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 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	**1984 US HIGHWAY 70 SWANNANOA, NC 28778**

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F 000	INITIAL COMMENTS On onsite complaint investigation survey was conducted 11/01/22 through 11/03/22. Event ID# 4DX011. The following intakes were investigated: NC00192577, NC00191750, NC00192603, NC00192619, NC00192704, NC00193332, NC00192055, and NC00194517. 2 of 16 complaint investigations were substantiated resulting in deficiencies. Event ID# 4DX011.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		11/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/16/2022

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.

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff and Medical Doctor (MD) the facility failed to notify the physician of a newly identified open area on the right heel resulting in a delay in treatment for wound that developed signs of infections for 1 of 3 residents reviewed for notification (Resident #3). The findings included: Resident #3 was admitted to the facility on 08/09/22 with diagnoses including dementia, diabetes mellitus, and peripheral vascular disease. Resident #3 was discharged to the community on 08/29/22.	F 580	1. F580 Notify of Changes was cited. Based on the findings, it was alleged that the facility failed to notify the physician of a newly identified open area to resident #3s right heel that worsened. Resident was admitted on 8/9/22 however, discharged to the community on 8/29/22. Resident has a dx of PVD, dementia, and DM. Upon admission, staff identified that the resident had a reddened blanchable open area to her R heel, but a treatment as not initiated until 8/18/22 when the MD was notified. 2. Current facility residents could be at risk of being affected by the alleged deficient practice. 100% skin	

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	345418	A. BUILDING ______ B. WING ______	C 11/03/2022

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F 580 Continued From page 2

Review of the admitting 3-day skin assessments for Resident #3 revealed on 08/09/22 and 08/10/22 Nurse #1 documented a blanchable open area was present on the right posterior heel. On 08/11/22 Nurse #2 documented a blanchable open area was present on right posterior heal.

Review of Resident #3's medical records revealed no evidence or documentation the Medical Doctor (MD) or Nurse Practitioner (NP) were notified of the open area on the right heel identified on the admitting skin assessments.

Review of the document titled; "Weekly Pressure Wound Observation Tool" dated 08/18/22 revealed the MD or NP were notified on 08/18/22 of an unstageable pressure ulcer (a wound obscured by dead tissue) on the right heel of Resident #3. Treatment orders were provided, and the note indicated the wound was acquired on 08/09/22.

Review of the Wound Care NP progress note revealed on 08/18/22 an initial exam of Resident #3's right heel identified an unstageable pressure ulcer measured 2.9 cm in length and 3 cm in width and 0 cm in depth. Treatment orders were to clean the area with normal saline and apply a debriding ointment and cover with a silicone foam dressing every day and as needed.

Review of the Wound Care NP progress note dated 08/25/22 revealed the size of right heel pressure ulcer increased and measured 3.9 cm in length and 3 cm in width and 0.3 in depth with 80 % slough (moist non-viable tissue). The Wound Care NP recommended antibiotics and noted the reason as being increased drainage, odor, pain, and redness.

F 580

assessments performed by Director of Nursing and Unit Managers began on 11/3/22 and were completed by 11/4/22. Any new concerns were added to the wound care log by the Director of Nursing and notifications were made to the MD, RPs and other as applicable. Tx orders obtained by Wound care nurse. 100% audit of the current in-house wounds was performed by the Director of Nursing on 11/3/22 with no further concerns noted.

3. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: All nurses were educated by the Director of Nursing and the Staff Development Coordinator (SDC) for proper notification of family, resident, Medical Director or Nurse Practitioner and responsible party r/t any change, injury, decline, room, etc. The education began on 11/4/22 and was completed on 11/15/22. On-going education was added to the Orientation documentation on 11/15/22 and will be provided by the Staff Development Coordinator and the Director of Nursing on F580 (Notify of Changes) for any newly hired staff and agency staff.

