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 07/24/2015

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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews with resident and staff the facility failed to provide showers to 1 of 3 sampled residents. (Resident #152) The findings included: Resident #152 was admitted to the facility 07/09/15 with diagnoses which included schizoaffective disorder and chronic obstructive pulmonary disease. The admission Minimum Data Set for Resident #152 dated 07/16/15 assessed Resident #152 with moderately impaired cognition and requiring supervision with set-up help with bathing. The admission care plan for Resident #152 included the following problem area and approaches: Support self directed, independent leisure pursuits and activities. -provide an opportunity for decision making, self-expression, creative expression The resident has an activity of daily living self-care performance deficit related to dementia, confusion, tremors	F 242	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center¿s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F242 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ Resident #152 showered upon notification that he had not received shower on 7/22/2015 as he had desired. How corrective action will be accomplished for those residents having the potential to be affected by the same	8/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/13/2015

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F 242	Continued From page 1 -bathing/showering. The resident is able to perform with supervision, cues and some assist. On 07/22/15 at 12:57 PM Resident #152 reported his assigned weekly showers were given on Wednesday and Saturday. Resident #152 stated he needed minimal assistance with showers, noting he required help with removing shoes, socks and some of his clothing. Resident #152 stated that, since admission, he had not received the showers on Saturday as scheduled. Resident #152 stated he had not refused showers, was in the facility on shower days and, prior to admission, was used to having a shower every other day. Review of the electronic medical record and paper charting noted Resident #152 had showers scheduled on 07/11/15, 07/15/15, 07/18/15 and 07/22/15. Documentation in the electronic and paper charting noted showers had been given Wednesday 07/15/15 and 07/22/15 but did not indicate a shower was given on Saturday 07/11/15 or 07/18/15. The electronic record included a section where staff could note if a resident was not available or refused and this was not indicated on 07/11/15 or 07/18/15. On 07/23/15 at 3:20 PM Nurse Assistant (NA) #1 (that was one of the nurse assistants assigned the hall Resident #152 resided on 07/18/15) reported the daily assignment sheet identified which staff member was responsible for a residents shower on the schedule. On 07/23/15 at 6:00 PM NA #2 (that was one of the nurse assistants assigned the hall Resident #152 resided on on 07/11/15 and 07/18/15) stated she did not recall if she was assigned to Resident	F 242	deficient practice ¿ Residents were interviewed to find out preference for showers and completed on 8/11/2015. PCC updated and completed by 8/14/2015. Measures to be put in place or systemic changes made to ensure practice will not re-occur- Nurses and CNA¿s were in-serviced by Administrator, Director of Nursing or designeed on making sure resident¿s choice of showers is honored and put in the CNA task to match resident desire. DON, Unit Manager or Designee will complete an audit of new residents admitted to the facility to ensure that their shower preferences have been acknowledged and scheduled. Current residents, the Unit Manager and designee will check the shower schedule daily Monday ¿ Friday to ensure that showers have been completed. Any deviations from the schedule will result in re-education/disciplinary action. This audit will be completed daily (Monday-Friday) x4 weeks, bi-weekly 6 new admits if applicable x2 months and monthly 6 admits for 3 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-Choices will be care planned and notated in Point of Care Tasks for CNA to ensure choices are followed. All audits will be reviewed during weekly risk meeting and presented to the QA Committee monthly x3 and Quarterly x3 to ensure continued compliance and revisions to the plan if needed.	

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F 242	Continued From page 2 #152 on 07/11/15 or 07/18/15 or anything related to a shower. On 07/23/15 at 6:30 PM NA #3 (that was one of the nurse assistants assigned the hall Resident #152 resided on 07/18/15) stated she could not remember who she was assigned to care for on 07/18/15 but that she always signed the paper charting and electronic charting if a shower had been given to a resident. On 07/24/15 at 11:35 AM the Director of Nursing (DON) stated daily assignment sheets were not retained by the facility and she was unable to locate the assignment sheets for 07/11/15 and 07/18/15 to determine which staff member was assigned to assist with a shower for Resident #152. The DON stated she expected showers to be given as scheduled unless the resident was not available or refused the shower. The DON reviewed the paper charting and electronic documentation from 07/11/15 and 07/18/15 for Resident #152 and verified a shower had not been given to Resident #152 as scheduled. The DON stated she could not explain why a shower had not been given to Resident #152 on 07/11/15 and 07/18/15 and was surprised because it was not a difficult task because of the resident being fairly independent.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		8/21/15

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F 272	Continued From page 3 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete Sections C (cognitive pattern) and D (mood) of a comprehensive Minimum Data Set for 1 of 8 residents reviewed for comprehensive assessments (Resident #97).	F 272	F272 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿	

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F 272	Continued From page 4 The findings included: Resident #97 was admitted to the facility on 05/13/15 with diagnoses of coronary artery disease, hypertension and muscle weakness. A review of the admission Minimum Data Set (MDS) dated 05/20/15 for Resident #97 revealed Section C contained no codes for sections C0100 through C1000 (mental status assessment by resident interview or staff making the assessment). Section D contained no codes in sections D0100 through D0650 (assessment of mood by resident interview or staff making the assessment). The 05/20/15 comprehensive assessments for cognition and mood were not completed for Resident #97. In Section Z, entitled Assessment Administration, the corporate MDS Consultant (MDSC) had her signature in Z0400 and Z0500. The signature in Z0400 indicated that the MDSC was responsible for completing sections C and D on 06/01/15. The signature in Z0500 of Section Z verified all sections of the comprehensive assessment were complete on 06/01/15. During an interview conducted on 07/24/15 at 6:13 PM with the Administrator he revealed the facility went through a period of time without an in-house MDS Coordinator. He stated during that time the MDSC helped keep MDS assessments on schedule. The Administrator explained the MDSC was not in the facility during the 7 to 14 day assessment reference date (ARD) of the 05/20/15 comprehensive MDS for Resident #97. No one in the facility completed the assessments for cognition or mood during the ARD period. Therefore, the assessments were missed.	F 272	On 7/24/15, an audit was conducted of MDS¿s completed from 3/1/15-7/24/15 to ensure all current residents had the interview sections (cognition, mood and preferences) on the MDS and not ¿coded as not assessed¿. OBRA MDS were scheduled for the residents who did not have an interview completed to ensure their interview portion was assessed and their MDS were completed accurately on all current resident as of 8/12/2015. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ Ensure the MDS resident/staff interviews are completed timely, Data Analysis and Verification Specialist (DAVS) provided training to the MDS Coordinator (MDSC), Discharge (DC) Planner, and DON, on the completion of the MDS resident/staff interview, DC If the resident has an unplanned discharge, then a staff interview will be conducted and completed within 72 hours of discharge. MDSC will complete the MDS resident/staff interview preferably prior to or on the day of the ARD. In absence of MDSC, DC Planner will serve as the back up to complete MDS resident/staff interview to assess the resident¿s cognition (BIMS), mood (PHQ-9) and preferences. In absence of both MDSC and DC Planner, the DON or DON¿s designee will complete the MDS resident/staff interview. If the MDS resident/staff interview is missed, the MDSC or the designee, will still complete the MDS resident/staff interview. The answers from the interview	

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F 272	Continued From page 5	F 272	will be documented on a paper copy of the MDS, and scanned under the MISC Tab in PCC. The care plan will be updated to reflect the resident¿s plan of care. The answers from the interview will not be coded on the MDS if a missed interview occurs. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- MDSC will monitor MDS for accurate completion of MDS resident/staff interviews for the following schedule. ¿ 5 random MDS¿s a week for 4 weeks ¿ 5 random MDS¿s Bi-monthly for 1 month ¿ 5 random MDS¿s Monthly for 4 months The list of charts audited will be provided to the DON/Administrator to present during Quality Assurance. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Results of audit will be reported to the Quality Assurance Risk Management Committee to ensure continued compliance or revisions to the plan if needed.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		8/21/15

