 6/28/18, the Director of Nursing conducted 100% chart audit of other residents discharged from facility (either due to death or hospitalization) within the last 90 days to review for vital sign monitoring, change of condition, and following of standing orders. Area for opportunity was self-identified in 1 of 15 residents with no negative outcomes noted as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discussed with IDT / Medical Director on 6/29/18.

" On 6/28/18, the facility's Staff Development Coordinator gathered the facility's policies and procedures regarding abuse, neglect, abuse reporting, and resident rights and began 100% in-servicing of all staff on this topic with post - test administered. Starting on 6/28/18, no staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 on abuse, neglect, abuse reporting, and resident rights. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employee's respective department manager.

This training included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14 1. Resident Rights - specific focus on §483.12 that "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms 2. Abuse - As defined by the "Centers for Medicare and Medicaid Services, Abuse is the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." 3. Procedure - If an employee suspects or witnesses abuse, they are to immediately protect the resident from abuse. Staff must intervene to assure the safety of the resident and other residents. The alleged perpetrator must be removed from the facility, and cannot be left unattended, to avoid any further contact with residents. The staff member will immediately report the incident or suspicions to their supervisor, Director of Nursing, or Administrator. Appropriate agencies will be notified by the Administrator within two hours of any suspected	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15 abuse, neglect, mistreatment or exploitation. " On 6/28/18, the facility's Staff Development Coordinator gathered the facility's policies and procedures regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. SDC, MDS, DON, and ADON began 100% in-service education of all clinical staff (LPN, RN, CNA, contract therapy) on this topic with post - test administered. Starting on 6/28/18, no clinical staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employee's respective department manager. This training included: 1. MD Orders / Standing Orders - Educated on process including explanation that there are hard copies orders for all residents in the narcotics book. When a nurse needs to implement a Standing order, facility requires nurse to place that order in the computer (EMR), and complete an E-Interact change of condition form along with that order, and to also document communication in the MD communication book. The expectation is that MD orders will be followed at all times.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 600 Continued From page 16 F 600

2. Interventions for respiratory distress / low O2 levels - facility processes include:
" Staff member is to be present if resident is noted to be in distress and have a low O2 saturation,
" Nurse will request that another staff member go and retrieve O2 concentrator or tank with tubing.
" Staff will follow protocol for administering Oxygen, and how to observe oxygen saturation by using Pulse Ox per protocol.
" Nurses will delegate to other staff to stay with resident once resident is stable.
" After resident is stable the nurse is to call MD for orders.
" Nurse will place all orders into the computer including orders implemented from Standing orders (ex: oxygen placement and settings. Refer to Order/care plan guide for items to include in orders).
" Nurse will then start completing the required paper work to transfer out if order received. Paperwork includes E-interact Change of Condition, and transfer form.
" If in an emergent situation arises and the nurse does not feel that the resident is stable, nurse will instruct another staff member to call 911 and help gather the required paperwork.

3. Change of Condition / MD Notification / Resident Assessment- With any change of condition, vital signs need to be obtained appropriately, and frequently, vital signs should be taken at time of incident. If any abnormal VS, vitals need to be obtained at a minimum of every 4 hours until VS stable per baseline.

" Oxygen - the resident should not be left alone until O2 is at an acceptable level (at acceptable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

baseline), continue to monitor.

" Blood pressure- if you have an abnormal blood pressure for the resident, you are to notify the MD immediately and obtain orders, continue to monitor.
" Pulse- if you have an abnormal pulse for the resident, you are to notify the MD immediately and obtain orders, continue to monitor.
" Respirations- encourage resident to purse lip breath. In through their nose out through their mouth. Slow, deep and steady.
" Temperature- Administer medications per standing orders, notify MD, and continue to monitor.

4. Updating / Following of Care Plan - It is the expectation of the facility that nursing staff will follow and / or update each resident's specific plan of care.

" On 6/28/18, the Staff Development Coordinator, Director of Nursing, MDS Nurse, and ADON began 100% in-service education with nursing staff that the on-call nurse is to be notified immediately with any and all resident changes in condition.
" On 6/28/18, the Administrator / RVP reported the 5/29/18 event to the NC Department of Health and Human Services via Fax. The Administrator will proceed with required subsequent reporting protocol (5-day report, etc.) as required.
" On 6/28/18, the Administrator / RVP began neglect investigation by having DON, ADON, SDC, MDS and Regional Nurse complete 100% interviews with interviewable residents (BIMS>8) to ensure they are free from abuse and neglect. No negative findings were noted during these interviews. On 6/28/18, the DON, ADON, SDC,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18 MDS and Regional Nurse also completed 100% observation and skin assessments of non-interviewable residents (BIMS<8) to ensure there are no signs or symptoms of fear, neglect, or abuse. No negative findings were noted during these observations and skin assessments. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: " Starting on 6/29/18, each unit's 24-hour report and available "push reports" will be reviewed daily (M-F) in clinical meeting to validate identified at-risk residents' vitals are within normal limits, care plans are followed, code statuses honored, and appropriate O2 protocol is being followed as appropriate. " On 6/29/18, the Regional Nurse Consultant developed a monitoring flow sheet to check and validate at-risk residents as identified by the 24-hour report or available "push report." This flow sheet includes assessment of abnormal vitals, honoring of code status and care plans, and oxygen protocol being followed as indicated. Starting 6/29/18, this flow sheet will be populated and reviewed daily (M-F) in morning clinical meeting to review and track at-risk residents over the previous 24 hours (72 hours if weekend). " Starting on 6/29/18, the DON, ADON, SDC, MDS, Regional Nurse, or designated nurse manager will conduct (3) random audits of patient charts to review vitals, code status changes, incident reports, orders, change of condition and required notifications therein, as well as care plans 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to monitor delivery of quality care and to ensure resident is free from neglect. Any noted issues from audits will be discussed with the IDT and QA committee	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19 and addressed immediately. " Starting on 6/30/18, the DON, ADON, SDC, MDS, Regional Nurse, Manager on Duty, or designated nurse will conduct random abuse post-tests with (3) staff each shift daily x 2 weeks, then (3) staff each shift 2x per week x 4 weeks, then (3) staff each shift 1x per week x 4weeks with score of 100% to ensure staff are well informed of facility abuse / neglect policies and protocols. Any noted issues from post-tests will be discussed with IDT and QA committee and addressed immediately. " Starting on 6/30/18, the DON, ADON, SDC, MDS, Regional Nurse, Manager on Duty, or designated nurse manager with conduct (3) random resident interviews with residents with BIMS > 8 and (3) random resident skin assessments / observations for residents with BIMS < 8 daily x 2 weeks, then 3x per week x 4 weeks, then weekly x 4 weeks to ensure residents are free from abuse and neglect. Any noted issues from interviews / skin assessments will be discussed with IDT and QA committee and addressed immediately. " Starting 6/29/18, the Inter Disciplinary Team and Medical Director will attend QAPI meeting to review the efficacy of the aforementioned plan weekly x 4 weeks, then bi-weekly x 1 month, and then monthly thereafter to ensure continued compliance with the requirements of participation. The IDT includes the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Activities Director, Business Office Manager, Admissions Coordinator, Staff Development Coordinator, Housekeeping Director, Maintenance Director, MDS Nurse, Dietary Director, Medical Director, and Pharmacist.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