4. The Director of Nursing will audit any newly acquired or changes to current wounds for proper notification 3x/week for 12 weeks. All new admissions and re-admissions will be audited daily by the Director of Nursing to ensure skin check is performed and treatment orders in place if appropriate. Director of Nursing or

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	345418	A. BUILDING ______ B. WING ______	C 11/03/2022

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F 580

Continued From page 3

During an interview on 11/01/22 at 2:43 PM the Wound Care Nurse revealed she first saw Resident #3's wound on 08/17/22 and described it as an unstageable pressure ulcer with eschar (scab like dead skin either black, brown, or tan in color). She cleaned the wound and covered it with a dressing and notified the Wound Care NP who saw Resident #3 right heel wound on 08/18/22. The Wound Care Nurse confirmed there were no treatments in place for an open area identified on the admitting skin assessments done on 08/09/22, 08/10/22, and 08/11/22.

During an interview on 11/01/22 at 4:22 PM Nurse #1 confirmed he documented the skin assessments for Resident #3 on 08/09/22 and 08/10/22. Nurse #1 revealed he didn't verbally report Resident #3 had an open area on the right heel to the MD or NP. Nurse #1 stated the Wound Care Nurse reviewed the weekly skin assessments therefore he didn't report the open area on Resident #3's right heel.

An interview was conducted on 11/02/22 at 11:22 AM with the MD. The MD revealed the skin assessments done on 08/09/22, 08/10/22, and 08/11/22 identified an open area on the right heel he would expect the nurse to notify the physician, or the NP to obtain treatment orders. The MD revealed a delay in treatment would put Resident #3 at risk for developing an infection if the area on the right heel was left untreated.

During an interview on 11/02/22 at 1:56 PM Nurse #2 confirmed she documented the skin assessment on 08/11/22. Nurse #2 revealed she didn't report an open area on heel of Resident #3 because there were 2 previous assessments

F 580

Wound Nurse will monitor The Director of Nursing or Wound Care nurse will audit in-house skin assessments on 3 residents per unit 5 x a week for 4 weeks: 3 residents per unit 3 x a week for four weeks, and 3 residents per unit 1 x a week for four weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not provide recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with notification of changes.

5. Date of Completion is 11/18/22.

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	345418	A. BUILDING ______ B. WING ______	C 11/03/2022

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F 580	Continued From page 4 prior to hers and the physician should've already been notified with treatment orders in place. An interview was conducted on 11/03/22 at 3:08 PM with the Director of Nursing (DON). The DON revealed she expected Nurses to notify the Wound Care Nurse, her, and the MD or NP to ensure concerns related to the skin weren't missed and the area was evaluated right away. The DON revealed after her review of the admitting skin assessments she couldn't find any evidence to support the open area to the right heel was reported or a treatment was in place prior to 08/18/22. During an interview on 11/03/22 at 3:31 PM the Administrator revealed the process in place if the Nurse finds something abnormal during a resident's skin assessment, they need to call either the on-call or inform NP or MD so treatment orders can be put in place.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the	F 607		11/18/22

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F 607	Continued From page 5 QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow their abuse policy and procedure by not immediately reporting an allegation of resident-to-resident abuse to the Administrator for 1 of 6 sampled residents reviewed for abuse (Resident #1). Findings included: The facility policy titled, "Abuse, Neglect and Exploitation implemented 11/01/20, read in part: "it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. All alleged violations will be reported to the Administrator within specified timeframes: Immediately, but not later than 2 hours after the allegation is made." Resident #1 was admitted to the facility on	F 607	Facility failed to implement abuse policy and procedures in the area of reporting when an allegation of resident-to-resident abuse was not immediately reported to the Administrator. The Administrator confirmed she did not submit the initial report to the State Agency regarding the allegation of alleged abuse until she was informed of the event the following day. The 24-Hour Initial Report and 5- Day Working Report for stated incident was submitted to the State Agency on 8.30.22 and 9.5.22 respectively. 2. Current facility residents are at risk of being affected by the deficient practice. Regional Director of Operations (RDO) conducted an audit of all grievances from 8/1/22 to 11/3/22 identify any areas of reportable concerns. All staff were questioned to identify any abuse allegations that may have not been reported. No further areas of concern	

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F 607	Continued From page 6	F 607		

04/29/21 with multiple diagnoses that included major depression, bipolar disorder, and anxiety.