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F 278	Continued From page 6 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Sections C (cognitive pattern) and D (mood) of quarterly Minimum Data Set assessments for 2 of 13 residents reviewed for quarterly assessments. (Residents #26 and #112). The findings included: 1. Resident #26 was admitted to the facility 11/14/14 with diagnoses which included anxiety, major depressive disorder, and Alzheimer's disease.	F 278	F278 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #112 and Section C & D were completed on 7/24/2015. Resident #26, Section C & D were completed on 8/12/2015. How corrective action will be accomplished for those residents having the potential to be affected by the same	

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F 278	Continued From page 7 A review of a quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 06/25/15 revealed Section C contained no codes for sections C0100 through C1000 (mental status assessment by resident interview or staff making the assessment). Section D contained no codes in sections D0100 through D0650 (assessment of mood by resident interview or staff making the assessment). The 06/25/15 quarterly assessments for cognition and mood were not completed for Resident #26. In Section Z, entitled Assessment Administration, the corporate MDS Consultant (MDSC) had her signature in Z0400 and Z0500. The signature in Z0400 indicated that the MDSC was responsible for completing sections C and D on 07/13/15. The signature in Z0500 of Section Z verified all sections of the quarterly assessment were complete on 07/13/15. An interview was conducted with the Administrator on 07/24/15 at 6:13 PM. The Administrator stated the facility went through a period of time without an in-house MDS Coordinator. During that time, the MDSC helped keep MDS assessments on schedule. The Administrator explained the MDSC was not in the facility during the 7 to 14 day ARD date of the 06/25/15 quarterly MDS for Resident #26. No one in the facility completed the assessments for cognition or mood during the ARD period. Therefore, the assessments were missed. 2. Resident #112 was admitted to the facility 11/03/14 with diagnoses which included depressive disorder, and cancer of the liver.	F 278	deficient practice ¿ Ensure the MDS resident/staff interviews are completed timely, DAVS provided training to the MDSC, DC Planner, and DON, on the completion of the MDS resident/staff interview, DC If the resident has an unplanned discharge, then a staff interview will be conducted and completed within 72 hours of discharge. MDSC will complete the MDS resident/staff interview preferably prior to or on the day of the ARD. In absence of MDSC, DC Planner will serve as the back up to complete MDS resident/staff interview to assess the resident¿s cognition (BIMS), mood (PHQ-9) and preferences. In absence of both MDSC and DC Planner, the DON or DON¿s designee will complete the MDS resident/staff interview. If the MDS resident/staff interview is missed, the MDSC or the designee, will still complete the MDS resident/staff interview. The answers from the interview will be documented on a paper copy of the MDS, and scanned under the MISC Tab in PCC. The care plan will be updated to reflect the resident¿s plan of care. The answers from the interview will not be coded on the MDS if a missed interview occurs. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- MDSC will monitor MDS for accurate completion of MDS resident/staff interviews for the following schedule. ¿ 5 random MDS¿s a week for 4 weeks	

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F 278	Continued From page 8 A review of a quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/20/15 revealed Section C contained no codes for sections C0100 through C1000 (mental status assessment by resident interview or staff making the assessment). Section D contained no codes in sections D0100 through D0650 (assessment of mood by resident interview or staff making the assessment). The 05/20/15 quarterly assessments for cognition and mood were not completed for Resident #112. In Section Z, entitled Assessment Administration, the corporate MDS Consultant (MDSC) had her signature in Z0400 and Z0500. The signature in Z0400 indicated that the MDSC was responsible for completing sections C and D on 06/29/15. The signature in Z0500 of Section Z verified all sections of the quarterly assessment were complete on 06/29/15. An interview was conducted with the Administrator on 07/24/15 at 6:13 PM. The Administrator stated the facility went through a period of time without an in-house MDS Coordinator. During that time, the MDSC helped keep MDS assessments on schedule. The Administrator explained the MDSC was not in the facility during the 7 to 14 day ARD date of the 06/25/15 quarterly MDS for Resident #112. No one in the facility completed the assessments for cognition or mood during the ARD period. Therefore, the assessments were missed.	F 278	¿ 5 random MDS¿s Bi-monthly for 1 month ¿ 5 random MDS¿s Monthly for 4 months The list of charts audited will be provided to the DON/Administrator to present during Quality Assurance. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Results of audit will be reported to the Quality Assurance Risk Management Committee to ensure continued compliance or revisions to the plan if needed.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		8/21/15

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F 279	Continued From page 9 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a care plan for 1 of 1 resident reviewed for Hospice (Resident #149). The findings included: Resident #149 was admitted to the facility on 07/08/15 with diagnoses of renal insufficiency, diabetes and non-Alzheimer's dementia. The admission Minimum Data Set (MDS) dated 07/15/15 revealed Resident #149 was severely cognitively impaired. The MDS further revealed Resident #149 received Hospice care. Review of the Hospice services sign in sheets revealed Resident #149 received visits from the Hospice Nurse and Social Worker on 07/09/15, Hospice Nurse on 07/15/15 and 07/16/15, Hospice Chaplin and Nurse on 07/22/15 and the Hospice Social Worker on 07/23/15.	F 279	F279 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #149 had a hospice care plan placed on 7/24/2015. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ As of 8/12/2015 there are no other Hospice patients at this time. Current Staff Nurses educated on Nursing Policy #2602, Care Planning.	

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F 279	Continued From page 10 Review of the medical record on 07/23/15 revealed the care plan dated 07/17/15 did not address Hospice care for Resident #149. During an interview on 07/24/15 at 3:38 PM the MDS Nurse stated if a resident was admitted to Hospice care they should have a facility care plan. She stated she was not aware Resident #149 received Hospice services and she should have been care planned for Hospice. An interview with the Director of Nursing (DON) on 07/24/15 at 9:58 AM revealed Resident #149 should have had a care plan for hospice services. She stated Hospice and the facility had a care plan and worked together to meet the goals and interventions for the resident.	F 279	Measures to be put in place or systemic changes made to ensure practice will not Re-occur- All new admissions and readmissions will be reviewed for Hospice needs. The Director of Nursing/Unit Manager or designee will review charts for Hospice and care planned appropriately. Meeting with Administrator, DON and Hospice to discuss communication between the two agencies and care planning. The DON, Unit Manager, SDC or Designee will audit daily (Monday ¿ Friday) new patients weekly x 2 weeks, bi-monthly x 1 month, and monthly x 1 to ensure Hospice patients are care planned on admission. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- The Director of Nursing or designee will report results of these audits in weekly Quality Assurance Risk Meetings X 3 months and Quarterly Quality Assurance Meetings X1 for further problem resolution.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews with staff the facility failed follow physician orders through failure to check	F 281	F281 How corrective action will be accomplished for each resident found to	8/21/15