(4) The title of the person responsible for implementing the acceptable plan of correction:
" The individual responsible for implementing the credible plan of correction is the Administrator.

Immediate Jeopardy was removed on 6/29/18 when the facility demonstrated that staff had been trained on the topics of abuse, neglect, resident rights, Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan.

" a.
" 6.28.18 (08:00) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/29/18. Facility was cited with F600 for neglect.
Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for low oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in neglect, defined by CMS as "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." (See 42 CFR Part 488.301.). Interview with LPN #1 states that nurse had instructed CNA #1 to "get oxygen" while he was completing documentation to send Resident #1 to hospital. Per LPN #1, he believed that Resident #1 was sitting on edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying O2 to resident. Interview with LPN #1 revealed that he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21 understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1's change of condition. Resident #1's O2 saturation rate was 78% which justified supplemental oxygen and monitoring until baseline O2 saturation rate is achieved The plan to correct this identified concern includes the completion of a thorough investigation surrounding the event on 5/29/18, completion of a Root Cause Analysis to identify the variables that led to the process failure, house-wide education and in-service training to appropriate staff on areas for opportunity to include topics of abuse, neglect, abuse reporting, resident rights, Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plans. The facility will also implement monitoring measures and random audits spread over the course of the next 90 days to ensure compliance and efficacy of this plan. Lastly, all audit results will be shared with the facility Quality Assurance Performance Improvement team and the Medical Director no less than monthly for review. All negative audit results will be immediately brought before the QAPI team and Medical Director for immediate review and remedy. (2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: " On 6/28/18, the Director of Nursing immediately suspended LPN #1 pending investigation regarding neglect and failure to provide quality of care. If investigation is substantiated, facility will follow policy of terminating LPN #1's employment and reporting event to required agencies and licensing boards,	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22 as appropriate. On 6/28/18, the Director of Nursing, Staff Development Coordinator, MDS nurse, and Assistant Director of Nursing created a timeline of events surrounding the 5/29/18 occurrence in order to successfully conduct a Root Cause Analysis of the process failure. Process failure was determined after reviewing timeline by DON and Administrator on 6/28/18. The failed process identified was that LPN #1 did not follow facility O2 protocols when he observed resident with 78% O2 saturation rate. At the time a low saturation rate was observed, LPN #1 should have placed resident on supplemental Oxygen, elevated head of bed, and remained with resident until resident could reach a baseline O2 saturation rate, which LPN #1 failed to do. " On 6/28/18, the Director of Nursing conducted 100% chart audit of other residents discharged from facility (either due to death or hospitalization) within the last 90 days to review for vital sign monitoring, change of condition, and following of standing orders. Area for opportunity was self-identified in 1 of 15 residents with no negative outcomes noted as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discussed with IDT / Medical Director on 6/29/18. " On 6/28/18, the facility's Staff Development Coordinator gathered the facility's policies and procedures regarding abuse, neglect, abuse reporting, and resident rights and began 100% in-servicing of all staff on this topic with post - test administered. Starting on 6/28/18, no staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 on abuse, neglect, abuse reporting, and resident rights. All staff who have	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 23	F 600		

not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employee's respective department manager.

This training included:

4. Resident Rights - specific focus on §483.12 that "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms

5. Abuse - As defined by the "Centers for Medicare and Medicaid Services, Abuse is the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

6. Procedure - If an employee suspects or witnesses abuse, they are to immediately protect the resident from abuse. Staff must intervene to assure the safety of the resident and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 24 residents. The alleged perpetrator must be removed from the facility, and cannot be left unattended, to avoid any further contact with residents. The staff member will immediately report the incident or suspicions to their supervisor, Director of Nursing, or Administrator. Appropriate agencies will be notified by the Administrator within two hours of any suspected abuse, neglect, mistreatment or exploitation. " On 6/28/18, the facility's Staff Development Coordinator gathered the facility's policies and procedures regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. SDC, MDS, DON, and ADON began 100% in-service education of all clinical staff (LPN, RN, CNA, contract therapy) on this topic with post - test administered. Starting on 6/28/18, no clinical staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employee's respective department manager. This training included: 5. MD Orders / Standing Orders - Educated on process including explanation that there are hard copies orders for all residents in the narcotics	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 25	F 600		

book. When a nurse needs to implement a Standing order, facility requires nurse to place that order in the computer (EMR), and complete an E-Interact change of condition form along with that order, and to also document communication in the MD communication book. The expectation is that MD orders will be followed at all times.

