PRINTED: 02/11/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345432	B. WIN	B. WING 02/0		02/0	1/2013
	ROVIDER OR SUPPLIER	PTIST HOME	4	213	ET ADDRESS, CITY, STATE, ZIP CODE RICHMOND HILL DRIVE HEVILLE, NC 28806	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	0.00110	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282 SS=D	PERSONS/PER CAR The services provided must be provided by accordance with each care. This REQUIREMENT by: Based on observation and staff interviews, the fall interventions that a plan, of mobility alarm bed/recliner/wheelchate the wheelchair for two residents (Resident #6 The findings are: 1. Resident #60 was a diagnoses of dementia dizziness, and deprese Minimum Data Set (Mindicated that for the Estatus (BIMS) the resident status (BIMS) the resident status assistance with transferactivities of daily living devices of walker and revealed the resident admission and two fall injury. A review of the resident revealed a care plan of addressed a history of intervention included to	d or arranged by the facility qualified persons in resident's written plan of is not met as evidenced as, medical record review, me facility failed to institute were identified in the care as on the ir and a non-slip material in (2) of three (3) sampled 30 and #31). Admitted to the facility with a (Alzheimer's type), sion. The most recent DS), dated 12/13/12, 3rief Interview for Mental dent was moderately ated she did need ers, bed mobility, and most a Resident requires mobility wheelchair. The MDS also had a history of falls prior to is since admission without ant's medical record lated 01/23/13 which		282	A) Resident 31 and #60's interventions were immediately implement the care key and the care key and the care key and the care key and the cassistant assigned to the Residents #31's non-slit material was placed in wheel chair and the whole chair alarm was placed wheel chair. The charge nurses, certified nursing assistants and the nurse supervisors were in-sect to the importance of reand implementing the keys and care plans each in order to familiarize themselves to the reside information in regards individual risks of falling those interventions recommended and documented by the caste plan team continued to the care plan team continued to the care plan coordinate social worker, activity dand the dietary managements.	nted per are plan g her neel in #60's ge g erviced as eviewing care ch shift dents to their g and re plan mittee. sists of or, director er. The	(X6) DATE

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 discretely able 148 2 8 2013 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to communed

program participation.

by:

Administ Ator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345432	B. WIN	B. WNG		02/01/2013	
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME			2.	EET ADDRESS, CITY, STATE, ZIP CODE 13 RICHMOND HILL DRIVE SHEVILLE, NC 28806	N N		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	90000	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 282	on the bed and wheel attempts to rise unass. On 01/28/13 at 2:37 Fobserved in her room without a mobility alar. On 01/29/13 at 8:45 Aobserved in her room without a mobility alar. On 01/30/13 at 1:15 Fobserved in her room without a mobility alar. On 01/31/13 at 2:57 Fobserved in her room without a mobility alar. On 01/31/13 at 4:45 Fobserved in her room without a mobility alar. On 01/31/13 at 4:45 Fobserved in her room without a mobility alar. On 01/31/13 at 4:45 Fobserved in her room, sitting for Resident #6 need to check with her the alarms. On 02/1/13 at 10:20 Aobserved in her room, sitting in her wheelcha attached. On 02/1/13 at 10:30 Aobserved that each rocare key" that is to be when caring for a resident #6 place.	chair "to alert staff to sisted." "M resident #60 was sitting in her recliner mattached. "M PM resident #60 was sitting in her wheelchair mattached. "M resident #60 was sitting in her wheelchair mattached. "M resident #60 was sitting in her wheelchair mattached. "M resident #60 was sitting in her wheelchair mattached. "M resident #60 was sitting in her wheelchair mattached. "M Licensed Nurse #1 was dishe was unaware of any 60. She stated she would r supervisor in reference to	F	282	Falls committee consists of the home administrator, the direct nursing, the care plan coordinated activity director, the social wortherapy manager and the dieta manager. B) All residents could be affect residents at risk for falls will had care keys reviewed each shift is charge nurses and the certified assistants. All residents are exfor fall risks at the time of administration and quarterly and on needed thereafter by the regist nurse supervisor. All nursing strin-serviced in this regard as of February 2013. C) The nursing supervisor will the fall interventions on the cath and the care plans for accuracy communicate with the charge and the certified nursing assists and all fall interventions and enthe correct implementation of interventions by conducting phychecks each shift. None of the staff will be allowed to work present actions.	tor of ator, the ary ted. All we their by the linursing aluated ission, eks after as tered taff were 25 review re keys y, nurse ants any nsure those ysical nursing	