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F 281	Continued From page 11 wanderguards (alarming safety devices) for placement and function for 4 of 6 sampled residents with wanderguards. (Residents #61, #94, #151 and #45) The findings included: 1. Resident #151 was admitted to the facility 07/13/15 with diagnoses which included Alzheimer's, lack of coordination, anxiety and episodic mood disorder. The admission Minimum Data Set dated 07/20/15 assessed Resident #151 with significant cognitive impairment and no wandering behaviors since admission. The admission care plan dated 07/22/15 for Resident #151 included a problem area, The resident is an elopement risk/wanderer due to dementia related to impaired safety awareness. Approaches to this problem area included, wanderguard (an alarming safety device) right arm and check for placement. A physician's order dated 07/13/15 included right arm wanderguard and to check placement every shift and function every week. Review of the July 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for Resident #151 noted the order to check placement of the wanderguard every shift and function every week was not included on either the MAR or TAR. Nursing progress notes in the medical record of Resident #151 did not indicate Resident #151 had ever attempted to exit the facility since admission	F 281	have been affected by the deficient practice ¿Resident #61 complete order on 7/30/2015, #94 complete order on 7/30/2015, #151 complete order on 7/13/2015 (revised), #45 complete order on 8/10/2015. Wander Guard placed on resident. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ The Director of Nursing/Unit Manager or designee will audit current residents Wander Risk Assessments to ensure that if wander guard is needed that they are in place and care-planned, physician and RP notified of Placement. Current patient¿s with a wander guard ¿ the patients MAR was checked to ensure that: 1) Wander guard ¿ Check function every week. 2) Wander guard ¿ Check placement every shift was added to the patients MAR to ensure monitoring by nurses every shift Current nurses on staff in-serviced on completing wandering assessments on admission and with cognitive change of condition with patients and quarterly. All new admissions requiring a wander guard as determined by the assessment will have the following added to their MAR orders: 1) Wander guard ¿ Check function every week. 2) Wander guard ¿ Check placement every shift. Anyone that does not complete 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 07/24/2015

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 281	Continued From page 12 07/13/15. Observations of Resident #151 on 07/21/5 at 4:05 PM and 07/24/15 at 3:22 PM noted a wanderguard on the resident's right arm. On 07/24/15 at 4:00 PM Nurse #3 stated nursing staff were aware of residents with a wanderguard based on orders in the individual residents TAR. Nurse #3 explained, when the order was placed on the TAR, the electronic TAR flagged the nurse to check the wanderguard for placement or function. Nurse #3 stated she was not aware Resident #151 had a wanderguard because it was not in the resident's TAR. On 07/24/15 at 4:30 PM the wanderguard on Resident #151 was checked and it was in place and functional. On 07/24/15 at 6:15 PM the Director of Nursing (DON) and administrator stated the use of a wanderguard on a resident was initiated if there was any indication of wandering behaviors. The DON stated the admission nurse was responsible for ensuring any orders for checking placement or function of a wanderguard were placed on a residents TAR. The DON noted the nurses were responsible for checking placement of the wanderguard every shift and functionality every week. The DON stated if a particular button on the electronic system was not engaged the order to check placement and function would not go on the individual resident's TAR and nursing staff would not be aware of the need to check placement and function. The DON stated she was not aware the July 2015 TAR for Resident # 151 did not include to check placement and function of the wanderguard. The DON stated	F 281	in-service will be removed from the schedule until education received on Behavioral Assessment/Behavior Monitor which included ¿ 1) An assessment related to patterns of behavior will be completed in order to clarify the underlying cause of the behavior and help develop effective management interventions. 2. Patients will be observed by staff on all shifts and report any untoward behavior, that is observed, to a licensed nurse. 3. The Interdisciplinary Team will develop a plan of care to attain or maintain the highest practicable level of psychosocial well-being while pursuing causes and interventions for the disruptive behavior through a behavior management program. 4. Evaluation of the behavioral management plan and interventions can be analyzed and changes made by the care plan team at any time. Evaluation should occur at least quarterly with the care plan review. 5. The Care Plan will identify behavior problems, have measurable goals, appropriate interventions, and be coordinated with the interdisciplinary team, patient, and family. Revise as changes in the patient¿s condition dictates. 6. A licensed Nurse will document targeted behaviors and noted side effects on the	

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 13 there were so many new nurses at the facility they were trying to get all nurses educated on the facility electronic system. 2. Resident #61 was admitted to the facility 10/25/11 with diagnoses which included mental disorder and anxiety. A quarterly Minimum Data Set dated 06/12/15 assessed Resident #61 with significant cognitive impairment and with no wandering behaviors (at the time of the assessment). The care plan for Resident #61 was last updated 07/23/15 and included the following problem areas: The resident is resistive to care at times, combative with care routine, agitation with confusion related to dementia and The patient's goal is for long term care due to her need for 24 hour care and supervision. The care plan for Resident #61 did not address a wanderguard (an alarming safety device). A Device Assessment in the medical record of Resident #61 dated 09/05/14 and 09/23/14 indicated the need of a wanderguard for the resident for safety and mobility and due to being an elopement risk. A Wandering Risk Assessment in the medical record of Resident #61 dated 07/24/15 noted Resident #61 was disoriented, forgetful, with a short attention span and did not understand surroundings. The Assessment included Resident #61 ambulated with one assist, took antidepressant and antianxiety medication on a daily basis.	F 281	Behavior/Intervention Monitoring Sheet or document on eMAR via Point Click Care. 7. At the time of admission; elopement/wandering behaviors are recorded on the Admission/Nursing Assessment/Screening. Update care plan and evaluate quarterly on the Wandering/Elopement Risk Assessment. 8. If a patient begins demonstrating unsafe aimless wandering behaviors after the initial admission to the Center; utilize the Wandering/Elopement Risk Assessment and re-evaluate at least quarterly and update care plan accordingly. Measures to be put in place or systemic changes made to ensure practice will not re-occur- The Director of Nursing/Unit Manager or designee will audit new admissions ¿ by observational rounding and chart review to verify that the orders for wander guard monitoring has been implemented on patients deemed at risk on the MAR (Monday ¿ Friday) x 4 weeks, bi-monthly x 1 month, and monthly x 4. How facility will monitor corrective action(s) to ensure deficient practice will not Re-occur- The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings X 3 months and Monthly Quality Assurance Meetings X6 for further problem resolution.	

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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

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F 281	Continued From page 14	F 281		

Physician orders in the medical record of Resident #61 included two orders on 07/23/15, Wanderguard check placement every shift and check function every week.

Review of the June 2015 and July 2015 Treatment Administration Record (TAR) for Resident #61 noted the wanderguard was not included to be checked for placement and function until 07/23/15.

On 07/24/15 at 3:15 PM Nurse #4 stated she was very familiar with Resident #61 and was aware there was a wanderguard in place on the resident's ankle. At the time of the interview Nurse #4 went to the room of Resident #61 to show the wanderguard was in place on the resident's ankle. Nurse #4 stated she was aware to check placement of the wanderguard because it would be flagged on the resident's electronic TAR. Nurse #4 stated though the need to check placement and function of the wanderguard had not been on the TAR of Resident #61 until 07/23/15 she was aware it was in place and working because the resident set the wanderguard alarm off so much due to wandering behaviors.

On 07/24/15 at 6:15 PM the Director of Nursing (DON) and administrator stated the use of a wanderguard on a resident was initiated if there was any indication of wandering behaviors. The DON stated the nurse was responsible for ensuring any orders for checking placement or function of a wanderguard were placed on a residents TAR. The DON noted the nurses were responsible for checking placement of the wanderguard every shift and functionality every week. The DON stated if a particular button was

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 07/24/2015

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

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F 281	Continued From page 15	F 281		

not engaged the order to check placement and function would not go on the individual resident's TAR and nursing staff would not be aware of the need to check placement and function. The DON stated the Wandering Assessment and Device Assessment were the tools used by the facility to note if there were any behaviors that put a resident at risk for wandering and if a wanderguard should be used to monitor a residents whereabouts. The DON stated when wanderguards were initiated by the nurse they would include an order to check for placement and function as well as a care plan. The DON stated the orders and care plan should be in place at the time a wanderguard is indicated for use on a resident. The DON stated she was not working at the facility at the time the wanderguard was placed on Resident #61 in September of 2014 and could not explain why the need to check placement and function was not included on the resident's TAR until 07/23/15. The DON stated she had worked on updating the facility Wandering Profile Book (a book in place at each nurses station which listed residents with a wanderguard) but did not check each residents TAR to ensure there was an order to check placement and function of the wanderguard. The DON stated there were so many new nurses at the facility they were trying to get all nurses educated on the facility electronic system.

3. Resident #94 was admitted to the facility 09/16/14 with diagnoses which included glaucoma, depression, insomnia, anxiety and Alzheimer's dementia.

A quarterly Minimum Data Set dated 07/13/15 assessed Resident #94 with significant cognitive impairment and without wandering behavior (at

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 07/24/2015

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

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F 281	Continued From page 16	F 281		

the time of the assessment).

The care plan for Resident #94 included the following problem areas which were initiated on the date noted:
04/29/15 The resident has the potential to be physically aggressive related to diagnosis dementia with behavior disturbances. The resident is resistive to care (yelling/aggressive behavior) at times toward caregivers related to dementia, anxiety and delusional thinking.
07/23/15 The resident is an elopement risk/wanderer related to resident wanders aimlessly, impaired safety awareness, disoriented to place. An approach to this problem area was a wanderguard (an alarming safety device).

A Device assessment in the medical record of Resident #94 dated 09/09/14 indicated the need for a wanderguard for safety.

Physician orders in the medical record of Resident #94 included two orders on 07/23/15, Wanderguard check placement every shift and check function every week.

Review of the June 2015 and July 2015 Treatment Administration Record (TAR) for Resident #94 noted the wanderguard was not included to be checked for placement and function until 07/23/15.

On 07/24/15 at 3:15 PM Nurse #5 stated nursing staff were aware of residents with a wanderguard based on orders in the individual residents TAR. Nurse #5 explained, when the order was placed on the TAR, the electronic TAR flagged the nurse to check the wanderguard for placement or function. Nurse #5 went to the room of 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 07/24/2015

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

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F 281	Continued From page 17	F 281		

#94 and demonstrated how the device was checked for functionality.

On 07/24/15 at 6:00 PM Nurse #1 stated she updated the care plan and orders of Resident #94 on 07/23/15 after being asked to ensure these were up to date for all residents with wanderguards.

On 07/24/15 at 6:15 PM the Director of Nursing (DON) and administrator stated the use of a wanderguard on a resident was initiated if there was any indication of wandering behaviors. The DON stated the nurse was responsible for ensuring any orders for checking placement or function of a wanderguard were placed on a residents TAR. The DON noted the nurses were responsible for checking placement of the wanderguard every shift and functionality every week. The DON stated if a particular button was not engaged the order to check placement and function would not go on the individual resident's TAR and nursing staff would not be aware of the need to check placement and function. The DON stated the Wandering Assessment and Device Assessment were the tools used by the facility to note if there were any behaviors that put a resident at risk for wandering and if a wanderguard should be used to monitor a residents whereabouts. The DON stated when wanderguards were initiated by the nurse they would include an order to check for placement and function as well as a care plan. The DON stated the orders and care plan should be in place at the time a wanderguard is indicated for use on a resident. The DON stated she was not working at the facility at the time the wanderguard was placed on Resident #94 in September of 2014 and could not explain why the need to

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 07/24/2015

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

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F 281	Continued From page 18	F 281		

check placement and function was not included on the resident's TAR until 07/23/15. The DON stated she had worked on updating the facility Wandering Profile Book (a book in place at each nurses station which listed residents with a wanderguard) but did not check each residents TAR to ensure there was an order to check placement and function of the wanderguard. The DON stated there were so many new nurses at the facility they were trying to get all nurses educated on the facility electronic system.

4. Resident #45 was admitted to the facility on 09/05/07 with diagnoses of Alzheimer's disease and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 04/28/15 revealed Resident #45 was moderately cognitively impaired and no wandering behaviors during the 7 day lookback.
The care plan for Resident #45 was last updated 07/23/15 and included the following problem area: Resident #45 had a wandering/elopement risk related to poor safety awareness.
Review of the physician orders dated 07/24/14 indicated Resident #45 was to wear a wander guard for safety and staff were to check placement and function of the wander guard every shift.
Review of the July 2015 Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for Resident #45 revealed the order to check placement and function of the wander guard every shift was not included on the MAR or TAR.
Observations of Resident #45 on 07/23/15 at 1:30 PM and 07/24/15 at 3:45 PM revealed a wander guard on the residents left wrist.
On 07/24/15 at 3:47 PM Nurse #7 stated nursing staff were aware of residents with wander guards

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 07/24/2015

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 281	Continued From page 19 based on the physician orders placed on the TAR. Nurse #7 looked at Resident #45's TAR and MAR and stated there was no order to check for placement and function of the wander guard each shift. He further stated he knew Resident #45 had a wander guard because he had set off the alarm 3 times that day. An interview conducted on 07/24/15 at 6:15 PM with the Director of Nursing (DON) and Administrator stated the use of a wander guard on a resident was initiated if there was any indication of wandering behaviors. The DON stated the admission nurse was responsible for ensuring any orders for checking placement or function of a wander guard were placed on the TAR. The DON noted the nurses were responsible for checking placement of the wander guard every shift and functionality every week. The DON stated if a particular button on the electronic documenting system was not engaged the order to check placement and function would not go on the individual resident's TAR and nursing staff would not be aware of the need to check placement and function. The DON stated she was not aware the July 2015 TAR for Resident #45 did not include to check placement and function of the wander guard. The DON stated she had worked on updating the facility Wandering Profile Book (a book in place at each nurses station which listed residents with a wander guard) but did not check each residents TAR to ensure there was an order to check placement and function of the wander guard. She stated there were so many new nurses at the facility they were trying to get all nurses educated on the facility electronic documenting system.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		8/21/15

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 07/24/2015

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 309	Continued From page 20 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to assess a resident that had a psychiatric diagnosis who exhibited wandering behaviors and would at times exit the facility as evidenced in 2 different incidences for 1 of 1 resident reviewed for wellbeing. (Resident #112). The findings included: A review of a facility policy dated 02/01/15 and entitled Behavioral Assessment/Behavior Monitor specified in part: If a resident began demonstrating unsafe aimless wandering behaviors after the initial admission to the facility, utilize the Wandering/Elopement Risk Assessment and re-evaluate at least quarterly and update care plan accordingly. Resident #112 was admitted to the facility 11/13/14 with diagnoses which included depressive disorder, anxiety, schizophrenia, and cancer of the liver. A care plan revised 12/04/14 described Resident #112 had a potential for altered psychosocial wellbeing related to cancer, anxiety, and depression. Care plan goals specified the resident would identify copying mechanisms, verbalize feelings related to an emotional state, and will utilize effective coping mechanisms.	F 309	F309 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ Resident #112 wandering assessment was completed on 7/23/2015 and 7/25/2015. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ An audit of the in-house patients by Nurse Consultant to ensure that all current residents had wandering assessments on the chart. All residents current within quarterly time frame per policy. Measures to be put in place or systemic changes made to ensure practice will not re-occur- Licensed nurses received education on Behavioral Assessment/Behavior Monitoring which included 1) An assessment related to patterns of behavior will be completed in order to clarify the underlying cause of the behavior and help	

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 07/24/2015

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 309	Continued From page 21 Interventions included consult with psych services and monitor and document the resident's usual response to problems. A Minimum Data Set (MDS) dated 04/15/15 indicated Resident #112's cognition was moderately impaired. The MDS specified the resident was independent with all activities of daily living, could understand others and was understood, demonstrated minimal depression, and had exhibited no wandering behavior. A review of Resident #112's medical record revealed a Wandering Risk Assessment dated 05/16/15. The assessment noted the resident had recently experienced a room change and transfer from one unit to another. The assessment further noted Resident #112 was presently taking antipsychotics, antidepressants, anti-anxiety/hypnotics, and narcotic medications. No other Wandering Risk Assessments were noted in Resident #112's medical record following this assessment. Further medical record review revealed a progress note written by a Psychologist and dated 07/06/15. The note contained the focus of this session was to continue to address issues related to cancer and feeling confined at the facility and "needing to go somewhere else." Continued review of Resident #112's medical record revealed a nurse's note written 07/17/15 at 11:34 PM by Nurse #2. The note specified the Director of Nursing (DON) reported to this nurse that Resident #112 had advanced outside to the roadside and appeared to be attempting to cross the road. Additional medical record review revealed a nurse's note written 07/20/15 at 12:58 PM by Nurse #2. The note specified Resident #112 was agitated this shift when he was told he was changing rooms. The resident was further	F 309	develop effective management interventions. 2. Patients will be observed by staff on all shifts and report any untoward behavior, that is observed, to a licensed nurse. 3. The Interdisciplinary Team will develop a plan of care to attain or maintain the highest practicable level of psychosocial well-being while pursuing causes and interventions for the disruptive behavior through a behavior management program. 4. Evaluation of the behavioral management plan and interventions can be analyzed and changes made by the care plan team at any time. Evaluation should occur at least quarterly with the care plan review. 5. The Care Plan will identify behavior problems, have measurable goals, appropriate interventions, and be coordinated with the interdisciplinary team, patient, and family. Revise as changes in the patient¿s condition dictates. 6. A licensed Nurse will document targeted behaviors and noted side effects on the Behavior/Intervention Monitoring Sheet or document on eMAR via Point Click Care. 7. At the time of admission; elopement/wandering behaviors are recorded on the Admission/Nursing Assessment/Screening. Update 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 07/24/2015

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 309	Continued From page 22 described refusing to allow staff to help move his belongings saying he would move his own things. Additional note review revealed later the resident was observed pushing his wheelchair out the front door (of the facility). The Administrator and another staff member followed the resident around the building and up into the woods (behind the facility). The resident remained agitated but finally agreed to come back inside for this nurse (Nurse #1). Staff tried to reassure the resident that we would help him get placement where ever he wanted to be but this was not the appropriate way to go about it. The note further contained Nurse #1 explained to the resident that we (the facility) were responsible for his safety. The note also contained 15 minute checks were initiated. An observation of Resident #112 was conducted during an interview on 07/21/15 at 1:49 PM. The resident was observed sitting in his wheelchair at a table in the day room. During the interview he constantly scratched the palms of both of his hands. As the interview continued, the resident began to roll from one position at the table to another. Before the interview ended, the resident was observed rolling back and forth to all 3 sides of the table. An interview was conducted with Nurse Aide (NA) #5 on 07/23/15 at 2:55 PM. NA #5 stated Resident #112 had tried to leave the building once not long ago. NA #5 brought up the Nurse Aide Kardex in the computer. The NA explained this was the guide that provided the information nurse aides needed to care for the residents. NA #5 confirmed Resident #112's kardex did not indicate the resident had demonstrated wandering tendencies. An interview was conducted with the Administrator and DON on 07/23/15 at 4:25 PM.	F 309	and evaluate quarterly on the Wandering/Elopement Risk Assessment. 8. If a patient begins demonstrating unsafe aimless wandering behaviors after the initial admission to the Center; utilize the Wandering/Elopement Risk Assessment and re-evaluate at least quarterly and update care plan accordingly. Quarterly assessment will be done to coincide with the quarterly MDS. Education will be provided by the Administrator, Director of Nursing or designee by August 21, 2015. New admissions charts are checked the next business day by Unit Manager, DON or designee to ensure that Wandering Assessment has been completed weekly x4, 5 new admission charts bi-monthly x2 and 5 new admissions monthly x2. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed by DON or designee and reported to QA&A Committee monthly to ensure continued compliance and revisions to the plan if needed.	

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 07/24/2015

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ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 309	Continued From page 23	F 309		

The DON stated Resident #112 followed Nurse #1 out the front door on 07/17/15. The DON explained the parking lot was being resurfaced at the time and the staff had to park their cars across the highway located in front of the facility.
The Administrator described the incident noted on 07/20/15. He stated he was in his office located off the front lobby when the receptionist notified him of Resident #112 pushing his wheelchair out of the facility's front door. The Administrator stated he and another staff member followed the resident out of the building. The Administrator explained Resident #112 went around the side of the building to the back. He stated Nurse #1 went outside and talked Resident #112 into coming back into the building. During this interview Resident #112's medical record was reviewed and revealed no Wandering Risk Assessment had been completed since the 2 incidences of the resident going out the front door.
An interview was conducted with the Nurse Consultant (NC) on 07/23/15 at 5:52 PM. He stated an elopement assessment should be done annually. The NC added the assessment should also be done anytime there was an issue regarding elopement or wandering.
An interview was conducted with Resident #112 on 07/24/15 at 8:18 AM. The resident stated he was not supposed to go out the front door but he had done it before. He added he had no desire to leave here but if he did go out front he might decide to take a short walk up and down the road. Resident #112 stated it might be dangerous for other residents to walk on the road, but it would not be for him. He stated he would walk and not use his wheelchair. The resident added he might take a walk up into the woods behind the facility. During this interview, Resident #112 was

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 309	Continued From page 24 observed looking out a nearby window where he could see cars going up and down the highway in front of the facility. At that time the resident stated it might be hard to walk up and down the road. The resident explained he could go out any door in the facility without setting off an alarm. An interview was conducted via phone with the Psychologist on 07/24/15 at 9:53 AM. He stated he had been seeing Resident #112 for a while and described the resident as complicated. The Psychologist stated Resident #112 changed every week and he did not know where the resident will be mentally each week. The Psychologist stated he talked with Resident #112 on 07/23/15 and found him becoming more bazar in his thinking. The Psychologist stated he did not consider Resident #112 to be an elopement risk until the recent events of the resident's exiting the building through the front door. He stated he did consider Resident #112 to be an elopement risk at this time. A continued interview was conducted with the DON 07/24/15 at 6:13 PM. The DON added the Wandering Risk Assessment and observations of the resident should be utilized as assessment tools.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		8/21/15

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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F 314	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to assess and monitor a pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident #144). The findings included: Resident #144 was admitted to the facility on 06/19/15. Diagnoses included hip fracture and diabetes. Review of Resident #144's care plan dated 06/19/15 revealed a problem area of pressure ulcers. Goals and interventions included a plan to support healing. The admission Minimum Data Set dated 06/26/15 indicated the resident was cognitively intact, required extensive assistance of two staff members for bed mobility and transferring, and two Stage II pressure ulcers were present on admission. Review of the medical record revealed a Wound Record for Wound #5 dated 07/08/15 documenting one Stage II pressure ulcer on the buttock had healed. Further review revealed a Wound Record for Wound #1 dated 07/08/15 documenting one Stage II pressure ulcer on the sacrum had worsened. Both documents were signed by Nurse #5. A Weekly Skin Assessment dated 07/14/15 documented two Stage I pressure ulcers to both of Resident #144's heels and a blister to the resident's right toe. There was no documentation related to the Stage II pressure ulcer on the resident's sacrum. The assessment was signed by the Unit Manager. A Weekly Skin Assessment dated 07/22/15 was blank.	F 314	F314 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ While surveyors were in the building the Unit Manager audited the current wounds in the facility and updated the DON¿s QI weekly wound report and completed on 7/25/2015. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. DON, Unit Manager or Designee audited the Skin Assessments and Wound Records for residents in-house to ensure accuracy of reporting and assessing. This audit was completed on 8/19/2015 and any corrections were made. Measures to be put in place or systemic changes made to ensure practice will not Re-occur- Nurses were re-in-serviced on Nursing Policy 2401 - Skin Assessment and Nursing Policy -A licensed nurse will ensure that the skin risk assessment is done upon admission, and quarterly thereafter. 2. A skin assessment will also be completed upon re-entry to the Center (i.e., after ER visit, dialysis, etc.) 3. The weekly skin assessment will be completed thereafter.	

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F 314	Continued From page 26 A Weekly Pressure Ulcer Special Care Report dated 07/23/15 did not list Resident #144 as having a Stage II pressure ulcer on the sacrum. On 07/23/15 at 3:01 PM, Nurse #5 was observed to change the dressing on Resident #144's sacrum, according to the physician's order. A small, open area observed on the resident's sacrum was consistent with a Stage II pressure ulcer. An interview was conducted with the Unit Manager (UM) on 07/24/15 at 3:35 PM. He stated he was responsible for filling out the Weekly Pressure Ulcer Special Care Report and understood Resident #144's pressure ulcer on the sacrum had healed. The UM explained he compiled the information for the Special Care Report from the assessments the nurses completed every week in order to take the information a weekly administration meeting. He further stated he relied on the nurses and nurse aides (NAs) to relay to let him know when a pressure ulcer healed or worsened. The UM explained he had never visualized Resident #144's sacral pressure ulcer. An interview was conducted with Nurse #5 on 07/24/15. She stated it was the responsibility of the nurses to monitor the wounds. The nurse explained she had discussed Resident #144's pressure ulcers with the UM on 07/08/15 and told him the pressure ulcer on the buttock had healed while the pressure ulcer on the sacrum had worsened. She stated she understood the expectation was to complete the Weekly Skin Assessment and the Wound Record on a weekly basis. She further stated she forgot to complete the Weekly Skin Assessment for Resident #144 on 07/22/15. Nurse #5 explained when she got home, she called the facility and asked the UM to complete the assessment for her, and he agreed	F 314	4. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs. 2402 - Pressure Ulcer Monitoring & Documentation - 1. A licensed nurse will assess patients for the presence of pressure ulcers; if a pressure ulcer is present, the nurse will evaluate for complications. 2. Provide pain management prior to pressure ulcer treatment as indicated. 3. The Wound Record will be completed weekly by a licensed nurse for any patient with pressure ulcers. 4. There will be a Wound Record for each site. Education provided by Administrator, Director of Nursing or designee. Weekly the Unit Manager or Designee will run Skin Assessment and Wound Record report and compare Wound Records to Skin Assessments to ensure all wounds are captured. This will be completed weekly x 4 weeks, bi-weekly x2 months and monthly 6 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- DON or Administrator will present audits to QA&A monthly times 12 months for review and revision. This time frame can be extended at the discretion of the Administrator/DON based on findings of audits.	

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 314	Continued From page 27 to do so. An interview was conducted with the Director of Nursing (DON) on 07/24/15 at 7:36 PM. She stated the ideal situation would be for the UM to visualize the pressure ulcer on admission and then weekly until healed. The DON further stated she expected the Weekly Skin Assessments to be completed accurately to reflect the residents' skin conditions.	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's medication error rate was greater than 5% as evidenced by 4 medication errors out of 45 opportunities, resulting in a medication error rate of 8.9%, for 2 of 5 residents observed during medication pass (Residents #40 and #73). Findings included: 1) Resident #73 was admitted to the facility on 04/28/14. Diagnoses included hypertension and hyperlipidemia. A medication administration observation was conducted for Resident #73 on 07/23/15 at 4:19 PM. Nurse #9 was observed to administer fish oil 1000 milligrams (mg) 1 capsule to Resident #73. Review of Resident #73's medical record revealed a physician order for fish oil softgel 500-100 mg 4 capsules by mouth twice daily. An interview was conducted with the Pharmacist	F 332	F332 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ Medication Error reports were completed for both medications administered incorrectly. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ Licensed Nurses educated on proper medication administration, time requirements and medication error reporting. Audited nasal, eye gtts and fish oil to ensure that dosages and orders match and completed by 8/21/2015.	8/21/15

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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F 332	Continued From page 28 on 07/24/15 at 10:54 AM. He stated the fish oil capsule administered to Resident #73 was not the same medications as the fish oil softgel ordered by the physician. An interview was conducted with the Director of Nursing (DON) on 07/24/15 at 11:26 AM. She stated her expectation was for all medications to be administered as ordered by the physician and at the scheduled time. 2) Resident #40 was admitted to the facility on 06/24/15. Diagnoses included hypertension and hyperlipidemia. A medication administration observation was conducted for Resident #40 beginning at 9:17 AM on 07/24/15. Nurse #8 was observed to administer cyclosporine, a medicated eye drop for chronic dry eye, two drops in Resident #40's left eye and two drops in the right eye. Review of Resident #40's medical record revealed a physician's order for cyclosporine one drop in each eye twice daily. An interview was conducted with Nurse #8 on 07/24/15 at 10:37 AM. She stated it was Resident #40's preference to have two drops of the cyclosporine in each eye. The nurse also stated she would clarify the resident's preference with the physician. An interview was conducted with the Director of Nursing (DON) on 07/24/15 at 11:26 AM. She stated her expectation was for all medications to be administered as ordered by the physician and at the scheduled time. 3) Resident #40 was admitted to the facility on 06/24/15. Diagnoses included hypertension and hyperlipidemia. A medication administration observation was conducted for Resident #40 beginning at 9:17 AM on 07/24/15. Nurse #8 was observed to administer fluticasone, a medicated nasal spray	F 332	Measures to be put in place or systemic changes made to ensure practice will not re-occur- At least 5 patients receiving medications and at least two of those will need to have Nasal administrations or eye drops. This medication pass will be observed by the DON, Unit Manager or Designee to ensure correct administration of ordered product will be completed as well as the correct dosage for all other meds given following physician orders during the med pass observation. There will be an observation for all three shifts, weekly x4, bi-monthly x2 and monthly x1. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed by DON or designee and reported to QA&A Committee monthly to ensure continued compliance and revisions to the plan if needed.	

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F 332	Continued From page 29	F 332		

for allergy relief, two sprays in Resident #40's left nostril and two sprays in the right nostril.
Review of Resident #40's medical record revealed a physician order for fluticasone one spray in both nostrils every morning.
An interview was conducted with Nurse #8 on 07/24/15 at 10:37 AM. She stated she thought the order was for two sprays of fluticasone in each nostril. The nurse then verified the physician's order and stated she should have administered one spray in each nostril.
An interview was conducted with the Director of Nursing (DON) on 07/24/15 at 11:26 AM. She stated her expectation was for all medications to be administered as ordered by the physician and at the scheduled time.
4) Resident #40 was admitted to the facility on 06/24/15. Diagnoses included anxiety.
Review of Resident #40's medical record revealed a physician order for clonazepam, an anti-anxiety medication, 0.125 mg by mouth twice a day. The medication was scheduled to be administered at 9:00 AM.
A medication administration observation was conducted for Resident #40 beginning at 9:17 AM on 07/24/15. Nurse #8 was observed to administer Resident #40's medications but failed to include the ordered clonazepam.
An interview was conducted with Nurse #8 on 07/24/15 at 10:37 AM. She stated she did not know how she missed administering the clonazepam but would administer it immediately although it would be late. Nurse #8 was then observed to administer the clonazepam as ordered.
An interview was conducted with the Director of Nursing (DON) on 07/24/15 at 11:26 AM. She stated her expectation was for all medications to be administered as ordered by the physician and

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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F 332	Continued From page 30 at the scheduled time.	F 332		
F 360 SS=D	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and resident interviews the facility failed to recognize an allergy to fish for 1 of 3 sampled residents with a documented allergy to seafood. (Resident #12) The findings included: Resident #12 was admitted to the facility 6/17/15 with diagnoses which included Friedreich's ataxia, seizure disorder, depression, spina bifida and functional quadriplegia. Resident #12 was admitted after hospitalization 06/15/15-06/17/15. Hospital records documented an allergy to fish products, noting a reaction of nausea and vomiting. The admission Minimum Data Set for Resident #12 dated 06/25/15 noted no problems with cognition. The admission care plan dated 06/17/15 included a problem area, The resident has nutritional problem or potential nutritional problem with approaches which included, serve diet as ordered.	F 360	F360 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ Allergy was verified with the patient and physician notified, who determined the patient did not have an allergy to fish and had the allergy removed from the chart. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ Audit of the remaining residents documented allergies in Point Click Care and compared those allergies to the food allergies listed on the dietary tray cards for each resident. Dietary staff, Nurses and CNA¿s were in-serviced on looking at dietary tray cards to ensure that residents do not receive food items that could be a listed allergy. Measures to be put in place or systemic changes made to ensure practice will not	8/21/15

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 360	Continued From page 31 Documentation in the medical record of Resident #12 included a nutrition progress note dated 06/19/15 which indicated it was the 'Initial dietary visit. Discussed menu, alternates, food preferences. Added likes and dislikes to tray card." Review of the tray card of Resident #12 on 07/23/15 at 12:45 PM included an underscored note at the top of the card which read, "ALLERGY-NO FISH". The "allergy sticker" on the paper chart of Resident #12 included "fish" as an allergy. The electronic record of Resident #12 noted "fish" as a severe allergy causing "nausea/vomiting". Review of the facility preplanned menus noted "krabby cakes" was the entree for the lunch meal on 07/23/15. On 07/23/15 at 12:47 PM Nurse Assistant (NA) #4 stated she assisted Resident #12 with the lunch meal and that Resident #12 ate crab cakes for lunch. NA #4 stated she did not realize Resident #12 was allergic to fish. On 07/23/15 at 12:55 PM Resident #12 stated she ate crab cakes for the first time and enjoyed them. Resident #12 stated she did not have an actual allergy to fish. On 07/23/15 at 12:57 PM the corporate Registered Dietician (RD) was asked about the crab cakes and stated there was no fish in crab cakes. At the time of the interview the ingredient label for the prepared crab cakes was reviewed and the first 3 ingredients of the crab cakes were imitation crab meat (pollock, cod and or whiting). The Food Service Director (FSD) and RD were present and stated they were not aware fish was the main ingredient of the crab cakes.	F 360	re-occur- Dietary manager or designee will audit all new admissions to ensure dietary allergies are listed on the dietary tray card. Dietary will do audits of food allergy patients trays prior to sending out to patient to ensure that no item is delivered to a patient with an allergy to the food product, weekly x4 weeks, bimonthly x4 and monthly x3. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be reviewed and reported to QA&A Committee monthly and Quarterly thereafter for continued compliance/revisions to the plan if needed for a period of 6 months.	

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	345418	A. BUILDING _____ B. WING _____	C 07/24/2015

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F 360	Continued From page 32	F 360		

On 07/23/15 at 1:11 PM the unit manager (on the unit Resident #12 resided) stated he spoke to the husband of Resident #12 and the husband stated Resident #12 had an intolerance to white fish and that it caused stomach cramps and discomfort.

In a follow up interview on 07/24/15 at 3:50 PM the corporate RD stated staff had not entered crab cakes as a dislike/allergy in the electronic tray card system for Resident #12 because crab cakes would be considered a shellfish, not a fish product. The corporate RD stated, as a result, the electronic tray card system indicated to serve the crab cakes to Resident #12 on 07/23/15 at the lunch meal. The corporate RD stated the Physician Assistant (PA) assessed Resident #12 immediately after the lunch meal on 07/23/15 and determined no negative physical outcome to eating the crab cakes. The corporate RD stated the PA removed the fish allergy from the record of Resident #12 after talking with the resident because he determined it was not an actual allergy. The corporate RD stated she thought the Nurse Aide that assisted Resident #12 with the lunch meal was aware of the fish allergy and asked the resident about the fish allergy before serving the crab cakes.

In a follow-up interview on 07/24/15 at 4:15 PM NA #4 stated she was not aware Resident #12 had an allergy to fish when she assisted the resident with the lunch meal on 07/23/15. NA #4 stated she informed Resident #12 what was served with the lunch meal and the resident responded she had never had crab cakes before and wanted to try them. NA #4 stated Resident #12 ate all the crab cakes and it wasn't until after the meal that she found out the resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 360	Continued From page 33 allergic to fish On 07/24/15 at 7:30 PM the administrator and Director of Nursing reported they understood the concern of fish being served to a resident with a documented fish allergy and acknowledged it could have been an issue if the resident did have a true allergy to fish. The administrator stated they had reviewed all food allergies with the planned menu in the electronic tray card system to ensure food identified as an allergy would be identified and not served to residents.	F 360		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431		8/21/15

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 07/24/2015

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F 431	Continued From page 34 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to discard one expired punch card of Phenergan (medication for nausea and vomiting) in 1 of 4 medication carts. The findings included: Resident #18 was admitted to the facility on 08/15/13 with diagnoses of heart failure, hypertension and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 05/15/15 revealed Resident #18 was severely cognitively impaired. Review of the physician order dated 07/15/14 for Resident #18 indicated Phenergan 12.5 milligrams (mg) 1 tablet every 6 hours as needed for nausea and vomiting was ordered with an indefinite end date. Review of the Medication Administration Record (MAR) from 12/2014 through 07/2015 revealed Phenergan 12.5mg was given on the following dates: · 12/10/14 and 12/17/15 · 01/05/15 and 01/24/15 · 02/13/15 · 04/20/15 · 05/04/15, 05/10/15 and 05/20/15 · 06/05/15	F 431	F431 How corrective action will be accomplished for each resident found to have been affected by the deficient practice ¿ The Phenergan was removed from the cart and returned to pharmacy on 5/13/2015. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice ¿ Drugs and biologicals in each applicable storage area will be audited and any expired items will be removed and disposed of per facility policy by the Director of Nursing, Unit Manager or Staff Development Coordinator, this will be completed by August 21, 2015. Nurses will be in-serviced on storage and expiration of drugs and biologicals specifically emphasizing where expiration date is located on Punch Cards filled by pharmacy but covering expiration dates	

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F 431	Continued From page 35 Observations of the 200 Hall medication cart on 07/24/15 at 5:15 PM revealed one punch card of Phenergan 12.5mg with a total of 30 doses and 17 doses left in the card with an expiration date of 11/30/14. During an interview conducted on 07/24/15 at 5:30 PM with Nurse #6 she stated the pharmacy checked the medication carts for expired medications and the nurses should also check the expiration date before giving the medication. She stated she had not given Phenergan to Resident #18 and was not aware it had expired in 11/2014. Nurse #6 further stated the expired medication should not have been left in the medication cart due to the possibility of being given to the resident. An interview on 07/24/15 at 5:45 PM with the Director of Nursing revealed the pharmacy checked the medication carts and medication storage rooms monthly for expired medications. She further stated it was her expectation for each nurse to check the expiration date of the medication before administering it to a resident and discard the medication if it was out of date.	F 431	and the need to monitor for all medications.. Measures to be put in place or systemic changes made to ensure practice will not re-occur, Nurses on all shifts will audit the Med Carts each shift and audit tool completed and signed by the nurse completing the cart check. In addition the Med Rooms will be audited by the night shift nurse weekly on Monday night to ensure that there is no expired medications and an audit completed and signed and turned into the Unit manager or designee. The Unit Manager or designee will conduct audit of drugs and biologicals in each applicable medication cart and med room on Tuesday weekly X 4 weeks, bi-monthly (Every other Tuesday) x1 and monthly (First Tuesday of the Month) x4. Director of Nursing or designee will perform random audit once a month for 6 months. Re-education and/or disciplinary action will be documented for all infractions found. Results will be reviewed in weekly quality assurance risk management meeting for further analysis. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- Results of audit will be reported during monthly QA for further analysis and revision if needed for a period of 6 months.	
F 520	483.75(o)(1) QAA	F 520		8/21/15

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F 520 SS=D	Continued From page 36 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2014 and again in March of 2015. This was for 4 recited deficiencies which were originally cited in May of 2014 on a recertification survey and again on the current recertification	F 520	F520 How the corrective action will be accomplished for the resident(s) affected. F160 - Refunds were done for Resident #6 on 7/29/2015. F242 - Resident #152 showered upon notification that he had not received shower on 7/22/2015 as he had desired. F309 - Resident #112 wandering	

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F 520	Continued From page 37 survey. One of these deficiencies was cited the second time in January of 2015 on a complaint investigation and again on the current recertification survey. The deficiencies were in the areas of conveyance of resident funds, choices, pressure ulcers, and expired medications. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F160: Conveyance of Resident Funds: Based on review of business office records and staff interview the facility failed to convey all funds owed to 1 of 3 residents that expired. (Resident #6). On the recertification survey in May of 2014, the facility was cited for F160 for failing to convey monies within 30 days of residents' deaths. On the current recertification survey, the facility withdrew monies to cover a resident's liability before conveying resident funds to the expired resident's estate. b. F 242: Choices: Based on medical record review and interviews with resident and staff the facility failed to provide showers to 1 of 3 sampled residents. (Resident #152) On the recertification survey in May of 2014 the facility, failed to finalize and have available in the medical record documents addressing a resident's and family's wishes for no resuscitative	F 520	assessment was completed on 7/23/2015 and 7/25/2015. F314 - While surveyors were in the building the Unit Manager audited the current wounds in the facility and updated the DON¿s QI weekly wound report and completed on 7/25/2015. F431 - The Phenergan was removed from the cart for Resident #18. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Individual actions denoted on said area for citations F-160, F-242, F-309, F-314, F-431. Measures in place to ensure practices will not re-occur. Corporate Education provided to Facility Administration on QA process and it¿s relation to Plan of Correction by Corporate Nurse Consultant on 7/25/2015. Administrator, DON, Unit Manager, or designee will ensure completion of audits for F160, F242, F309, F314 and F431,is completed on Mondays, Wednesday and Fridays for a period of 2 months, then every Wednesday x10 months. The DON will review during Interdepartmental Risk Meeting weekly to discuss findings and changes in process if needed. How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/DON will present audits to QA&A monthly times 12 months for review and revision as needed. This time frame can be extended at the discretion of the	

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F 520	Continued From page 38 effort. On the current recertification survey, the facility failed to provide showers according to the resident's wishes. c. F309: Wellbeing: Based on record review, staff and resident interviews, the facility failed to assess a resident that had a psychiatric diagnosis who exhibited wandering behaviors and would at times exit the facility as evidenced in 2 different incidences for 1 of 1 resident reviewed for wellbeing. (Resident #112). On the recertification survey in May of 2014, the facility failed to administer medication to a resident as ordered by the physician. On the current recertification survey, the facility failed to assess a resident for elopement probability after exhibiting wandering tendencies on 2 occasions. d. F314: Pressure Ulcers: Based on observations, record reviews, and staff interviews the facility failed to assess and monitor a pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident #144). On the recertification survey in May of 2014, the facility failed to measure and evaluate a pressure ulcer weekly for a resident. On the complaint investigation of 01/22/15 the facility failed to follow physician's orders for treatment of a pressure ulcer. On the current recertification survey, the facility again failed to assess and monitor a resident's pressure ulcer. e.F431: Expired Medications: Based on observations, record review and staff interviews the facility failed to discard one expired punch card of Phenergan (medication for nausea and vomiting) in 1 of 4 medication carts. On the recertification survey in May of 2014, the facility failed to discard Novolog insulin that had	F 520	Administrator/DON based on findings of audits.	

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F 520	Continued From page 39 been expired for 3 days. Again on the recent recertification survey, the facility failed to discard a medication that had been in use for 6 months after the medication's expiration date. During an interview on 07/24/15 at 7:27 PM, the Administrator stated the facility had experienced a recent turnover in Administration and Director of Nursing positions. He explained he knew the facility had issues to fix and systems that were broken. The Administrator stated the frequency of Quality Assessment and Assurance Committee meetings had been increased from quarterly to monthly meetings. He stated in the past action plans were not followed through to improve systems. It was his plan to correct the issues presented in this survey and develop systems to keep the issues from reoccurring.	F 520		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345418	A. BUILDING: _____ B. WING _____	7/24/2015

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 160 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

This REQUIREMENT is not met as evidenced by:
Based on review of business office records and staff interview the facility failed to convey all funds owed to 1 of 3 residents that expired.
(Resident #6)

The findings included:

Resident #6 expired at the facility on 04/08/15. Review of the trust account of Resident #6 noted that at the time of expiration, Resident #6 had $990.00 in his trust account. An adjustment to the resident's trust account was made on 04/30/15 with $.14 added as interest for a total of $990.14. On 05/11/15 $157.73 was withdrawn from the resident's trust account and noted toward the resident's liability leaving a total of $832.41 in the resident's trust account. On 05/12/15 the $832.41 was issued to the estate of Resident #6.

On 07/23/15 at 4:00 PM a representative from the facility's corporate business office stated the facility had a new business office manager that was in training and, in the interim, a staff member from the corporate office was coming to the facility to assist with business office matters. The representative stated the staff member (from the corporate office) withdrew the $157.73 from the trust account of Resident #6 on 05/11/15 to go toward the resident's April liability. The representative was quick to note the facility should not have withdrawn the monies after the resident's expiration and should have sent the full amount of $990.00 to the resident's estate. In a follow-up interview on 07/23/15 at 4:30 PM the representative stated he was able to get in contact with the staff member from the corporate office that withdrew the $157.73 from the trust account of Resident #6 and this staff member stated it had been withdrawn in error and the $157.73 would be sent to the resident's estate.

F 256 483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS

The facility must provide adequate and comfortable lighting levels in all areas.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff and resident interviews, the facility failed to provide adequate lighting in 1 of 20 sampled resident bathrooms.
The findings included:
On 07/21/15 at 3:23 PM, Resident #25's bathroom was observed. The light would not illuminate when the

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ASHEVILLE HEALTH CARE CENTER	**1984 US HIGHWAY 70 SWANNANOA, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 256	Continued From Page 1

switch was in the "ON" position. A fluorescent bulb was observed over the sink with only both of the ends lighting up a very dim yellow.
Another observation was made on 07/23/15 at 6:10 PM. The fluorescent bulb's ends were observed to glow a very dim yellow when the switch was in the "ON" position.
An interview was conducted with Resident #25 on 07/23/15 at 6:11 PM. She stated she used the shared bathroom. The resident explained she knew the light was out but could not remember for how long. She further stated sometimes the light would come on, but most of the time it would not. She also stated when the light would not come on, she could not use the bathroom.
An interview was conducted with the Maintenance Director on 07/24/15 at 5:13 PM. He stated he was responsible for changing out light bulbs when needed. He explained he did monthly room checks but expected staff to put in a work order for any necessary maintenance in between but had not received a work order to change the light bulb in Resident #25's bathroom. When shown the light in Resident #25's bathroom, the Maintenance Director stated he was not aware of the issue and he would change it immediately.