6. Interventions for respiratory distress / low O2 levels - facility processes include:
" Staff member is to be present if resident is noted to be in distress and have a low O2 saturation,
" Nurse will request that another staff member go and retrieve O2 concentrator or tank with tubing.
" Staff will follow protocol for administering Oxygen, and how to observe oxygen saturation by using Pulse Ox per protocol.
" Nurses will delegate to other staff to stay with resident once resident is stable.
" After resident is stable the nurse is to call MD for orders.
" Nurse will place all orders into the computer including orders implemented from Standing orders (ex: oxygen placement and settings. Refer to Order/care plan guide for items to include in orders).
" Nurse will then start completing the required paper work to transfer out if order received. Paperwork includes E-interact Change of Condition, and transfer form.
" If in an emergent situation arises and the nurse does not feel that the resident is stable, nurse will instruct another staff member to call 911 and help gather the required paperwork.

7. Change of Condition / MD Notification / Resident Assessment- With any change of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 26	F 600		

condition, vital signs need to be obtained appropriately, and frequently, vital signs should be taken at time of incident. If any abnormal VS, vitals need to be obtained at a minimum of every 4 hours until VS stable per baseline.

" Oxygen - the resident should not be left alone until O2 is at an acceptable level (at acceptable baseline), continue to monitor.

" Blood pressure- if you have an abnormal blood pressure for the resident, you are to notify the MD immediately and obtain orders, continue to monitor.
" Pulse- if you have an abnormal pulse for the resident, you are to notify the MD immediately and obtain orders, continue to monitor.
" Respirations- encourage resident to purse lip breath. In through their nose out through their mouth. Slow, deep and steady.
" Temperature- Administer medications per standing orders, notify MD, and continue to monitor.

8. Updating / Following of Care Plan - It is the expectation of the facility that nursing staff will follow and / or update each resident's specific plan of care.

" On 6/28/18, the Staff Development Coordinator, Director of Nursing, MDS Nurse, and ADON began 100% in-service education with nursing staff that the on-call nurse is to be notified immediately with any and all resident changes in condition.
" On 6/28/18, the Administrator / RVP reported the 5/29/18 event to the NC Department of Health and Human Services via Fax. The Administrator will proceed with required subsequent reporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 27 protocol (5-day report, etc.) as required. " On 6/28/18, the Administrator / RVP began neglect investigation by having DON, ADON, SDC, MDS and Regional Nurse complete 100% interviews with interviewable residents (BIMS>8) to ensure they are free from abuse and neglect. No negative findings were noted during these interviews. On 6/28/18, the DON, ADON, SDC, MDS and Regional Nurse also completed 100% observation and skin assessments of non-interviewable residents (BIMS<8) to ensure there are no signs or symptoms of fear, neglect, or abuse. No negative findings were noted during these observations and skin assessments. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: " Starting on 6/29/18, each unit's 24-hour report and available "push reports" will be reviewed daily (M-F) in clinical meeting to validate identified at-risk residents' vitals are within normal limits, care plans are followed, code statuses honored, and appropriate O2 protocol is being followed as appropriate. " On 6/29/18, the Regional Nurse Consultant developed a monitoring flow sheet to check and validate at-risk residents as identified by the 24-hour report or available "push report." This flow sheet includes assessment of abnormal vitals, honoring of code status and care plans, and oxygen protocol being followed as indicated. Starting 6/29/18, this flow sheet will be populated and reviewed daily (M-F) in morning clinical meeting to review and track at-risk residents over the previous 24 hours (72 hours if weekend). " Starting on 6/29/18, the DON, ADON, SDC, MDS, Regional Nurse, or designated nurse manager will conduct (3) random audits of patient	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 28 charts to review vitals, code status changes, incident reports, orders, change of condition and required notifications therein, as well as care plans 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to monitor delivery of quality care and to ensure resident is free from neglect. Any noted issues from audits will be discussed with the IDT and QA committee and addressed immediately. " Starting on 6/30/18, the DON, ADON, SDC, MDS, Regional Nurse, Manager on Duty, or designated nurse will conduct random abuse post-tests with (3) staff each shift daily x 2 weeks, then (3) staff each shift 2x per week x 4 weeks, then (3) staff each shift 1x per week x 4weeks with score of 100% to ensure staff are well informed of facility abuse / neglect policies and protocols. Any noted issues from post-tests will be discussed with IDT and QA committee and addressed immediately. " Starting on 6/30/18, the DON, ADON, SDC, MDS, Regional Nurse, Manager on Duty, or designated nurse manager with conduct (3) random resident interviews with residents with BIMS > 8 and (3) random resident skin assessments / observations for residents with BIMS < 8 daily x 2 weeks, then 3x per week x 4 weeks, then weekly x 4 weeks to ensure residents are free from abuse and neglect. Any noted issues from interviews / skin assessments will be discussed with IDT and QA committee and addressed immediately. " Starting 6/29/18, the Inter Disciplinary Team and Medical Director will attend QAPI meeting to review the efficacy of the aforementioned plan weekly x 4 weeks, then bi-weekly x 1 month, and then monthly thereafter to ensure continued compliance with the requirements of participation. The IDT includes the Administrator, Director of	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 29 Nursing, Assistant Director of Nursing, Social Worker, Activities Director, Business Office Manager, Admissions Coordinator, Staff Development Coordinator, Housekeeping Director, Maintenance Director, MDS Nurse, Dietary Director, Medical Director, and Pharmacist. (4) The title of the person responsible for implementing the acceptable plan of correction: " The individual responsible for implementing the credible plan of correction is the Administrator. Immediate Jeopardy was removed on 6/29/18 at 3:35 PM when the facility staff were interviewed and demonstrated they had been trained on the topics of abuse, neglect, resident rights, Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan.	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		6/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 30

Based on record review, staff, family, Physician, Nurse Practitioner, and Emergency Medical Service interviews the facility failed to provide basic and expected nursing care for a resident who was experiencing shortness of breath and assessed with a decreased oxygen saturation of 78 percent. The resident was sent to the emergency room for evaluation and treatment of pneumonia (Resident #1).