	OF DEFICIENCIES F CORRECTION				(X3) DATE SURVEY COMPLETED		
		345432	B. WING		02/0	1/2013	
WESTERN NORTH CAROLINA BAPTIST HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI	2 ⁻	EET ADDRESS, CITY, STATE, ZIP CODE 13 RICHMOND HILL DRIVE SHEVILLE, NC 28806 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
F 282	#60 having an un-witr there had been no corresident should have stated that the fall corsuggestions for an interview an order for the nurse receives the ordinal implemented. At that to observed on resident recliner with NA #1 and On 02/01/13 at 12:10 was interviewed. She committee meetings, care plans for the nurse stated her; being a Lic responsible for inform intervention is recomminately been a change to On 02/01/13 at 12:20 was interviewed. She order for alarms after the stated she committed with the stated she committed with the stated that it is her expects for the alastated that it is her expects for the Residents Care Keeps and the stated she care Keeps with the stated she care with the stat	ed she knew of Resident dessed fall on 01/23/13 but mmunication with her that an alarm in place. She mmittee meets and makes dervention on care plans, der it would be der it	F:	282	Being retrained in the in-service D) The director of nursing will at the care keys and care plans we care plan team and the falls contonensure accuracy, and perform physical weekly spot checks in to the residents at fall risk and accompanying interventions at the quality assurance committed quarterly. This will be on going quality assurance committee confit the medical director, the administrator, the director of nother care plan coordinator, the sworker, the activity director, the dietary manager, the therapy me the and the pharmacy consultation. E) 28 February 2013	review ith the mmittee m . regards their nd brief ee . The onsists ursing, social e nanager,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345432	B. WN	B. WING		02/0	02/01/2013	
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME		,	21	EET ADDRESS, CITY, STATE, ZIP CODE 13 RICHMOND HILL DRIVE SHEVILLE, NC 28806				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 282	Continued From page	3	F	282				
	Infection (UTI), Alzhei The most recent Minir significant change wa The score for the Brie indicated resident's codecision making was never/rarely made demaximum assist with daily living. The mobil wheelchair for this Re The Care Area Asses 01/10/13 showed that risk for falls. The MDS that the resident had days. A review of Resident of 01/08/13 at 12:00 PM reviewed by the interconneslip material will be wheelchair. A review of the reside 01/17/13 revealed an material placed in the The facility form titled to inform the nurse as needs are revealed un	cumulative diagnoses completed on 01/10/13. If Interview for Mental Status completed on Gally severely impaired. Resident cisions. Resident required transfers and activities of ity device required is a sident. Interview for Mental Status completed on Gally severely impaired. Resident cisions. Resident required transfers and activities of ity device required is a sident. Interview for Mental Status completed on Gally severely impaired. Resident document (CAA) dated the Resident #31 was at completed on Gally severely impaired is a sident. Interview for Mental Status completed on O1/10/13. Interview for Mental Status completed on O1/10/12. Interview						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		JRVEY TED
		345432	B. WING		02/	01/2013
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME			STREET ADDRESS, CITY, STATE, ZIP COD 213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806	Ε		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	sitting in her wheelcher non-slip material in the On 02/01/13 at 1:16 Frevealed she was not material was to be us also revealed that she resident care key. On 02/01/13 at 1:18 Find Licensed Nurse #2 she material should be plaresident is up. On 02/01/13 at 1:20 Find Director of Nursing she was seated on a specified the non-slip material in On 02/01/13 at 1:43 Find Therapist revealed the approached her and a Resident #31 to see if non-slip material need indicated that when she room the non-slip material need indicated that when she resident's recliner and the resident was sitting stated when a fall