The quarterly Minimum Data Set (MDS) dated 08/23/22 assessed Resident #1 with intact cognition.

Resident #2 was admitted to the facility on 08/25/22 with multiple diagnoses that included right femur fracture and bipolar disorder.

The admission Minimum Data Set (MDS) dated 08/31/22 assessed Resident #2 with intact cognition.

Review of the initial investigative report submitted by the facility to DHSR noted an allegation type of resident abuse involving Resident #1 and Resident #2, a cognitively intact male, on 08/29/22. Review of the facility's investigation summary revealed on 08/29/22 between 10:30 PM and 11:30 PM, Resident #1 reported she was woken from sleep by Resident #2 touching her breasts without her permission. Resident #1 told Resident #2 to leave her room, he left and Resident #1 immediately reported the incident to nursing staff. It was noted the facility was made aware of the allegation on 08/30/22 at 8:30 AM, the initial report was submitted to DHSR via fax transmission on 08/30/22 at 9:25 AM and law enforcement was notified.

Resident #1 was out of the facility and unable to be interviewed at the time of this investigation.

Resident #2 was discharged to another nursing facility on 09/22/22 and unable to be interviewed.

During a telephone interview on 11/02/22 at 9:33

identified. Completed: 11.15.22.

3. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: On 11.4.22, the Regional Directors of Operations (RDO) re-educated the Administrator, Staff Development Coordinator (SDC), and Director of Nursing (DON) on the Identification of abuse allegations and timely reporting to state agencies; as well as the facility Abuse, Neglect and Exploitation policy and Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy, stressing the importance of identifying and reporting any allegations to the Administrator or Director of Nursing (DON). Beginning 11.4.22, the Staff Development Coordinator (SDC) re-educated all facility and agency staff on the facility Abuse, Neglect and Exploitation Policy including identification of abuse allegations & reporting timeline requirements. 100% of staff, including agency, to be educated by 11.16.22. Newly hired facility and agency staff will receive Abuse, Neglect and Exploitation Policy and Compliance with Reporting Allegations of Abuse/Neglect/Exploitation Policy education upon hire and prior to first shift worked by. The Administrator and /or Director of Nursing (DON) will report violations to NC State Agency immediately but no later than 2 hours if the allegation involves abuse and results of investigation will be submitted within 5 working days of the incident.

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	345418	A. BUILDING ______ B. WING ______	C 11/03/2022

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F 607	Continued From page 7 AM, Nurse Aide (NA) #2 confirmed she worked the evening of 08/29/22 and was assigned to provide Resident #1 and Resident #2's care. NA #2 could not recall the exact time but stated when she answered Resident #1's call light and went into her room, Resident #1 stated she had been asleep and woke up to Resident #2 touching her breasts. NA #2 recalled Resident #2 was not in Resident #1's room at the time and Resident #1 stated she had told him to leave. NA #2 stated she immediately reported Resident #1's statement to Nurse #1. During a telephone interview, Nurse #1 confirmed he worked the evening of 08/29/22 and was assigned to provide Resident #1 and Resident #2's care. Nurse #1 recalled around 10:30 PM to 11:00 PM, he was informed by NA #2 that Resident #1 alleged Resident #2 came into her room while she was asleep and touched her breasts. Nurse #1 stated when he spoke to Resident #1 she told him Resident #2 came into her room and was sitting on her bed, she fell asleep and woke up to Resident #2 touching her breasts. Nurse #1 stated Resident #1 was assessed with no injury or signs of distress. Nurse #1 stated Resident #2 denied the incident occurred, was instructed to remain in his room remainder of the night and staff were instructed to monitor both residents closely. Nurse #1 could not recall the exact time but stated he notified the Director of Nursing (DON) of the incident via text message the next morning, 08/30/22. Nurse #1 explained when the incident was reported to him on 08/29/22, he did not know an allegation of abuse was supposed to be reported to Administration immediately. During an interview on 11/03/22 at 8:15 AM, the	F 607	4. The Regional Director of Operations (RDO) or Regional Director of Clinical Services (RDCS) will audit all facility allegations of abuse for timely state agency reporting 3 x a week for 4 weeks, then 1-time weekly for 8 weeks. The Administrator or Director of Nursing (DON) will complete abuse questionnaires with 5 current staff members to verify understanding of identifying and reporting of abuse weekly for 12 weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not provide recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with Abuse Policy and Reporting. 5. Date of compliance: 11.18.22	