Immediate Jeopardy began on 05/29/18 when Nurse #1 neglected to raise the head of the bed and administer oxygen for Resident #1 who was experiencing shortness of breath and a decreased oxygen saturation of 78%. The resident was sent out to the emergency room for evaluation and treatment of pneumonia. Immediate Jeopardy was removed on 06/29/18 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective.

The findings included:

Resident #1 was admitted to the facility on 07/06/17 with diagnoses of heart failure, chronic obstructive pulmonary disease, respiratory failure, and high blood pressure.

Review of the Facility Standing Orders updated 08/2011 revealed the following for acute shortness of breath:

a. Elevate head of bead.

F 684

Disclaimer:
Submission of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is submitted solely because it is required by the provision of federal and state law.

F684 □ Quality of Care □ CFR(s): 483.25

(1) Plan for correcting specific area of concern identified, include the process that led to the concern:
It was observed that on 05/29/2018 that LPN #1 failed to ensure the delivery of quality care or to ensure the highest practicable physical, mental, and psychosocial well-being.
The process breakdown that lead to the concern was as follows:
Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1□s change of condition including implementation of interventions for low oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in failure to deliver an acceptable level of quality care or to ensure the highest practicable physical, mental, and psychosocial well-being of the resident. Interview with LPN #1 states that nurse had instructed CNA #1 to get oxygen while he was completing documentation to send Resident #1 to hospital. Per LPN #1, he believed that Resident #1 was sitting on edge of bed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684

Continued From page 31

b. Check oxygen saturation on room air before application of oxygen.

c. Apply oxygen to get oxygen saturation to 90%.

d. Obtain and monitor vital signs (temperature, heart rate, respirations) and check oxygen saturation after application of oxygen.

e. Notify physician after above completed.

Review of the most recent quarterly Minimum Data Set (MDS) dated 04/17/17 revealed Resident #1 was severely cognitively impaired and required limited to extensive assistance with most activities of daily living. The MDS was not coded for oxygen use for Resident #1.

Review of the care plan dated 04/25/18 revealed Resident #1 had altered respiratory status/difficulty breathing related to emphysema and a history of pneumonia. The goal was for Resident #1 to maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern through the review date and his pulse oximetry will remain greater than 90% through the review date. The interventions included: Monitor for signs and symptoms of respiratory distress and report to MD as needed. Monitor pulse oximetry as needed.

Review of the nurse's notes dated 05/30/18 revealed the following note was written by Nurse #1 at 1:20 AM: Resident #1 was moaning intermittently and restless, he indicated left flank, side, pain when asked where he hurt. Resident

F 684

and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying O2 to resident. Interview with LPN #1 revealed that he understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1s change of condition. Resident #1s O2 saturation rate was 78% which justified supplemental oxygen and monitoring until baseline O2 saturation rate is achieved The plan to correct this identified concern includes the completion of a thorough investigation surrounding the event on 5/29/18, completion of a Root Cause Analysis to identify the variables that led to the process failure, house-wide education and in-service training to appropriate staff on areas for opportunity to include topics of Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plans. The facility will also implement monitoring measures and random audits spread over the course of the next 90 days to ensure compliance and efficacy of this plan. Lastly, all audit results will be shared with the facility Quality Assurance Performance Improvement team and the Medical Director no less than monthly for review. All negative audit results will be immediately brought before the QAPI team and Medical Director for immediate review and remedy. The root cause of this event was that that LPN #1 made a poor judgement call and requested another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 32

#1 appeared to doze for short periods while sitting up and his oxygen saturation would drop, then rise again once he roused. Adventitious, abnormal sounds heard over a patient's lungs and airways, lung sounds. The Family Nurse Practitioner (FNP) had ordered lab work, urinalysis with a culture and sensitivity, and a chest x-ray. Resident #1's family member, stated she wanted him sent to the emergency room (ER) for evaluation and treatment, stating she thought he was having a heart attack. The on-call FNP was contacted via telephone at 6:20 PM and agreed to have Resident #1 sent to the ER. The Director of Nursing (DON) was notified via telephone. Emergency Management System (EMS) was contacted via telephone for pickup. Resident #1 departed the facility at 6:45 PM. Vital signs were blood pressure - 104/67, pulse - 113, respirations - 28, temperature - 98.1 (orally), oxygen saturation 78% on room air. Nurse #1 contacted the ER at 11:00 PM and was informed that Resident #1 had been admitted to the hospital for pneumonia. The DON was notified via telephone at 11:10 PM.