occite the circumstances of the need for a new interverses on sible for updation and the Resident Care	PM resident was observed air and there was no e wheelchair. PM an interview with NA #2 aware that a non-slip ed for Resident #31. She edid not see it listed on edid not see in the wheelchair when edid that the resident edialty cushion but did not see in the resident's wheelchair. PM an interview with the edit the MDS Nurse had asked her to check on another piece of the edid to be cut. The Therapist he went to the resident's derial was lying in the edit was not in the wheelchair in the wheelchair in the interdisciplinary fing morning and reviews the fall and establishes the ention. The MDS Nurse is not the Resident's Care Plan edice Key. If there is a need for the placed in a resident's poist is responsible for	F 2	82		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345432	B. WNG		02/01	1/2013
	ROVIDER OR SUPPLIER	PTIST HOME	2	REET ADDRESS, CITY, STATE, ZIP CODE 113 RICHMOND HILL DRIVE ASHEVILLE, NC 28806	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 282 F 323 SS=D	responsible for that rematerial is in place. 483.25(h) FREE OF A HAZARDS/SUPERVIOLEMENT The facility must ensure environment remains as is possible; and ear	Nurse and the Nurse Aide; sident's care, that the ACCIDENT SION/DEVICES re that the resident as free of accident hazards	F 282	A) Resident #60 and res #31's interventions w immediately impleme the care key and care the certified nursing a assigned to them. Res #31's non-slip materia placed in her wheel cl the wheel chair alarm placed in #60's wheel	ere ented per plan by essistants eident al was nair and was	
	by: Based on observation medical record review implement preventive with multiple falls (Resensure interventions is multiple falls (Resident The findings are: 1. Resident #60 was a diagnoses of dementional dizziness, and depress Minimum Data Set (Mindicated that for the Estatus (BIMS) the resimpaired. Resident state assistance with transfactivities of daily living devices of walker and revealed the resident.	t, the facility failed to measures for a resident sident #60), and failed to he place for a resident with it #31). Indicate to the facility with a (Alzheimer's type), sion. The most recent DS), dated 12/13/12, Brief Interview for Mental dent was moderately		The charge nurses, the certified nursing assist the nurse supervisors serviced as to the important of reviewing and impless the recommendations documented by the cateam and the falls continued the care plan team continued the care plan coordinates social worker, the activity director of nursing care plan coordinator, activity director, the soworker, the dietary mand the therapy manager.	tants and were in- ortance ementing are plan mittee. nsists of ator, the vity ry mmittee strator, the the ocial anager,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	30 33	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345432	B. WN	B. WNG 02/0		02/0	1/2013
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME			21	EET ADDRESS, CITY, STATE, ZIP CODE 3 RICHMOND HILL DRIVE SHEVILLE, NC 28806	o.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
in A read in or at O ob will o ob sit at O	ddressed a history of tervention included to the bed and wheel tempts to rise unass on 01/28/13 at 2:37 Proserved in her room it hout a mobility alar on 01/29/13 at 8:45 And proserved in her room it hout a mobility alar on 01/30/13 at 1:15 Proserved in her room it hout a mobility alar on 01/31/13 at 2:57 Proserved in her room it hout a mobility alar on 01/31/13 at 4:45 Proserved in her room it hout a mobility alar on 01/31/13 at 4:45 Proserved in her room it hout a mobility alar on 01/31/13 at 1:20 proserved in her room, it in 02/01/13 at 10:20 proserved in her room, it in 02/01/13 at 10:30 processed in her room, it in 02/01/13 at 10:30 processed in her wheelchalt and 02/01/13 at 10:30 p	nt's medical record dated 01/23/13 which f frequent falls. One the use of a mobility alarm chair "to alert staff to sisted." M resident #60 was sitting in her recliner m attached. M PM resident #60 was sitting in her wheelchair m attached. M resident #60 was sitting in her wheelchair m attached. M resident #60 was sitting in her wheelchair m attached. M resident #60 was sitting in her wheelchair	F3	323	B) All residents could be affect residents care keys and care puthose residents at falls risk are reviewed each shift for their a and implementation by the charges and certified nursing at All nursing staff were inserviced in this regard as of 25 February 2013. C) The registered nurse super review the care keys and care all residents who need interver regarding falls to ensure the factorrect implementation of the interventions and communicate the charge nurses and certifie assistants as well as perform puthecks of those interventions shift. None of the nursing staff allowed to work prior to being retrained in the in-service. D) The administrator and the of nursing will review the care care plans with the care plan of falls committee to ensure according and the resident's super regards to the resident's super regards	clans for e to be accuracy narge ssistants. Seed in this in- control of the second of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		* NACH * NAME AND THE OF	(X2) MULTIPLE CONSTRUCTION A. BUILDING		RVEY FED	
