

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2018
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NAME OF PROVIDER OR SUPPLIER SKYLAND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 193 ASHEVILLE HIGHWAY SYLVA, NC 28779
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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
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F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, family, and staff interviews the facility failed to maintain a hazard free environment by not properly storing the chemical substance isopropyl alcohol for 1 of 1 residents reviewed for accidents/hazards (Resident #5).</p> <p>Findings included:</p> <p>Resident #5 was admitted to the facility 01/20/18 and readmitted 02/09/18 with diagnoses including panic disorder and major depression.</p> <p>Review of the admission Minimum Data Set dated 02/16/18 assessed Resident #5 to be cognitively intact, needing extensive assistance with bed mobility, transfers, and toilet use.</p> <p>During an observation on 05/29/18 at 2:49 PM, a 16-ounce bottle of 50% isopropyl alcohol was observed on a nightstand located at the foot of the bed of Resident #5.</p> <p>During an interview on 05/29/18 at 2:49 PM, a family member explained she had provided the bottle of alcohol for the resident to use.</p>	F 689	<p>1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.</p> <p>Resident # 5 daughter brought in isopropyl alcohol for the resident to use for personal hygiene. Resident # 5 daughter should have brought the alcohol to the nurse, the nurse would have assessed the resident for safety using the alcohol, and if deemed safe a lock box would have been placed in the resident's room. The nurses, CNA's, and Housekeeping staff did not notice the alcohol sitting on the resident's night stand. The alcohol was open but very little used.</p> <p>2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.</p> <p>The alcohol was immediately removed from the resident's room and given to the</p>	6/19/18
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/19/2018

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

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F 689	<p>Continued From page 1</p> <p>During an interview on 05/29/18 at 2:49 PM, Resident #5 explained she used the alcohol to clean under her breast and underarms, or when she gets a small cut.</p> <p>An observation on 05/29/18 at 4:49 PM revealed the alcohol bottle remained on the nightstand at foot of the resident's bed.</p> <p>An observation on 05/30/18 at 9:08 AM, revealed the alcohol bottle remained on the nightstand at foot of the resident's bed.</p> <p>During an interview on 05/30/18 at 11:01 AM, Nurse #1 explained she provided the resident her morning medications, but didn't notice the alcohol bottle on the nightstand. Nurse #1 revealed the resident shouldn't have alcohol in the room sitting out where other residents could reach and she removed the bottle. The nurse opened the lid and revealed the foil had been punctured and the alcohol had been used.</p> <p>During an interview on 05/30/18 at 11:06 AM, the Director of Nursing (DON) explained cognitively intact residents were informed of the risk of keeping possible hazardous chemicals in their room and the facility would properly store those chemicals. She revealed a physician order would be needed for Resident #5 to use the alcohol. The DON revealed it was her expectation the nurse would explain to the resident why alcohol could not be kept in the room were other residents might wander. She expected the nurse would have removed the alcohol and confirmed there were wandering residents that might enter the room.</p>	F 689	<p>nurse on 5/30/2018. The administrator had a conversation with the resident and daughter on 6/3/2018 explaining why it was not safe to keep the alcohol sitting out on the resident's night stand. I explained that all OTC medications should be given to the nurse, assessed for safety, obtain doctors order if needed, and a lock box provided at bedside. The resident and daughter stated that it was not important and did not wish to continue using the alcohol. We also sent a letter to all residents and responsible family members addressing the proper procedure for bringing in medications for resident use. An in-service was completed for nurses, CNA's, and housekeepers to complete daily checks for OTC / Hazardous items sitting out in resident rooms. If items are found they are to be removed and given to the nurse, education given to resident / family, and assessments completed for safety and competency for using the product.</p> <p>3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.</p> <p>In-service completed for nurses, CNA's, and housekeepers to check each time entering a resident's room for OTC medications / hazardous chemicals. This was also added to the daily check list completed by housekeepers each time they clean a resident's room. When a housekeeper cleans the residents room</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2018
FORM APPROVED
OMB NO. 0938-0391

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F 689	Continued From page 2	F 689	<p>they will initial stating that they did not find OTC medications / hazardous chemicals sitting out in the resident's room. If items are found they will immediately turn them in to the nurse. In addition, the Housekeeping Supervisor will check all rooms 3x per week for 3 months and then weekly as a double check to the housekeepers. She will report her findings directly to the Administrator and turn in a monthly report along with the housekeeping checklist to be reviewed by the monthly QAPI committee.</p> <p>4. The title of the person responsible for implementing the acceptable plan of correction.</p> <p>Administrator is responsible for implementing plan of correction and follow up each month in the QAPI meeting to assure compliance.</p> <p>Date Back in Compliance: 6/19/2018</p>		