Review of the Emergency Medical Services (EMS) run report dated 05/29/18 revealed they were called by the facility at 6:27 PM for transport of a resident having difficulty breathing to the emergency room (ER). The EMS report revealed they arrived at the facility at 6:41 PM and to Resident #1's bedside at 6:44 PM. They departed the facility for the ER at 7:04 PM and arrived at the hospital at 7:35 PM. The report further revealed when they arrived at the facility they found Resident #1 lying flat on his bed with adventitious lung sounds. His family member was at the bedside and stated he had some congestion lately but was worse today. They sat

F 684

staff member (who was not a licensed nurse) to retrieve and set up oxygen for a resident and it was ultimately not administered. LPN #1 failed to ensure that they, the licensed nurse assigned to the patient, administered oxygen and monitored resident until O2 saturation baseline was achieved which is facility protocol.

(2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
On 6/28/18, the Director of Nursing immediately suspended LPN #1 pending investigation regarding failure to provide quality of care. If investigation is substantiated, facility will follow policy of terminating LPN #1□s employment and reporting event to required agencies and licensing boards, as appropriate.

On 6/28/18, the Director of Nursing, Staff Development Coordinator, MDS nurse, and Assistant Director of Nursing created a timeline of events surrounding the 5/29/18 occurrence in order to successfully conduct a Root Cause Analysis of the process failure. Process failure was determined after reviewing timeline by DON and Administrator on 6/28/18. The failed process identified was that LPN #1 did not follow facility O2 protocols when he observed resident with 78% O2 saturation rate. At the time a low saturation rate was observed, LPN #1 should have placed resident on supplemental Oxygen, elevated head of bed, and remained with resident until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684

Continued From page 33

Resident #1 up in bed and he was able to pivot with assistance to the gurney. Physical exam revealed lower extremity swelling, lung sounds full of fluid throughout, and skin was cool and clammy. Review of the oxygen saturation readings on the EMS report revealed the following: 6:57 PM - 69%, 6:59 PM - 73%, 7:00 pm - 89%, 7:07 PM - 80%, 7:17 - 92 %, 7:24 - 91%, and 7:32 PM - 93%. Oxygen via nasal cannula was applied at 7:01 PM and a CPAP, continuous positive airway pressure is a form of positive airway pressure ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are able to breathe spontaneously on their own, was applied at 7:03 PM.

Review of the hospital discharge summary dated 05/30/18 revealed Resident #1 likely expired due to his severe pneumonia, which may have been a result of aspiration and was significantly affected by his congestive heart failure.

Review of the death certificate for Resident #1 revealed he expired on 05/30/18 from pneumonia.

An interview conducted on 06/28/18 at 12:10 PM with Nurse #2 stated she observed Resident #1 on 05/29/18 on the 7:00 AM to 3:00 PM shift and he was drowsier than usual and acting different. She stated she reported it to the FNP and she ordered lab work and a chest x-ray. Nurse #2 further stated she reported to Nurse #1 about Resident #1 being drowsier and acting different and that the FNP had ordered lab work and a chest x-ray earlier that day.

An interview conducted on 06/28/18 at 1:39 PM

F 684

resident could reach a baseline O2 saturation rate, which LPN #1 failed to do.

On 6/28/18, the Director of Nursing conducted 100% chart audit of other residents discharged from facility (either due to death or hospitalization) within the last 90 days to review for vital sign monitoring, change of condition, and following of standing orders. Area for opportunity was self identified in 1 of 15 residents with no negative outcomes noted as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discussed with IDT / Medical Director on 6/29/18.

On 6/28/18, the facility□s Staff Development Coordinator gathered the facility□s policies and procedures regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. SDC, MDS, DON, and ADON began 100% in-service education of all clinical staff (LPN, RN, CNA, contract therapy) on this topic with post □ test administered. Starting on 6/28/18, no clinical staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 34

with the Nurse Practitioner stated she saw Resident #1 on 05/29/18 at 11:15 AM per his family member and Nurse #2's request due to being resistive to care and having an increase in agitation. She stated he was not congested or having shortness of breath (SOB) or difficulty breathing when she assessed him. She stated he had complaints of pain at the site of his broken rib and she ordered a chest x-ray per the family's request. She reported Nurse #1 called her that evening around 6:15 PM and reported Resident #1 was SOB and had a low oxygen saturation and she gave the order to send him to the ER for evaluation. She stated she was not informed Resident #1's oxygen saturation was 78% and would have expected staff to raise the head of the bed and provide oxygen per standing orders to bring his oxygen level back up.

An interview conducted on 06/28/18 at 11:17 AM with Nurse Aide (NA) #1. NA #1 stated he was at the nurses desk on the East Hall the evening of 05/29/18 when the EMS arrived and told Nurse #1 they were there for Resident #1 and asked where his room was and if anyone was in the room with him, he heard the nurse say no and pointed in the direction of Resident #1's room. NA #1 stated he offered to take the EMS workers to Resident #1's room. He stated when they walked in the room Resident #1 was lying flat in bed and he could hear him trying to breathe, he sounded very congested and short of breath. NA #1 stated Resident #1 didn't have any oxygen on and there wasn't an oxygen concentrator or oxygen tank in the room. NA #1 further stated he was not assigned to Resident #1 that evening and had not seen him before taking EMS personnel to his room around 6:45 PM.

F 684

assessments, and updating / following care plan. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employee□s respective department manager.
This training included:
MD Orders / Standing Orders □ Educated on process including explanation that there are hard copies orders for all residents in the narcotics book. When a nurse needs to implement a Standing order, facility requires nurse to place that order in the computer (EMR), and complete an E-Interact change of condition form along with that order, and to also document communication in the MD communication book. The expectation is that MD orders will be followed at all times.

Interventions for respiratory distress / low O2 levels □ facility processes include:

(a) Staff member is to be present if resident is noted to be in distress and have a low O2 saturation,

(b) Nurse will request that another staff member go and retrieve O2 concentrator or tank with tubing.

