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	345418	A. BUILDING _____ B. WING _____	C 07/20/2023

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/17/23 through 07/20/23. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID# LIIP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/17/23 through 07/20/23. Event ID# LIIP11. The following intakes were investigated: NC00201780, NC00203233, NC00201920, NC00202067, NC00201418. NC00203649, NC00203644, NC00202153. 7 of the 26 complaint allegations resulted in deficiencies.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		8/9/23

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

Electronically Signed | 08/09/2023

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations the facility failed to develop and implement care plan interventions for hearing (Resident #73) and limited Range of Motion (ROM) (Resident #75) for 2 of 4 sampled residents. 1. Resident #73 was admitted to the facility on 03/03/23 with diagnoses which included muscle weakness, dementia, and hypertension. Review of Resident #73's quarterly Minimum Data Set (MDS) dated 06/08/23 revealed Resident #73 was moderately cognitively	F 656	1) The facility failed to develop and implement comprehensive care plans for two residents (73# and 75# respectively) in regard to hearing aids and adaptive equipment implementation. Resident #73 was care planned for hearing aids and 100% staff educated on assisting resident in donning and offing hearing aids and charge them, when she allows. Staff were educated on donning and offing palm guards on Resident #75 in addition to ensuring her hands remain clean. These were completed by 8.8.23 by the Staff Development Coordinator.	

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F 656	Continued From page 2 impaired and required supervision for most of activities of daily living (ADL). The MDS further revealed Resident #73 was coded for a hearing aide device. Review of Resident #73's care plan revealed no goals or interventions regarding Resident #73's hearing aids. Review of Resident #73's Physician orders dated 04/03/23 staff were to assist the resident with applying hearing aids in the morning and removing them in the evening. An observation was conducted on 07/17/23 at 3:50 PM and revealed Resident #73 had a sign behind her bed that stated, "please assist resident with charging her hearing aids by removing them at night and putting them on charger in box by the refrigerator." The resident's hearing aides were observed to be on the charger and not on the resident. An interview was conducted with Resident #73's family member and revealed she had asked staff multiple times to charge Resident #73's hearing aids but they were always dead when they visited. An observation conducted on 07/18/23 at 2:30 PM revealed Resident #73 sitting up in her bed watching television without her hearing aids in. The hearing aides were observed on Resident #73's charging box. An interview conducted with Nurse #6 revealed she was from an agency and had not worked with Resident #73 often. Nurse #6 further revealed she was not aware Resident #73 had hearing aides and that there was a sign above her bed.	F 656	2) Current facility residents are at risk of being affected by this alleged deficient practice. A 100% audit of all residents who have palm guards and/or hearing aids was conducted by the unit managers, Director of Therapy, Social worker, and Minimal Data Set coordinator by 8.7.23. The residents whom have these devices have current orders□, care plans and Kardex that reflect the need for an apron and/or palm guards. 3) Education was provided to 100% of direct care staff on the importance of following the care plans for each resident in regard to ensuring assistance with donning and doffing palm guards and hearing aids by and completed by 8.9.23 by Staff Development Coordinator. In addition, the Interdisciplinary team was educated by the Minimal Data Set Regional Coordinator on the importance of care planning hearing aids; and implementing care plan interventions. Newly hired direct care staff will also be educated upon hire, annually, and as needed. 4) Director of Nursing and unit managers will audit placement of palm guards and hearing aids with the Minimal Data Set Coordinator will audit care plans to ensure devices are care planned appropriately for 5 resident per week for four weeks; 3 resident per week for the next four weeks, then 1 resident per week for the next four	