		345432	B. WING		02/0	1/2013
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME			:	REET ADDRESS, CITY, STATE, ZIP COD 213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806	E	
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 323	care key" that is to be when caring for a resi realize that Resident in place. On 02/01/13 at 10:45 interviewed. She state #60 having an un-with there had been no concesident should have stated that the fall consuggestions for an intimative an order for the nurse receives the ordinary recliner with NA #1 are On 02/01/13 at 12:10 was interviewed. She committee meetings, care plans for the nurse stated her; being a Lid responsible for inform intervention is recommitted that it is her expects for the ale stated that it is her expects the care keys for the ale stated that it is her expects for the ale stated that	looked at and followed dent. NA stated she did not #60 was to have an alarm in AM Licensed Nurse #2 was ed she knew of Resident nessed fall on 01/23/13 but mmunication with her that an alarm in place. She nmittee meets and makes ervention on care plans, a intervention, and when the der it would be time no alarms were as bed, wheelchair, or ad Nurse #2. PM the MDS Coordinator stated she attends the fall She stated she updates the sing staff and the resident ing assistants. She also censed Nurse, are	F 323	And assistive devices to accidents weekly and refalls committee and the assurance committee queen going basis. The qual committee consists of the director, the administrated director of nursing, the coordinator, the social wactivity director, the diethe therapy manager, the consultant and the mediclerk. E) 28 February 2013	port to the quality uarterly on an ity assurance ne medical tor, the care plan worker, the tary manager, ne pharmacy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345432	B. WING		02/01/2013	
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME			1	REET ADDRESS, CITY, STATE, ZIP CODE 213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION	
F 323	Continued From page	8	F 323			
	include: Osteoporosis Infection (UTI), Alzhei The most recent Minis significant change wa The score for the Brie indicated resident's or decision making was never/rarely made de maximum assist with daily living. The mobil wheelchair for this Resident of 1/8/13 at 12:00 PM or reviewed by the interconnessip material will be wheelchair. A review of the resided 01/17/13 revealed an	cumulative diagnoses s, Recent Urinary Tract imer's disease, and Anxiety. mum Data Set (MDS) for a ss completed on 01/10/13. If Interview for Mental Status ognitive skills for daily severely impaired. Resident cisions. Resident required transfers and activities of ity device required is a ssident. #31 nurses notes dated documented that a fall was disciplinary team and a see placed in the resident's				
	to inform the nurse as needs are revealed up	ety" a non-slip material was				
	sitting in her wheelche non-slip material in th					
	revealed she was not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345432	B. WING		02/01/2013	
NAME OF PROVIDER OR SUPPLIER WESTERN NORTH CAROLINA BAPTIST HOME			2	EET ADDRESS, CITY, STATE, ZIP CODE 13 RICHMOND HILL DRIVE SHEVILLE, NC 28806		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	material was to be us also revealed that she resident care key. On 02/01/13 at 1:18 F Licensed Nurse #2 sh material should be plaresident is up. On 02/01/13 at 1:20 F Director of Nursing sh was seated on a specthe non-slip material in On 02/01/13 at 1:43 F Therapist revealed the approached her and a Resident #31 to see in non-slip material need indicated that when shoom the non-slip material material material in the second that when shoom the non-slip material mate	ed for Resident #31. She e did not see it listed on PM an interview with the indicated that a non-slip faced in the wheelchair when PM during an interview with the stated that the resident tialty cushion but did not see in the resident's wheelchair. PM an interview with the fact the MDS Nurse had tasked her to check on if another piece of the fact the went to the resident's the went to the resident's the was lying in the if was not in the wheelchair	F 323			