(c)Staff will follow protocol for administering Oxygen, and how to observe oxygen saturation by using Pulse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 35 An interview was conducted on 06/28/18 at 12:05 PM with EMS Worker #1. She stated when they arrived at the facility the nurse was at the desk and she told him they were there for Resident #1 for a respiratory distress call and he pointed down the hall, she asked if someone was with him and he said no, she told him she needed report and he continued to sit at the desk and do paperwork. She stated NA #1 told her he would take them to Resident #1's room, she reported when they walked into Resident #1's room he was lying flat in bed, with no oxygen on, and she could hear him trying to breathe. EMS Worker #1 stated there were no staff present in Resident #1's room when they arrived and she didn't see an oxygen tank or concentrator in the room. She further stated Resident #1's family member was in the room with him and she was crying, when she asked her why she told her she thought he was having a heart attack and he was going to die. An interview conducted on 06/28/18 at 12:15 PM with Nurse #1, who worked with Resident #1 on the 3:00 PM to 11:00 PM shift on 05/29/18, revealed he was in the middle of his medication pass and Resident #1's family member asked him to assess Resident #1 because he was having difficulty breathing and pain in his chest around 6:00 PM. Nurse #1 stated he went to Resident #1's room and assessed him while NA #2 obtained his vital signs. Nurse #1 stated Resident #1's oxygen saturation was 78% at that time. Nurse #1 stated the resident pointed to his ribs and not his heart when he asked him where his pain was but his family was insistent that he be sent to the ER. Nurse #1 stated he went to the nurse's desk to call the on-call provider for order's and start the transfer paperwork and thought he told NA #2 to put oxygen on Resident #1 per	F 684	Ox per protocol. (d) Nurses will delegate to other staff to stay with resident once resident is stable. (e)After resident is stable the nurse is to call MD for orders. (f) Nurse will place all orders into the computer including orders implemented from Standing orders (ex: oxygen placement and settings. Refer to Order/care plan guide for items to include in orders). (g) Nurse will then start completing the required paper work to transfer out if order received. Paperwork includes E-interact Change of Condition, and transfer form. (h) If in an emergent situation arises and the nurse does not feel that the resident is stable, nurse will instruct another staff member to call 911 and help gather the required paperwork. Change of Condition / MD Notification / Resident Assessment With any change of condition, vital signs need to be obtained appropriately, and frequently, vital signs should be taken at time of incident. If any abnormal VS, vitals need to be obtained at a minimum of every 4 hours until VS stable per baseline. Oxygen - the resident should not be left alone until O2 is at an acceptable level (at acceptable baseline) , continue to monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36 facility standing orders due to his oxygen saturation being 78% when the vital signs were checked but did not think about raising the head of the bed. Nurse #1 stated he called the FNP, DON and the EMS and started the paperwork for the transfer and he did not go back and assess Resident #1 due to trying to get the paperwork completed and did not go with the EMS to his room when they arrived because he wasn't finished with the paperwork. An interview conducted with the Director of Nursing revealed Nurse #1 called her on 05/29/18 and informed her he was sending Resident #1 to the ER per his family's request. She stated she was not informed Resident #1's oxygen saturation was 78%. She stated all nurses were trained on standing orders and there was a copy of the standing orders on every medication administration book and her expectation was for all nurses to follow the facility standing orders and raise the resident's head of bed and apply oxygen to get the oxygen saturation back to 90%. She further stated Nurse #1 should have followed the facility standing orders and administered oxygen and raised the head of the bed for Resident #1. An interview conducted on 06/28/18 3:16 PM with Resident #1's family member revealed she was with Resident #1 all day on 05/29/18 because he asked her to stay with him. She stated he complained of chest pain and the FNP saw him that day and ordered lab work and a chest x-ray to be done. The family member reported Resident #1 started having difficulty breathing that evening and she checked his oxygen saturation with her own machine and showed it to NA #2 who checked it with the facility machine. She stated NA #2's oxygen saturation reading	F 684	Blood pressure- if you have an abnormal blood pressure for the resident, you are to notify the MD immediately and obtain orders, continue to monitor. Pulse- if you have an abnormal pulse for the resident, you are to notify the MD immediately and obtain orders, continue to monitor. Respirations- encourage resident to purse lip breath. In through their nose out through their mouth. Slow, deep and steady. Temperature- Administer medications per standing orders, notify MD, and continue to monitor. Updating / Following of Care Plan It is the expectation of the facility that nursing staff will follow and / or update each residents specific plan of care. On 6/28/18, the Staff Development Coordinator, Director of Nursing, MDS Nurse, and ADON began 100% in-service education with nursing staff that the on-call nurse is to be notified immediately with any and all resident changes in condition. (3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements: Starting on 6/29/18, each units 24-hour report and available push reports will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 37

was 78% around 6:00 PM and she reported it to Nurse #1. Resident #1's family member stated Nurse #1 did not assess Resident #1 but he did come to the door of his room and ask her if she wanted him sent to the ER. She further stated she asked staff to give Resident #1 oxygen due to his shortness of breath and difficulty breathing but no one ever did until the EMS arrived around 6:30 PM and they provided oxygen for him.

An interview conducted on 06/28/18 3:07 PM NA #2 revealed Resident #1's family member called her to his room on 05/29/18 around 6:00 PM and showed her the oxygen saturation reading she got on her own private machine and it was 75%. NA #2 stated she checked Resident #1's oxygen saturation with the facility machine and got a reading of 78% and immediately informed Nurse #1. She stated Nurse #1 assessed Resident #1 and she took oxygen into the room for him to put on Resident #1. She stated she didn't see Nurse #1 put the oxygen on Resident #1 and she didn't return to the room after she took the oxygen to the room. She further stated Resident #1 was lying flat in bed and he was having difficulty breathing.