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F 656	Continued From page 3 Nurse #6 stated she should have offered to assist Resident #73 with her hearing aids. An interview conducted with the MDS Coordinator on 07/20/23 at 9:15 AM revealed Resident #73 did have an order and was coded for hearing aids. The MDS coordinator further revealed she had failed to add hearing aids to Resident #73's care plan. An interview conducted with Director of Nursing (DON) on 07/20/23 at 10:00 AM revealed she was aware Resident #73 had hearing aids and expected nursing staff to assist Resident #73 with her hearing aids. The DON further revealed hearing aid interventions should have been added to the resident's care plan. An interview conducted with the Administrator on 07/20/23 at 2:40 PM revealed Residents #73's order of hearing aides should have been added to the resident's care plan and the interventions should have been followed. 2. Resident #75 was admitted to the facility on 03/04/22 with diagnoses which included muscle weakness and a disorder that affects movement and muscle tone or posture. Review of Resident #75's quarterly Minimum Data Set dated 06/05/23 revealed Resident #75 was severely cognitively impaired and was totally dependent for all Activity's of Daily Living. Review of Resident #75's care plan revised on 04/13/23 revealed Resident #75 had potential impairment to skin integrity due to limited mobility secondary to a disorder that affects movement and muscle tone or posture. The goal was for	F 656	weeks. The Director of Nursing and the Minimal Data Set will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with completing quarterly Minimum Data Sets assessments. 5) Date of Compliance: 8.9.23	

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F 656	Continued From page 4	F 656		

Resident #75 to maintain or develop clean and intact skin by the review date. Interventions included for Resident #75 to wear palm braces to both hands and remove them once a day or during shower.

Physician orders dated 06/08/23, stated Resident #75 was to wear bilateral palm guards as tolerated and to remove them daily to clean the resident's hands.

An observation was conducted on 07/17/23 at 2:10 PM revealed Resident #75's hands were contracted and she did not have palm guards placed on her. In addition, no palm guards were observed in Resident #75's room.

An interview conducted with Nurse #7 and Nurse Aide (NA) #5 on 07/19/23 at 3:50 PM, revealed they had assisted Resident #75 with her palm guards before but were unsure why they were not present in Resident #75's room. NA #5 further revealed Resident #75 had moved from another hall about two weeks ago and believed her palm guards got lost in the move.

An observation and interview were conducted with the facility Occupational Therapist (OT) on 07/19/23 at 4:10 PM and revealed the OT brought new palm guards and put them on Resident #75 on 07/19/23. The OT further revealed he had educated and trained staff on putting palm guards on Resident #75 in April and was unsure why she did not have any in her room. The OT stated Resident #75 had no skin impairment but wanted Resident #75 to wear them as much as possible to prevent skin issues.

An interview conducted with the Director of

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F 656	Continued From page 5 Nursing (DON) on 07/20/23 at 10:00 AM revealed she was not aware Resident #75 did not have palm guards in place but expected for nursing staff to follow Resident #75's care plan and to document if the resident refused. The DON further revealed, therapy educates and trains nursing staff on Range of Motion interventions and she expected nursing staff to follow through with interventions. An interview conducted with the Administrator on 07/20/23 at 2:40 PM revealed Resident #75's palm guards should have been placed on her daily and expected for interventions to be carried out by nursing staff.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §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 record reviews and resident and staff interviews, the facility failed to have a plan in place for providing minimum supervision and assistance with applying a smoking apron for a resident during the hours there was not a staff member assigned to supervise residents in the designated smoking area. Resident #52 was required to wear a smoking apron at all times when he was smoking and was not able to apply it independently. This deficient practice occurred	F 689	1) The facility failed to ensure minimal supervision and assistance with applying a smoking apron for Resident #52. Resident #52 was made a supervised smoker, per the Safe Smoking Assessment on 8.2.23 by the West Unit Manager. The Staff Development Coordinator educated all staff regarding the importance and necessity of assisting him with donning an apron while smoking	8/9/23

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F 689	Continued From page 6 for 1 of 3 residents reviewed for smoking (Resident #52). The findings included: Review of revised facility smoking policy dated 01/27/23 revealed residents who smoke would be assessed using the resident safe smoking assessment during the admission process and during each quarterly or comprehensive Minimum Data Set (MDS) assessment process. The policy also revealed safe smoking privileges would be revoked indefinitely for residents with smoking incidents resulting in a burn to clothing, skin, hair, or other bodily injury not determined by administration to be accidental and failure to smoke in designated smoking area. Resident #52 was admitted to the facility on 11/15/21. Diagnoses included type 2 diabetes, tremors, muscle weakness, and tobacco use. Review of the resident safe smoking assessment dated 04/06/23 completed by Director of Nursing (DON) for Resident #52 indicated he did not meet the criteria for a safe smoker and required at minimum supervision while smoking due to having history of smoking-related incidents: burning clothing, dropping ashes on self, and smoking in a non-smoking area. Review of the Administrator progress note dated 04/08/23 revealed she had spoken with Resident #52 about his concerns regarding smoking materials being misplaced. The interdisciplinary team (IDT) met to discuss safety concerns related to Resident #52's care and smoking. Resident #52 would be a supervised smoker going forward.	F 689	8.4.23 - 8.8.23. 2) Current facility residents are at risk of being affected by this alleged deficient practice. The Unit Managers assessed all current residents using tobacco 8.4.23 - 8.8.23. Two previously identified residents requiring smoking aprons were included in all updates and education by the Unit Managers 8.8.23. All current smoking assessments are reflected in Point Clock Care (EMR system) with no concerns noted. The Staff Development Coordinator updated all current tobacco using residents care plans and Kardex as well as the Smoking Binder 8.8.23. 3) The Staff Development Coordinator and the Social Worker provided education related to safe smoking practices ensuring aprons, that are assessed to be appropriate, are utilized during all smoking times to 100% of staff 8.9.23. Newly hired direct care staff and Interdisciplinary team members will also be educated upon hire, annually, and as needed. 4) The Social Worker and/or another member of the Interdisciplinary Team will ensure that all residents requiring aprons are appropriately worn during smoking times. Audit 3 residents, 5x per week for the first four weeks; then will decrease to three residents 3x a week for the next four weeks; then 3 residents once per week for the next four weeks. The Social Worker will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months. The plan will be adjusted as necessary to maintain compliance with ensuring	

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F 689	Continued From page 7 Review of the resident safe smoking assessment dated 05/09/23 completed by Nurse #5 revealed Resident #52 had a history of smoking related incidents: burning clothing and required at minimum supervision while smoking but was assessed as being able to smoke independently. The quarterly Minimum Data Set (MDS) dated 06/12/23 revealed Resident #52 was cognitively intact. The revised care plan dated 07/10/23 revealed Resident #52 was an independent smoker, and the goal was he would not have any smoking related incidents through the next review date. Interventions included instructing Resident #52 about the facility policy on smoking: locations, times, safety concerns, notifying charge nurse immediately it suspected Resident #52 had violated facility smoking policy, and Resident #52 was required to wear a smoking apron while smoking. Observation and interview with Resident #52 on 07/18/23 at 10:25 AM revealed him finishing smoking in the designated smoking area, taking off his smoking apron, and placing his lighter back inside his locked box while the facility Smoking Aide was present. He was observed having a burn hole in his shirt and when asked he stated that it was from a past incident where he had dropped ashes on himself. Resident #52 revealed he was able to smoke whenever he wanted but was told he had to wear the smoking apron and staff assisted him with putting apron on. When asked if he was able to apply smoking apron when staff were not present, Resident #52 did not answer and went back inside facility.	F 689	residents requiring safety equipment while smoking have them during all smoking sessions. 5) Date of Compliance: 8.9.23	

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An interview was conducted with Medication Aide (MA) #1 dated 07/18/23 at 10:25 AM revealed she had been assigned as facility smoking aide and was responsible for providing smoking materials, assistive and safety devices, and supervision of all supervised smokers. She stated unsupervised smokers were allowed to smoke at any time and were assigned a key and locker to keep their smoking materials locked. MA #1 revealed she was familiar with Resident #52, and he was an unsupervised smoker but was required to wear a smoking apron at all times. She stated Resident #52 required assistance with retrieving and applying his smoking apron, but she had not seen any issues with his ability to retrieve his smoking materials or light and smoke his cigarette appropriately. She revealed she had not seen any issues with Resident #52's ability to ash or distinguish his cigarette appropriately since wearing the smoking apron.

A telephone interview with Nurse #5 on 07/20/23 at 9:33 AM revealed she had been responsible for completing Resident #52's smoking assessment in May 2023. She stated she was not as familiar with the smoking assessment and had been asked by administration to complete the smoking assessment for Resident #52 and make him an unsupervised smoker. She revealed Resident #52 had a smoking incident the month prior and had been assessed to require supervision while smoking and she assumed that after 30 days he could be assessed as requiring no supervision while smoking as long as he wore a smoking apron at all times. Nurse #5 stated the facility had implemented a Smoking Aide during daytime hours to provide supervision to supervised smokers, but unsupervised smokers

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were allowed to smoke at any time with no restrictions or supervision. She revealed Resident #52 would be responsible for applying his own smoking apron when the smoking aide was not present, and she was not aware if he was able to apply smoking apron by himself or not.

Observation and interview with Resident #52 on 07/20/23 at 10:23 AM revealed him exiting the facility to smoking area unsupervised and retrieving his cigarettes and lighter from his locked box. The box with the smoking apron was located on the wall of the smoking area and Resident #52 was able to open the box and take out smoking apron but was not aware of how to apply the smoking apron and had to be assisted by the Smoking Aide who was present. Resident #52 stated he was aware he had to wear his smoking apron while smoking and required assistance with applying apron from staff outside, when asked if he wore smoking apron when staff were not present, he did not answer. Resident #52 was able to light, smoke, and distinguish cigarettes properly, he did have a burn hole in his shirt, but he stated that was from a past incident.

An interview with the Administrator and Director of Nursing (DON) on 07/20/23 at 11:25 AM revealed they were familiar with Resident #52 and he had some issues a few months ago with him not following the smoking policy, he was smoking in non-smoking areas, having smoking materials inside facility, and observations of burn holes in clothing, so he was assessed to require supervision while smoking and his smoking materials were locked and only provided during scheduled smoking times by staff. They stated Resident #52 began having behavioral issues due to the supervised smoking, so they implemented

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F 689	Continued From page 10 a facility Smoking Aide to work from 7:00 AM to 8:30 PM and his behaviors improved. The Administrator and DON revealed when his last smoking assessment was completed in May 2023, he was assessed to be an unsupervised smoker with the restriction of wearing a smoking apron. They stated although Resident #52 had smoking violations in the past, they felt this would be the least restrictive option for him and the Smoking Aide would be able to assist with him wearing the smoking apron. They revealed they were not able to say for sure if Resident #52 would be wearing smoking apron if smoking aide was not present, and if he would be a safe smoker without smoking apron due to past concerns with him dropping ashes on himself and burning holes in his clothing. The Administrator and DON stated all resident smoking assessments should be completed accurately and reflect all concerns.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		8/9/23

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F 812	Continued From page 11 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure staff wore hair coverings when working in food production areas for 1 of 1 meal production observation. This practice had the potential to affect food served to residents. The findings included: An observation and interview conducted on 07/17/23 at 9:45 AM revealed Dietary Aide #1 did not have a hair covering on while he was preparing food over the stove. The Dietary Aide #1 revealed he had forgotten to put his hair covering on before entering the kitchen. An interview conducted on 07/17/23 at 9:50 AM with the Dietary Manager (DM) revealed he was not aware Dietary Aide #1 was not wearing a hair covering but expected all staff to wear hair coverings in the kitchen. An interview conducted with the Administrator on 07/20/23 at 2:45 PM revealed all kitchen staff were expected to wear hair coverings, and Dietary Aide #1 should have been wearing a hair covering while preparing food.	F 812	1) A. The dietary staff failed to ensure all staff were donning hair nets while in the kitchen. Staff was immediately educated and did don a hairnet immediately. 2) Current facility residents are at risk of being affected by this alleged deficient practice. Immediate education to 100% of dietary staff was conducted to include: always wearing a hair net while in the kitchen including while preparing and serving food. An audit of the next tray line, 7.19.23, was conducted by the Registered Dietician to ensure it maintained a sanitary tray line, including donning hair nets, with no concerns found. B. Education was provided to the Dietary Manager on the expectation of wearing hair nets while in the kitchen, preparing and serving food. This was completed on 7.19.23 by the Regional Culinary Manager. Newly hired dietary staff will also be educated upon hire, annually, and as needed. C. The administrator and/or Dietary Manager will monitor 5 tray lines per week for 4 weeks to ensure sanitary tray line procedures of donning hair nets while in the kitchen 100% of the time. Then audits will decrease to 3x a week for 4 weeks then 1x weekly for four weeks. The Dietary Manager will report findings of the	

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	345418	A. BUILDING _____ B. WING _____	C 07/20/2023

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F 812	Continued From page 12	F 812	monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with ensuring a sanitary tray lie with 100% donning of hair nets while in the kitchen are maintained. D. Date of Compliance: 8.9.23	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint and recertification survey that occurred on 11/23/21. The failure was for one deficiency that was originally cited in the area of Food Procurement (F812). The repeat deficiency during two surveys of record shows a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F812: Based on observations and staff	F 867	1) The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the complaint and recertification survey completed on 11/23/21. The failure was for one deficiency that was originally cited in the area of Food Procurement (F812 □ failure to cover and label refrigerated food items). Current F812 -failure to ensure staff wore hair coverings 100% of the time while in the kitchen/preparing and serving food. The repeat deficiency during two surveys of record shows a pattern of the facility's inability to sustain an effective QA program. Facility had an Ad Hoc QAPI meeting on 8/7/2023 to review repeat	8/9/23

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F 867	Continued From page 13 interviews the facility failed to ensure staff wore hair coverings when working in food production areas for 1 of 1 meal production observation. This practice had the potential to affect food served to residents. During the recertification and complaint investigation survey conducted 11/23/21, the facility failed to cover, label and date 4 contains of fruit, cover and label a 6-liter container of fruit dated 11/07/21, label, and date 8 small plastic containers with a green food item in them, and label, and date a plastic grocery bag with 2 plastic containers in it in Refrigerator #1, label, and date 2 plastic containers of whipped topping and a container of lunch meat in Refrigerator #2, label, and date an opened container of ice cream, and label, and date a frozen entrée in nourishment room Freezer #1 and clean the dust on the intake fan of the dishware air dryer in the kitchen. During an interview with the Administrator on 07/20/23 at 1:43 PM, she reported previously their citation was for uncovered and unlabeled foods and they had done a process improvement plan (PIP), educated, and monitored staff, reported through their QA committee, and had achieved compliance with food storage. She stated this was a new issue and given the staff in the kitchen was new they would need to expand their process to include sanitary conditions in the kitchen and provide additional education to the new staff in the kitchen and again monitor for compliance.	F 867	citations and plans put in place to prevent future citations and have a successful and productive Quality Assurance and Performance Improvement (QAPI) Committee. 2) All residents have the potential to be affected by this deficient practice. The facility initiated a weekly QAPI risk meeting to review the results of the ongoing audits per the plan of correction and its continued effectiveness on 8/9/2023 by the Interdisciplinary Team. Changes will be made to the plan as necessary to maintain compliance and to ensure an effective QAPI program to prevent future repeat citations. 3) The measures that have been put into place to ensure the deficient practice does not recur are as follows: The Vice-President of Quality Assurance (VPQA) educated QAPI committee members on maintaining an effective QAPI program and monitoring system to prevent repeat citations on 8/8/2023. QAPI meetings to be held weekly, monthly, and as needed by the facility QAPI committee with oversight by the regional team. All newly hired Interdisciplinary team members will be educated upon hire, annually, as needed by the Administrator. 4) The Regional Director of Clinical Services (RDCS) or VPQA will monitor weekly for 4 weeks then, monthly for 2 months for compliance with daily/weekly/monthly/PRN Ad Hoc QAPI risk review of audits of repeat tags for proper monitoring of effectiveness by QAPI committee to maintain an effective	

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F 867	Continued From page 14	F 867	QAPI program that prevents repeat citations by effective monitoring. Results of monitoring will be presented to the Quality Assurance Performance Improvement committee (QAPI) by the administrator monthly for three (3) months. At that time the QAPI committee and RDCS or VPQA will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. 5) Date of Compliance: 8/9/2023	