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F 607	Continued From page 8 DON confirmed she received a text message from Nurse #1 the morning of 08/30/22, sometime between 7:00 AM and 8:00 AM, while on her way to the facility. When she arrived at the facility, she immediately contacted the Administrator, placed Resident #2 on one-to-one staff supervision and an investigation was initiated. During an interview on 11/03/22 at 3:39 PM, the Administrator confirmed she was notified the morning of 08/30/22 of the resident-to-resident incident that occurred the evening of 08/29/22 involving Resident #1 and Resident #2, the initial report was submitted to DHSR and an investigation was immediately initiated. The Administrator was not sure why Nurse #1 did not contact her or the DON when the allegation was first reported to him by Resident #1 on 08/29/22 and explained all staff were previously educated on the facility's abuse policy which included reporting allegations of abuse immediately. The Administrator added all staff had since been re-educated on the abuse policy.	F 607		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F 640		11/18/22

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F 640	Continued From page 9 reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 640	1) Facility failed to complete and	

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F 640

Continued From page 10

facility failed to complete discharge Minimum Data Set (MDS) assessments within 14 days of the discharge date for 3 of 4 sampled residents reviewed for discharge (Residents #2, #10, and #3).

Findings included:

1. Resident #2 was admitted to the facility on 08/25/22.

A Social Worker progress note dated 09/22/22 at 11:30 AM revealed Resident #2 discharged to another nursing facility.
Review of Resident #2's medical record revealed the last completed MDS assessment was an admission dated 08/31/22. A discharge MDS assessment dated 09/21/22 noted a status of "in progress."

During an interview on 11/03/22 at 10:12 AM, MDS Coordinator #1 revealed she started her employment with the facility in October 2022. MDS Coordinator #1 confirmed a discharge MDS assessment was started for Resident #2 but had not been completed. She was not sure what had happened or how the assessment was overlooked but stated it should have been completed within 14 days of Resident #2's discharge.

During an interview on 11/03/22 at 3:39 PM, the Administrator explained for a period of time the facility did not have any full-time MDS Coordinators and MDS assessments got behind. The Administrator stated when the two MDS Coordinators started last month, they prioritized the MDS assessments that needed completed, oldest first, and the discharge assessment for

F 640

transmit discharge assessments within 14 days of the assessment reference date for 2 of 4 sampled residents (Resident #3, #10 and #2). Resident #3, #10 and Resident #2 discharge assessments were completed and transmitted on (#3) 11.1.22 and (#10 and #2) 11.3.22 respectively by the Minimum Data Set (MDS) nurse.

2) Current facility residents are at risk for being affected by this alleged deficient practice. Minimum Data Set Nurses completed an audit of Discharged residents within the past 30 days to ensure that Discharge Assessment (ND) was completed and Transmitted for all Discharged residents on 11.16.22 with no other assessments found to be out of compliance.

3) Education was provided to the MDS nurse(s) and the Interdisciplinary Team on completing discharge assessments within 7 days and transmitting within 14 days after a facility completes the resident□s assessment, this was completed on 11.15.22 by the Regional Clinical Reimbursement Nurse. Newly hired Interdisciplinary team members, MDS nurses, and agency MDS nurses will also be educated during orientation and upon hire.