An interview conducted on 06/29/18 at 9:00 AM with the facility Physician revealed it was his expectation for a resident who was short of breath and had an oxygen saturation of 78% to have oxygen applied and the head of the bed raised per facility standing orders. He further stated the on-call provider should be called immediately.

On 06/28/18 at 4:45 PM the Administrator and the DON were notified of Immediate Jeopardy.

F 684

reviewed daily (M-F) in clinical meeting to validate identified at-risk residents vitals are within normal limits, care plans are followed, code statuses honored, and appropriate O2 protocol is being followed as appropriate.

On 6/29/18, the Regional Nurse Consultant developed a monitoring flow sheet to check and validate at-risk residents as identified by the 24-hour report or available push report. This flow sheet includes assessment of abnormal vitals, honoring of code status and care plans, and oxygen protocol being followed as indicated. Starting 6/29/18, this flow sheet will be populated and reviewed daily (M-F) in morning clinical meeting to review and track at-risk residents over the previous 24 hours (72 hours if weekend).

Starting on 6/29/18, the DON, ADON, SDC, MDS, Regional Nurse, or designated nurse manager will conduct (3) random audits of patient charts to review vitals, code status changes, incident reports, orders, change of condition and required notifications therein, as well as care plans 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to monitor delivery of quality care. Any noted issues from audits will be discussed with the IDT and QA committee and addressed immediately.

Starting 6/29/18, the Inter Disciplinary Team and Medical Director will attend QAPI meeting to review the efficacy of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 38 On 06/29/18 at 2:44 PM the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included: (1) Plan for correcting specific area of concern identified, include the process that led to the concern: It was observed that on 05/29/2018 that LPN #1 failed to ensure the delivery of quality care or to ensure the highest practicable physical, mental, and psychosocial well-being. The process breakdown that lead to the concern was as follows: " 5.28.18 (11:37pm) LPN #1 documented agitation and verbal aggression as well as insomnia. Zyprexa IM given. " 5.29.18 Patient seen by Nurse Practitioner related to increased agitation, insomnia, and flank pain. No documented fever, dyspnea, cough. Order for chest x-ray, urinalysis, CMP, and left rib x-ray given by nurse practitioner. Respiratory assessment by nurse practitioner shows poor compliance and diminished without wheezes, rales, or rhonchi. New orders for ibuprofen as requested for pain. " 5.29.18 (6:19pm) LPN #1 documented change of condition assessment related to shortness of breath, oxygen saturation of 78% on room air. Orders noted to send to emergency room. " 5.29.18 (6:35pm) LPN #1 completed transfer form. Oxygen was not documented as an intervention at this time. Per the transfer form to the hospital - - O2: 78%, Res: 28, Pulse: 113, B/P: 104/67. Pain eval conducted; rated as 4 of 10. Known d/x of COPD and CHF " Statements from EMS surrounding this event revealed that no staff member was present in room with Resident #1 and head of bed not	F 684	aforementioned plan weekly x 4 weeks, then bi-weekly x 1 month, then monthly thereafter to ensure continued compliance with the requirements of participation. The IDT includes the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Activities Director, Business Office Manager, Admissions Coordinator, Staff Development Coordinator, Housekeeping Director, Maintenance Director, MDS Nurse, Dietary Director, Medical Director, and Pharmacist. (4) The title of the person responsible for implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39 elevated at time EMS arrived and that oxygen was not being administered. " 5.30.18 (01:22pm) LPN #1 documented nurses note related to change of condition and orders to send to hospital. Attending physician notified and sister aware and in room. Resident left facility at 6:45pm. At, 11:00pm facility was notified that resident was admitted to the hospital related to pneumonia. " 6.28.18 (08:00) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/29/18. Facility was cited with F684 for Quality of Care. Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for low oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in failure to deliver an acceptable level of quality care or to ensure the highest practicable physical, mental, and psychosocial well-being of the resident. Interview with LPN #1 states that nurse had instructed CNA #1 to "get oxygen" while he was completing documentation to send Resident #1 to hospital. Per LPN #1, he believed that Resident #1 was sitting on edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying O2 to resident. Interview with LPN #1 revealed that he understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1's change of condition. Resident #1's O2 saturation rate was 78% which justified supplemental oxygen and monitoring until baseline O2 saturation rate is achieved The plan to correct this identified concern includes the completion of a thorough	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 investigation surrounding the event on 5/29/18, completion of a Root Cause Analysis to identify the variables that led to the process failure, house-wide education and in-service training to appropriate staff on areas for opportunity to include topics of Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plans. The facility will also implement monitoring measures and random audits spread over the course of the next 90 days to ensure compliance and efficacy of this plan. Lastly, all audit results will be shared with the facility Quality Assurance Performance Improvement team and the Medical Director no less than monthly for review. All negative audit results will be immediately brought before the QAPI team and Medical Director for immediate review and remedy. The root cause of this event was that that LPN #1 made a poor judgment call and requested another staff member (who was not a licensed nurse) to retrieve and set up oxygen for a resident and it was ultimately not administered. LPN #1 failed to ensure that they, the licensed nurse assigned to the patient, administered oxygen and monitored resident until O2 saturation baseline was achieved which is facility protocol. (2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: " On 6/28/18, the Director of Nursing immediately suspended LPN #1 pending investigation regarding failure to provide quality of care. If investigation is substantiated, facility will follow policy of terminating LPN #1's employment and reporting event to required agencies and licensing boards, as appropriate.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 41 On 6/28/18, the Director of Nursing, Staff Development Coordinator, MDS nurse, and Assistant Director of Nursing created a timeline of events surrounding the 5/29/18 occurrence in order to successfully conduct a Root Cause Analysis of the process failure. Process failure was determined after reviewing timeline by DON and Administrator on 6/28/18. The failed process identified was that LPN #1 did not follow facility O2 protocols when he observed resident with 78% O2 saturation rate. At the time a low saturation rate was observed, LPN #1 should have placed resident on supplemental Oxygen, elevated head of bed, and remained with resident until resident could reach a baseline O2 saturation rate, which LPN #1 failed to do. " On 6/28/18, the Director of Nursing conducted 100% chart audit of other residents discharged from facility (either due to death or hospitalization) within the last 90 days to review for vital sign monitoring, change of condition, and following of standing orders. Area for opportunity was self-identified in 1 of 15 residents with no negative outcomes noted as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discussed with IDT / Medical Director on 6/29/18. " On 6/28/18, the facility's Staff Development Coordinator gathered the facility's policies and procedures regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. SDC, MDS, DON, and ADON began 100% in-service education of all clinical staff (LPN, RN, CNA, contract therapy) on this topic with post -	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 42	F 684		