4) MDS nurse(s) to monitor at least 5 discharge Minimum Data Sets 1x weekly for four weeks then monthly for 3 months to ensure they are completed within 7 days and transmitted within 14 days after

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 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	**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 640	Continued From page 11 Resident #2 got overlooked. She added discharge MDS assessments should have been completed within 14 days of discharge. 2. Resident #10 was admitted to the facility on 09/02/22. A nurse progress note dated 09/20/22 at 11:14 AM revealed Resident #10 discharged to the community. Review of Resident #10's medical record revealed the last completed MDS assessment was an admission dated 09/09/22. A discharge MDS assessment dated 09/20/22 noted a status of "in progress." During an interview on 11/03/22 at 10:12 AM, MDS Coordinator #1 revealed she started her employment with the facility in October 2022. MDS Coordinator #1 confirmed a discharge MDS assessment was started for Resident #10 but had not been completed. She was not sure what had happened or how the assessment was overlooked but stated it should have been completed within 14 days of Resident #10's discharge. During an interview on 11/03/22 at 3:39 PM, the Administrator explained for a period of time the facility did not have any full-time MDS Coordinators and MDS assessments got behind. The Administrator stated when the two MDS Coordinators started last month, they prioritized the MDS assessments that needed completed, oldest first, and the discharge assessment for Resident #10 got overlooked. She added discharge MDS assessments should have been completed within 14 days of discharge.	F 640	facility completes the resident□s assessment. Minimum Data Set Nurse will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with completing quarterly Minimum Data Sets assessments. 5) Date of Compliance: 11.18.22.	

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 11/03/2022

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F 640	Continued From page 12 3. Resident #3 was admitted to the facility on 08/09/22 and was discharged to the community on 08/29/22. Review of Nurse Practitioner (NP) discharge summary dated 08/26/22 revealed Resident #3 was being evaluated for discharge home. Review of the discharge Minimum Data Set (MDS) assessment for Resident #3 revealed the date of completion was 11/01/22. During an interview on 11/03/22 at 10:12 AM, MDS Coordinator #1 revealed she started her employment with the facility in October 2022. MDS Coordinator #1 confirmed a discharge MDS assessment was completed for Resident #3 on 11/01/22. She stated the discharge MDS assessment should have been completed within 14 days of Resident #3's discharge from the facility. During an interview on 11/03/22 at 3:39 PM, the Administrator explained there was a period of time the facility did not have any full-time MDS Coordinators and MDS assessments got behind. The Administrator stated when the two MDS Coordinators started last month, they prioritized the MDS assessments that needed completed, oldest first, and the discharge assessment for Resident #3 got overlooked. She added discharge MDS assessments should have been completed within 14 days of discharge.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		11/18/22

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 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 641	Continued From page 13 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess and document an existing open area was present on the admission Minimum Data Set (MDS) for 1 of 3 residents reviewed for pressure ulcers (Resident #3). The findings included: Resident #3 was admitted to the facility on 08/09/22 with diagnoses including dementia, diabetes mellitus, and peripheral vascular disease. Review of the admitting 3-day skin assessments for Resident #3 revealed on 08/09/22 and 08/10/22 Nurse #1 documented a blanchable open area was present on the right posterior heel. On 08/11/22 Nurse #2 documented a blanchable open area was present on right posterior heal. Review of the admission Minimum Data Set (MDS) assessment dated 08/16/22 indicated Resident #3 was at risk but did not have any unhealed pressure ulcers or other skin conditions. Treatments included a pressure reducing device for the bed and chair. During an interview on 11/02/22 at 12:52 PM the Wound Care Nurse revealed when she became aware of the area on the right heel and after reviewing Resident #3's skin assessments she determined the pressure ulcer wound was present upon admission.	F 641	1. The facility failed to accurately assess and document an existing pressure ulcer on an admission assessment. Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessment for Resident #3. Minimum Data Set (MDS) Assessment with Assessment Reference Date (ARD) 08/16/2022 has been modified by the Regional Minimal Data Set coordinator to include a stage II on 11.15.22. The MDS for Resident # 3 is now current as per Resident Assessment Interview (RAI) guidelines for Section/s M0210 / M0300. 2. All current facility residents who have pressure ulcer wounds have the potential to be affected by this alleged deficient practice. All current Residents with Pressure Ulcers will be reviewed by the Minimal Data Set Nurse(s) for MDS accuracy and all MDS assessments and will be current on 11.16.22. 3. Measures put in place to ensure the alleged deficient practice does not recur include: The Clinical Management Team including Administrator, Director of Nursing (DON), Unit Managers, Minimum Data Set (MDS) Coordinator, Social Work Director, Activity Director and have been educated on accuracy of MDS on 11.16.22.	

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	345418	A. BUILDING ______ B. WING ______	C 11/03/2022

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F 641	Continued From page 14	F 641	4. Minimum Data Set (MDS) of residents with current and unhealed Pressure Ulcers will be audited weekly for 3 months by Director of Nursing (DON), Administrator or Unit Manager (UM). Findings of the monitoring will be reported to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with completing quarterly Minimum Data Sets assessments. 5. Date of compliance: 11.18.22	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff, the Wound Care Nurse Practitioner, and Medical Doctor the facility failed to provide necessary care and services for a newly identified open area on the right heel and failed to	F 686	1. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer was cited. Based on the findings, it was alleged that the facility failed to provide necessary care and treatment to a wound identified for	11/18/22

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 11/03/2022

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F 686	Continued From page 15 accurately complete the weekly skin assessment and shower audit tool for an existing wound on the right heel that developed signs of infection for 1 of 3 residents reviewed for pressure ulcers (Resident #3). The findings included: Resident #3 was admitted to the facility on 08/09/22 with diagnoses including dementia, diabetes mellitus, and peripheral vascular disease. Resident #3 was discharged to the community on 08/29/22. Review of the admitting 3-day skin assessments for Resident #3 revealed on 08/09/22 and 08/10/22 Nurse #1 documented a blanchable open area was present on the right posterior heel. On 08/11/22 Nurse #2 documented a blanchable open area was present on right posterior heal. Review of the bathing records revealed on 08/12/22 Nurse Aide #1 initialed the shower audit tool to indicate Resident #1 received a bed bath and documented the skin was intact and good. Review of Resident #3's weekly skin assessment revealed on 08/15/22 Nurse #3 documented the skin was intact. Review of the admission Minimum Data Set (MDS) dated 08/16/22 assessed the cognition of Resident #3 as being moderately impaired and indicated extensive assistance was needed with bed mobility, transfers, and toilet use. The MDS indicated Resident #3 was at risk but did not have any unhealed pressure ulcers or other skin conditions and treatments included a pressure reducing device for the bed and chair.	F 686	Resident #3 on 8.9.22. The initial treatment orders were not initiated until 8.18.22 by the wound nurse and the NP. 2. Current facility residents are at risk of being affected by the alleged deficient practice. 100% skin assessments performed by Director of Nursing and Unit Managers on 11/3/22 and were completed by 11/4/22. No new skin issues were identified at that time. In addition, 100% audit of the current in-house wounds was performed by the Director of Nursing on 11.3.22, all wound and treatment orders with their supplemental documentation were present with no other concerns noted. 3. All nurses were educated by the Director of Nursing, Unit Managers, and/or Staff Development Coordinator for proper identification and care of wounds to ensure proper healing. The education began on 11/4/22 and was completed on 11/17/22. Newly hired facility and agency staff will receive education for proper identification and care of wounds to facilitate proper healing upon hire and prior to first shift worked by Staff Development Coordinator or Director of Nursing. 4. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: The Unit Managers or the Wound Nurse will review all shower sheets 5 x a week for 4 weeks, 3 x a week for 4 weeks, then 1 a week for	

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 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 686 Continued From page 16

Review of a progress note dated 08/17/22 revealed the Wound Care Nurse documented Resident #3 was notified of treatment orders and a plan of care for the right heel. The treatment was to apply an antiseptic solution of povidone-iodine and cover with a silicone foam dressing and scheduled to be changed three times a week and as needed when soiled or dislodged for a deep tissue injury (non-blanchable, darkly pigmented skin resulting from prolonged pressure).

Review of the document titled; "Weekly Pressure Wound Observation Tool" signed by the Wound Care Nurse revealed on 08/18/22 the Medical Doctor (MD) or alternate was notified, and the current treatment in place was to clean the right heel with normal saline and apply a nickel thick amount of a debriding ointment (removes dead tissue) to the wound bed and cover with a silicone foam dressing. The treatments were scheduled to be changed daily and as needed. An air mattress and heel boots were recommended to offload pressure. The documentation indicated this was the first observation of a pressure ulcer that was present on admission on 08/09/22 and currently measured 2.9 centimeter (cm) in length and 3.2 cm in width and 0 cm in depth with a moderate amount of bloody drainage.

Review of the Wound Care Nurse Practitioner (NP) progress note revealed on 08/18/22 the initial exam of Resident #3's right heel identified an unstageable pressure ulcer (a wound obscured by dead tissue) measuring 2.9 cm in length and 3 cm in width and 0 cm in depth. The Wound Care NP recommended to clean the area with normal saline and apply a debriding ointment

F 686

four weeks, to determine if any new skin areas are identified. The Director of Nursing or Wound Care nurse will audit in-house skin assessments on 3 residents per unit 5 x a week for 4 weeks: 3 residents per unit 3 x a week for four weeks, and 3 residents per unit 1 x a week for four weeks. All new admissions and re-admissions will be audited 5x a week for 12 weeks by the Director of Nursing or Unit Managers to ensure skin checks are performed and treatment orders are in place, if appropriate. The Director of Nursing will audit at least 2 current wounds per the wound report weekly for 12 weeks to ensure all steps are being taken to anticipate proper wound healing.

5. Date of Completion is 11/18/22.

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 11/03/2022

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PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 686	Continued From page 17	F 686		

and cover with a silicone foam dressing every day and as needed.

Review of the care plan initiated on 08/18/22 identified Resident #3 had the potential for pressure ulcer development related to limited physical mobility, diagnosis of dementia, and diabetes mellitus. Interventions included skin assessments per protocol or Medical Doctor order and report any skin changes or abnormalities.

Review of the Wound Care NP progress note dated 08/25/22 revealed the size of right heel pressure ulcer increased to 3.9 cm in length and 3 cm in width and 0.3 in depth with 80 % slough (moist non-viable tissue). The Wound Care NP recommended antibiotics and noted the reason as being increased drainage, odor, pain, and redness.

Review of the NP progress note dated 08/25/22 revealed Resident #3 was evaluated for a right heel wound. The note revealed the Wound Care NP reported increased redness and slough with signs of possible infection. The note revealed Resident #3 had no increased pain associated to the worsening wound and remained afebrile (no fever). A wound culture and pain management were ordered.

Review of the wound culture report revealed on 08/26/22 a culture was collected. The report revealed the lab received and reported the results on 08/31/22 the specimen was out of stability and no culture was obtained.

An interview was conducted on 11/01/22 at 2:43 PM with the Wound Care Nurse. The Wound

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 11/03/2022

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PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 686	Continued From page 18	F 686		

Care Nurse revealed she first saw Resident #3's wound on 08/17/22 and described it as an unstageable pressure ulcer with eschar (scab like dead skin either black, brown, or tan in color). She cleaned the area and covered it and notified the Wound Care NP. The Wound Care NP assessed Resident #3's pressure ulcer and provided treatment orders on 08/18/22. The Wound Care Nurse confirmed no treatment orders were in place when the wound was first identified on the admitting skin assessments on 08/09/22, 08/10/22, and 08/11/22.

During an interview on 11/01/22 at 4:22 PM Nurse #1 confirmed he documented the skin assessments for Resident #3 dated 08/09/22 and 08/10/22. Nurse #1 revealed he didn't verbally report Resident #3 had an open area on the right heel and stated he documented the results on the skin assessments. Nurse #1 stated the Wound Care Nurse reviewed the weekly skin assessments therefore he didn't report the open area on Resident #3's right heel.

A second interview was conducted on 11/02/22 at 12:52 PM with the Wound Care Nurse. The Wound Care Nurse revealed she did not review weekly skin assessments for residents unless a concern was communicated to her then she would and physically looked at the area. The Wound Care Nurse revealed when she became aware of the area on the right heel and after reviewing Resident #3's skin assessments she determined the wound was present upon admission.

During an interview on 11/02/22 at 1:56 PM Nurse #2 confirmed she documented the skin assessment dated 08/11/22. Nurse #2 revealed

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 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 686	Continued From page 19	F 686		

she would've reported her findings to the Wound Care Nurse but since Resident #3 was admitted on 08/09/22 and there were 2 previous assessments prior to hers she assumed treatment orders were in place. Nurse #2 revealed she checked treatment orders when she identified an open area on a Resident's skin and if not in place would notify the Wound Care Nurse. When informed no treatments were in place until 08/18/22 Nurse #2 stated something was missed.

An interview was conducted with Nurse #3 on 11/02/22 at 9:52 AM. Nurse #3 confirmed she documented the weekly skin assessment for Resident #3 indicating the skin was intact on 08/15/22. Nurse #3 stated she was unsure if the skin was intact since the previous assessments identified an open area on the right heel. Nurse #3 stated she would report to the Unit Supervisor or Wound Care Nurse if a resident had an open area on the heel or skin.

An interview was conducted on 11/02/22 at 11:22 AM with the Medical Doctor (MD). The MD revealed Resident #3 was at risk for the development of pressure ulcers due to predisposing diagnoses including peripheral vascular disease. The MD revealed a delay in treatment would put Resident #3 at risk for developing an infection if an open area on the right heel was identified upon admission and left untreated.

An interview was conducted on 11/02/22 at 3:13 PM with Nurse Aide (NA) #1. NA #1 confirmed she documented the shower audit sheet dated 08/12/22 indicating Resident #3's skin was intact and good. NA #1 revealed she documented 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 11/03/2022

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PELICAN HEALTH AT ASHEVILLE	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 686	Continued From page 20 skin was good on 08/12/22 meaning there were no open areas or nothing new on the skin she hadn't previously observed. NA #1 stated she would report to the nurse when she identified an open area on the skin. A second interview was conducted on 11/03/22 at 8:04 AM with Nurse #1. Nurse #1 didn't recall providing a treatment to the right heel of Resident #3. Nurse #1 stated he could only recall doing the necessary paperwork for the skin assessment. During an interview on 11/03/22 at 10:40 AM the Wound Care NP revealed her first assessment on 08/18/22 Resident #3 had an unstageable pressure ulcer on her right heel. Resident #3 denied pain to area and there was no odor to indicate infection. On her next visit on 08/25/22 the pressure ulcer presented with increased redness, slough, and had an odor. With Resident #3 having pain to the area and the other changes she noted those were signs of an infection. The Wound Care NP revealed she couldn't say how long the wound was present but if an open area on the right heel was identified on the admission skin assessments and the area was left uncovered or without treatments in place that would increase the risk of a pressure ulcer becoming infected. An interview was conducted on 11/03/22 at 3:08 PM with the Director of Nursing (DON). The DON revealed she expected Nurses to notify the Wound Care Nurse, her, and the MD or NP to ensure concerns related to skin weren't missed and the area was evaluated right away. The DON revealed after her review of the admitting skin assessments she couldn't find any evidence to support the open area to the right heel was	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT ASHEVILLE	**1984 US HIGHWAY 70 SWANNANOA, NC 28778**

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F 686	Continued From page 21 reported or a treatment was in place prior to 08/18/22. During an interview on 11/03/22 at 3:31 PM the Administrator revealed the process in place if the Nurse finds something abnormal during a resident's skin assessment, they need to call either the on-call physician or inform NP or MD so treatment orders can be put in place.	F 686		