test administered. Starting on 6/28/18, no clinical staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan. All staff who have not completed in-person / over the phone education and post-tests will be mailed a copy of each via USPS Certified Mail and will not be permitted to work until this education and post-test is completed. Compliance will be ensured and tracked by each employee's respective department manager.
This training included:
1. MD Orders / Standing Orders - Educated on process including explanation that there are hard copies orders for all residents in the narcotics book. When a nurse needs to implement a Standing order, facility requires nurse to place that order in the computer (EMR), and complete an E-Interact change of condition form along with that order, and to also document communication in the MD communication book. The expectation is that MD orders will be followed at all times.

2. Interventions for respiratory distress / low O2 levels - facility processes include:
" Staff member is to be present if resident is noted to be in distress and have a low O2 saturation,
" Nurse will request that another staff member go and retrieve O2 concentrator or tank with tubing.
" Staff will follow protocol for administering Oxygen, and how to observe oxygen saturation by using Pulse Ox per protocol.
" Nurses will delegate to other staff to stay with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 43	F 684		

resident once resident is stable.
" After resident is stable the nurse is to call MD for orders.
" Nurse will place all orders into the computer including orders implemented from Standing orders (ex: oxygen placement and settings. Refer to Order/care plan guide for items to include in orders).
" Nurse will then start completing the required paper work to transfer out if order received. Paperwork includes E-interact Change of Condition, and transfer form.
" If in an emergent situation arises and the nurse does not feel that the resident is stable, nurse will instruct another staff member to call 911 and help gather the required paperwork.

3. Change of Condition / MD Notification / Resident Assessment- With any change of condition, vital signs need to be obtained appropriately, and frequently, vital signs should be taken at time of incident. If any abnormal VS, vitals need to be obtained at a minimum of every 4 hours until VS stable per baseline.

" Oxygen - the resident should not be left alone until O2 is at an acceptable level (at acceptable baseline), continue to monitor.

" Blood pressure- if you have an abnormal blood pressure for the resident, you are to notify the MD immediately and obtain orders, continue to monitor.
" Pulse- if you have an abnormal pulse for the resident, you are to notify the MD immediately and obtain orders, continue to monitor.
" Respirations- encourage resident to purse lip breath. In through their nose out through their mouth. Slow, deep and steady.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 44	F 684		

" Temperature- Administer medications per standing orders, notify MD, and continue to monitor.

4. Updating / Following of Care Plan - It is the expectation of the facility that nursing staff will follow and / or update each resident's specific plan of care.

" On 6/28/18, the Staff Development Coordinator, Director of Nursing, MDS Nurse, and ADON began 100% in-service education with nursing staff that the on-call nurse is to be notified immediately with any and all resident changes in condition.

(3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and / or in compliance with regulatory requirements:

" Starting on 6/29/18, each unit's 24-hour report and available "push reports" will be reviewed daily (M-F) in clinical meeting to validate identified at-risk residents' vitals are within normal limits, care plans are followed, code statuses honored, and appropriate O2 protocol is being followed as appropriate.

" On 6/29/18, the Regional Nurse Consultant developed a monitoring flow sheet to check and validate at-risk residents as identified by the 24-hour report or available "push report." This flow sheet includes assessment of abnormal vitals, honoring of code status and care plans, and oxygen protocol being followed as indicated. Starting 6/29/18, this flow sheet will be populated and reviewed daily (M-F) in morning clinical meeting to review and track at-risk residents over the previous 24 hours (72 hours if weekend).

" Starting on 6/29/18, the DON, ADON, SDC, MDS, Regional Nurse, or designated nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C 06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 45	F 684		

manager will conduct (3) random audits of patient charts to review vitals, code status changes, incident reports, orders, change of condition and required notifications therein, as well as care plans 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to monitor delivery of quality care. Any noted issues from audits will be discussed with the IDT and QA committee and addressed immediately.

" Starting 6/29/18, the Inter Disciplinary Team and Medical Director will attend QAPI meeting to review the efficacy of the aforementioned plan weekly x 4 weeks, then bi-weekly x 1 month, and then monthly thereafter to ensure continued compliance with the requirements of participation. The IDT includes the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Activities Director, Business Office Manager, Admissions Coordinator, Staff Development Coordinator, Housekeeping Director, Maintenance Director, MDS Nurse, Dietary Director, Medical Director, and Pharmacist.

(4) The title of the person responsible for implementing the acceptable plan of correction:

" The individual responsible for implementing the credible plan of correction is the Administrator.

Immediate Jeopardy was removed on 6/29/18 at 3:35 PM when the facility staff were interviewed and demonstrated they had been trained on the topics of Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident assessments, and updating / following care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING ______ B. WING ______	C **06/29/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	**1984 US 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE