PRINTED: 04/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						С
		345174	B. WING _			03/28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIF 91 VICTORIA ROAD ASHEVILLE, NC 28801	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 000	Resident #96 smoker roommate used conticoncentrator. Though transferred to another materials were allowed Resident #96 up throform the facility on 03 Jeopardy was removed when the facility proved acceptable credible at The facility remains on the scope and severity of that is not immediate	began on 02/05/15 when d in his room while the nuous oxygen via an oxygen h Resident #96 was r room on 02/05/15, smoking ed to be maintained by ugh the time of discharge 8/09/15. Immediate ed on 03/28/15 at 7:45 PM ided and implemented an illegation of compliance. But of compliance at a lower of E (a pattern, no actual or more than minimal harm, jeopardy) to complete ure monitoring systems put	FO	000		
	Resident #96 smoker roommate used conticoncentrator. Though transferred to another materials were allowed Resident #96 up throfrom the facility on 03 Jeopardy was removed when the facility proved acceptable credible at The facility remains on the scope and severity of that is not immediate	began on 02/05/15 when d in his room while the nuous oxygen via an oxygen h Resident #96 was r room on 02/05/15, smoking ed to be maintained by ugh the time of discharge 8/09/15. Immediate ed on 03/28/15 at 7:45 PM ided and implemented an allegation of compliance. But of compliance at a lower of E (a pattern, no actual or more than minimal harm, jeopardy) to complete ure monitoring systems put				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE

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

Electronically Signed

04/22/2015

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345174	B. WING			C / 28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 000	Resident #96 smoker roommate used conticoncentrator. Though transferred to another materials were allowed Resident #96 up throform the facility on 03 Jeopardy was removed when the facility proved acceptable credible at The facility remains on the scope and severity of that is not immediate	began on 02/05/15 when d in his room while the muous oxygen via an oxygen h Resident #96 was room on 02/05/15, smoking ed to be maintained by ugh the time of discharge 8/09/15. Immediate ed on 03/28/15 at 7:45 PM ided and implemented an allegation of compliance. but of compliance at a lower of E (a pattern, no actual or more than minimal harm, jeopardy) to complete ure monitoring systems put	F 00				
F 159 SS=B	provided to the facilit citation F-279, was a report. Event ID# OT 483.10(c)(2)-(5) FAC PERSONAL FUNDS Upon written authoriz facility must hold, saf account for the persodeposited with the fa paragraphs (c)(3)-(8)	ration of a resident, the reguard, manage, and resident funds of the resident cility, as specified in	F 15	59		4/17/15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	345174	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	 <u>-</u>	03/28/2015
ASHEVILL	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 159	funds in excess of \$5 account (or accounts the facility's operating all interest earned on account. (In pooled a separate accounting) The facility must main funds that do not except bearing account, interest petty cash fund. The facility must estathat assures a full an accounting, according accounting principles	o in an interest bearing that is separate from any of graccounts, and that credits resident's funds to that accounts, there must be a for each resident's share.) Intain a resident's personal eed \$50 in a non-interest rest-bearing account, or Ablish and maintain a system draccomplete and separate grace to generally accepted grace of each resident's personal eracility on the resident's	F 1	59		
	resident funds with far of any person other the farmer of any person other the through quarterly start the resident or his or the facility must notiful Medicaid benefits who resident's account resident's account resident's account resident's other notiful for section 1611(a)(3)(B) amount in the account the resident's other notiful for reaches the SSI resonant in the section in t	al record must be available tements and on request to her legal representative. Ty each resident that receives en the amount in the aches \$200 less than the one person, specified in of the Act; and that, if the act, in addition to the value of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C	
NAME OF D	DOVIDED OD CURRUER	343174	1 2: 11:10 _	CTDEET ADDRESS CITY CTATE 710.	•	3/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
ASHEVILL	E NURSING & REHA	BILITATION CENTER		91 VICTORIA ROAD			
-				ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 159	Continued From page	age 3	F 1	59			
	This REQUIREME	NT is not met as evidenced					
	by:	. The field and a straighted					
		eview and interview with the		"This plan of correction is	the facility's		
		anager the facility failed to		credible allegation of comp			
		I resident with greater than		Preparation and executive			
	2000 in his resider			correction does not constit	•		
	(Resident #52)			or agreement by the provide			
	(**************************************			of the facts alleged or con-			
	The findings include	led:		forth in the Statement of D			
				The plan of correction is p	repared or		
	Record review rev	ealed Resident #52 had a		executed solely because it	t is required by		
	balance greater the	an \$2000.00 in the resident		provisions of federal and s	•		
	trust account for th	e past 3 months.					
	01/31/15 end of m	onth balance for Resident					
	#52=\$2027.51			The facility wtth written au	thorization of a		
	02/28/15 end of m	onth balance for Resident		resident will hold, safegua	rd, manage and		
	#52=\$2081.51			account for the personal fu	unds. Funds in		
	03/28/15 end of m	onth balance for Resident		excess of \$50 will be held	in an interest		
	#52=\$2130.51			bearing account that is se			
				facility operating accounts	•		
		4 PM the Business Office		ensure there is no coming	-		
		ated she took over the resident		having a seperate interest	-		
		nd of January after a former		account. Quarterly statement			
		ployee terminated employment		given to the resident or his			
	·	ne BOM stated she knew there		designee.The facility will n			
	·	h the resident trust account.		resident when they are wit			
		the payment source for		allowed limit if they are a N	viedicald or SSI		
		Medicaid. The BOM stated		reciepient.			
	l -	f one other resident on a balance greater than \$2000		Resident #52 balance is \$	1670.02		
		t account and efforts were		Resident #32 balance is \$	1079.03.		
		lress the concern. The BOM		All resident balances were	checked to		
	•	t aware Resident #52 had		ensure that no resident is			
) in the end of month balance		limit or within \$200 of the a			
	, • ·	at account the past 3 months			anomou mille.		
		e concern should be addressed		Quarterly statements were	e mailed on Anril		
		esponsible party. The BOM		15, 2015.	aiioa on Aprii		
	stated she usually			.5, 25 .5.			
		le party when the account		The BOM and Administrate	or will review 2		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			l	28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHABII	LITATION CENTER		91 VI	EET ADDRESS, CITY, STATE, ZIP CODE CTORIA ROAD EVILLE, NC 28801	1 03/	20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 161 SS=B	balance was between 483.10(c)(7) SURET PERSONAL FUNDS The facility must pure otherwise provide as Secretary, to assure funds of residents de This REQUIREMENT by: Based on interview was Manager and review record review the fac adequate coverage in	Y BOND - SECURITY OF chase a surety bond, or surance satisfactory to the the security of all personal eposited with the facility. T is not met as evidenced with the Business Office of the surety bond and cility failed to maintain in the surety bond for 3 of 4 doer 2014-February 2015.	F1	tii ru aa \$ a ru na aa at ti ee ween T con oo 61	imes per month the balances in each esident trust account to ensure that no account is over the allowed limit or with \$200 of the allowed limit which could affect their Medicaid or SSI eligibility. The sesident or responsible party will be notified by the BOM or Social Worker with a phone call and documented on the account if the account is nearing the limit hat would affect Medicaid or SSI eligibility. Efforts will be made to work with the resident or responsible party to aducate them on items that the resident may need purchased. The BOM will present to the QA committee the results of the audits each nonth to the QAPI committee for a periof 3 months. The facility will maintain a surety bond all personal funds of residents deposited the facility. The bond was increased from \$30,000 and \$10,000 on \$4/1/2015. The CFO will be notified monthly by entire the committee the solution of the committee the solution of the committee the solution of \$20,000 on \$4/1/2015. The CFO will be notified monthly by entire the committee the solution of the committee the committ	in The with hit for d to	4/17/15	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING			03/2	8/2015	
	ROVIDER OR SUPPLIER E NURSING & REHABIL			STREET ADDRESS, CI 91 VICTORIA ROAD ASHEVILLE, NC 2		1 03/2	.0/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5) COMPLETION DATE	
F 161 F 253 SS=D	Business Office Mana 2:34 PM covered \$30 Review of the end of resident trust accoun 2014-February 2015 follows: November balance=\$ December balance=\$ January balance=\$ January balance=\$ On 03/28/15 at 2:34 Itaken over the reside January when a form terminated employme BOM stated she knew the resident trust acc surety bond did not p amount of monies in 3 of the past 4 month 483.15(h)(2) HOUSE MAINTENANCE SEF	arety bond provided by the ager (BOM) on 03/28/15 at 0,000. month balance in the ts from November noted the balance as 333,804.39 34,013.90 4,919.98 19,835.33 PM the BOM stated she had nt trust account the end of er business office employee ent with the facility. The v there were problems with ount but was not aware the rovide full coverage for the the resident trust account for s. KEEPING & RVICES	F1	correspondent in the surety by The BOM will balances in earthat it does not amount. The EAdministrator resident trust. The Administrator reviewed and month. The Administrator to the QAPI confor a period of	review monthly the ach resident trust to ensure to ensure to ensure the ach resident trust to ensure the ensure that the ensure the ensure that the end CFO the balance in eversus the bond amount. The ensure that it has being in compliance each ensure that the ensure that the ensure that it has being in compliance each ensure that the ensure that th	ee. Its assis	4/17/15	
	by: Based on observation facility failed to secur sampled bathrooms a tiles for 1 of 5 sample. The findings included			maintenance s maintain a sar comfortable in	ill provide housekeeping services necessary to nitary, orderly, and nterior. 2 has been scraped,	and		

OLIVILIV	OT OIL WILDIO, WE G	WEDIO/ ND CEITTIOEC					2. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50.25	_		ļ ,	С
		345174	B. WING			1	28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				9	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	LITATION CENTER		Α	SHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 253	Continued From page	e 6	F	253			
	at 4:00 PM. The follo				prepped, and painted. The toilet has b	een	
	concerns were obser	_			secured to the floor. The moist black	CCII	
		2 on the 100 hall, paint was			debris has been removed at the base	of	
		ed, peeled, and chipped in			the toilet and it has been recaulked.		
		toilet was observed to be					
		achment to the floor and			Shower room 6 has been fully converte	∍d	
	easily moveable 2 to	4 inches to the left and to			to a storage room.		
	the right. Additionally	, there was moist, black					
	debris around the bas	se of the toilet.			Room 211 toilet has been secured to to	Э	
	b. In Shower Room 6	6 on the 200 hall, the toilet			floor.		
		oosened from its attachment					
		moveable 2 to 4 inches to			Room 212 ceiling tiles have been insta	lled	
	the left and to the righ				and no cords are visible or exposed.		
		om in room 211, the toilet oosened from its attachment			Room 212 bathroom exhaust fan work		
		moveable 2 to 4 inches to			has been completed.		
	the left and to the righ				nas been completed.		
	_	om in room 212, a ceiling tile			All staff were re-educated by the DON	and	
		ceiling and a black cord			RN Supervisor from March 28, 2015 to		
		rved to be hanging down			April 16, 2015 on reporting items in ne		
	from the ceiling 10 to	12 inches.			of repair by entering them in the		
	An interview was con	ducted with the Maintenance			maintenance work order book at each		
		at 4:20 PM. He stated he			nursing station. The education has bee	∍n	
		loose toilets or the bubbled,			added to the orientation process.		
		paint. He explained he was			TI MILL BY		
	replacing a bathroom				The Maintenance Director and Assista		
		t yet completed the project. ector stated the facility was			are completing an audit tool 1-2 times week in all rooms and shower rooms	hei	
		rpleting upgrades as quickly			ensure that toilets remain secure, vent	c	
		d immediately secure the			and ceiling tiles are in place, escheute		
		e explained staff were to put			plates, call lights are operational, A/C	J.1	
		nance book located at the			covers in place, wall in good repair, do	or	
	200 hall nurses' static				closes and latches, there are no door		
	An interview was con				obstructions preventing closure, and		
	Administrator on 03/2	27/15 at 4:52 PM. She			oxygen signs are in place.		
		a plan to update the building,					
	and the plan was beir				The facility has a room painting schedu		
	Maintenance Director				that includes rooms, door jambs, show	er	
	Maintenance Director	r. The Administrator			rooms, halls, and corridors.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY
		245474	B. WING			l	С
		345174	B. WING _			03/	28/2015
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			VICTORIA ROAD		
				AS	SHEVILLE, NC 28801		
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F 253	Continued From page	e 7	F 2	253			
		cluded new paint and new ated the toilets would be s soon as possible.			The audit tool is reviewed weekly by the Adminsrator and Director of Maintenan to ensure compliance.		
F 279	483.20(d), 483.20(k)(1) DEVELOR	F 2	70	The Maintenance Director will report monthly the results of the audit to the QAPI committee for a period of 3 month	hs.	4/17/15
SS=E	COMPREHENSIVE (F 2	.79			4/1//15
		e results of the assessment d revise the resident's of care.					
	plan for each resident objectives and timeta medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive					
	to be furnished to atta highest practicable ph psychosocial well-bei §483.25; and any ser be required under §48 due to the resident's a	•					
	by: Based on observatio resident and staff inte	ns, record review, and erviews, the facility failed to tare plans for 10 of 17			The facility will use the results of the assessment to develop, review and rev the residents comprehensive plan of care		

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345174	B. WING		0	3/28/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
A CHEVILL	E NUIDOINO 9 DELLADI	LITATION CENTED		91 VICTORIA ROAD			
ASHEVILL	E NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 279	Continued From pag	e 8	F 27	9			
	•	ho smoked. (Residents #23, #86, #91, #96, #126 and d:		Our care plans will include me objectives and timetables to m resident's medical, nursing, an and psychosocial needs that h identified in a comprehensive of	eet a d mental ave been		
	administrator on 03/2 admission packet) w and 01/08/15 include -All residents that de assessed upon admi (as needed), for leve determine if the resident restrictions, if any, w resident's smoking p -The facility interdisc the determination as -Based upon the smoresident may be requapron and the resider-Information regarding	sire to smoke will be ission, quarterly, and PRN el of safety awareness to dent is responsible, and what ill need to be placed on the rivileges. iplinary team will then make		The DON and RN Supervisor/Coordinator educated the staff smoking policy from March 28 April 16, 2015. The smoking pleen added to the orientation No one was allowd to work unhave completed the education smoking policy. Resident #96 no longer reside facility. Resident #126 no longer reside facility. Resident #73 has had a safe sideta collection tool completed	Clincal on the 2015 to colicy has of new staff. tilt they on the s at the es at the		
	1. Resident #96 was 04/16/14 with diagnoral alcohol and tobacco Minimum Data Set (I assessed Resident #impairment. The Smoking Policy Resident #96 on 04/material would not be A "Safe Smoking Ne available on the resident."	signed on admission by		been deemed a "safe smoker" plan is reflective of the safe sn designation. The resident is a cigarettes in her room and is n to lock them in any box or area room. The resident has signed smoking policy and is aware o guidelines to safe smoking. Th is not allowed to keep any ligh materials in the room including butane, matches or other lighting Resident #86 has had a safe state collection tool completed deemed an "unsafe smoker".	. Her care noker ble to keep ot required a of the lithe safe f the resident ting lighter, ing material.		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345174	B. WING			С	
NAME OF D		343174	B. WING	OTDEET ADDRESS SITV STATE 71D SODE	0	3/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD			
				ASHEVILLE, NC 28801			
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F 279	Continued From page	e 9	F 27	9			
F 2/9	04/16/14 - 03/09/15. MDS Nurse #1 stated were completed on a needed. MDS Nurse closed medical record record on 03/26/15 as smoking assessment Resident #96. MDS Nurse and throughout his stay at A care plan for Resident updated on 01/20 resident's smoking as Summaries of Care Fon 10/29/14 and 01/20 #96 smoked unsuper PM MDS Nurse #1 st why the care plan for address smoking.	On 03/25/15 at 12:43 PM d smoking assessments dmission, quarterly and as # 1 checked the resident's d and electronic medical t 10:35 AM and confirmed a had not been done on Nurse #1 did not know why a had not been done	F 27	plan reflects the "unsafe smoker designation. The resident is not keep cigarettes, lighter or any of smoking items in the room or on persons. The resident has signed "unsafe smoker" policy. The resisupervised by assigned staff medesignated smoking times and it designated smoking area in the courtyard of the facility. The resisupervised by facility staff when own cigarettes with the machine loose tobacco. The items need his own cigarettes is kept in the office of the Activity Department. Cigarettes that are rolled are the the secure smoking storage conthe 200 hall med room. Resident #131 had a safe smok collection tool completed and is an "unsafe smoker". His care pareflects the "unsafe smoker" desident "desident" desident "desident" desident" desident "desident" desident "desident "desident" desident "desident "de	able to ther his ed the sident is embers at an the front sident is rolling his e and locked All n put in tainer at ing data deemed lan		
	Minimum Data Set (N 03/10/15 assessed R	y disease. The admission MDS) assessment dated tesident #126 with no and indicated Resident		The resident is not able to keep cigarettes, lighter or any other sitems in the room or on his persident has signed the "unsafe policy. The resident is supervise assigned staff members at designed staff members at design	ons. The smoker" ed by		
	on 03/03/15 did not in with Resident #126 re	•		assigned staff members at design smoking times and in the design smoking area in the front courty facility. The smoking supervisor this resident with smoking since	nated ard of the assists he is		
	Resident #126 on 03. material would not be A care plan for Resid	signed on admission by //03/15 noted smoking e kept in the resident's room. ent #126 dated 03/14/15		unable to hold his cigarette. The does request to wear a smoking eventhough not required to since supervised by staff. The care placets the resident choice to we	apron e he is lan ear a		
		rea that stated: "I am safe		smoking apron at this time. The	care plan		

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ASHEVILL	E NURSING & REH	ABILITATION CENTER		ASHEVILLE, NO	C 28801		
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F 070							
F 279	Continued From p	-	F 2				
		pproaches to this problem area		I	sed based on the resident		
		e my visitors about the smoking		_	arding wearing a smoking		
		a Safe Smoking Assessment to		apron.			
		needs while smoking, Ensure ible party understand the facility		Posidont #	23 had a safe smoking data		
	Smoking Policy.	ible party differstand the facility			cool completed and is deeme	d	
	omoking rolley.				smoker". His care plan	ŭ	
	On 03/25/15 at 11	1:44 AM an interview with			e "unsafe smoker" designatio	n.	
		her room revealed she kept her			ent is not able to keep		
		nter in an unlocked drawer in		cigarettes,	lighter or any other smoking		
		esident #126 opened the drawer			e room or on his persons. TI		
	_	and showed the surveyor her			as signed the "unsafe smoke	r"	
		nter. The roommate of Resident		1 ' -	e resident is supervised by		
		ed with continuous oxygen in			staff members at designated		
		nula which was attached to an		1	mes and in the designated	ho	
	oxygen concentra	IIOI.		facility.	rea in the front courtyard of the	ne	
		39 PM the Director of Nursing					
		ator and MDS Nurse #1 stated			36 has had a safe smoking		
		re the Smoking Policy signed by			ction tool completed and has		
		dmission 03/03/15 included			ned a "safe smoker". Her ca	re	
	_	would not be kept in the MDS Nurse #1 stated the care			ective of the safe smoker		
		resident was a safe or unsafe		_	 The resident is able to keen in the resident in the resident is not required. 	-	
	·	ninistrator and DON stated they		-	m in any box or area of the	eu	
		moking materials unsecured in			resident has signed the safe		
		and the expectation was for			olicy and is aware of the		
		their smoking material in a			to safe smoking. The resider	nt	
	secure area of the			is not allow	ved to keep any lighting		
				materials ir	n the room including lighter,		
		vas admitted to the facility on		butane, ma	atches or other lighting mater	rial.	
		gnoses which included chronic					
		nary disease and depressive.			444 has had a safe smoking		
		nimum Data Set (MDS)			ction tool completed and has	_	
		d 03/03/15 assessed Resident		I	ned a "safe smoker". His car	е	
	_	tive impairment. The MDS		'	ective of the safe smoker	en	
	mulcaled Resider	nt #73 used oxygen.			 The resident is able to keen in his room and is not require 		
	Δ "Safe Smoking	Needs Assessment" completed			m in any box or area of the	~	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345174	B. WING _			o	3/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				91	I VICTORIA ROAD			
ASHEVILL	E NURSING & REHA	BILITATION CENTER		A	SHEVILLE, NC 28801			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	'	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 279	Continued From p	age 11	F 2	279				
	on 02/25/15 did no	ot indicate any needs or issues			room. The resident has signed the safe	е		
		related to smoking.			smoking policy and is aware of the			
					guidelines to safe smoking. The reside	nt		
	The Smoking Police	cy signed on admission by			is not allowed to keep any lighting			
	Resident #73 on 0	2/24/15 noted smoking			materials in the room including lighter,			
	material would not	be kept in the resident's room.			butane, matches or other lighting mate	rial.		
	Review of Resider	nt #73's physician's orders			Resident #91 has had a safe smoking			
	revealed an order	dated 02/24/15 for oxygen at 1			data collection tool completed and has	;		
	to 5 liters per minu	ite to keep oxygen saturation			been deemed a "safe smoker". His ca	re		
	levels above 90%.				plan is reflective of the safe smoker			
					designation. The resident is able to ke			
		sident #73 dated 03/08/15			cigarettes in his room and is not requir	ed		
	included a problen				to lock them in any box or area of the			
		for injury related to smoking			room. The resident has signed the safe	е		
		ential for seizure." Approaches			smoking policy and is aware of the	4		
		ea included: Resident must			guidelines to safe smoking. The reside	:mt		
		ed areas only, during Resident to utilize smoking			is not allowed to keep any lighting materials in the room including lighter,			
	_	ng per facility policy, Staff to			butane, matches or other lighting mate			
		esident with smoking activity as			batane, materies of other lighting mate	ilai.		
	' '	moking habits and behaviors			Resident #47 had a safe smoking data	4		
		d report, document and assess.			collection tool completed and is deeme			
		,			an "unsafe smoker". His care plan			
	On 03/25/15 at 10	:05 AM Resident #73 was			reflects the "unsafe smoker" designation	on.		
	observed sitting or	utside in the designated			The resident is not able to keep			
		other residents. Resident #73			cigarettes, lighter or any other smoking	3		
	was not wearing a	smoking apron at the time of			items in the room or on his persons. T	he		
	the observation ar	nd had a lit cigarette in her			resident has signed the "unsafe smoke	∍r"		
	hand. No staff me	mber was present with the			policy. The resident is supervised by			
	residents.				assigned staff members at designated			
					smoking times and in the designated			
	_	w with Resident #73 on			smoking area in the front courtyard of	the		
		AM about the smoking apron,			facility.			
		ed she had been assessed as						
	_	and didn't need to wear a			Supervised residents will not be requir	ed		
	smoking apron.				to wear a smoking apron during			
	On 03/35/45 at 44	:40 AM Decident #72 stated			supervised smoking.			
	On 03/25/15 at 11	:40 AM Resident #73 stated					1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	343174	B: Willo_	ет	FREET ADDRESS, CITY, STATE, ZIP CODE	03/	/28/2015
NAME OF PI	ROVIDER OR SUPPLIER						
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				A:	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page	e 12	F 2	79			
	she kept her cigarette	es and lighter locked in her			Care plans for all residents will be		
		acket pocket. Resident #73			updated at least quarterly but more		
		ot of people who wander and			frequently if there is a significant chang	e.	
		ee them they won't bother					
	them." An oxygen co				Resident smoking care plans will be		
		s observed beside the bed			brought to the morning department		
	and Resident # 73 st	ated she used it all the time			manager meeting for review on a week	ly	
	except when she wer	nt outside to smoke and she			basis or more frequently if necessary.		
	was getting ready to	go outside to smoke.			The MDS/Care Plan Nurse will maintain	n	
					the smoking compliance binder that wil	l	
		rse #5 on 03/25/15 at 5:15			be reviewed at the morning departmen	t	
	PM revealed she was	s regularly assigned to			manager meeting.		
	1 -	dent #73. Nurse #5 stated					
		ne oxygen continuously when			The Administrator and DON will review		
		and the only time she left the			with the MDS nurse on a weekly basis		
	room was to go smok	ke.			and more frequently if necessary all resident care smoking care plans.		
		PM the Director of Nursing					
		and MDS Nurse #1 stated			The MDS/Care Plan team will put out a		
	· ·	ne Smoking Policy signed by			monthly calendar with the names of all	the	
		ssion 02/24/15 included			residents that will have updates due		
	smoking material wor				including care plans.		
		S Nurse #1 stated the care			TI MDO/O DI III (
	·	sident was a safe or unsafe			The MDS/Care Plan nurse will report	_	
		strator and DON stated they			monthly for a period of 3 months all car		
		king materials unsecured in			plans that are associated with smoking		
		d the expectation was for ir smoking material in a			residents.		
	secure area of their r	_					
	secure area or triell r	oom.					
	On 03/27/15 at 6:30 I	PM MDS Nurse #1 stated					
		care plan for Resident #73					
		ion for a smoking apron and					
		oking apron was indicated.					
		admitted to the facility on					
		ses including tobacco use.					
		led a physician's order dated					
	06/25/14 for oxygen a						
	shortness of breath a						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	· ,	TE SURVEY MPLETED	
		345174	B. WING _			C 03/28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 91 VICTORIA ROAD ASHEVILLE, NC 28801		3/20/2013	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	Resident #86 on 06/2 material would not be The most recent Mir 03/23/15 coded Resi with no mood or beh used tobacco. A care plan dated 10 of Resident #86 apt a unauthorized areas a and complaints from visitors. This care pl to continue the probl was updated becaus in the building. Appr Resident #86 to smo with verbal reminder apron. Review of a "Safe Si	signed on admission by	F 2				
	Resident #86 had dr the intervention indice a smoking apron. On 03/25/15 at 9:54 observed seated in h The resident said he Observation of his of plastic bag of loose to rolling cigarettes. Reshis own cigarettes are lighter in his room. If smoke he wears an at On 03/25/15 at 12:43 staff who assess restand watch residents safe smoker based of their cigarette, exting they dropped ashes	AM Resident #86 was a wis wheel chair in his room. was going out to smoke. Wer bed table revealed a cobacco with a machine for esident #86 stated he rolled and kept the tobacco and the said when he goes out to apron. By PM MDS Nurse #1 stated idents to smoke go outside and determine if they are a son a residents ability to light puish their cigarette and if					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE:			
		345174	B. WING _			1	28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER	'	STREET ADDRESS, CITY, STATE, ZIP C 91 VICTORIA ROAD ASHEVILLE, NC 28801	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
F 279	there had been any of mental status, medicing physical changes and resident's ability to state on 03/25/15 at 1:23 observed to go out to to when he arrived at the observed to pick up a back of the chair next material side out and material out. Observed irectly supervising the assist Resident #86 with the retardant side outside to return to had his smoking material was answered yes and state of cigarettes and lighter pack was empty been cigarettes. On 03/25/15 at 6:39 (DON), Administrator they were unaware to the resident on administration of the process of the plan indicated if a resident's room. MD plan indicated if a resident's room and resident's room and resident's room and residents to keep the secure area of their room 03/25/15 at 7:14 MDS Nurse #1 states.	quarterly and done again if change in the resident's ation changes, reports of d unsafe behaviors affecting moke. PM Resident #86 was the courtyard to smoke he table to smoke he was a smoking apron lying on the to him and put it on with the I not the shiny retardant vation revealed no staff the smokers or available to to put the smoking apron on le out. PM Resident #86 was with him and he moved his empty pack of the stated that his cigarette ause he needed to roll more PM the Director of Nursing or and MDS Nurse #1 stated the Smoking Policy signed by sision 06/21/14 included and not be kept in the Sident was a safe or unsafe strator and DON stated they king materials unsecured in did the expectation was foreir smoking material in a	F 2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 3/28/2015	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		0/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279		ge 15 n. MDS Nurse #1 stated s own personal apron and	F 2	79			
	that she was not aw Resident #86 not pu MDS Nurse #1 state February 2015 when the facility he was st because he could lighis cigarette and wo prevent a burn from Nurse #1 stated Resertain smoking mate. On 03/26/15 at 10:4 tobacco was observed box, and his rolling	are of any instances of titing his apron on correctly. d after the incident in n Resident #86 smoked inside till considered a safe smoker till considered, extinguish are a smoking apron to ashes. For this reason, MDS sident #86 was allowed to					
	table from the mach not have a locking of stated he had not as 5. Resident #131 w 03/13/15 with diagnous visually impaired an The smoking policy Resident #131 on 03 material would not be The most recent Mir 03/20/15 coded Resintact with no mood that he used tobaccorder dated 06/25/12 liters per minute per of chronic obstructive The care plan dated of Resident #131 at smoking activity to it must have direct sur	ine. The bedside dresser did rawer and Resident #86 sked for a lock for the drawer. as admitted to the facility on oses including quadriplegia,					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345174	B. WING _				28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABII	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 91 VICTORIA ROAD ASHEVILLE, NC 28801	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 279	safety during smokin designated areas on apron and resident's be maintained by face Review of a "Safe Sr for Resident #131 da with total or limited rath hands, diminished firhold a cigarette, drop to use ashtray to extit assessment noted R a smoking apron and cigarette. On 03/25/15 at 11:05 observed being assist designated smoking light Resident #131's in his mouth, remove Resident's mouth, flicand place the cigaret mouth. On 03/25/15 at 1:35 observed seated in hwaiting to be taken to was observed to hav on his lap with the lig cellophane cover of the would put his cigardrawer of his bedside doctor's appointment #131's bedside dress lock on the drawer. outside of Resident #	or safety and report, is his ability to maintain g, ensure he smokes in y and wears a smoking smoking materials were to illity staff at all times. Inoking Needs Assessment ange of motion in arms and the motor skills needed to to sashes on self and unable inguish cigarette. The esident #131 required use of a for staff to extinguish his area. Staff was observed to a cigarette, place the cigarette of the cigarette from the cast the ashes in the ashtray, the back in Resident #131 was is wheel chair, in his room, or a doctor's appointment. He is a pack of cigarettes lying ther located in the he cigarette pack. He stated arettes and lighter in his top to table before he left for the company of the company of the pack of Resident was no An oxygen sign was on the	F2	279			
	oxygen concentrator.	being provided via an . PM a cigarette pack and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED C		
	345174	B. WING		03/28/2015		
ROVIDER OR SUPPLIER LE NURSING & REHAE	BILITATION CENTER		91 VICTORIA ROAD	1 00/20/2010		
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE COMPLETION		
lighter were observed table of Resident # splints on both handwaring a nasal carprovided via an oxyon On 03/25/15 at 6:39 (DON), Administration they were unaware the resident on administration they were unaware the resident on administration of the resident of the	ed stored on the over bed 131. Resident #131 had ds and his roommate was nulla with oxygen being rgen concentrator. 9 PM the Director of Nursing or and MDS Nurse #1 stated the Smoking Policy signed by nission 03/13/15 included rould not be kept in the DS Nurse #1 stated the care esident was a safe or unsafe nistrator and DON stated they oking materials unsecured in nd the expectation was for neir smoking material in a room. 9 PM an interview was Admission Coordinator who nired. She stated she goes Policy with residents who of the admission process. She gn the Smoking Policy. She have been informed that the an assessment and an keep their smoking se without supervision. 3 PM an interview was S Nurse #1. She could not ent #131 would have cigarettes om noting he was a and it was inconsistent with e plan.	F 279				
	Continued From palighter were observed table of Resident # splints on both handwaring a nasal carprovided via an oxyon on 03/25/15 at 6:38 (DON), Administrate they were unaware the resident on administrate they were unaware the resident on administrate they were unaware the resident on administrate they were unaware the resident for a management of the secure area of their on 03/25/15 at 7:30 (Conducted with the had recently been they were unaware the resident's room a resident's room a resident's room a resident to keep the secure area of their over the Smoking Finds and all residents in reported residents i	CORRECTION IDENTIFICATION NUMBER:	A BUILDING 345174 B. WING ROVIDER OR SUPPLIER E NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Ighter were observed stored on the over bed table of Resident #131. Resident #131 had splints on both hands and his roommate was wearing a nasal cannula with oxygen being provided via an oxygen concentrator. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/13/15 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. On 03/25/15 at 7:30 PM an interview was conducted with the Admission Coordinator who had recently been hired. She stated she goes over the Smoking Policy with residents who smoke at the end of the admission process. She said all residents sign the Smoking Policy. She reported residents have been informed that the nurse will complete an assessment and determine if they can keep their smoking materials and smoke without supervision. On 03/27/15 at 5:13 PM an interview was conducted with MDS Nurse #1. She could not explain why Resident #131 would have cigarettes and lighter in his room noting he was a supervised smoker and it was inconsistent with what was in his care plan. 6. Resident #23 was admitted to the facility on 09/01/03 with diagnoses including depression and history of tobacco use.	A SUILDING 345174 ROVIDER OR SUPPLIER E NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD RECOLLATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Ighter were observed stored on the over bed table of Resident #131. Resident #131 had splints on both hands and his roommate was wearing a nasal cannula with oxygen being provided via an oxygen concentrator. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 03/13/15 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. On 03/25/15 at 7:30 PM an interview was conducted with the Admission Coordinator who had recently been hired. She stated she goes over the Smoking Policy with residents who smoke at the end of the admission process. She said all residents sign the Smoking Policy. She reported residents have been informed that the nurse will complete an assessment and determine if they can keep their smoking materials and smoke without supervision. On 03/27/15 at 5:13 PM an interview was conducted with MDS Nurse #1. She could not explain why Resident #131 would have cigarettes and lighter in his room noting he was a supervised smoker and it was inconsistent with what was in his care plan. 6. Resident #23 was admitted to the facility on 09/01/03 with diagnoses including depression and history of tobacco use.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (91 VICTORIA ROAD ASHEVILLE, NC 28801	CODE	33/25/2010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 279	The most recent Min 03/02/15 assessed Fintact with moderate annual MDS dated 1 tobacco. Review of a "Safe Sidated 05/24/13 for Ridiminished fine motohold his cigarette, he and he must wear a the "Safe Smoking Night dated 03/25/15 revea A care plan dated 12 03/02/15 identified a risk for injury related Approaches included smoking apron, educ of smoking, evaluate level per policy to desmoker or unsafe smon 03/25/15 at 1:06 observed seated in hand he had a pack of was holding his light stated he kept his cigroom because he was Resident #23 also in smoking apron. On 03/25/15 at 1:22 observed outside un area. He was smoking apron on. On 03/25/15 at 6:15	king material would not be coom. imum Data Set (MDS) dated Resident #23 as cognitively by impaired vision. His 2/02/14 revealed he used moking Needs Assessment" esident #23 revealed he had or skills, needed to securely dropped ashes on himself smoking apron. Review of leeds Assessment" form aled no problems. 1/08/14 and updated on problem of Resident #23 at to cigarette smoking. 1/2 supervision and use of a cation on the danger/hazards of the resident for smoking termine if he was a safe moker. PM Resident #23 was as wheelchair in his room of cigarettes on his lap and the rin his hand. Resident #23 garettes and lighter in the last considered a safe smoker. In the last	F2	279		
	outside in the design	wn the hall from smoking ated area for residents to 3 reported he had his				

	E SURVEY PLETED	
	C 03/28/2015	
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	120/2013	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279 Continued From page 19 smoking materials and lighter with him and was returning to his room. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 04/29/13 included smoking material would not be kept in the resident's room. MDS Nurse #1 stated the care plan indicated if a resident was a safe or unsafe smoker. The administrator and DON stated they had never seen smoking materials unsecured in a resident's room and the expectation was for residents to keep their smoking material in a secure area of their room. On 03/26/15 at 1:08 PM a follow-up interview was conducted with Minimum Data Set (MDS) Nurse #1. She stated Resident #23 was assessed as a safe smoker but must be supervised and wear an apron. MDS Nurse #1 revealed Resident #23 was a safe smoker because he could flick off his own ashes, light his own cigarette, take the cigarette out of the pack and put the cigarette to his mouth. MDS Nurse #1 stated some of Resident #23's clothes had holes and she did not know if the holes in his clothes were burns from cigarettes because there were no brown edges around the holes. MDS Nurse #1 stated Resident #23 was supposed to wear his apron and that staff supervising residents who smoked should know if a resident needed a smoking apron or not. 7. Resident #36 was admitted to the facility on 12/11/07 and readmitted on 08/17/12 with diagnoses including chronic airway obstruction. The Smoking Policy signed by Resident #36 on		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345174	B. WING _				C 03/28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 91 VICTORIA ROAD ASHEVILLE, NC 28801	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE				
F 279	02/09/15 coded Resi with no mood or behat tobacco. A care plan dated 11. 02/24/15 identified a at risk for injury related Approaches included smoke in designated encourage her to we smoke breaks becaus smoking and has a haresidents cigarettes. approach included the and lighter must be least approach included the and lighter must be least. Review of the "Safe Assessment" dated 0 revealed no problem: On 03/25/15 at 10:58 observed seated in har courtyard with several smoke break with no #36 was observed srapron on. Interview time revealed she ke in her locked dresser On 03/25/15 at 11:52 observed going to he smoked. Resident # cigarette and lighter iduring waking hours.	imum Data Set (MDS) dated dent #36 as cognitively intact avior problems and use of //24/14 and reviewed problem Resident #36 was ed to cigarette smoking. It to allow Resident #36 to smoking areas only, to ar a smoking apron during se she nods off while istory of lighting other. In addition, another lat Resident #36's cigarettes ocked up on the smoking. Smoking Needs 03/25/15 for Resident #36 s. BAM Resident #36 was er wheel chair out in the all other residents during the staff supervision. Resident moking with no smoking with Resident #36 during this pt her cigarettes and lighter of drawer in her room. PM Resident #36 was er room after she had 36 reported she kept her in a case on her wheelchair Resident #36 stated she and lighter in the drawer on	F 2	279				
		PM the Director of Nursing and MDS Nurse #1 stated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			C 03/28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 91 VICTORIA ROAD ASHEVILLE, NC 28801	DE	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 279	the resident on admismoking material wo resident's room. MD plan indicated if a resident. The adminishad never seen smoda resident's room and residents to keep the secure area of their residents.	ne Smoking Policy signed by ssion 04/29/13 included uld not be kept in the S Nurse #1 stated the care sident was a safe or unsafe strator and DON stated they king materials unsecured in d the expectation was for ir smoking material in a oom.	F2	279			
	conducted with MDS did not realize the ca included an approach be locked in the smo apron. 8. Resident #44 was 11/06/14. Diagnoses pulmonary disease, i spinal cord injury. An annual Minimum 10/10/14 indicated R quarterly MDS dated resident was cognitive. The Smoking Policy 11/07/14 noted smok kept in the resident's A review of the care 03/12/15 identified a #44 wishing to smok to keep the resident supervision while sme cigarettes and lighter a smoking schedule. identify a need for Resmoking apron.	signed by Resident #44 on ing material would not be room. Dan revised 09/03/14 and problem area of Resident e cigarettes. The goal was safe through the next review. d providing one-on-one oking, nursing to keep in a safe area, and to create The care plan did not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			C 03/28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP COD 91 VICTORIA ROAD ASHEVILLE, NC 28801		30.20.20	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 279	and no nursing intermands to wear a smoking at the wear a smoking of the smoking of smoking area. He was a pron and was not be member. Resident #44 was in 12:49 PM. He stated whenever he wanted cigarettes and lighted the right side of his word the bag revealed a lighter were clearly was a lighter were clearly was a lighter were unawared to the waste of the bag revealed a lighter were unawared the resident on admits moking material was resident's room. ME plan indicated if a resmoker. The adminishad never seen smodal resident's room and residents to keep the secure area of their secure area	or isk factors for smoking ventions related to smoking. ed the need for Resident #44 pron while smoking. 9 PM, Resident #44 was utside in the designated vas not wearing a smoking reing supervised by a staff terviewed on 03/25/15 at do he went outside to smoke do. He explained he kept his rin a small bag attached to wheelchair seat. Observation a pack of cigarettes and a visible. PM the Director of Nursing rand MDS Nurse #1 stated the Smoking Policy signed by ission 11/07/14 included build not be kept in the DS Nurse #1 stated the care sident was a safe or unsafe istrator and DON stated they whigh materials unsecured in dothe expectation was for heir smoking material in a room. PM MDS Nurse #1 stated in a room. PM MDS Nurse #1 stated in why the care plan for the care plan for the place." The readmitted to the facility on the sincluded hypertension and rosis.	F2	279			
	apron and was not be member. Resident #44 was in 12:49 PM. He stated whenever he wanted cigarettes and lighte the right side of his wof the bag revealed a lighter were clearly with the right of the bag revealed a lighter were clearly with the resident on admit smoking material wore resident's room. MD plan indicated if a resmoker. The adminishad never seen smoda resident's room and resident's room and resident's room and resident's room and resident to keep the secure area of their to 100 03/27/15 at 5:13 she could not explain Resident #44 indicated and lighter in a safe 9. Resident #91 was 12/25/14. Diagnose coronary atherosclet An annual Minimum	terviewed on 03/25/15 at d he went outside to smoke d. He explained he kept his r in a small bag attached to wheelchair seat. Observation a pack of cigarettes and a visible. PM the Director of Nursing r and MDS Nurse #1 stated the Smoking Policy signed by ission 11/07/14 included build not be kept in the DS Nurse #1 stated the care sident was a safe or unsafe istrator and DON stated they oking materials unsecured in d the expectation was for eir smoking material in a room. PM MDS Nurse #1 stated In why the care plan for teed "nursing to keep cigarette place." Is readmitted to the facility on s included hypertension and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 91 VICTORIA ROAD ASHEVILLE, NC 28801	•	10,20,20,10	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 279	02/11/14 noted sn kept in the resider A "Safe Smoking on 12/25/14 for Refactors for smokin to be implemented Smoking Needs A 03/25/15 for Resident #91 to we cigarette holder we A review of Resident #91 to we cigarette holder we A review of Resident #91 to we cigarette holder we A review of Resident #91 to we cigarette holder we A review of Resident wear as a superiodic supervision wear the smoking Observation of Repular Phase Ph	cognitively intact. cy signed by Resident #91 on noking material would not be nt's room. Needs Assessment" completed esident #91 documented no risk g and no nursing interventions d related to smoking. A "Safe assessment" completed dent #91 noted no risk factors g but indicated the need of rear an apron and have a hen smoking. ent #91's care plan revised a problem area of smoking. eep the resident safe through The interventions included the moking apron and to provide on when resident refused to	F 2	7.79			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			C 03/28/2015		
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	•	00/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 279	plan indicated if a resmoker. The adminhad never seen smora resident's room an residents to keep the secure area of their 10. Resident #47 w. 12/18/13 and readmin which included para history of traumatic lenging and depriment. The sign assessed Resident impairment. The sign assessment comple Resident #47 with use the side of th	OS Nurse #1 stated the care sident was a safe or unsafe istrator and DON stated they oking materials unsecured in id the expectation was for eir smoking material in a room. as admitted to the facility on itted 02/05/15 with diagnoses lysis, acute respiratory failure, orain injury, late effect ression. The current MDS) dated 02/10/15 #47 with no cognitive inficant change MDS ted 07/04/14 assessed se of tobacco. signed on admission by 18/13 noted smoking e kept in the resident room. reds Assessment" completed 16/15 did not indicate any in Resident #47 related to moking Needs Assessment" Resident #47 noted issues im while sitting or standing", for skills needed to securely drop ashes on self".	F2	279				
	Interventions to prot was to "apply smoki The care plans for R following problem ar A problem area date 02/25/15 noted, "I ar	ect the resident from injury ng apron". Resident #47 included the reas and approaches:						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION B	COMPLETED
		345174	B. WING		03/28/2015
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE COMPLETION
F 279		-	F 27	79	
	Safe Smoking Asser needs while smoking responsible party of Policy. A problem area dat 03/24/15 noted, "R non-compliance be 07/23/14 and upda has episodes of yerefusing/resisting of policies with period of the conserved outside, sarea designated for observed outside, sarea designated for observation, Residicigarette and lighter pocket or in a locked 03/25/15 at 11:06 At the dresser, in the door of the room we eyesight on the dresser, in the door of the observation	le I am smoking, Complete a ressment to identify my safety and and Ensure that I/my inderstand the facility Smoking seed 12/21/13 and updated resident is exhibiting and cursing: A care plan dated red 02/25/15 noted, "Resident are and following facility is of agitation/angry outbursts". 20 AM Resident #47 was remoking independently in the remoking. At the time of the remoking. At the time of the remoking in the room of Resident #47. The remoking in the room at the remoking in the remoking material in the room at the remoking material in the room at the remoking policy signed by remoking in the room in the room at the remoking Policy signed by remoking policy signed by remoking policy signed by remoking round in the room in the room room of Resident remoking Policy signed by remoking round my stated the round round not be kept in the room room of Resident remoking Policy signed by remoking round ro			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C 03/28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		3372372010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 279 F 281 SS=D	smoker. The adminish ad never seen smokar resident's room and residents to keep the secure area of their residents for their residents for their residents for the services provided must meet profession. This REQUIREMENT by: Based on record revifacility failed to obtain administer medicated post-operative discharesidents reviewed for medications following. The findings included. Resident #78 was ad 11/16/11 with diagnostipolar disorder with Alzheimer's disease. Further review of Resident #78 was se following cataract surface.	ident was a safe or unsafe strator and DON stated they sting materials unsecured in a the expectation was for ir smoking material in a com. ICES PROVIDED MEET ANDARDS Id or arranged by the facility hal standards of quality. It is not met as evidenced liew and staff interview the physician's orders to leve drops as directed in arge instructions for 1 of 1 or administration of eye eye surgery (Resident #78).	F 28		an order to d by the orders were sident is as was 3/30/2015. Clinical ng staff 6, 2015, on ding orders	4/17/15	
	documentation on Re	esident #78's medical record ident had cataract surgery		physicians must be written on toorder slips at each nursing state A nurse will verify orders from orders.	telephone ion.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			03/2	8/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	1 00/2	0/2010	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD				
				ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ID TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE	
F 281	Continued From page	e 27	F 2	81				
	every day after surge written in above "ope was documented as	2015 MAR were: still one drop in operated eye ry (stop date?) with "L" rated eye" - the medication given 03/06 - 03/14/15. ate 1% instill one drop in		physicians with the restaction facility physician. All orders are being concepted Records.	·			
	operated eye three til surgery with "L" writte the medication was d -03/13/15. 3. Prednisolone Aceta right eye every day fo	mes a daystart after en in above "operated eye" - ocumented as given 03/06 ate 1% instill one drop in the or ten days with "right"		All orders are being at Supervisor/ Clinical Commonday-Friday with worked on Monday. The checking the order to some onto the MAR for accurate.	oordinators reekend orders be The audits includ the transcription	eing		
	03/28/15. 4. Besivance 0.6% - surgery instill one drotimes a day with "L" veye" - the medication	mented as given 03/01 - starting 2 days before up in operated eye three vritten in above "operated was documented as started in three times a day through		The DON or RN Supe Coordinator are review morning clinical meeting. The DON or RN Supe Coordinator will report audits to the QAPI cormonthly basis for 3 more coordinates.	wing all orders in ng Monday-Frida ervisor/Clinical t the results of the mmittee on a	ay.		
	Resident #78's eye dhad cataract surgery Nurse #6 was unable drops to the left eye of stated they might be Upon request, the Me checked for any unfile #78 and located a ph the ophthalmologist of the progress note rev medications listed to post-operatively: 1. Timolol 0.5% 1 dro	edical Records coordinator ed documents for Resident ysician's progress note from lated 03/13/15. Review of realed the following be administered p to left eye every day drop every day as directed in						

		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345174	B. WING		03/28/201	5
	ROVIDER OR SUPPLIER LE NURSING & REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	337237231	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETION
F 281	day as directed in the 4. Besivance 0.6% of eye - discontinue 03. An interview on 03/2 Director of Nursing (#78's medical record physician's orders for that clarified the met progress note. The I ophthalmologist always with specific instruct she expected the numedication list to writelephone order and MAR. 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessar or maintain the high mental, and psychos accordance with the and plan of care. This REQUIREMENT by: Based on medical resident medical interviews the facility	tate 1% 1 drop three times a se operative eye after surgery drop three times a day in left (1/13/15). 28/15 at 7:40 PM with the (DON) revealed Resident d should have included or eye drops to the left eye dications listed on the DON stated the ays sent a list of medications ions for administration and are who received the ite the medications on a lenter it on the resident's ARE/SERVICES FOR SING Treceive and the facility must are care and services to attain est practicable physical, social well-being, in comprehensive assessment T is not met as evidenced ecord review and staff y failed to administer	F 28 ²	The facility will provide the necessary care and services to attain or maintain	n the	5
	telephone order and MAR. 483.25 PROVIDE C HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psychos accordance with the and plan of care. This REQUIREMEN by: Based on medical r interviews the facility medication and obta	ARE/SERVICES FOR ARE/SE	F 309	The facility will provide the necessary	/ n the and e	l/17/1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			1	C 28/2015
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	20.20.0
				91	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		Α	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 29	F3	309			
F 309	The findings included 1. Resident #47 was 12/18/13 and readmit which included gastro respiratory failure, his injury, late effect hem hypertension. Review of physician p medical record of Res note dated 02/23/15 v a Complete Blood Co revealed hemoglobin history of anemia, me hematemesis." The o noted by the physicia unspecified-get stool and start protein pum deficiency, will need i work and if not iron d Folate." An order was written for CBC, Basic Metal iron. A review of lab of Resident #47 note the CBC, BMP and to lab results was a note 03/02/15 to, "Start Fe day for 2 months ther CBC." Review of March 201	admitted to the facility and ted 02/05/15 with diagnoses ostomy, paralysis, acute story of traumatic brain hiplegia, depression and progress notes in the sident #47 noted a progress which included, "Patient had bunt (CBC) done which 10, hematocrit 29.4 with no belena, no abdominal pain or diagnosis and assessment in included, "Anemia, for hemocult, total iron level in pinhibitor. If iron ron added. Will await blood beficiency, get B12 and by the physician on 02/23/15 poolic Package (BMP), total results in the medical record do no 02/25/15 the results of otal iron. Handwritten on the experience by the physician dated arrous Sulfate 325 twice and discontinue. Recheck	F3	809	Resident #47 The Ferrous Sulfate was started on 3/27/2015 and ordered received to draw CBC on 3/30/2015. T lab results were received on 3/30/2015 and called to physician with no new orders. Resident #60 had a TSH drawn on 3/30/2015 and no new orders for this resident because it fell within normal range. The DON re-eduated the RN Supervisors/Clinical Coordinators verb on their responsibility for verifying that labs are checked daily and been drawn They were also re-educated on notification of the physician, resident, responsible/interested parties, RN Supervisor/Clinical Coordinators w be doing rounds with physicians. All orders will be written on order sheets a flagged for nursing staff to identify that order has been written. The RN Supervisor/Clinical Coordinator will review orders 3-5 times per week to ensure that all orders were transcribed correctly. The audit sheet and copies of the MD orders will be brought to the DO with the RN Supervisor/Clinical Coordinator initials verifying that all ord have been transcribed to the MARS or	ally all n. ill and an or of ON ers	
	(MAR) for Resident #	on Administration Record 47 noted a physician order for the Ferrous Sulfate or			TARS accurately. All lab orders received by a physician must be placed on the the log in the La Log Book. Lab sheets will be complete		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING			l ,	C	
NAME OF D	ROVIDER OR SUPPLIER			et.	REET ADDRESS, CITY, STATE, ZIP CODE		03/28/2015	
NAIVIE OF FI	ROVIDER OR SUFFLIER				VICTORIA ROAD			
ASHEVILL	E NURSING & REH	ABILITATION CENTER						
	I			A	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFIC	PY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	Continued From p	page 30	F3	309				
	On 03/27/15 at 10	0:50 AM Nurse #1 stated when			and placed under the date tag when du	ıe.		
	lab results were r	eceived, unless it was critical,						
		ced in the residents chart and			The RN Supervisor/Clinical Coordinato			
		ne physician's book. Nurse #1			will receive a copy of all orders and wil			
		se made rounds with the doctor			verify that lab slips were filled out and I	og		
	1	re written on a residents lab responsibility of the nurse			sheet was filled out in the lab book.			
		write the physician's orders.			A daily audit sheet is in each lab book	for		
		that in February there was			each day. The audit sheet will be brou			
		aking rounds with the physician			to the clinical meeting Monday-Friday a	•		
		s no longer working at the			reviewed by the DON or RN			
		reviewed the physician orders			Supervisor/Clinical Coordinator and			
		work of Resident #47 as well as			Administrator. All weekend orders will			
		physician orders and MAR and			audited and the copies of the orders ar			
		or Ferrous Sulfate and repeat			the audit will be brought to the DON for	•		
	lab work was mis	sed.			review on Monday.			
	On 03/28/15 at 7:	00 PM the administrator stated			The RN Supervisor/Clinical Coordinate			
		s doing rounds with the			will report results of the audits to the Q	API		
	' '	uary should have processed the			committee for a period of 3 months.			
		work of Resident #47 but failed						
		ministrator stated the nurse that						
		s no longer worked at the facility able to be interviewed. The						
		ed an order should have been						
		rrous Sulfate and repeat lab						
		ot explain what happened.						
	0= 02/20/45 = 7.	OF DNA the Director of Number						
		05 PM the Director of Nursing staff member that was making						
		hysician in February recently						
		yment with the facility and						
		or interview. The DON stated						
		ous Sulfate and repeat lab work						
		written and could not explain						
		The DON stated after she						
		the omission, the physician						
		orders were written for Ferrous						
	Sulfate and the re	epeat lab work for Resident #47.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				28/2015
	ROVIDER OR SUPPLIER E NURSING & REHABIL	ITATION CENTER	<u> </u>	9	TREET ADDRESS, CITY, STATE, ZIP CODE 1 VICTORIA ROAD ASHEVILLE, NC 28801	1 03/	20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 31	F	309			
	11/19/12 with diagnose mellitus type II, hyper debility. A quarterly Massessment indicated moderately impaired decision making. Review of Resident #revealed a physician's 03/18/15 which indicated and been gradually debilitated and was reactivities of daily living. Review of Resident #revealed an order data following laboratory to (CBC), comprehensive Depakote level and the (TSH) level. Review of Resident #results revealed result CBC, CMP and Depakelevel. An interview with the on 03/28/15 at 7:23 Process for obtaining receiving the order folab book with the data nurse working the 11:	cognitive skills for daily 60's medical record s progress note dated ated Resident #60 was being f nursing staff because he eclining, looked frail and equiring increased help with					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 03/28/2015
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	1 33/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5475
F 309 F 312 SS=D	outside laboratory p facility between 5:00 morning to draw any DON stated either s (QA) nurse compare with the lab book ev ordered labs were o either she or the QA results as they came DON stated the QA discovered the TSH compared the lab re book on 03/18/15 or back on 03/20/15. 483.25(a)(3) ADL CA DEPENDENT RESI A resident who is un daily living receives	facility had a contract with an rovider who came to the AM and 7:00 AM every labs that were ordered. The he or the Quality Assurance at the lab requisition forms ery day to verify that all btained. The DON stated a nurse also compared the lab in with the lab book. The nurse should have level wasn't done when she quisition forms with the lab when the other labs came	F 309		4/17/15
	by: Based on observati interview, the facility of 4 residents review (ADL). (Resident #5). The findings include Resident #5 was ad 10/19/99 with diagnory joint contracture of the	on, record review and staff y failed to trim fingernails for 1 wed for activities of daily living d: mitted to the facility on oses including hemiplegia, he hands, aphasia, and shavior disturbance. The m Data Set (MDS) dated		All residents that are unable to carry of activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Resident #5 nails have been trimmed a filed and the nails are not jagged. The DON and RN Supervisor/Clinical Coordinator re-educated nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25				С	
		345174	B. WING _			₀ ,	3/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7/20/2010	
					VICTORIA ROAD			
ASHEVILL	E NURSING & REHA	BILITATION CENTER			SHEVILLE, NC 28801			
	CLIMMAD	/ STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From p	age 33	F3	312				
	-	I Resident #5 was cognitively			from March 30, 2015 to April 15, 2015	on		
		d or behavior problems,			ADL care which included nails being	0		
		ometimes understood and			trimmed and cleaned at the time ADL's	3		
	•	ds. The MDS specified the			are done.			
	resident required of	extensive assistance with staff						
	assist of 1 for pers				The RN Supervisor/Clinical Coordinate			
	•	L dated 12/26/12 and reviewed			auditing nails for each resident 1-2 tim			
		Resident #5 required AM/PM			per week and if nails need to be trimm	ed		
		morning and evening and the			the nurse,RN Supervisor/Clinical			
		completed, and with bathing to			Coordinator or C.N.A will trim the nails and clean them at that time.			
		kin checks and record findings. er schedule revealed Resident			and clean them at that time.			
		cheduled Tuesdays and Fridays			The DON or RN Supervisor/Clinical			
		nowed what personal hygiene			Coordintor will review the audit sheets	at		
		mpleted such as hair washed,			morning clinical meeting for compliance	е		
	nails trimmed, teet	th brushed, etc. Review of the			Monday-Friday.			
	shower sheet date	ed 03/03/15 revealed resident						
		shed with no documentation			The results of the audit are reviewed v	/ith		
		trimmed. No other shower			the Administrator 1 time per week.			
		able for this resident for the rest			TI DOM '''			
	of the month of Ma				The DON will report the results of the	4la la c		
		03/25/15 at 1:00 PM revealed pernails on both hands			audit to the QAPI committee on a mon	trily		
		nately ¼ inch beyond the end of			basis for a period of 3 months.			
		the left thumb nail was jagged						
		on the left index finger.						
		ations on 03/26/15 at 8:45 AM						
	and on 03/27/15 a	t 8:25 AM and 6:16 PM						
	revealed Resident	#5's fingernails on both hands						
		ond the end of the resident's						
		agged left thumb nail.						
		00 PM Nurse Aide (NA) #2, who						
		on the hall Resident #5 resided						
		providing feeding assistance to						
		meal. She was interviewed						
		finished eating about ADL care. se aides do showers because						
		ver team. She stated residents						
		a week on Monday and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING _				C 28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER		91	REET ADDRESS, CITY, STATE, ZIP CODE VICTORIA ROAD SHEVILLE, NC 28801		20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312	and Saturday. She s showers they can rec the shower NA #2 sa to check residents sk nails need trimmed (t shaves need done ar revealed nurse aides nurse and the nurse shower room and treastated the nurse sign completed. NA # 2 w nails and she said sh were long while provi he should have had t On 03/27/15 at 6:16 I (DON) was shown Renoted they were long jagged. In an intervie she revealed she expshould have been trir 483.25(h) FREE OF AHAZARDS/SUPERVI	aid if residents request more seive more showers. During id nurse aides are supposed in for any skin conditions, if soe nails and finger nails), and hair washed. NA #2 report any problems to the will check the resident in the at the problem. NA # 2 s the shower sheet when was shown Resident #5's e had not noticed his nails ding feeding assistance and hem trimmed. PM the Director of Nursing esident #5's fingernails and and the left thumb nail was sew with the DON at this time sected Resident #5's nails mmed. ACCIDENT ISION/DEVICES		312			4/17/15	
	by: Based on observation resident and staff into	r is not met as evidenced ons, record review, and erviews, the facility failed to ce smoking rules for 13 of 17			The facility will ensure that the residen environment remains as free as possib of accident hazards and each resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345174	B. WING			1	C (28/204 <i>E</i>
NAME OF PE	ROVIDER OR SUPPLIER	0.0	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/	/28/2015
TVAINE OF T	COVIDER OR GOLT EIER				VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	LITATION CENTER			SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					DEI IGIENGT)		
F 323	Continued From page		F 3	23			
	(Residents #86, #96 retain smoking mater	Three of the 13 residents and #133) were allowed to ial in their room after staff			receives adequate supervsion and assistive devices to prevent accidents. On March 26, 2015 the Interdisciplinary	,	
	discovered them smoking within the facility. (Residents #23, #36, #44, #47, #73, #86, #91, #96, #126, #129, #131, #132, #133).				Team developed a new smoking policy which includes a safe smoking policy, unsafe smoking policy, staff responsible		
	Resident #96 smoked roommate used conticoncentrator. Thoughtransferred to anothe materials were allowed Resident #96 up throfrom the facility on 03 Jeopardy was remove when the facility provacceptable credible at The facility remains of scope and severity of	r room on 02/05/15, smoking ed to be maintained by ugh the time of discharge			and a Safe Smoking Data Collection To Facility staff were educated on the smoking policy from 3/26/2015 to 3/28/2015 and no staff was allowed to work until they had been educated on to policy. The smoking policy has been added to the orientation process which done by the Staff Development Coordinator. The smoking guidelines clearly state the designated smoking area is in the front courtyard of the building and the staff control of the smoking and the staff courtyard of the building and the staff control of the smoking and the staff courtyard of the building and the staff courtyard of the smoking area is sin the front courtyard of the building and the staff courtyard of the staff courtyard of the smoking courtyard of the staff courty and courtyard of the staff courty and courtyard of the staff courty and c	he is	
	that is not immediate	jeopardy) to complete ure monitoring systems put			monitors it on a regular basis to ensure residents are only smoking in the designated area. The Administrator and Admission Directions of the designation of the des	•	
	administrator on 03/2	Policy (provided by the			added the new smoking policy to the admission packet as an addendum. The resident, responsible party are required sign the smoking policy stating that the understand the policy and agree to abi	ne d to y	
	and 01/08/15 include -The facility Administr Supervisor have eval	d the following: rator/Maintenance			by the policy. A resident or responsible party that does not agree to abide by the policy will not be admitted to the facility Residents being admitted to the facility	ne v.	
	-All residents that des	sire to smoke will be ssion, quarterly, and PRN el of safety awareness to			give their cigarettes and lighters to the Admissions person or Charge Nurse utheir "safe smoker data collection tool"		

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		A. BOILDING			С	
345174	B. WING _				28/2015	
		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
TION CENTED		91	VICTORIA ROAD			
IION CENTER		AS	SHEVILLE, NC 28801			
ST BE PRECEDED BY FULL	ID PREFI) TAG	×			(X5) COMPLETION DATE	
is responsible, and what ed to be placed on the ges. ary team will then make he above. It is assessment, the sto wear a smoking are plan will be updated. It is en assessed as unsafe moke without the direct ble staff member, visitor, envision must be provided obting period. It is unsafe and wishing the documented in the sen assessed as being moke independently garettes, pipes, and aide. It is an any other forms of gas and the permitted to retain any ont in his/her personal. All smoking equipment is left with the smoking eriodic checks to o smoke have any	F3	323	has been completed and evaluated and signed by the Interdisciplinary Team. To cigarettes and lighting materials will marked with the resident name by the charge nurse or staff member receiving the smoking materials. The Director of Social Services will male the resident aware of the designation as "safe" or "unsafe". The resident or responsible party will sign the correct smoking policy including if they are deemed "safe" or "unsafe". A safe smoker will be allowed to keep their cigarettes in their room and they are not required to lock them up. There are to no lighters in any resident room. The Administrator is auditing new admission packets 2-5 times per week to ensure that the policy is in the file and signed by the resident or responsible party. The result of the audits will be brought to the QA/QAPI committee on a monthly basis for a period of 3 months. No resident that has portable oxygen tanks are allowed in the designated smoking area. The portable tank or howill have a "no smoking, oxygen in use sign attached to the bag, tank or wheelchair. The Administrator and Smoking Supervisors are monitoring the designated smoking area to ensure that no residents are in the designated	he Kes It be It s It		
	FION CENTER MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	FION CENTER JENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) JENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) JENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) FIGURE 1 AND THE PRECEDED BY FULL DENTIFYING INFORMATION) FIGURE 2 AND THE PRECEDED BY FULL DENTIFYING INFORMATION) FIGURE 2 AND THE PRECEDED BY FULL DENTIFY TAG FIGURE 2 AND THE PRECED BY FULL DENTIFY TAG FIGURE 2 AND THE PRECED BY FULL DENTIFY TAG FIGURE 2 AND THE PRECED BY FULL DENTIFY TAG FIGURE 2 AND THE PRECED BY FULL DENTIFY TAG FIGURE 2 AND THE PRECED BY FULL DENTIFY TAG FIGURE 2 AND THE PRECED BY TAG FIGURE 2 AND THE PRE	INTON CENTER RENT OF DEFICIENCIES SIT BE PRECEDED BY FULL DENTIFYING INFORMATION) F 323 IS responsible, and what ed to be placed on the ges. ary team will then make he above. g assessment, the to wear a smoking hare plan will be updated. here assessed as unsafe moke without the direct ble staff member, visitor, revision must be provided oking period. hirect supervision to d as unsafe and wishing howed inside the facility at moking privileges, be documented in the en assessed as being moke independently garettes, pipes, and haide. s, any other forms of gas I not be retained by the unsafe and he permitted to retain any not in his/her personal hall smoking equipment he left with the smoking eriodic checks to ho smoke have any violates the facility's he facility has suspicion	STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 ID PROVIDER'S PLAN OF CORRECTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIA DENTIFYING INFORMATION) F 323 Is responsible, and what ed to be placed on the ges. Bay team will then make to above. By assessment, the to wear a smoking are plan will be updated. Been assessed as unsafe moke without the direct ble staff member, visitor, rivision must be provided by sing period. By as unsafe and wishing as unsafe and wishing privileges, be documented in the en assessed as being moke independently garettes, pipes, and laide. By any other forms of gas into the retained by the nothing period of 3 months. STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 PROVIDER'S PLAN OF CORRECTION (CARCHOLD BY CARCHOLD BY	STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 ID PREFIX TAG PRECEDED BY FULL DENTIFYING INFORMATION) IS responsible, and what ed to be placed on the ges. any team will then make te above. a same seed as unsafe moke without the direct bile testiff member, visitor, rivision must be provided bile staff member, visitor, rivision must be provided bile staff member, visitor, rivision must be provided bile staff member, visitor, rivision to a sunsafe and wishing area assessed as being moke independently garetles, pipes, and aide. so, so, any other forms of gas a not be retained by the Insafe and the permitted to retain any mit in his/her personal All smoking equipment as left with the smoking enricidates the facility has suspicion ID PREFIX TAGODESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 PROVIDER'S RAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) In as been completed and evaluated and signed by the Interdisciplinary Team. The cigaretes and lighting materials will marked with the resident name by the charge nurse or staff member receiving the smoking materials will marked with the resident name by the charge nurse or staff member receiving the smoking particulary of the designation as "safe" or "unsafe". The resident or responsible party will sign the correct smoking policy including if they are deemed "safe" or "unsafe". A safe smoker will be allowed to keep their cigarettes in their room and they are not required to lock them up. There are to be no lighters in any resident room. The Administrator is auditing new admission packets 2-5 times per week to ensure that the policy is in the file and signed by the resident or responsible party. The results of the audits will be brought to the QA/QAPI committee on a monthly basis for a period of 3 months. No resident that has portable oxygen tanks are allowed in the designated smoking area to ensure that no residents are in the designated Self with the smoking area with portable oxygen ta	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
	345174		B. WING		03/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		00/20/2010
				91 VICTORIA ROAD		
ASHEVILLE NURSING & REHABILITATION CENTER				ASHEVILLE, NC 28801		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION DATE
F 323	Continued From pag	e 37	F 32	23		
		have smoking equipment in		removed from the area, and the		
	their possession. Th			Administrator and DON are notif	ied. The	
		aff members, and the		resident is put on q15 minute che		
		party will be notified and		the resident is educated on the h		
	given the opportunity	•		going into a smoking area with o	xygen.	
		ent is found, staff will explain				
		he articles must be removed.		The weekend managers are requ		
	nurse to store.	nen be given to the charge		complete the supervised smoking	•	
	-Admissions Coordin	nator/Social Services		tool for each supervised smoking they are monitoring on the week		
		Il review the Resident		concerns or problems experience	•	
		the resident/responsible		weekend smoking supervisors m		
		admission and as needed		called to the Adminsitrator and D		
	thereafter on an indiv			weekend manager report is turne	_	
	-The Director of Nurs	sing Services/Designee will		the Administrator on Monday mo		
	provide inservice trai	ining regarding the Resident		review in the morning departmer	nt	
	Smoking policy to the	e facility staff during		manager meeting.		
	orientation, annually	and as needed.				
				The resident audit tool is being of		
		ate smoking policy was		for a period of 4 weeks with two		
	provided by the adm			questions and 2 additional obser		
	interview on 03/25/1			The answer of "yes" to any of the		
		the second policy came from ovided to administration by		questions must immediately report the Administrator and Director of		
		December of 2014. The		for immediate follow up. The qu	•	
		she was not aware there		are as follows: 1) do you smoke,		
		moking policies, the specifics		you ever smoked, and if so how		
		t the two policies contradicted		Those residents identified as sm		
	each other. The sec	•		month ago or less will have the "		
	December 2014 police			smoking data collection tool" cor		
	following:			regardless of whether they are c		
		mission, residents shall be		smoking or not and the care plar		
		imitations on smoking,		updated according to our revised	l smoking	
		smoking areas, and the		policy.		
		acility can accommodate their				
	smoking or non-smo	•		The additional observations as p		
	example, in making r	_		resident audit are as follows: 1) I	-	
	-	s shall be strictly enforced in		see any smoking materials in the		
	all nonsmoking areas	S.		and 2) Do you see a lighter in the	e room.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 BOILEST				С
345174		345174	B. WING			0.5	3/28/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2010
				91	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		Α	SHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 38	F:	323			
	-The staff shall consu				Department Managers are to report		
		ector of Nursing Services to			immediately to the Administrator or		
	determine any restric				Director of Nursing a lighter or smoking	1	
	smoking privileges.				materials that are not allowed to be in t		
	-Any smoking related	privileges, restrictions, and			room. The lighter will be removed from	ì	
	concerns (for example				the room by the Department Manager		
		oted on the care plan, and			immediately. The resident audit tool is		
		or the resident shall be			completed 1x a week by an assigned		
	alerted to these issue				department manager and the		
		ose smoking restrictions on			Adminstrator reviews them 1x per weel	<	
		if it is determined that the safely with the available			and the results of the audit tools are	_	
	levels of support and				discussed in the morning meeting. The cumulative results, patterns, concerns		
		stricted smoking privileges			be identified and corrective action	WIII	
	requiring monitoring s				implementation will be done by the		
		member, family member,			Administrator on a weekly basis.		
		orker at all times while			,		
	smoking.				Residents that violate the smoking poli-	су	
	-The staff will review	the status of a resident's			are re-educated by The Director or Soc		
	smoking privileges pe	eriodically, and consult as			Services, Director of Nursing or the		
	needed with the Direct	ctor of Nursing Services and			Administrator and they will discuss the		
	the attending physicia				infraction with the resident and assure		
	•	residents with independent			they have an understanding of the		
	smoking privileges:				smoking policy. A second infraction by		
		ve independent smoking			the resident will result in an immediate	-	
		rmitted to keep cigarettes,			day discharge notice with safe discharge	-	
	possession	er smoking articles in their			planning being done by the Director of Social Services. If the rsident was		
	•	ly keep disposable safety			considered a "safe smoker" and has tw	/ O	
		ns of lighters, including			infractions that are resulting in the 5 da		
	matches, shall be pro				immediate discharge they will then be	,	
		t have or keep lighter fluids,			moved to "unsafe smoker" and will		
	_	or any other forms of gas or			supervised during smoking until their		
	fluids, at any time.	-			discharge takes place to protect the oth	ner	
	d. Residents with ind	lependent smoking			residents from potential harm.		
		e smoking articles to other					
		ed smoking privileges			The Administrator and Director of Nurs	ng	
	_	be permitted in bed, at any			will report the results of the following		
	time, except under di	rect supervision.	1		audits: resident audit tool, supervised		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		345174	B. WING		0	C 3/28/2015
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 91 VICTORIA ROAD ASHEVILLE, NC 28801		0/20/2010
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	privileges may not I smoking articles, in etc., except when the supervision. b. Smoking shall nedirect supervision. c. Anyone who provesidents shall be a restrictions/concern to smoking. -This facility may chif residents have an of our smoking policany such articles, a nurse/unit manager 1. Resident #96 wa 04/16/14 with diagralcohol and tobaccommunications.	or residents without ng privileges: ut independent smoking have or keep any types of cluding cigarettes, tobacco, hey are under direct ot be permitted in bed without evides smoking supervision to advised of any has and the plan of care related heck periodically to determine hy smoking articles in violation cies. Staff shall confiscate and shall notify the charge that they have done so. has admitted to the facility on hoses which included history of to abuse. The most recent (MDS) dated 01/21/15	F 32	,	e of smoking infractions of admission A/QAPI	
	Minimum Data Set (MDS) dated 01/21/15 assessed Resident #96 with no cognitive impairment. The Smoking Policy signed on admission by Resident #96 on 04/16/14 noted smoking material would not be kept in the resident's room. A "Safe Smoking Needs Assessment" was not available on the resident's medical record throughout his admission at the facility from 04/16/14 - 03/09/15. On 03/25/15 at 12:43 PM MDS Nurse #1 stated smoking assessments were completed on admission, quarterly and as needed. MDS Nurse # 1 checked the resident's closed medical record and electronic medical					

C 03/28/201 DRESS, CITY, STATE, ZIP CODE IA ROAD
DRESS, CITY, STATE, ZIP CODE
LE, NC 28801
PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X COMPLIANCE DATE: DA
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING		03/28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	1 03/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 323	10:34 AM indicated from the facility at 8 Further review of R revealed document began on 02/05/15 through 02/08/15 at checks were document AM which continued PM. Additional safe on 02/14/15 at 7:00 Review of a facility "Incident/Accident FAM indicated NA not smelled smoke. The room and he admitt cigarette. Resident and oriented X 3. The physician was not resident on admission of the president on admission of the resident on admission. The they were unaware the resident's room. The they received a polimanagement comp	the directive of the arse's note dated 03/09/15 at Resident #96 was discharged at 45 AM on 03/09/15. Resident #96's medical record ation of 15 minute checks that at 1:45 PM and continued at 1:45 PM. No other safety mented until 02/12/15 at 12:00 at through 02/13/15 at 10:30 at through 02/13/15 at 10:30 at through 12:00 PM. document titled Report" dated 02/05/15 at 5:30 of the nurse entered the resident's red to smoking part of a at 496 was assessed as alert. The form indicated the notified of the incident. Department PM The Director of Nursing for and MDS Nurse #1 stated the Smoking Policy signed by hission 04/16/14 included ould not be kept in the ney stated in December 2014 cy manual from the new any and, when they reviewed	F 32	,		
	policy was in direct by residents on admadministrator stated employment with th were allowed to ma their room. The DC	5/15, they noted the smoking conflict with the policy signed nission. The DON and I when they began e company in 2014 residents intain smoking materials in DN and administrator stated nts to maintain smoking				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	. ,	COMPLETED	
		345174	B. WING _			C 03/28/2015
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	· · · · · ·	03/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	the smoking assess stated residents de smoke unsupervise designated smoking Nurse #1 stated if a to independently sr would be locked in Nurse #1 stated if a intact, could light ar independently and they were consider Nurse #1 stated the resident was a safe administrator and E seen smoking materoom and the experience of the storage in resident of the 02/05/moved to another rechecks and dischard DON could not expedid not begin until 1 resident was found not consistently per through the time of DON could offer no smoking material freconsidered after the	m unless contraindicated in sment or care plan. The DON emed safe smokers could d, at any time, in the g area for residents. MDS a resident was deemed unsafe noke their smoking material the medication room. MDS a resident was cognitively and extinguish their cigarette not drop ashes on themselves ed a safe smoker. MDS a care plan indicated if a cor unsafe smoker. The DON stated they had never wrials unsecured in a resident's ctation was for residents to material in a secure area of DN stated there was not a monitor smoking material rooms. 22 PM the DON stated as a 15 incident, Resident #96 was boom, placed on 15 minute ge plans were initiated. The lain why the 15 minute checks :45 PM on 02/05/15 (when the smoking at 7:27AM) and were formed on Resident #96 discharge on 03/09/15. The explanation why removal of the plant was not a monitor smoking at 7:27AM and were formed on Resident #96 was not	F3	23		
	remembered Resid regularly assigned	ent #96, revealed he was to provide care to Resident #7 esident #96 on 02/05/15) and				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE C 03/28/20	2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILLE NURSING & REHABILITATION CENTER 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/28/2015	
	(X5) OMPLETION DATE	
Resident #96. Nurse #3 stated Resident #7 was on continuous oxygen 24 hours a day/7 days a week. During an interview on 03/27/15 at 11:52 AM with Nurse #4 she stated she regularly provided care to Resident #7 and revealed he always wore his oxygen and she did not recall ever seeing him without oxygen in use. An interview on 03/27/15 at 12:21 PM with the Staff Development Coordinator (SDC) revealed she worked from 11:00 PM on 02/04/15 until 7:00 AM on 02/05/15. The SDC stated she was notified by a NA that she smelled smoke so she went to investigate and determine the location of the smoke smell. The SDC stated she determined the smell was coming from the room of Resident #96. She stated when she entered his room he was lying in bed and was not wearing his oxygen. The SDC stated she didn't observe a cigarette in his hand or on his bed and did not check the bathroom. She stated she assumed he put the cigarette out in the toliet but didn't know that for sure. The SDC stated she recalled that his roommate, Resident #7, was in bed with oxygen in use at the time of the incident. The SDC stated she didn't oxygen in use at the time of the incident. The SDC stated she didn tot remove the cigarettes or lighter from Resident #7 but she informed the DON of the incident and was told to fill out the incident report. In a follow-up interview on 03/27/15 at 6:00 PM MDS Nurse #1 stated removal of smoking material from Resident #96 site the the 02/05/15 incident was not considered because he was assessed a safe smoker because he was assessed a safe smoker because he was assessed as acconditively intact, could light and destinguish a		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		03/28/2015
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	1 00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	assessed safe to sm retain their smoking On 03/27/15 at 6:27 with the administrator incident involving Rethe decision was machecks and pursue of Resident #96 was min because his room continuous oxygen. discussed removing Resident #96 so here his room through dis On 03/28/15 at 12:20 residents that smoke smoke around oxyge specifics of where to their room was not do a resident wanted to in their nightstand the from the maintenance if staff saw any smoke room that was not secured. 2. Resident #126 was 03/03/15 with diagnoobstructive pulmonal Minimum Data Set (103/10/15 assessed Forcognitive impairment #126 used tobacco. A "Safe Smoking Ne	ong as a resident was oke they were allowed to material in their room. PM the SW stated she spoke of after the 02/05/15 smoking sident #96. The SW stated do to initiate 15 minute discharge. The SW stated oved from the room he was mate (Resident #7) was on The SW stated staff had not smoking material from detained smoking material in charge on 03/09/15. I PM the DON stated do were informed not to en but, other than that, store smoking material in discussed. The DON stated did were informed not to en but, other than that, store smoking material in discussed. The DON stated did gey needed to request a lock de director. The DON stated did grade and the curely stored it should be seen sadmitted to the facility on deses which included chronic by disease. The admission MDS) assessment dated desident #126 with no and indicated Resident ded and indicated any needs or issues	F 32	3	

	:D	245474			(X3) DATE SURVEY COMPLETED		
	<u>l</u>	345174	B. WING			C 3/28/2015	
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	•		
DEFICI	CIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
g Policy 26 on uld not for Reproblem 19 at 11 points of at 11	Resident em area Approacte my vie a Safe ty needs esible parea a hes or a 11:44 AM ner rooghter in Residen dand she ghter. The short and she can a 14:44 AM ner rooghter in Residen dand she ghter. The short and she can a 14:44 AM ner rooghter in Residen dand she ghter. The short and she can a 14:44 AM ner rooghter in Residen dand she ghter. The short and	ned on admission by 1/15 noted smoking ept in the resident's room. It #126 dated 03/14/15 a that stated: "I am safe ches to this problem area sistors about the smoking a Smoking Assessment to swhile smoking, Ensure entry understand the facility. If Resident #126 was in the facility's designated and was not observed with a lighter. If an interview with come revealed she kept her an unlocked drawer in the facility of the surveyor her he roommate of Resident in continuous oxygen in which was attached to an a light Resident #126 was ing independently in the oking. If the Director of Nursing and MDS Nurse #1 stated	F 32	23			
26 on uld not for Reproblement." A ducate plete a safety sponsibility. 5 at 11 pointing in atches and light posterior and light posterior at 2:4 atside, atted for at 6:5	on 03/03 not be keep and the marea and produce a Safe by needs a sible part of the marea and the side and should and should and should and should and the side and the	in the resident's room. It #126 dated 03/14/15 In that stated: "I am safe ches to this problem area sistors about the smoking is Smoking Assessment to so while smoking, Ensure arty understand the facility. If Resident #126 was in the facility's designated and was not observed with a lighter. If an interview with comerce and the surveyor her an unlocked drawer in the transparence of Resident in continuous oxygen in which was attached to an an I Resident #126 was ing independently in the oking. If the Director of Nursing					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
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		345174	B. WING				28/2015
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00//	20/2010
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ASHEVILL	E NURSING & REHAB	SILITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN REGULATORY OI	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 323	Continued From page	ge 46	F	323			
	management comp	any and, when they reviewed					
	the manual on 03/2	5/15, they noted the smoking					
	policy was in direct	conflict with the policy signed					
	by residents on adn	nission. The DON and					
	administrator stated	I when they began					
		e company in 2014 residents					
		intain smoking materials in					
		N and administrator stated					
	_	nts to maintain smoking					
		m unless contraindicated in					
		sment or care plan. The DON					
		emed safe smokers could d, at any time, in the					
		g area for residents. MDS					
		resident was deemed unsafe					
		noke their smoking material					
		the medication room. MDS					
		resident was cognitively					
		nd extinguish their cigarette					
	_	not drop ashes on themselves					
	they were considere	ed a safe smoker. MDS					
	Nurse #1 stated the	care plan indicated if a					
		or unsafe smoker. The					
		ON stated they had never					
	seen smoking mate	rials unsecured in a resident's					
		ctation was for residents to					
		material in a secure area of					
		ON stated there was not a					
		nonitor smoking material					
	_	rooms. In a follow-up					
		15 at 12:21 PM the DON					
		t smoked were informed not					
		xygen but, other than that, o store smoking material in				ĺ	
		discussed. The DON stated if					
		o lock their smoking material				ĺ	
		ney needed to request a lock				ĺ	
	_	ce director. The DON stated				ĺ	
		oking material in a resident				ĺ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION 3	' '	COMPLETED		
		345174	B. WING			C 03/28/2015	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	.	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 323	3. Resident #73 wa 02/24/15 with diagr obstructive pulmon An admission Minir assessment dated #73 with no cognitive indicated Resident A "Safe Smoking Non 02/25/15 did not with Resident #73 m O2 material would not Review of Resident revealed an order of to 5 liters per minut levels above 90%. A care plan for Resident is at risk activity due to pote to this problem area smoke in designated times, Fapron while smokin physically assist reseded, Monitor smeasurements.	securely stored it should be as admitted to the facility on noses which included chronic ary disease and depressive. In the state of th	F 32	23			
	On 03/25/15 at 10:0 observed sitting ou	05 AM Resident #73 was tside in the designated other residents. Resident #73					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		· ,	(X3) DATE SURVEY COMPLETED C		
	345174	B. WING			03/28/2015		
ROVIDER OR SUPPLIER LE NURSING & REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801				
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE		
was not wearing as the observation and hand. No staff mem residents. During an interview 03/25/15 at 10:05 A Resident #73 states afe for smoking ar smoking apron. On 03/25/15 at 11:4 she kept her cigare nightstand or in her stated: "We have a I figure if they can't them." An oxygen cannula attached wand Resident # 73 except when she was getting ready to An interview with N PM revealed she was getting ready to An interview with N PM revealed she was in her roor room was to go sm On 03/25/15 at 6:38 (DON), Administrat they were unaware the resident on adn smoking material was resident's room. The	smoking apron at the time of d had a lit cigarette in her ober was present with the with Resident #73 on AM about the smoking apron, d she had been assessed as and didn't need to wear a with the smoking apron, d she had been assessed as and didn't need to wear a with the smoking apron, d she had been assessed as and didn't need to wear a with the smoke and lighter locked in her packet pocket. Resident #73 lot of people who wander and see them they won't bother concentrator with nasal was observed beside the bed stated she used it all the time rent outside to smoke and she to go outside to smoke. Sident #73. Nurse #5 stated the oxygen continuously when an and the only time she left the oke. Sident #73 Nurse #1 stated the Smoking Policy signed by mission 02/24/15 included rould not be kept in the ney stated in December 2014	F 32	3				
	Continued From particles was not wearing as the observation and hand. No staff memoresidents. During an interview 03/25/15 at 10:05 A Resident #73 states afe for smoking ar smoking apron. On 03/25/15 at 11:4 she kept her cigare nightstand or in her stated: "We have a I figure if they can't them." An oxygen cannula attached wand Resident #73 except when she was getting ready to the work of the work	TIDENTIFICATION NUMBER: 345174 ROVIDER OR SUPPLIER E NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 was not wearing a smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents. During an interview with Resident #73 on 03/25/15 at 10:05 AM about the smoking apron, Resident #73 stated she had been assessed as safe for smoking and didn't need to wear a	A BUILDING 345174 B. WING B. WING ROVIDER OR SUPPLIER E NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 was not wearing a smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents. During an interview with Resident #73 on 03/25/15 at 10:05 AM about the smoking apron, Resident #73 stated she had been assessed as safe for smoking and didn't need to wear a smoking apron. On 03/25/15 at 11:40 AM Resident #73 stated she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated: "We have a lot of people who wander and I figure if they can't see them they won't bother them." An oxygen concentrator with nasal cannula attached was observed beside the bed and Resident #73 stated she used it all the time except when she went outside to smoke and she was getting ready to go outside to smoke and she was getting ready to go outside to smoke and she was getting ready to go outside to smoke and she was getting ready to go outside to smoke have an in her room and the only time she left the room was to go smoke. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 02/24/15 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed	ROVIDER OR SUPPLIER E NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 was not wearing a smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents. During an interview with Resident #73 on 03/25/15 at 10:05 AM about the smoking apron, Resident #73 stated she had been assessed as safe for smoking and didn't need to wear a smoking apron in her jacket pocket. Resident #73 stated when they work the had and Resident #73 stated who was did the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents. During an interview with Resident #73 on 03/25/15 at 11:40 AM Resident #73 stated who was a safe for smoking apron, Resident #73 stated who was a safe for smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the residents. On 03/25/15 at 11:40 AM Resident #73 stated she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated who was regularly assigned to provide care for Resident #73 stated she used it all the time except when she went outside to smoke and she was regularly assigned to provide care for Resident #73. Nurse #5 stated Resident #73 used the oxygen continuously when she was in her room and the only time she left the room was to go smoke. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 02/24/15 included smoking material would not be kept in the residents room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed	A BUILDING 345174 345174 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 SUMMARY STATEMENT OF DEDICENCIES (EACH DEPCISION) FURLE REPROCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 was not wearing a smoking apron at the time of the observation and had a lit cigarette in her hand. No staff member was present with the resident #73 stated she had been assessed as safe for smoking apron. CO 30/25/15 at 10:05 AM about the smoking apron, Resident #73 stated she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated she kept her cigarettes and lighter locked in her nightstand or in her jacket pocket. Resident #73 stated when he was not wear a smoking apron. An oxygen concentrator with nasal cannula attached was observed beside the bed and Resident #73 stated she was regularly assigned to provide care for Resident #73. Nurse #5 stated Resident #73 used the oxygen continuously when she was in the room and the only time she left the room was to go smoke. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on admission 02/24/16 included smoking material would not be kept in the resident room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345174	B. WING				28/2015	
NAME OF PI	ROVIDER OR SUPPLIER	L		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	20/2010	
				91	I VICTORIA ROAD			
ASHEVILL	E NURSING & REHA	BILITATION CENTER		A	SHEVILLE, NC 28801			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 323	Continued From pa	age 49	F;	323				
	by residents on ad	mission. The DON and						
	•	d when they began						
	employment with the	ne company in 2014 residents						
	were allowed to ma	aintain smoking materials in						
	their room. The Do	ON and administrator stated						
		ents to maintain smoking						
		om unless contraindicated in						
		sment or care plan. The DON						
		eemed safe smokers could						
		ed, at any time, in the						
	designated smoking area for residents. The DON stated there was not a staff member present to							
		assessed as safe smokers to						
		apron was in place when the						
	_	ing. MDS Nurse #1 stated if a						
		ed unsafe to independently						
		ng material would be locked in						
	the medication roo	m. MDS Nurse #1 stated if a						
	resident was cogni	tively intact, could light and						
		arette independently and not						
		nselves they were considered						
		OS Nurse #1 stated the care						
	•	resident was a safe or unsafe						
		nistrator and DON stated they						
		noking materials unsecured in						
		and the expectation was for heir smoking material in a						
		r room. The DON stated there						
		n place to monitor smoking						
		resident rooms. In a follow-up						
	_	/15 at 12:21 PM the DON						
		at smoked were informed not						
	to smoke around o	xygen but, other than that,						
	specifics of where	to store smoking material in						
		discussed. The DON stated if						
		to lock their smoking material						
	_	they needed to request a lock						
		nce director. The DON stated						
	if staff saw any sm	oking material in a resident						

ON NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
I5174 B. W	VING		1	28/2015		
<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	1 03/	20/2015		
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3 was gen in use 3 was 's th other as providing garette in #1 stated esident #73 g apron and s indicated. facility on bacco use. c order dated l) for sion by king dent's room. (MDS)dated nitively intact and that he I a problem tes in brientation staff and	F 32	3				
F FON S SYMPT SING SECOND	45174 B. V R SIENCIES	R SIENCIES DED BY FULL UFORMATION) F 32 should be '3 was gen in use '3 was gen in use '41 stated desident #73 ng apron and s indicated. '5 facility on bacco use. s order dated N) for ssion by oking ident's room. (MDS)dated gnitively intact and that he d a problem ttes in orientation staff and on 01/07/15 n 02/16/15 it	R STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 ID PREFIX ID PREFIX TAG FORMATION) F 323 Should be 3 was gen in use 3 was ys ith other thas providing igarette in #1 stated tesident #73 and apron and so indicated. a facility on bacco use. so order dated N) for ssion by oking ident's room. (MDS)dated initively intact and that he d a problem tes in orientation staff and on 01/07/15 n 02/16/15 it	R STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801 PREFIX TAG FORMATION) FORMATION F 323 Should be F 323 Should be #1 stated tesident #73 tog apron and tog indicated. #1 stated tesident #70 tog apron and tog indicated. #1 stated tesident #70 tog apron and tog indicated. #1 stated tesident #70 tog apron and tog indicated. #1 stated tesident #70 tog apron and tog indicated. #1 stated tesident #70 tog apron and tog apron an		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	343174	J:	STREET ADDRESS, CITY, STATE, ZIP CO	•	3/28/2015	
TO WILL OF T	NOVIDER OR OUT FIER			91 VICTORIA ROAD	552		
ASHEVIL	LE NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From pag	e 51	F 3	323			
F 323	in the building. Appr Resident #86 to smo with verbal reminder: apron. Review of a "Safe Sr for Resident #86 date concerns identified re Review of another "Same activities and an inte required application of 03/25/15 another "Same activities and an inte required application of 03/25/15 another "Same activities and an inte required application of 03/25/15 another "Same activities and an inte required application of 03/25/15 another "Same activities and an inte required application of 03/25/15 another "Same activities and an inte required application indicated that at appr noticed a smell of cig near the nurse's des and out of rooms who in the second resident #86 leaned his eyes closed at the smoke area. The nut that he should lie do Ambien (a medication resident told her he was smoked. According propelled himself out cigarette was observe (with ash attached) or resident had been sing resident the cigarette	we in designated areas only is for him to put on a smoking moking Needs Assessment" and 06/30/14 revealed no regarding safe smoking. Safe Smoking Needs 03/11/15 for Resident #86 rep easily during tasks or revention indicated he of a smoking apron. On refe Smoking Needs mpleted and revealed opped ashes on himself and revealed in the hallway, it, and the nurse walked in the osmoke was noted. The ctivity dining room and found back in his wheel chair with the door going out to the rese stated to the resident with the rest because he had an infor insomnia) and the would lie down after he to the note, as Resident #86		523			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		03/2	8/2015
	NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	1 00/2	0/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pag		F 32	3		
	informed of the incic On 03/25/15 at 9:54 observed seated in The resident said her Observation of his or plastic bag of loose rolling cigarettes. Resident said his own cigarettes at lighter in his room. In smoke he wears an had ever smoked in bathroom or some of resident stated her facility in February becountyard to smoke reported after the 02 by the administrator facility because of fine was able to keep and lighter in his poon 03/25/15 at 10:00 observed seated in courtyard smoking won 03/25/15 at 12:4 staff who assess resident safe smoker based their cigarette, extinuthey dropped ashes smoking. MDS Nurrodone on admission, there had been any mental status, mediciphysical changes ar resident's ability to so On 03/25/15 at 1:23 observed to go out to	AM Resident #86 was his wheel chair in his room. was going out to smoke, wer bed table revealed a tobacco with a machine for esident #86 stated he rolled and kept the tobacco and He said when he goes out to apron. He was asked if he the facility, either in the other part of the facility. The ad lit up a cigarette inside the defore he went out to the because it was cold. He 2/16/15 incident he was told he could not smoke in the re laws. Resident #86 stated whis rolling machine, tobacco essession. 5 AM Resident #86 was his wheel chair out in the with a smoking apron on. 3 PM MDS Nurse #1 stated sidents to smoke go outside and determine if they are a con a residents ability to light guish their cigarette and if on themselves when se #1 stated assessments are quarterly and done again if change in the resident's cation changes, reports of and unsafe behaviors affecting				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
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	ROVIDER OR SUPPLIER	343174	15: *******	OTDEET ADDRESS SITV STATE TO SODE	03	/28/2015	
	ASHEVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 323	back of the chair next material side out and material out. Observed directly supervising the assist Resident #86 to with the retardant side. On 03/25/15 at 6:14 fobserved coming down outside to return to his had his smoking material work was empty becarding arettes and lighter pack was empty becarding rettes. On 03/25/15 at 6:39 for (DON), Administrator they were unaware the resident on admission smoking material work resident's room. The they received a policy management compart the manual on 03/25/policy was in direct compart to by residents on admission administrator stated the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compart to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct compared to the manual on 03/25/policy was in direct	a smoking apron lying on the to him and put it on with the not the shiny retardant ation revealed no staff ne smokers or available to o put the smoking apron on e out. PM Resident #86 was we the hall from smoking s room. He was asked if he erials with him and he rowed his empty pack of the stated that his cigarette ause he needed to roll more. PM the Director of Nursing and MDS Nurse #1 stated he Smoking Policy signed by ssion 06/21/14 included alld not be kept in the sy stated in December 2014 or manual from the new my and, when they reviewed 15, they noted the smoking ponflict with the policy signed ssion. The DON and they allowed residents to sterial in their room unless the smoking assessment or stated residents deemed moke unsupervised, at any and stependently smoke their	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345174	B. WING _			03/28/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				91 VICTORIA ROAD			
ASHEVILI	LE NURSING & REHA	BILITATION CENTER		ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	plan indicated if a smoker. The adminated never seen so a resident's room a residents to keep the secure area of the was not a system in material storage in On 03/25/15 at 7:1 MDS Nurse #1 state supervision while shis smoking aprone Resident #86 had that she was not a Resident #86 not pm MDS Nurse #1 state to retain smoking rought 10/2/16/15 because smoker due to the extinguish his cigal aprone to contain an #1 stated as long a safe to smoke they smoking material in On 03/26/15 at 100 tobacco was observed a box, and his rollicated he had not a An interview was comply material in On 02/16/15. Nurse model in the hall in the nurse stated stated in the nurse stated stated in the hall in the nurse stated stated in t	DS Nurse #1 stated the care resident was a safe or unsafe inistrator and DON stated they noking materials unsecured in and the expectation was for heir smoking material in a ir room. The DON stated there in place to monitor smoking a resident rooms. 4 PM in a follow-up interview, ted Resident #86 required smoking to make sure he had on. MDS Nurse #1 stated his own personal apron and ware of any instances of outting his apron on correctly. Ited Resident #86 was allowed material in his room (after the he was considered a safe fact he could light his cigarette, rette and wore a smoking my dropped ashes. MDS Nurse as a resident was assessed of were allowed to retain their	F3				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
				91 VICTORIA ROAD			
ASHEVILL	E NURSING & REHA	BILITATION CENTER		ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Continued From parentered the activity Resident #86 sitting to the courtyard who nurse said she obstattached in front of the floor. Nurse #7 resident if he had a smoking. The nurse aide had reported the resident did not she called the one DON placed Resident and Nurse #7 did not not 15 minute check Administrator came the Administrator came the Administrator at that was all she did knew, and was told the building because residents and himself her knowledge she smoking incident where the told the smoking incident where the told th	age 55 If dining room and found Ig in front of the door going out Intere residents smoke. The Intereved a cigarette with ashes Iresident #86's wheel chair on Ireported she had asked the Ismoked and he denied Ise told the resident that a nurse Intereved a smoked and she said It admit it. Nurse #7 revealed It admit it. Nurse #7 stated the It into the facility and she told It is into	F 3	DEFICIENCY)	PROPRIATE	DATE	
	specifics of where their room was not a resident wanted in their nightstand from the maintenan if staff saw any sm	gen but, other than that, to store smoking material in discussed. The DON stated if to lock their smoking material they needed to request a lock nce director. The DON stated oking material in a resident securely stored it should be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,				(X3) DATE COMP	SURVEY LETED
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		345174	B. WING			03/	28/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
401151//11	E AULDOING & DELLABU	ITATION OFNITED		9	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		1	ASHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 56	F	323			
	secured. The DON c	ould offer no explanation					
		s were only done for 2 days					
	•	was not given to remove					
		m the room of Resident #86					
	after he was found sn	noking in the facility on					
	02/16/15.						
		s admitted to the facility on					
		ses including quadriplegia,					
	visually impaired and						
		igned on admission by					
	Resident #131 on 03/	•					
		kept in the resident's room. mum Data Set (MDS) dated					
		dent #131 as cognitively					
		r behavior problems and					
		. His roommate had an					
		for continuous oxygen at 3					
		nasal cannula for diagnoses					
	of chronic obstructive						
		03/22/15 identified a problem					
	of Resident #131 at ri	isk for injury related to					
		clude approaches that he					
	•	ervision provided during the					
		I, monitor smoking habits				ſ	
	and behaviors for poo	-					
		s his ability to maintain					
		g, ensure he smokes in					
		y and wears a smoking					
	•	smoking materials were to					
	be maintained by faci	=					
		noking Needs Assessment" ted 03/25/15 noted resident				ſ	
		nge of motion in arms and				ſ	
		e motor skills needed to				ĺ	
		s ashes on self and unable				ſ	
	to use ashtray to extin					ſ	
		esident #131 required use of				ſ	
		for staff to extinguish his				ſ	
	cigarette.	J					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	040114		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/28/2015
				91 VICTORIA ROAD		
ASHEVIL	LE NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 57	F 3	223		
F 323	On 03/25/15 at 11:05 observed being assist designated smoking light Resident #131's in his mouth, remove Resident's mouth, flicand place the cigarer mouth. On 03/25/15 at 1:35 observed seated in hwaiting to be taken to was observed to have on his lap with the lig cellophane cover of the would put his cigardrawer of his bedside doctor's appointment #131's bedside dress lock on the drawer. outside of Resident #100 roommate of Resid	sted by staff out to resident area. Staff was observed to a cigarette, place the cigarette at the cigarette from the ck the ashes in the ashtray, atte back in Resident #131's PM Resident #131 was as wheel chair, in his room, or a doctor's appointment. He are a pack of cigarettes lying after located in the attention the cigarette pack. He stated arettes and lighter in his top at table before he left for the attention of Resident ser revealed there was no an oxygen sign was on the attention of the arettes and the mit #131 was wearing a nasal being provided via an and the over bed attention of the over bed and his roommate was and with oxygen being	F 3	323		

AND DUAN OF CODDECTION IN INDED.		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345174	B. WING_			C
	ROVIDER OR SUPPLIER LE NURSING & REHABI			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	ı	03/28/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	administrator stated maintain smoking m contraindicated in the care plan. The DON safe smokers could time, in the designat residents. MDS Nur deemed unsafe to in smoking material we medication room. M resident was cognitive xtinguish their cigad drop ashes on them a safe smoker. MDS plan indicated if a resident's room an resident's room an a resident's room an a resident's room an residents to keep the secure area of their was not a system in material storage in a On 03/25/15 at 7:30 conducted with the A had recently been hid over the Smoking Posmoke at the end of said all residents in urse will complete a determine if they can materials and smoke On 03/27/15 at 5:13 conducted with MDS explain why Resider and lighter in his room	they allowed residents to aterial in their room unless e smoking assessment or stated residents deemed smoke unsupervised, at any ed smoking area for se #1 stated if a resident was dependently smoke their old be locked in the DS Nurse #1 stated if a vely intact, could light and rette independently and not selves they were considered S Nurse #1 stated the care sident was a safe or unsafe strator and DON stated they king materials unsecured in d the expectation was for eir smoking material in a room. The DON stated there place to monitor smoking resident rooms. PM an interview was admission Coordinator who red. She stated she goes olicy with residents who the admission process. She in the Smoking Policy. She are been informed that the an assessment and in keep their smoking e without supervision. PM an interview was S Nurse #1. She could not at #131 would have cigarettes in noting he was a and it was inconsistent with	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHAB	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	'	30,20,20
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	conducted with the I residents that smoke smoke around oxygo specifics of where to their room was not of a resident wanted to in their night stand the from the Maintenanci if staff saw any smoor oom that was not secured. The DON smoking material was Resident #131. 6. Resident #23 wa 09/01/03 with diagnorand history of tobact The Smoking Policy 04/29/13 noted smokept in the resident in the resident of the Smoking Policy 04/29/13 noted smokept in the resident of the Smoking Policy 04/29/13 noted smokept in the resident of the Smoking Policy 04/29/13 for Ediminished fine mote of the Smoking apron, education of the Smoking appoint of the Smoking appoint of the Smoking appoint of the Smoking	1 PM an interview was DON. She stated that ed were informed not to en but, other than that, o store smoking materials in liscussed. The DON stated if a lock their smoking material mey needed to request a lock the Director. The DON stated king material in a resident ecurely stored it should be had no explanation why as retained in the room of the sadmitted to the facility on poses including depression to use. Isigned by Resident #23 on king material would not be room. Inimum Data Set (MDS) dated Resident #23 as cognitively ly impaired vision. His 12/02/14 revealed he used moking Needs Assessment Resident #23 revealed he had or skills, needed to securely endropped ashes on himself smoking apron. Review of Needs Assessment" form	F3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) Di					
		345174	B. WING		0:	C 3/28/2015		
	ROVIDER OR SUPPLIER LE NURSING & REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 323	smoker or unsafe sr	etermine if he was a safe noker.	F 32	3				
	observed seated in and he had a pack of was holding his light stated he kept his circom because he w. Resident #23 also in smoking apron. On 03/25/15 at 1:22	PM Resident #23 was his wheelchair in his room of cigarettes on his lap and ter in his hand. Resident #23 garettes and lighter in the as considered a safe smoker. Indicated he did not need a						
	area. He was smok smoking apron on. On 03/25/15 at 6:15 observed coming do outside in the design smoke. Resident #2	PM Resident #23 was when the hall from smoking hated area for residents to 23 reported he had his						
	returning to his room On 03/25/15 at 6:39 (DON), Administrate they were unaware the resident on 04/2 material would not be	PM the Director of Nursing or and MDS Nurse #1 stated the Smoking Policy signed by 29/13 included smoking e kept in the resident's room.						
	policy manual from to company and, when 03/25/15, they noted direct conflict with the on admission. The	mber 2014 they received a the new management they reviewed the manual on the smoking policy was in the policy signed by residents DON and administrator stated to the maintain ampling.						
	material in their roor the smoking assess stated residents dee smoke unsupervised designated smoking stated there was no	nts to maintain smoking n unless contraindicated in ment or care plan. The DON ment safe smokers could d, at any time, in the area for residents. The DON t a staff member present to ssessed as safe smokers to						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONS		` ′	X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 03/28/2015	
	ROVIDER OR SUPPLIER	BILITATION CENTER		91 VICT	ADDRESS, CITY, STATE, ZIP CODE ORIA ROAD VILLE, NC 28801		00/20/2010	
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F 323	resident was smoking resident was deem smoke their smoking the medication roomersident was cognitextinguish their cigadrop ashes on them a safe smoker. ME plan indicated if a resident's room a resident's room a resident's room a residents to keep the secure area of their was not a system in material storage in On 03/26/15 at 1:00 conducted with Mir #1. She stated Resident storage in On 03/26/15 at 1:00 conducted with Mir #1. She stated Resides smoker but ma pron. MDS Nurse was a safe smoker own ashes, light his cigarette out of the his mouth. MDS Nicigarette out of the his mouth. MDS Nicigarette shecause around the holes. Resident #23 was a safe that staff super should know if a reapron or not. On 03/26/15 at 1:15 had his own smoking forget to bring it our smoke.	apron was in place when the ing. MDS Nurse #1 stated if a ed unsafe to independently ing material would be locked in inm. MDS Nurse #1 stated if a cively intact, could light and arette independently and not inselves they were considered in inselves they was a safe or unsafe in instrator and DON stated they oking materials unsecured in indicate the inselves they was for inselves they was a safe or unsafe in ins	F	323				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	<u>'</u>	30,20,20
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	She stated residents not to smoke around specifics of where to their room was not of a resident wanted to in their night stand their night saw and secured. 7. Resident #36 was 12/11/07 and readmed diagnoses including The Smoking Policy 04/29/13 noted smokept in the resident of the most recent Min 02/09/15 coded Reswith no mood or behalt to be with no mood or behalt to be with no mood or behalt to be smoke in designated at risk for injury related Approaches included smoke in designated encourage her to we smoke breaks because smoking and has a residents cigarettes. approach included the and lighter must be cart. Review of the "Safe Assessment" dated revealed no problem On 03/25/15 at 10:5	Director of Nursing (DON). It is that smoked were informed to a toxygen but, other than that, is store smoking materials in discussed. The DON stated if it lock their smoking material mey needed to request a lock the Director. The DON stated king material in a resident ecurely stored it should be as admitted to the facility on itted on 08/17/12 with chronic airway obstruction. Signed by Resident #36 on king material would not be room. Inimum Data Set (MDS) dated ident #36 as cognitively intact leavior problems and use of 1/24/14 and reviewed a problem Resident #36 was ted to cigarette smoking. It is moking areas only, to the sar a smoking apron during use she nods off while inistory of lighting other In addition, another mat Resident #36's cigarettes locked up on the smoking 1/25/15 for Resident #36	F3	23		

NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 63 courtyard with several other residents during the smoke break with no staff supervision. Resident #36 was observed smoking with no smoking apron on. Interview with Resident #36 during this time revealed she kept her cigarette and lighter in her locked dresser drawer in her room. On 03/25/15 at 11:52 PM Resident #36 was observed going to her room after she had smoked. Resident #36 reported she kept her cigarette and lighter in a case on her wheelchair	C 03/28/2015
ASHEVILLE NURSING & REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 63 courtyard with several other residents during the smoke break with no staff supervision. Resident #36 was observed smoking with no smoking apron on. Interview with Resident #36 during this time revealed she kept her cigarettes and lighter in her locked dresser drawer in her room. On 03/25/15 at 11:52 PM Resident #36 was observed going to her room after she had smoked. Resident #36 reported she kept her	(X5) COMPLETION
F 323 Continued From page 63 courtyard with several other residents during the smoke break with no staff supervision. Resident #36 was observed smoking apron on. Interview with Resident #36 during this time revealed she kept her cigarettes and lighter in her locked dresser drawer in her room. On 03/25/15 at 11:52 PM Resident #36 was observed sported she kept her com after she had smoked. Resident #36 reported she kept her	COMPLETION
courtyard with several other residents during the smoke break with no staff supervision. Resident #36 was observed smoking with no smoking apron on. Interview with Resident #36 during this time revealed she kept her cigarettes and lighter in her locked dresser drawer in her room. On 03/25/15 at 11:52 PM Resident #36 was observed going to her room after she had smoked. Resident #36 reported she kept her	
during waking hours. Resident #36 stated she locked her cigarette and lighter in the drawer on the bedside table at night. On 03/25/15 at 6:39 PM the Director of Nursing (DON), Administrator and MDS Nurse #1 stated they were unaware the Smoking Policy signed by the resident on 04/29/13 included smoking material would not be kept in the resident's room. They stated in December 2014 they received a policy manual from the new management company and, when they reviewed the manual on 03/25/15, they noted the smoking policy was in direct conflict with the policy signed by residents on admission. The DON and administrator stated they allowed residents to maintain smoking material in their room unless contraindicated in the smoking assessment or care plan. The DON stated residents deemed safe smokers could smoke unsupervised, at any time, in the designated smoking area for residents. The DON stated there was not a staff member present to monitor residents assessed as safe smokers to ensure a smoking apron was in place when the resident was smoking. MDS Nurse #1 stated if a resident was deemed unsafe to independently smoke their smoking material would be locked in the medication room. MDS Nurse #1 stated if a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		(X3) DATE SURVEY COMPLETED						
		345174	B. WING		C 03/28/2015			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION			
F 323	a safe smoker. MDS plan indicated if a resmoker. The admin had never seen smot a resident's room ar residents to keep the secure area of their was not a system in material storage in a On 03/27/15 at 5:13 conducted with MDS did not realize the caincluded an approach be locked in the smot apron. On 03/28/15 at 12:2 conducted with the IShe stated residents not to smoke around specifics of where to their room was not of a resident wanted to in their night stand to from the Maintenanci if staff saw any smot room that was not secured. 8. Resident #133 w 03/05/15. Diagnose and vertebral fractur A 5-Day Minimum Dindicated Resident #A review of the care revealed an Interim which did not address The Smoking Policy	selves they were considered S Nurse #1 stated the care sident was a safe or unsafe istrator and DON stated they oking materials unsecured in did the expectation was for eir smoking material in a room. The DON stated there place to monitor smoking a resident rooms. PM a follow up interview was S Nurse #1. She stated she are plan for Resident #36 th for cigarette and lighter to oking cart and for a smoking. 1 PM an interview was Director of Nursing (DON). Is that smoked were informed to oxygen but, other than that, to store smoking materials in the lock their smoking material in the lock their smoking material in the preded to request a lock the Director. The DON stated king material in a resident the ecurely stored it should be as admitted to the facility on a included intestinal fistula the case at a Set dated 03/12/15 that smoking. State Of the case of t	F 32					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING		03/28/2015	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 323	A "Safe Smoking N 03/06/15 document and no nursing interelated to smoking. Review of Resident revealed a nurses of PM and detailed as note read, Entered strong odor of cigal resident if he smok confirmed that he he knew this was a and he denied know educated on policy smoking area and of A social work note with a social work note indicated unaware of the facility and review of the fifte Resident #133 was minutes beginning ending 03/08/15 at Further review of the social worker note described the Social worker note described the Social worker note of the facility and return the facility and return smelled like he had behavior was a little smelled like he	eeds Assessment" completed and no risk factors for smoking reventions to be implemented at #133's medical record note dated 03/06/15 at 3:59 at a late entry for 8:00 AM. The resident's room and noted rette smoke. Nurse asked and in his room and resident if gainst the rules of the facility wing it was. Resident was and the location of the resident stated understanding. It was a cigarette in at 8:00 AM and subsequently minute checks. The social I Resident #133 stated he was lity's smoking policy and would oving forward. en-minute checks revealed observed every fifteen on 03/06/15 at 6:00 PM and 2:30 PM. He medical record revealed a dated 03/06/15. The note all Worker speaking with ut the rule against smoking in eresident voiced	F 32	3		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345174	B. WING			03/	28/2015
NAME OF PR	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
401151//11	E AULDOING & DELLADU	ITATION OF UTED	91 VICTORIA ROAD		91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 323	Continued From page	e 66	F	323	3		
		urse entered the room and	'	020			
	stated, you cannot sn						
	immediately extinguis						
		dent stated he was worried					
		ith his living situation and lit					
	a cigarette without thi	_					
	Another social service						
		Worker speaking again with					
		smoking in the room. The					
	Social Worker docum	_					
		sident due to failure to follow					
	the rules about smoki						
	A social services note	e dated 03/12/15					
	documented Residen	t #133 was discharged					
	home.						
	On 03/25/15 at 6:39 F	PM the Director of Nursing					
	(DON), Administrator	and MDS Nurse #1 stated					
	they were unaware th	e Smoking Policy signed by					
		sion 03/05/15 included					
	smoking material wou						
		y stated in December 2014					
		manual from the new					
		ny and, when they reviewed					
		15, they noted the smoking					
		onflict with the policy signed					
	by residents on admis						
		hey allowed residents to					
		terial in their room unless					
		smoking assessment or					
	•	stated residents deemed					
	time, in the designate	moke unsupervised, at any					
		e #1 stated if a resident was					
		lependently smoke their					
	smoking material wou						
	_	OS Nurse #1 stated if a					
		ely intact, could light and					
		ette independently and not					
		elves they were considered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345174	B. WING _		0	C 3/28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 91 VICTORIA ROAD ASHEVILLE, NC 28801	•	3/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	plan indicated if a resonoker. The administration had never seen smoota resident's room an residents to keep the secure area of their is was not a system in material storage in a An interview was core 03/26/15 at 10:12 AN who observed Resider room on 03/06/15 at she caught Resident the first time, she infollowed the resident the first time, she infollowed the residency she could not explain checks were not stare 03/06/15 nor why the documented after 2:3 however verified who done the fifteen-minuted of the completed from the stare of the completed from the completed from the completed from the stare of the completed from the stare of the completed from the completed from the completed from the start of the complete from the	S Nurse #1 stated the care sident was a safe or unsafe strator and DON stated they king materials unsecured in d the expectation was for sir smoking material in a room. The DON stated there place to monitor smoking resident rooms. Inducted with Nurse #1 on M. Nurse #1 was the nurse ent #133 smoking in his and 03/08/15. She stated after in #133 smoking in the room formed the Director of ial Worker. She explained ent on fifteen-minute checks. In why the fifteen-minute thed until 6:00 PM on exchecks were not as PM on 03/08/15. She en she was on duty she had ute checks after 2:30 PM on as how she observed king at 3:50 PM. Inducted with the Director of 63/26/15 at 10:29 AM. She atted the fifteen-minute checks in the first moment Resident facility up until the resident in the facility. She could not en-minute checks were not 30 PM on 03/08/15 and could	F3				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY MPLETED	
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		345174	B. WING				28/2015	
NAME OF P	ROVIDER OR SUPPLIER	-1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,		
				9	1 VICTORIA ROAD			
ASHEVILL	E NURSING & REHAB	ILITATION CENTER		Α	SHEVILLE, NC 28801			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFI	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
F 323	Continued From pag	ge 68	F;	323				
	resident smoked in	his room on 03/06/15, but she						
	had concerns of the	resident being able to fully						
	understand the reas building.	on for not smoking inside the						
	An interview was co	nducted with MDS Nurse #1						
	on 03/27/15 at 5:13	PM. She stated residents						
		ke were observed smoking a						
		would be deemed safe if they						
	could independently light, hold, and extinguish the							
	_	opping ashes on themselves.						
		ed Resident #133 was allowed						
	_	aterial in his room (after						
		(15) because he was						
		moker due to the fact he						
		ette, extinguish his cigarette						
	-	on himself. MDS Nurse #1						
	_	resident was assessed safe						
	_	allowed to retain their						
	_	their room. She could not						
	_	nt #133's Interim Care Plan						
		oblem area of smoking or sto address smoking.						
		1 PM an interview was						
		Director of Nursing (DON).						
		s that smoked were informed						
		d oxygen but, other than that,						
		store smoking materials in						
		discussed. The DON stated if						
		lock their smoking material						
		hey needed to request a lock						
	_	ce Director. The DON stated						
		king material in a resident				ĺ		
	_	ecurely stored it should be				ĺ		
	secured.	,				ĺ		
		s readmitted to the facility on						
		es included chronic obstructive						
		incomplete quadriplegia, and				ĺ		
	spinal cord injury.					ĺ		
		Data Set (MDS) dated						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345174	B. WING			03/:	28/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
V CHE//II I	E NURSING & REHABIL	ITATION CENTER		9	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	HATION CENTER		Α	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	quarterly MDS dated resident was cognitive The Smoking Policy's 11/07/14 noted smoking kept in the resident's A review of the care production of the care produc	esident #44 used tobacco. A 01/09/15 indicated the ely intact. Signed by Resident #44 on ing material would not be room. Olan revised 09/03/14 and problem area of Resident e cigarettes. The goal was safe through the next review. It is providing one-on-one oking, nursing to keep in a safe area, and to create The care plan did not esident #44 to wear a eds Assessment" completed or risk factors for smoking entions related to smoking. It is the need for Resident #44 from while smoking. It is a the while in bed for shortness ent #44 on 03/25/15 at 11:43 dent was sleeping in his nocentrator was on and paraphernalia was diately or easily accessible. PM, Resident #44 was tiside in the designated as not wearing a smoking eing supervised by a staff erviewed on 03/25/15 at he went outside to smoke	F	323			
	whenever he wanted.	He explained he kept his in a small bag attached to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	` '	TE SURVEY MPLETED	
			A. BOILD	NG _		Ι,	2	
		345174	B. WING				28/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				9	1 VICTORIA ROAD			
ASHEVILL	LE NURSING & REHA	BILITATION CENTER		4	ASHEVILLE, NC 28801			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 323	Continued From p	age 70	F	323				
	-	s wheelchair seat. Observation						
		d a pack of cigarettes and a						
	lighter were clearly							
		39 PM the Director of Nursing						
		tor and MDS Nurse #1 stated						
		the Smoking Policy signed by						
		/07/14 included smoking						
		be kept in the resident's room.						
		cember 2014 they received a						
		the new management						
	' '	en they reviewed the manual on						
		ed the smoking policy was in						
	direct conflict with	the policy signed by residents						
	on admission. The	e DON and administrator stated						
	they allowed resid	ents to maintain smoking						
	material in their ro	om unless contraindicated in						
	the smoking asses	ssment or care plan. The DON						
	stated residents de	eemed safe smokers could						
	smoke unsupervis	ed, at any time, in the						
	designated smokir	ng area for residents. MDS						
		a resident was deemed unsafe						
		moke their smoking material						
		the medication room. MDS						
		a resident was cognitively						
		and extinguish their cigarette						
		not drop ashes on themselves						
		red a safe smoker. MDS						
		e care plan indicated if a						
		e or unsafe smoker. The						
		DON stated they had never						
		erials unsecured in a resident's						
	·	ectation was for residents to						
		g material in a secure area of						
		ON stated there was not a						
		monitor smoking material						
	storage in a reside							
		88 AM Resident #44 stated the						
	l -	e smoking policy with him itted. He stated the designated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING		C 03/28/2015		
	ROVIDER OR SUPPLIER LE NURSING & REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
F 323	further explained he cigarettes and lighter During the interview lighter were observed his wheelchair seat. An interview was co on 03/27/15 at 5:13 nurses were responnursing admission a Safe Smoking Need residents who wishes smoking a cigarette safe if they could incextinguish the cigare on themselves. MD assumed the Admission at the Admission and the Admission that the cigare on the staff supervisions and lighter in a safe stated staff supervisions are a smoking and follow-up interview DON on 03/28/15 at the floor nurse, or the staff discussed with the staff discu	ne courtyard. The resident was allowed to keep his er when he was admitted. In a pack of cigarettes and a ed in the small bag attached to inducted with MDS Nurse #1 PM. She stated the admitting sible for completing the seessments, including the seessments, including the seessment. She stated ed to smoke were observed and they would be deemed dependently light, hold, and ette without dropping ashes S Nurse #1 explained she sions Coordinator told newly heir cigarettes and lighters. In a follow-up interview on MDS Nurse #1 stated she my the current care plan for ted, "nursing to keep cigarette place". MDS Nurse #1 ing residents smoking should pron was on place. In was conducted with the stated she, we nurse Supervisor would eent knew not to smoke centrators; however, none of with residents where to store alia. She stated she expected effects to be stored out of sight. In a nightstand. The sincluded hypertension and sincluded hypertension and sincluded hypertension and	F 323				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		345174	B. WING			l	28/2015
	ROVIDER OR SUPPLIER E NURSING & REHABIL	ITATION CENTER	•	91	TREET ADDRESS, CITY, STATE, ZIP CODE I VICTORIA ROAD SHEVILLE, NC 28801	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	indicated that Reside products and was cog The Smoking Policy's 02/11/14 noted smoking Policy's 02/11/14 noted smoking Policy's A "Safe Smoking Nee on 12/25/14 for Resident factors for smoking at to be implemented re Smoking Needs Asse 03/25/15 for Resident related to smoking but Resident #91 to wear cigarette holder where A review of Resident 03/25/15 revealed at The goal was to keep the next review. The resident wear a smoking and Observation of Resident Wear the smoking appropriate to the was not wearing a smoking was being such Administrator, the Dir Social Worker. On 03/26/15 at 8:54 of facility reviewed the swhen he was admitted the only place for him courtyard. He further cigarettes and lighter his pocket. On 03/25/15 at 6:39 for (DON), Administrator.	Data Set dated 03/17/15 Int #91 used tobacco gnitively intact. Signed by Resident #91 on ing material would not be room. Ind Assessment" completed dent #91 documented no risk and no nursing interventions related to smoking. A "Safe ressment" completed at #91 noted no risk factors at indicated the need of an apron and have a an smoking. If yell's care plan revised broblem area of smoking. If the resident safe through interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the string apron and to provide when resident refused to ron. Interventions included the strind aprovide aprovide aprovide and aprovide aprovide aprovide apro	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 3/28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 91 VICTORIA ROAD ASHEVILLE, NC 28801		<u> </u>	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	They stated in Dece policy manual from to company and, when 03/25/15, they noted direct conflict with the on admission. The I they allowed resider material in their room the smoking assessing stated residents dees smoke unsupervised designated smoking DON stated there was present to monitor in smokers to ensure a when the resident windependently smok would be locked in the Nurse #1 stated if a intact, could light an independently and in they were considered Nurse #1 stated the resident was a safe administrator and Down seen smoking matering admission and the expect keep their smoking in their room. The DON system in place to mostorage in a resident An interview was condon 03/27/15 at 5:13 nurses were responsing admission a Smoking Safety Needs	e kept in the resident's room. mber 2014 they received a he new management they reviewed the manual on I the smoking policy was in e policy signed by residents DON and administrator stated its to maintain smoking in unless contraindicated in ment or care plan. The DON med safe smokers could I, at any time, in the area for residents. The as not a staff member esidents assessed as safe smoking apron was in place as smoking. MDS Nurse #1 was deemed unsafe to e their smoking material he medication room. MDS resident was cognitively d extinguish their cigarette ot drop ashes on themselves d a safe smoker. MDS care plan indicated if a for unsafe smoker. The DN stated they had never ials unsecured in a resident's eation was for residents to material in a secure area of N stated there was not a onitor smoking material	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	•	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	deemed safe if they hold, and extinguish dropping ashes on the explained she assur Coordinator told new cigarettes and lighted A follow-up interview DON on 03/28/15 at the floor nurse, or the make sure the resid around oxygen condition the staff discussed with smoking parapherms all lighters and cigar She further explained Maintenance Director a lock to be placed of 11. Resident #47 with 12/18/13 and readministery of traumatic hemiplegia and depin Minimum Data Set (assessed Resident impairment. The siguitation and the sident #47 with under the sident #47 wit	cigarette, and they would be could independently light, the cigarette without hemselves. MDS Nurse #1 med the Admissions why admitted residents their res had to be locked up. was conducted with the 12:21 PM. She stated she, e nurse Supervisor would ent knew not to smoke tentrators; however, none of with residents where to store alia. She stated she expected ettes to be stored out of sight. d she would notify the or when a resident requested on a nightstand. The as admitted to the facility on itted 02/05/15 with diagnoses lysis, acute respiratory failure, orain injury, late effect ression. The current MDS) dated 02/10/15 #47 with no cognitive inficant change MDS ted 07/04/14 assessed	F3	323			
	Resident #47 on 12/material would not be A "Safe Smoking Ne on readmission 02/0 needs or issues with smoking. A "Safe S dated 03/25/15 for F	18/13 noted smoking e kept in the resident room. eds Assessment" completed 6/15 did not indicate any a Resident #47 related to moking Needs Assessment" Resident #47 noted issues m while sitting or standing",					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING		03/28/2015	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 323	hold cigarette" and Interventions to prowas to "apply smoke to "apply smoke". The care plans for following problem at A problem area dat 02/25/15 noted, "I at Approaches to this smoking apron while Safe Smoking Asseneeds while smoking responsible party ut Policy. A problem area dat 03/24/15 noted, "Renon-compliance be 07/23/14 and updath has episodes of year fusing/resisting cipolicies with period on 03/24/15 at 11:30 observed outside, sarea designated for observation, Reside cigarette and lighted pocket or in a locker 03/25/15 at 11:06 At the dresser, in the lighted position of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser, in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the dresser in the lighted problem area data of the d	otor skills needed to securely "drop ashes on self". steet the resident from injury	F 32	·		
	#47 (private room) time of the observa 03/25/15 at 11:32 A removed from the of PM Resident #47 s	was not in the room. Resident was not in the room at the tion. A second observation on M noted the lighter had been dresser. On 3/27/15 at 8:25 tated he never left a lighter on ald not explain how a lighter				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 91 VICTORIA ROAD ASHEVILLE, NC 28801	E	00/20/2010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	ge 76 t on the dresser. Resident	F3	23		
	#47 indicated he alw his pocket or locked	vays kept smoking material in bedside drawer.				
	(DON), administrator they were unaware to the resident on admissmoking material working resident room. They they received a policy management compathe manual on 03/25 policy was in direct of by residents on administrator stated.	PM the Director of Nursing r and MDS Nurse #1 stated the Smoking Policy signed by ission 12/18/13 included ould not be kept in the y stated in December 2014 by manual from the new any and, when they reviewed 5/15, they noted the smoking conflict with the policy signed vission. The DON and when they began e company in 2014 residents				
	were allowed to mai their room. The DO they allowed resider material in their roor the smoking assess	ntain smoking materials in N and administrator stated hts to maintain smoking n unless contraindicated in ment or care plan. The DON emed safe smokers could				
	designated smoking Nurse #1 stated if a to independently sm would be locked in t Nurse #1 stated if a intact, could light an independently and r they were considere Nurse #1 stated the resident was a safe administrator and Do seen smoking mater room and the expec- keep their smoking if	area for residents. MDS resident was deemed unsafe loke their smoking material he medication room. MDS resident was cognitively d extinguish their cigarette lot drop ashes on themselves d a safe smoker. MDS care plan indicated if a or unsafe smoker. The ON stated they had never rials unsecured in a residents tation was for residents to material in a secure area of N stated there was not a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER LE NURSING & REHAE	BILITATION CENTER	9	STREET ADDRESS, CITY, STATE, ZIP CODE OF VICTORIA ROAD ASHEVILLE, NC 28801	00/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 323	system in place to r storage in resident interview on 03/28/stated residents that to smoke around or specifics of where their room was not a resident wanted trin their nightstand their noom that was not secured. The DON any instances of Resunattended in his round their nightstand their nightsta	monitor smoking material rooms. In a follow-up 15 at 12:21 PM the DON at smoked were informed not exgen but, other than that, so store smoking material in discussed. The DON stated if so lock their smoking material hey needed to request a lock ce director. The DON stated obting material in a resident securely stored it should be stated she was not aware of esident #47 leaving a lighter from. Was admitted to the facility on loses of muscle weakness king. Y signed by Resident #129 on obting material would not be so room. Inum Data Set (MDS) 5 day 03/29/15 revealed cognitive ion making: Modified e difficulty in new situations 9 was identified for current	F 323			

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245474	B. WING	D. Marko		С	
		345174	B. WING			03/	28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABIL	ITATION CENTER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 1 VICTORIA ROAD ISHEVILLE, NC 28801		
(X4) ID PREFIX TAG			1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)			(X5) COMPLETION DATE
F 323	were shaking and she blouse. Resident # 12 her blouse until points. On 03/25/15 at 11:40 Resident # 129 revea smoking in the facility finished her cigarette room. She had her cighand, and sat down of the state of the bed, with her eye lighter were on the own of the bed linens, and lighters were on the bed linens, and lighters were on the bed linens, and lighters were on the bed linens, and lighters were unaware the the resident on admissmoking material worresident's room. The they received a policy management comparthe manual on 03/25/policy was in direct or by residents on admis administrator stated to maintain smoking material contraindicated in the care plan. The DON states of the should be shaded and the care plan. The DON states of the should be shaded and the care plan. The DON states of the shaded and the care plan. The DON states of the shaded and the care plan. The DON states of the shaded and the care plan. The DON states of the shaded and the care plan. The DON states of the shaded and the care plan.	g. Resident # 129's hands a dropped ashes on her 29 was unaware of ashes on ed out by a surveyor. AM an observation of led she was outside a courtyard. Resident # 129 and ambulated back to her garettes and lighter in her on the bed. PM an observation of led she was leaning back in a closed. Her cigarettes and are bed table. PM an observation of led she was sleeping on top led she she was slee	F	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C 03/28/2015
	PROVIDER OR SUPPLIER LE NURSING & REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		03/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	residents. MDS Nuwas deemed unsafes smoking material work medication room. Moresident was cognitic extinguish their cigal drop ashes on them a safe smoker. MDD plan indicated if a resident's room ar resident's room ar residents to keep the secure area of their was not a system in material storage in a conducted with the stated she went over residents who smok process. She stated smoking policy. She been informed that the assessment and design smoking materials a supervision. On 03/26/15 at 9:30 conducted with Residents who smoking materials a supervision. On 03/26/15 at 9:30 conducted with Residents who smoking materials a supervision. On 03/26/15 at 9:30 conducted with Residents was admitted she was told whenever she wanted on any dresser in he materials.	rise #1 stated if a resident to independently smoke their buld be locked in the IDS Nurse #1 stated if a vely intact, could light and rette independently and not selves they were considered S Nurse #1 stated the care esident was a safe or unsafe istrator and DON stated they oking materials unsecured in and the expectation was for eir smoking material in a room. The DON stated there place to monitor smoking a resident rooms. PM an interview was Admissions Coordinator. She or the smoking policy with any e at the end of the admission all residents sign the reported residents have the nurse will complete an termine if they can keep their	F 3:	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 3/28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 91 VICTORIA ROAD ASHEVILLE, NC 28801	•	0/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	could be kept in resident the locked drawer the admitting nurse of smoking assessment assessment was not residents were safe care plan was specificated or unsupsaid the care plan for approach for a resident was done immediated assessment had been resident # 129 was and the nurse should was safe or an unsaccompleted the smok the initial care plan, risk. She stated she admissions coordinated smoking materials has she did not make sutheir bedside drawer provided locks for residents that smoke smoke around oxyge specifics of where to their room was not do a resident wanted to in their nightstand the from the maintenance if staff saw any smokes.	d that cigarettes and lighters dent's room in the night stand. MDS Nurse #1 revealed was responsible for doing the t. She stated the smoking clear as to whether or unsafe to smoke but the ic if a resident should be ervised when smoking. She remokers provided an ent to be supervised or Nurse #1 reported the care ediately after the smoking en completed. She stated admitted on the weekend, dhave indicated whether she fe smoker when she ing assessment, and put it on under the falls and safety had assumed that the tor had told residents that ad to be locked up. She said re residents had a lock on and thought maintenance sident's drawers. I PM the DON stated at were informed not to en but, other than that, store smoking material in iscussed. The DON stated if lock their smoking material ey needed to request a lock edirector. The DON stated king material in a resident	F3	23			
	secured.	ecurely stored it should be vas admitted to the facility on					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C 03/28/2015	
NAME OF P	ROVIDER OR SUPPLIER	010114			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2015
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		9	1 VICTORIA ROAD SHEVILLE, NC 28801		
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F 323	pulmonary disease, of surgery. Review of the Minimul Assessment dated 03 skills for daily decision decisions consistent/s was identified for curron The Smoking Policys 03/21/15 noted smok kept in the resident's Review of the "Safe Sasessment" dated 0 132 had no concerns smoking. Review of an interim revealed smoking was for Resident # 132. On 03/25/15 at 11:40 Resident # 132 reveas smoking in the facility finished her cigarette to her room in a whee cigarettes and lighter observation revealed concentrator in her room on 03/25/15 at 1:16 Resident # 132 reveas and lighter with her, a from smoking, she hid on 03/25/15 at 6:25 Resident # 132 reveas bed. Her oxygen concentrator on the room smoking, she hid on 03/25/15 at 6:25 Resident # 132 reveas bed. Her oxygen concentrator on the room smoking, she hid on 03/25/15 at 6:25 Resident # 132 reveas bed. Her oxygen concentrator on the room smoking, she hid on 03/25/15 at 6:25 Resident # 132 reveas bed. Her oxygen concentrator on the room smoking on 03/25/15 at 6:25 Resident # 132 reveas bed. Her oxygen concentrator on the room smoking of the roxygen concentrator on the room smoking of the roxygen concentrator on the room smoking of the roxygen concentrator on the roxygen	ses of chronic obstructive chronic back pain, and arm Im Data Set (MDS) 5 day 3/28/15 revealed cognitive in making: Independent reasonable. Resident # 132 rent tobacco use. Signed by Resident #132 on ing material would not be room. Smoking Needs 3/21/15 revealed Resident # identified regarding safe care plan dated 03/22/15 is not identified as a problem AM an observation of alled she was outside or courtyard. Resident # 132 and propelled herself back elchair. She had her with her. Further she had an oxygen form, and it was on. PM an interview with alled she kept her cigarettes and after she came back in did them under her pillow.	F	3323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER LE NURSING & REHABII	LITATION CENTER		STREET ADDRESS, CITY, 91 VICTORIA ROAD ASHEVILLE, NC 2880		,	
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F 323	F 323 Continued From page 82		F 3	323			
	hand. She was moving stated she could not looking for her lighter observed on her bed smoking materials.	of unopened cigarettes in her ng about in her bed and find her lighter and was in her bed. No locks were side dresser to secure					
	(DON), Administrator they were unaware to the resident on admissmoking material wo resident's room. The they received a polic management compathe manual on 03/25 policy was in direct oby residents on administrator stated maintain smoking material to the they received a policy was in direct or the them.	ey stated in December 2014 by manual from the new my and, when they reviewed f/15, they noted the smoking conflict with the policy signed ssion. The DON and they allowed residents to aterial in their room unless					
	care plan. The DON safe smokers could stime, in the designate residents. MDS Nurs deemed unsafe to insmoking material wo medication room. M resident was cognitive extinguish their cigar drop ashes on thems a safe smoker. MDS plan indicated if a resident seen smooth a resident's room and residents to keep the secure area of their residents.	se #1 stated if a resident was dependently smoke their					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING		C 03/28/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/20/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 323	conducted with the stated she went ow residents who smol process. She stated smoking policy. She been informed that assessment and de smoking materials a supervision. On 03/26/15 at 9:18 she had her cigaret no one told her she further revealed she told her she would be safety and could se kept in resin the locked drawe admitting nurse was smoking assessment was nowere safe or unsafe was specific if a resunsupervised when plan for smokers president to be supe Nurse #1 reported to immediately after the been completed. Me # 132 was admitted nurse should have a specific in the locked drawere safe or unsafe was specific if a resunsupervised when plan for smokers president to be supe Nurse #1 reported to the Nurse	a resident rooms. Depth an interview was Admissions Coordinator. She are the smoking policy with any are at the end of the admission at all residents sign the are reported residents have the nurse will complete an attermine if they can keep their and smoke without Depth AM Resident # 132 stated tes and lighter with her, and could not have them. She are thought it was a nurse who are assessed for smoking noke any time after the	F 32	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			C
	ROVIDER OR SUPPLIER LE NURSING & REHAB	1		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	<u> </u>	03/28/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	the smoking assess care plan. She state admissions coordina smoking materials his she did not make sutheir bedside drawe provided locks for reconsideration of their provided locks for reconsideration of their reconsideration of their room was not on a resident wanted to in their nightstand thei	ment, and put it on the initial d she had assumed that the ator had told residents that ad to be locked up. She said re residents had a lock on and thought maintenance esident's drawers. 1 PM the DON stated ed were informed not to be but, other than that, o store smoking material in discussed. The DON stated if to lock their smoking material leey needed to request a lock be director. The DON stated king material in a resident ecurely stored it should be PM the administrator and of immediate jeopardy. The acceptable credible allegation 1/28/15 at 11:59 AM.	F3	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING		03/28/2015	
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	00/20/2010	
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F 323	Collection form will and readmissions to completed by the act the information will interdisciplinary teal considered a safe or resident upon admist their cigarettes and made if they are a stresident will be consinter-disciplinary teal Data Collection Form Residents will be intregarding safe or un of Social Services, assessments are conjuncterly, change or residents request. Smoking for resident designated area who using portable oxygidentified with a notion out in the designated A. Resident #1 (Residuated with a notion of the designated area who using portable oxygidentified with a notion out in the designated and cigarettes have resident room. The The resident has sign on 3/27/15, letters of members and/or RF by the Director of St 03/27/2015	he Safe Smoking Data be used on all new, existing of the facility. The form will be dmission Charge Nurse, and be submitted to the facility m to determine if resident is or unsafe smoker. The dighter until a determination is differed unsafe until the differed unsafe smoking by the Director Further smoking differed unsafe smoking differed unsafe until the differed unsafe until the differed unsafe smoking policy differed unsafe smoker". Lighters differed unsafe smoker". Lighters differed unsafe smoker". Lighters differed unsafe smoker". Lighters differed unsafe smoking policy	F 32	3		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER LE NURSING & REHABIL	ITATION CENTER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 1 VICTORIA ROAD ISHEVILLE, NC 28801	1 001	20/2010	
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F 323	and is determined an and cigarettes have be room. The care plan resident has signed to 3/27/15, letters were and/or RP regarding. Director of Social Ser 03/27/2015 Resident #3 (Resider been reassessed und and is determined an and cigarettes have be resident room. The or The resident has sign On 3/27/15, letters were members and/or RP by the Director of Social Ser 03/27/2015 Resident #4 (Resider been reassessed und and determined to be lighter has been removes ident care plan has resident #5 (Resider been reassessed und and determined to be lighter has been removes and/or RP regarding. Director of Social Ser 03/27/2015 Resident #5 (Resider been reassessed und and determined to be lighter has been removes ident care plan has resident care plan has resident care plan has and determined to be lighter has been removes ident care plan has resident care plan has and care plan has an an and care plan has an an an and care plan has an an an an and c	ler the new smoking policy "unsafe smoker". Lighters been removed from this has been updated. The ne new smoking policy. On sent to the family members the smoking policy by the vices. In #23 on the 2567)-Has ler the new smoking policy "unsafe smoker". Lighters been removed from this hare plan has been updated. heed the new smoking policy. here sent to the family regarding the smoking policy has ler the new smoking policy has a "safe smoker". The haved from the room. The has been updated. The has been updated. The has he new smoking policy by the vices. In #126 on the 2567)-Has her the new smoking policy has "safe smoker". The has been updated. The	F	323				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	members and/or RI by the Director of S 03/27/2015 Resident #6 (Resid been reassessed u and determined to I lighter has been rer resident care plan if resident has signed 3/27/15, letters wer and/or RP regarding Director of Social S 03/27/2015 Resident #7 (Resid been reassessed u and determined to I lighter has been rer resident care plan if resident has signed 3/27/2015, letters were members and/or RI by the Director of S 03/27/2015 Resident #8 (Resid been reassessed u and determined to I lighter has been rer resident care plan if resident care plan if resident care plan if resident care plan if resident has signed 03/27/2015, letters	ent #44 on the 2567)-Has nder the new smoking policy oe a "safe smoker". The moved from the room. The nas been updated. The lithe new smoking policy. On e sent to the family members go the smoking policy by the ervices. ent #36 on the 2567)-Has nder the new smoking policy by the ervices. ent #36 on the 2567)-Has nder the new smoking policy be a "safe smoker". The moved from the room. The nas been updated. The lithe new smoking policy. On were sent to the family or regarding the smoking policy ocial Services. ent #132 on the 2567)-Has nder the new smoking policy ocial Services. ent #132 on the 2567)-Has nder the new smoking policy ocial Services.	F 3:	23		
	resident care plan heresident has signed 3/27/2015, letters was members and/or RI by the Director of S 03/27/2015 Resident #8 (Resid been reassessed us and determined to lighter has been reresident care plan heresident has signed 03/27/2015, letters	the new smoking policy. On were sent to the family or regarding the smoking policy ocial Services. ent #132 on the 2567)-Has need the new smoking policy on a "safe smoker". The moved from the room. The has been updated. The I the new smoking policy. On were sent to the family or regarding the smoking policy.				
	1	ent #129 on the 2567)-Has nder the new smoking policy				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-RE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	and cigarettes have be resident room. The oresident has sign On 3/27/2015, letters members and/or RP by the Director of So 3/27/2015 Resident #10 (Reside been reassessed und and is determined and and cigarettes have be resident room. The oresident room. The oresident room and/or RP by the Director of So 3/27/2015 Resident #11 (Reside been reassessed und and determined to be lighter has been rem resident care plan has resident has signed to 3/27/2015, letters were sident room.	"unsafe smoker". Lighters been removed from this care plan has been updated. The deep the new smoking policy regarding the smoking policy cial Services. The smoker of the family regarding the smoking policy cial Services. The smoker of the family regarding the smoking policy of "unsafe smoker." Lighters been removed from this care plan has been updated. The smoking policy cial Services. The smoker of the family regarding the smoking policy cial Services. The oved from the 2567)-Has der the new smoking policy of a "safe smoker". The oved from the room. The sis been updated. The che new smoking policy. On the sent to the family regarding the smoking policy regarding the smoking policy regarding the smoking policy.	F3	323			
	facility on March 12, Resident #13 (Resident #13)	was discharged from the 2015. ent #96 on the was discharged from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING		03/28/2015
	ROVIDER OR SUPPLIER .E NURSING & REHAB	ILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE D1 VICTORIA ROAD ASHEVILLE, NC 28801	, 33.25.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 323	Continued From pa	ge 89 2 were re-educated on	F 323		
	recording and perfo checks by the Direct 3/27/2015	rming of the 15 minute tor of Nursing.			
	RP are educated or the Director of Admi were educated on the Director of Social So "safe" or "unsafe" so	issions and/or their family or in the new smoking policy by issions. All current residents the new smoking policy by the ervices and have signed the moking policy depending on in "Safe Smoking Data"			
	on a weekly basis rudignity, choice, pref services, has had the smoke?". Every resinterviewed every we team member design Champion. The reserviewed by the Adrifor the inter-discipling concern are address department. Those immediate attention that they smoke wo	ool which gathers information egarding staff professionalism, erences, ADL care, therapy he questions added "Do you sident in the facility is reek by the Inter-Disciplinary gnated to be their Resident sults on the interviews are ministrator and summarized hary team and areas of sed by the appropriate concerns that require such as a resident indicating uld immediately be made or of Nursing or Administrator.			
	assessments for the additional residents addressed on the in conducted on 3/26/3	ewed comprehensive e last 30 days to identify any that smoke and were not aitial list. An audit was 2015 and 3/27/2015 by the m in person to identify any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER	LITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		30,23,23,10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 90	F3	923		
	other potential smok identified in previous 3/27/2015	ers that may not have been audits.				
	26, 2015 by the faciliadded the following in added the following in Does the resident kind designated areas for get there independently light in does the resident extistion an appropriate recidispose of ashes or appropriately, has the incidents with smoking visible burns on the interdisciplinary team determine if resident resident require an abe kept at nursing strestrictions, family or restrictions, smoking signatures of all interdisciplinary teams of all inte	now the location of the symbolic symbol symb				
	3/27/2015 The residents that sr	moke were met with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		C 03/28/2015
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	1 00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 323	explain the new smodessessment results "unsafe". The reside the "safe" or "unsafe on their assessment 3/27/2015 C. The facility inter-disc safe smoking data coresidents that wish the smoke have been as updated by the MDS "unsafe" smoker. 3/27/2015 The facility has main smoking area which Various departments supervised smoking A.M., 1:30 P.M., 4:0 P.M. Residents ass smoke as preferred. 3/27/2015 Facility in-service is conducted by the Didevelopment Coord Coordinator with all policy, staff respons the policy is not follow smoking. Staff are resident assessment of the policy is staff are resident.	irector of Social Services to oking policy and what their were whether "safe" or ents were requested to sign " smoking policy depending	F 32	23	
	The smoking policy orientation program immediately.	will be added to the for new staff effective			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 03/28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 323	7:45 PM when interviresidents confirmed to training on the facility procedures and the earesident was found policy. Record review residents who smoke assessments and carconfirmed that all sm smokers were secure possession of safe sidesignated as safe sidesignat	was removed on 03/28/15 at ews with nursing staff and hey had received inservice 's new smoking policy and expected action to take when to not follow the smoking ws confirmed that all current had updated smoking e plans. Observations oking materials for unsafe ad with only cigarettes in the mokers. Residents mokers were observed to ap policy in obtaining and ated resident smoking area. It as unsafe smokers were th staff supervision in the	F 323	3	
F 333 SS=D	SIGNIFICANT MED I	ERRORS ure that residents are free of	F 33	3	4/17/15
	by: Based on record rev facility failed to admir solutions (eye drops)			The facility will ensure that residents a free from any significant med errors. The DON and RN Supervisor/Clinical Coordinator re-educated the nursing s from March 30, 2015 to April 16, 2015	taff

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		C 03/28/2015	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		\dashv
				91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC DATE	ON
F 333	Continued From pag	e 93	F 33	33		ĺ
	included:			medication administration		
	Prednisolone Acetate solution revealed the ophthalmic solution is short period of time. week unless the phy This is because it cate eye when used for located Review of manufactures and the solution of the s	decision making. The MDS nt with impaired vision and see large print but not regular agazines. The MDS indicated		Resident #78 orders have with the physician and the are being administered as physician orders and man recommendations. The otranscribed to the MAR by verified by the RN/Clinical The verification has been DON. The Medical Records Clescopy of all the telephone of Supervisor/Clinical Coordiall orders against the MAF ensure they have accurate transcribed. The RN Supercoordinator will initial there. All copies and the audit to brought to the DON with vinitials for each physician. The audit of physician ordingoing process. These audits are done 3-5 the RN Supervisor/Clinical The RN Supervisor/Clinical will review with the DON as 3-5x per week.	e medications coording to the ufacturers rder has been of the nurse and Coordinator. given to the The will make a orders. The RN finator will check RS and TARS to ely been ervisor/Clinical on as verification. To will be rerification order. The results of the service of the	
	that indicated the reson her left eye. Review of Resident a	esident #78's medical record sident had cataract surgery #78's physician's orders ted 02/20/15 which read:		Coordinator will report the audits to the QAPI commi of 3 months.	results of the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		C 03/28/2015
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	03/20/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 333	times a day for 10 divo times a day for eye once a day for to right eye every non the medical record eye. Review of Resident 2015 Medication Addrevealed document and Timolol eye drow February to the right March MAR indicat 1% 1 drop two times completed on 03/12 1 drop to right eye March MAR to be gentry had been cromedication was not 0.5% 1 drop in right on the March MAR out and "left written March MAR Reside Prednisolone for 10 eye from 03/13 - 03 not given the Timol right eye after 02/2 Listed on the March 1. Prednisolone Ac operated eye three surgery with "L" written medication was times a day 03/06 - 2. Prednisolone Ac right eye every day crossed out and "left words."	the 1% 1 drop to right eye three days, then 1 drop to right eye 10 days then 1 drop to right 10 days; Timolol 0.5% 1 drop norning. There were no orders ord for eye drops to the left the #78's February and March dministration Records (MARs) ration that the Prednisolone rops were given as ordered in the eye. Documentation on the led the Prednisolone acetate res a day to the right eye was 12/15. Prednisolone acetate 1% ronce daily was listed on the riven 03/13 - 03/22/15 but the resed through and the resed through and the resed through and the resed as given. Timolol respectively every morning was listed but "right" had been crossed "in above it. According to the rent #78 was not given the read days once daily in the right respectively as ordered and was respectively as ordered and was related 1% instill one drop in relation and the related 1% instill one drop in relation and the related 1% instill one drop in relation and the related 1% instill one drop in relation and the related 1% instill one drop in relation in above "operated eye" - related 1% instill one drop in relation in above "operated eye" - related 1% instill one drop in relation in above "operated eye" - related 1% instill one drop in relation in above "operated eye" - related 1% instill one drop in relation in above "operated eye" - related 1% instill one drop in relation in above "operated eye" -	F 33	3	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED	
		345174	B. WING _			C 03/28/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 91 VICTORIA ROAD ASHEVILLE, NC 28801	•	3/20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 333	surgery instill one dr times a day with "L" eye" - the medication on 03/04/15 and give 03/28/15 at 2:00 PM An interview with Nu Resident #78's eye of had cataract surgery Nurse #6 was unable drops to the left eye stated they might be Upon request, the M checked for any unfi #78 and located a pl the ophthalmologist the progress note re medications listed to post-operatively: 1. Timolol 0.5% 1 dro Discontinue Timolol 03/06/15. 2. Prolensa 0.07% 1 the operative eye aff 3. Prednisolone Aceday as directed in th 4. Besivance 0.6% 1 eye - discontinue 03 An interview on 03/2 Director of Nursing (#78's ophthalmologis instructions for the eabout their administr to explain why the in	- starting 2 days before op in operated eye three written in above "operated n was documented as started en three times a day through . rse # 6 on 03/28/15 about drops revealed Resident #78 on her left eye on 03/06/15. e to locate orders for eye on the resident's chart and in Medical Records. dedical Records coordinator led documents for Resident hysician's progress note from dated 03/13/15. Review of vealed the following be administered op to left eye every day. 0.5% to right eye on drop every day as directed in her surgery tate 1% 1 drop three times a le operative eye after surgery drop three times a day in left	F3	33			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345174	B. WING _		03/	28/2015
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	were not administere as ordered and stated. The DON was unable Prednisolone Acetate administered to Residumes a day from 03/01 - 03/28/15 the Prednisolone drodiscontinued. The DO why the Besivance w #78's left eye from 03 physician's progress discontinued on 03/13/483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and	lol and Prednisolone Acetate d to Resident #78's right eye d it was a medication error. e to explain why the 1 1% 1 drop was dent #78's left eye three 06 - 03/13/15 and once daily 5. The DON stated usually ps are tapered down and 0N was unable to explain as administered to Resident 6/04/15 - 03/28/15 when the note indicated it was to be 3/15. 0CURE, ERVE - SANITARY	F3	371		4/17/15
	by: Based on observation facility failed to keep clean and food service from moisture; failed in the kitchen refriger containers of condimination container for clean p			The facility will procure food from sou approved or considered satisfactory by Federal, State or local authorities and store, prepeare, distribute and serve founder sanitary condition.s The dietary staff was re-educated on 3/25/2015 by the Registeed Dietician a	/ will ood	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345174	B. WING _			03/	28/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
V & MEVII I	E NI IDRING & DELL	ABILITATION CENTER		91	VICTORIA ROAD		
ASHEVILI	LE NURSING & REFIA	ABILITATION CENTER		A:	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	CEDED BY FULL PREFIX (EACH CORRECTIVE ACT G INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	•						
F 371	Continued From p	page 97	F	371			
	remove dented ca addition, the facilities anitary condition. foods for 10 of 10 meals. (Residents #17, # #59, #130 and #1. The findings incluid 1. During the initious concerns were idea. At 9:36 AM 2 laready for use in clowere stacked on to footh pans was at 9:36 AM the Asstated service parstored wet with missions. At 9:47 AM the spills and food destored inside the range of the AM the ADM states been cleaned and stored in the microc. At 9:41 AM bol was observed stollabel and date. Ostated food items and discarded if the d. At 9:51 AM two observed in the record of the record of the part o	this stored ready for use. In the failed to serve food under as by not touching ready-to-eat residents observed during 21, #24, #31, #36, #45, #47, 35) ded: all tour of the facility kitchen on 6 AM-10:05 AM the following entified: arge metal pans were observed ean storage. The metal pans op of each other and the interior wet with moisture. On 03/23/15 sistant Dietary Manager, (ADM) as should be air dried and not oisture. e interior of the microwave had bris and a bowl of soup was microwave. On 03/23/15 at 9:47 at the microwave should have I food should not have been			Dietary Manager on microwave cleaning labeling and storing foods, removal and no use of dented cans, cleaning of iter in the dietary department to prevent a build up of sticky and greasy residue, a all items are to be air dried and not storal storal well of the property of the Registered Dietician Dietary Manager. Facility staff was re-educated from Ma 28, 2015 to April 16, 2015 on the property way to serve trays to a resident. All foods without a label and date have been discarded. The interior of the microwave is being cleaned at the end of each night. An at tool is completed and signed by the stamember closing the dietary department every evening. The Dietary Manager is verifying that the equipment is clean warriving in the morning. The audit tool reviewed with the Administrator 1 times week. Any dented cans have been removed placed in the appropriate area for return back to the food supplier for credit. All spices containers and other storage containers have been cleaned and do have a build up of sticky, greasy residuents 17, 21, 24, 31, 36, 45, 47, 55.	d ms and ored as and orch er e udit aff at is per and rn e not ue.	
	clean plastic ware of sticky greasy re	was observed with a build-up esidue on the top and sides of food debris on the inside of the			130, 135 are being served meals by the staff according to sanitary conditions be not touching ready to eat food.	ne	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI			، ا	c
		345174	B. WING				28/2015
NAME OF P	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	20/2013
				9.	1 VICTORIA ROAD		
ASHEVILI	LE NURSING & REHABII	LITATION CENTER		Α	SHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 371	Continued From page 98			371			
	container. On 03/23	/15 at 9:59 AM the ADM					
	stated the container	should have been cleaned			An audit tool was developed by the		
	inside and out before	e storing clean plastic ware			Registered Dietician and Dietary Mana	ger	
		ounce dented cans of			and is done 4-7x per week by the Dieta	ary	
	I =	ved stored ready for use in			Manager and 1x per week by the		
		23/15 at 10:01 AM the ADM			Administrator to ensure that the		
		d cans of peaches on			microwave is clean, food is dated and	_1	
	shelving in dry storag				labeled, no dented cans are being used and they are removed and placed on a		
	I -	on the designated area in ed cans to be returned to the			rack for return to the food supplier for		
	food service compan				credit, plastic spice and silverware		
		ntainer of thickner and			containers are clean, and dishes, pots		
	1 ~	f condiments including			and pans are allowed to air dry before		
		owder, garlic powder, lemon			storage.		
		d cajun seasoning were			3.0		
	observed stored on s				An audit tool was developed by the		
	preparation area. Th	ne containers had a build-up			Admninistrator and DON and is done 2	-3x	
	of sticky, greasy resi	due on the tops and sides.			per week to monitor the delivery and se	et	
	On 03/23/15 at 10:20	AM the ADM stated the			up of resident trays to ensure staff are		
		ve been wiped off and not			following sanitation guidelines for meal		
	stored with a build up	o of sticky, greasy residue.			service.		
	2. Observation of the	e lunch meal was observed			The facility is currently in contract		
	on the 200 hall on 03	3/23/15 beginning at 12:39			negotiations with Healthcare Services		
	PM. revealed the foll				Group to provide dietary services		
	a. Nurse Aide (NA) #	#1 was observed to set up a			beginning May 1, 2015.		
	lunch tray for Reside	nt #21. She was observed to					
		ad with her hands as she			The results of the audits are discussed		
	removed it from a pa				with the Administrator on a weekly bas	S.	
	1	ved to set up a lunch tray for					
		vas observed to touch a			The Dietary Manager will report month		
	1 -	er hands as she removed it			to the QAPI committee for a period of 3	5	
	from a paper bag.	ad to got up a lunch travifor			months regarding kitchen compliance.		
		ed to set up a lunch tray for vas observed to touch a			The Administrator will report monthly to		
		er hands as she removed it			the QAPI committee for a period of 3	,	
	from a paper bag.	ici nanus as sne removeu il			months the delivery of meals to resider	nte	
		ed to set up a lunch tray for			and observing senitation guidelines.		
		was observed to touch a			and oboot this outlidion guidelines.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION	1, ,	DATE SURVEY COMPLETED
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER E NURSING & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 91 VICTORIA ROAD ASHEVILLE, NC 28801	DE	03/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 371	from a paper bag. e. NA #1 was observed Resident #24. She we piece of bread with he from a paper bag. f. NA #1 was observed Resident #45. She we piece of bread with he from a paper bag. g. NA #1 was observed Resident #17. She we piece of bread with he from a paper bag. Another observation of conducted on the 2000 at 12:47 PM. h. NA #1 was observed Resident #47. She we dinner roll with her ha a paper bag. i. NA #1 was observed Resident #135. She we dinner roll her hands in paper bag. j. NA #1 was observed Resident #130. She we dinner roll with her ha a paper bag. An interview was content Nursing (DON) on 03.	er hands as she removed it ed to set up a lunch tray for as observed to touch a er hands as she removed it ed to set up a lunch tray for as observed to touch a er hands as she removed it ed to set up a lunch tray for as observed to touch a er hands as she removed it ed to set up a lunch tray for as observed to touch a er hands as she removed it ed to set up a lunch tray for as observed to touch a nds as she removed it from ed to set up a lunch tray for was observed to touch a as she removed it from a ed to set up a lunch tray for was observed to touch a as she removed it from a ed to set up a lunch tray for was observed to touch a as she removed it from ducted with the Director of (28/15 at 7:59 PM. She t touch a resident's food		441		4/17/15
	The facility must estal Infection Control Prog	blish and maintain an Iram designed to provide a				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OMPLETED
		345174	B. WING _			C 03/28/2015
	ROVIDER OR SUPPLIER	ILITATION CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		30,20,20
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From page	ge 100	F4	41		
		omfortable environment and development and transmission tion.				
	Program under which (1) Investigates, con in the facility; (2) Decides what proshould be applied to	ablish an Infection Control th it - trols, and prevents infections ocedures, such as isolation, o an individual resident; and rd of incidents and corrective				
	prevent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will track (3) The facility must hands after each direct washing is independent of professional practices. (c) Linens Personnel must hand	on Control Program sident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted				
	by: Based on observati	T is not met as evidenced ons of 1 of 3 nurses (Nurse medication administration to		The facility will maintain an Inf Control Program designed to p		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _				C 28/2015
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	,	
A 011E\#1.1	E AUIDONIO O DELLA DU	ITATION OF NEED		9	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABII	LITATION CENTER		A	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		JST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page	e 101	F4	141			
	2 of 4 residents (Res	idents #41 and #30), facility			safe, sanitary and comfortable		
	staff failed to wash or	•			environment and to prevent the		
	between residents. T	he findings included:			development and transmission of disea and infections.	ise	
		PM Nurse #5 was observed					
	_	ministration. Nurse #5			The DON, RN Supervisor/Clinical		
		Resident #41, donned gloves			Coordinator re-educated licensed staff		
		dent's blood glucose (BG).			from March 28, 2015 to April 16, 2015		
		ent's room, removed the If them in the trash can on			proper handwashing, glove changes, a medication administration. All staff wa		
	_	Nithout washing or sanitizing			re-educated by the DON and RN	5	
		unlocked the medication			Supervisor/Clinical Coordinator on		
		veral bubble packs of			disposing of dirty linen, handwashing, u	use	
	medication from the				of gloves, and serving of food to reside		
					from March 28, 2015 to		
	On 03/24/15 at 4:05	PM Nurse #5 was interrupted			April 16, 2015. The facility protocal is		
	by the surveyor, befo	re she prepared the			taught during the orientation process a	nd	
	medications, and ask	ed what the facility protocol			then annually thereafter.		
	_	anitizing her hands after					
	_	5 stated she should wash or			The DON, RN Supervisor/Clinical		
		ut did not do either, and			Coordinator will observe medication pa		
	proceeded to prepare				and patient care 1-2 times per week to		
		ncluded oral medications,			ensure that staff are following the facilit	iy	
	eye drops and insulin				protocal on infection control.		
		and gave the resident the ral medication, then donned			Resident #41 is having eye medication	c	
		ered an insulin injection in the			administered according to the facility	5	
	_	Wearing the same gloves,			protocal.		
		d eye drops to both of			protocali		
	Resident #41's eyes.	•					
	resident's room, remo				The DON, RN Supervisor/Coordinator	will	
	discarded them in the	e trash can on the			report the results of the audits to the		
		arded the insulin syringe in			Administrator on a weekly basis.		
		unlocked the medication					
		eye drops to the medication			The DON will report to the QAPI		
	cart.				committee the results of the audits for a	а	
	0 00/04//- / / := :				period of 3 months.		
		PM without washing or Nurse #5 removed Resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(2	(3) DATE SURVEY COMPLETED
		345174	B. WING			C 03/28/2015
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, 2 91 VICTORIA ROAD ASHEVILLE, NC 28801	ZIP CODE	33/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 441	that time Nurse #5 w surveyor, before she and asked again who washing or sanitizing procedure that requiresponded: "Do you medicine or wash my summoned to assist observed sanitizing I the medication cart to medication. An interview with the on 03/28/15 at 6:38 protocol for washing doing a procedure in revealed the staff shand after the proced nurses should changuse hand sanitizer be injection and giving the expectation was after performing a Be expected the nurse to the BG and before pasked what her expectation, the DON storemove the gloves resident's room, who insulin, before leaving preparing medication DON stated every new sanitizing the survey of	om the medication cart. At as interrupted by the prepared the medication, at the facility protocol was for the hands after doing a red wearing gloves. Nurse #5 want me to give this y hands?" She was another resident and was ner hands prior to returning to the protocol property of the protocol protoc	F	141		
F 490 SS=K	483.75 EFFECTIVE	RESIDENT WELL-BEING	F4	490		4/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		C 03/28/2015
	ROVIDER OR SUPPLIER LE NURSING & REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 VICTORIA ROAD ASHEVILLE, NC 28801	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 490	enables it to use its efficiently to attain o	ministered in a manner that resources effectively and r maintain the highest , mental, and psychosocial	F 490		
	by: Based on observatiresident and staff in administration failed policies in conjunctic place in the facility tresidents that smoke sampled residents. (Residents #23, #36 #96, #126, #129, #1 Immediate Jeopardy Resident #96 smoke roommate used conconcentrator. Thought transferred to anoth materials were allow Resident #96 up thr from the facility on Usepardy was remowhen the facility proacceptable credible. The facility remains scope and severity of harm with potential that is not immediate education and to en	to review the smoking on with smoking practices in o effectively manage ed which affected 13 of 17 o, #44, #47, #73, #86, #91,		The facility is being administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highesst practice physical, mental, and psychosocial well-being of each resident. The interdisciplinary team met and developed a new smoking policy. The Adminstrator was involved in the development of the new smoking polic and will be involved in the enforcement the policy with periodic reviews for compliance which will presented to the QA/QAPI committee on a monthly bas or more frequently if necessary. The Administrator and Director of Admissions updated the admission pato include a summary of the smoking policy. The summary explains that a resident is not allowed to smoke until "safe smoking collection tool has beer completed" by a licensed nurse. The resident is considered an "unsafe smountil the IDT meets on the next workind day to review all the data. The resider will need to give the Admissions Directions."	cket cket cket g nt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		0.45474	D MINIC				C	
		345174	B. WING _			03/	28/2015	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVII I	E NURSING & REHAE	RII ITATION CENTER		91	VICTORIA ROAD			
7101121122				AS	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 490	Continued From pa	ge 104	F4	490				
1 490	Cross refer F323. and enforce smokir residents. Three of were allowed to retaroom after staff disc the facility. On 03/26/15 at 6:40 Director of Nursing jeopardy. The facilic credible allegation at 11:59 AM. Credible Allegation A. Residents 1-13 (Re #73, #86, #91, #96, #133 on the 2567) room and or in their B. The Interdisciplinar smoking policy. The in the development and will be involved policy with periodic will be presented in smoking materials a containers on the 2	The facility failed to implement ag rules for 13 of 17 sampled if the 13 sampled residents ain smoking material in their covered them smoking within DPM the Administrator and were notified of immediate ity provided an acceptable of compliance on 03/28/2015 of Compliance sidents #23, #36, #44, #47, #126, #129, #131, #132, and smoking materials in their possession. The transfer of the reviews for compliance which the monthly QA meeting. All will be kept in plastic 00 hall med rom, however eemed "safe" smokers can		490	and lighter upon arrival into the facility No lighters, butane, matches or any of lighting material is able to be kept by a resident. The resident/responsible par will sign that they understand and agre abide by the facility smoking policy. The Administrator will review 1-2 times per week admission packets to ensure that the new smoking policy has been sign by the resident, family or RP. A review of the "safe smoking data collection tool" was completed by the literam including the Administrator on 3/28/2015, 4/7/2015, 4/15/2015 to ensure that it is an effective tool. No revisions were made to the Safe Smoker Data Collection Tool at that time. All smoking materials will be kept in a plastic container in the 200 hall med rohowever residents that are deemed "s smokers" can keep their cigaretts in the rooms. The Administrator will audit 1-per week that the smoking materials where stored properly in the 200 hall med room. The Administrator will be auditing the Weekend Smoking Observation tool completed by the Weekend Manager of Duty to ensure compliance with the nesimoking policy on the weekends. All weekend manager reports are turned on Monday morning during the mornin Department Manager Meeting.	her iny rty ee to he er it ed DT ure s oom afe eir 2x rill		
	the admission pack	irector of Admissions updated et to include the revised will explain that no smoking is			The Administrator will review and repo			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C 03/28/2015	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	00.20.20.0	
				91 VICTORIA ROAD			
ASHEVILL	E NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULI		(X5) COMPLETION DATE	
F 490	data collection tool h licensed nurse. The the Interdisciplinary t team will review the determination based the resident is "safe" Social Services will in parameters in which while a resident in th need to sign off that understand this polic review 1-2 times per verify that the resident the new smoking pol 03/25/2015 A review of the Safe was completed on M inter-disciplinary tean with revisions that no Does the resident kn designated areas for get there independen independently light s does the resident extin in an appropriate recidispose of ashes or appropriately, has th	dent until the new smoking as been completed by a evaluating nurse will inform eam of the evaluation. The information and make a on the information whether or "unsafe." The Director of inform the resident of the they are allowed to smoke is facility. The resident will they and their family y. The Administrator will week admission packets to int and or family/RP signed icy. Smoking Data Collection tool arch 25, 2015 by the including the Administrator ow include: ow the location of the smoking, can the resident	F 49	,	Any ave smoked afe Smoker d regardless t that time e Smoker ined by the ill be ed to the or unsafe) t that Ex per week een are plan is oking. inical ninute not ey or had an an be done icating 15 apleted for et. The nistrator oring		
	visible burns on the r Interdisciplinary team determine if resident smoking materials w the 200 hall med roo have been deemed " allowed to keep ciga	resident clothing, n recommendations, needs supervision. All ill be kept in a plastic box at m, however residents that safe smokers" will be		The Adminstrator is responsible auditing the following or review individuals assigned: Resident balances and bond audit 1x permore often if there is an increase admissions and this will include review with BOM.	ving with the t Fund er month or use in		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	ATE SURVEY MPLETED
		345174	B. WING _			C 03/28/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		372072013
				91 VICTORIA ROAD		
ASHEVILI	LE NURSING & REHAE	BILITATION CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 490	policy and they wer	by letters outlining the new re sent out by the Director of	F 4	Audit review with the Mainte Director weekly for complian	nce with F253,	
		taff notified of restrictions, in place, and the signatures of team members.		review with the DON or RN Supervisor/Clinical Coordin: week F281 the professional quality, F309 Monday-Frida reviews with the Director of	ator 1x per I standards of ay audit result Nursing or	
	the safe smoking d were informed of the smoking data collect Social Services and	licensed nurse will complete ata collection tool. Residents be outcome of the safe ction tool by the Director of d signed the appropriate e their understanding of the		Administrator, F312 reviewed week, F333 will be reviewed Director of Nursing or Admin 1x per week audit by the Adand review weekly with the Manager, and F441 audit reby Administrator weekly.	d daily with the nistrator, F371 dministrator Dietary	
	Administrator throu the policy including observation of residence "safe sign of smoking material resident rooms. Far policy will require rethe policy and its be 03/27/2015, the Dir Coordinator or the staff began in-servit policies and will receive and in some actual policy. Staff policies of this facil re-educated and the progressive disciplication of the staff will not be allowed by the policies of the same actual policy. Staff policies of this facil re-educated and the progressive disciplication of the progre	policies will be done by the gh audit tools appropriate to supervised smoking audits, dents determined to be mokers", audit of the storage Is not allowed to be kept in ailure to meet the goals of the eview and changes to enhance enefit to the resident. On rector of Nursing, the Clinical Staff Development Coordinator cing staff on changes to quire signature of in-service instances signature of the that fails to carry out the ity and company will be en if the problem persist, nary action may be involved. Signature of the other than the new policy.		The Administrator is respon Smoking Compliance Progresults of any aduits done in will be discussed at the more department manager meeting Monday-Friday. The Administrator is responsimplementing new company appropriate to the facility and Medical Director and Corpodany new policies developed approval will be approved, or revised within 1 week of being to the Medical Director or Coffice. Policies that are cur and require revision will be facility and present to the Coapproval with approval anticorreceived within 2 weeks of the presented.	ram F323. The in this program rining ing ing insible for a policies as ind with the prate approval. It is and seeking ing presented corporate ing presented corporate in the program in th	
	smoking data colled Social Services and document to ensure new policy. 03/27/2015 C. Enforcement of the Administrator throu the policy including observation of residences of smoking material resident rooms. Far policy will require rethe policy and its be 03/27/2015, the Dir Coordinator or the staff began in-servi policies and will red sheet and in some actual policy. Staff policies of this facil re-educated and the progressive disciplication of the staff will not be allowed the social staff will not be allowed to ensure the social services and will red sheet and in some actual policy. Staff policies of this facil re-educated and the progressive disciplication of the staff will not be allowed to ensure the social services and will red sheet and in some actual policy. Staff will not be allowed to ensure the social services and the soci	ction tool by the Director of disigned the appropriate end their understanding of the supervised smoking audits, dents determined to be mokers", audit of the storage Is not allowed to be kept in allure to meet the goals of the eview and changes to enhance enefit to the resident. On rector of Nursing, the Clinical Staff Development Coordinator of Staff Development Coordinator of staff on changes to enhance enter that fails to carry out the interest of the enterty and company will be entered the problem persist, nary action may be involved.		1x per week audit by the Adand review weekly with the Manager, and F441 audit reby Administrator weekly. The Administrator is responsomology Compliance Progresults of any aduits done in will be discussed at the more department manager meeting Monday-Friday. The Administrator is responsimplementing new company appropriate to the facility and Medical Director and Corpodary new policies developed approval will be approved, or revised within 1 week of beit to the Medical Director or Coffice. Policies that are current and require revision will be facility and present to the Capproval with approval antic received within 2 weeks of the conditions.	dministrator Dietary esults reviewed asible for the ram F323. The in this program rining ing asible for y policies as ind with the brate approval. d and seeking denied or ing presented corporate rrently in effect revised by the corporate for cipated to be the date	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	i	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	COMF	SURVEY
		345174	B. WING _				C / 28/2015
NAME OF PROVIDER OR SUF				91	TREET ADDRESS, CITY, STATE, ZIP CODE 1 VICTORIA ROAD SHEVILLE, NC 28801	1 03/	20/2013
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
policies will from the He a similar res meet the ne resources e well being o policies will recommend upon, if app discussed the 03/27/2015 Immediate 3.7:45 PM who residents contraining on the procedures a resident wholicy. Recommend the policy is a resident who policy. Recommend the smokers were possession designated a follow the near the procedure of the proce	n 03/27/2 be done in aton Man ource to eds of the fectively of the residue policy, and ongo deopardy en interving and ongo deopardy en interving and the east found ord review no smoke as and can at all smore secure of safe si ew smoking with the design estaff. QAA E-MEMB	2015 and ongoing a review of by the inter-disciplinary team ual, Healthtique Policies, or ensure that the policies eresidents and utilizes the and efficiently for the utmost dent. A list of reviewed in the QA book and I be discussed and acted after the QA committee has using was removed on 03/28/15 at ews with nursing staff and hey had received inservice is new smoking policy and expected action to take when to not follow the smoking was confirmed that all current had updated smoking eplans. Observations oking materials for unsafe and with only cigarettes in the mokers. Residents mokers were observed to no policy in obtaining and ne charge nurse and lated resident smoking area. If as unsafe smokers were the staff supervision in the smoking area, at the I with smoking material ERS/MEET	F 4	520	approval by the facility Team. They will not be presented until Corporate approhas been received. All specific Ftags will be reported mont in the QA/QAPI meeting by the person designated for period of 3 months.	val	4/17/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
345174			B. WING _			C 03/28/2015	
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	_ _	03/20/2013	
(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 COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 520			F 5	DEFICIENCY)	ee that ector of		
	sampled residents a inconsistencies with implement measure residents smoking v sampled residents (#133) were allowed their room after staf within the facility.	rce smoking rules for 13 of 17 and failed to identify the smoking policies and so to prevent reoccurrence of vithin the facility. Three of 13 Residents #86, #96 and to retain smoking material in faiscovered them smoking fa, #44, #47, #73, #86, #91,		members. The Administrator and Directo are the facilitators of the QA/Q meeting. The facility QA/QAPI committed a monthly basis to identify correspect to quality assurance as	r of Nursing QAPI ee meets on ncerns with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345174		B. WING _		C 03/28	/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	•	72013	
				91 VICTORIA ROAD			
ASHEVILL	E NURSING & REHA	ABILITATION CENTER		ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From p	page 109	F 5	520			
	·	#131, #132, #133).		assess the operations of timplement interventions re			
	Resident #96 smo	rdy began on 02/05/15 when oked in his room while the		correct concerns and meet the residents.	-		
	roommate used continuous oxygen via an oxygen concentrator. Though Resident #96 was transferred to another room on 02/05/15, smoking materials were allowed to be maintained by Resident #96 up through the time of discharge from the facility on 03/09/15. Immediate Jeopardy was removed on 03/28/14 at 7:45 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern, no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and to ensure monitoring systems put into place are effective related to resident smoking. The findings included: 1. Cross refer F323. The facility failed to implement and enforce smoking rules for 13 of 17 sampled residents. Three of the 13 sampled residents were allowed to retain smoking material in their room after staff discovered them smoking within the facility. On 03/26/15 at 6:10 PM the administrator and Director of Nursing (DON) stated issues with smoking had never been addressed through the Quality Assessment and Assurance committee. The administrator and DON stated they dealt with residents smoking inside the facility on an individual basis and didn't feel the issue was widespread.			The QA/QAPI committee 25, 2015 to discuss the sr and then on March 30, 20 the policy and it's effective newly revised policy. Areas that are identified a have the policy reviewed the facility is following the there are changes that ne they are revised and impliwith the necessary monitorensure continued complia. The incident/event log is the QA/QAPI meeting for reveany additional patters, tree	s concerns will to ensure that policy and that if ed to be made emented along oring tools to ince.		
				A summary of incidents/e presented during the mee weekly review done by the All areas of concerns will immediately by the Admin The resident audit tool was 3/27/2015 to include two assist in the identification residents that smoke that not indicate that they smoquestions are 1) have you and 2) if you have smoke how long ago? This resident audit tool cuinformation will be prsented.	ting from the e Adminstrator. be addressed istrator. Is updated on questions to of other previously did ked. The I ever smoked, d in the past, mulative		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING _	R WING		С		
NAME OF PROVIDER OR SUPPLIER			5:0 _		FREET ADDRESS, CITY, STATE, ZIP CODE	03/	/28/2015	
NAME OF FROVIDER OR SUFFLIER								
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			VICTORIA ROAD SHEVILLE, NC 28801			
()(1) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 520	Continued From page	e 110	F 5	520				
	The administrator sta	ted she assumed the admission packet was the			QA/QAPI meeting by the Adminisrator.			
		Policy in the new corporate			The Administrator will present informat	ion		
		ecember of 2014. The			on Safe Smoking Compliance including			
		he corporate office had			any problems, concerns, changes and	•		
	instructed her to infor	m them of any			challenges.			
	•	December 2014 policy						
	manual and existing			The Administrator will present policies	and			
	reviewed. The admir			procedures that are currently at the				
	had not reviewed the			Corporate Office for review or pending				
	or the Smoking Policy manual in the December 2014 manual prior to 03/25/15 she was not aware				approval for implementation. The facilit Administrator will review at least 2 police			
	of the discrepancies.			per momth from the Healtique Policy a				
	or the discrepancies.			Procedure Manual, the Heaton Manual				
	On 03/26/15 at 6:40 I	PM the Administrator and			other similiar resources to ensure that			
	Director of Nursing w	ere notified of immediate			are following the policy, make			
		provided an acceptable			recommendations for changes, and			
	credible allegation of 11:59 AM.	compliance on 03/28/15 at			implemention goals for new programs.			
					The DON,RN Supervisor/Clinical			
	Credible Allegation of	Compliance			Coordinator audit results for F312 and			
	Δ.				other nursing items to the QA/QAPI			
	A.	dents #23, #36, #44, #47,			committee regarding all nursing compliance programs.			
		126, #129, #131, #132,			compliance programs.			
		id smoking materials in their			The Maintenance Director will present	all		
	room and or in their p				audits results for F253 to the QA/QAPI			
					committee that are related to			
	The Interdisciplinary	team met to develop a new			maintenance, environment, or life safe	ty.		
	smoking policy. The	Administrator was involved						
		f the new smoking policy			The Dietary Manager will present all au	ıdit		
		n the enforcement of the			results for F371 to the QA/QAPI			
		eviews for compliance which			committee with regard to the dietary			
	-	monthly QA meeting. All			department complaince, sanitation,			
		Il be kept in plastic container			infrection control and food preparation.			
		oom, however residents that			The POM will propert all audite and wa	rl.		
		nokers can keep their			The BOM will present all audits and wo done on the Resident Trust, Bond	лК		
	cigarettes in their room. 03/25/2015				Verificiaton, Deceased Resident Funds	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		7 5 25			С
	345174	B. WING _	B. WING		03/28/2015
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP (91 VICTORIA ROAD ASHEVILLE, NC 28801	CODE	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
the admission packs smoking policy and permitted by the residata collection tool licensed nurse. The the Interdisciplinary team will review the determination based the resident is "safe Social Services will parameters in which while a resident in the need to sign off that understand this police review 1-2 times perverify that the resident the new smoking police including observation of resident considered "safe smoof smoking material resident rooms. Fare policy will require resident rooms and its bear policies and will resident and in some in actual policy. Staff policies of this facilities re-educated and the	rector of Admissions updated et to include the revised will explain that no smoking is sident until the new smoking has been completed by a e evaluating nurse will inform team of the evaluation. The information and make a d on the information whether "or "unsafe." The Director of inform the resident of the n they are allowed to smoke his facility. The resident will a they and their family cy. The Administrator will r week admission packets to ent and or family/RP signed	F5	returned to the State, any anticipated in the Residen balances within \$200 limit amount which could affect eligibility or SSI to the QA/committee. The Admission Coordinate all new admissions, how not smoke, and verify that all the documents were signed during admission process such a state facility smoking policy committee. The Social Services Direction any situations of residents the smoking policy or they problems with the smoking QA/QAPI committee. The MDS/Care Plan staff of changes to the Care Plans and the discussed plans are verified as accurrence and the quality will be discussed plans are verified as accurrence and resident to ensure compliance to the QA/QAPI. The cross referenced item under F253, F312, and F3 also referenced in this parsee above. The QA/QAPI process is complete.	t Trust, any of the allowed Medicaid 'QAPI' or will report on any of them the proper uring the sunderstanding to the QA/QAPI tor will report refused to sign are having policy to the will report any of residents. It was a whole the will report any of residents. It was a whole the will report any of residents. It was a whole the care and timely the continued PI committee. It is a relisted where the care that the will report any of residents. It was a whole the care that the will report any of the will	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	· '	(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 03/28/2015		
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801		00/20/2010		
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F 520	used by the facility to the potential to be a was updated. On 03 added to the audit to 1. Do you smoke? immediately do a saform and updated th 2. Have you ever stiff they have smoked admission a safe sm will be completed or nurse. The resident audit to question for a period residents to ensure potential smokers the smoking habits, if ar information will be bon a monthly basis to someone is identified resident interview where we will be to a discussion to identification assessment and any other smokes.	esident Audit Tool has been to identify residents that have effected by deficient practices 3/27/15 two questions were tool which are: If so, the MDS staff was to fe smoking data collection the care plan accordingly, moked? If so, how long ago? In the last month prior to moking data collection form the resident by the MDS tool was updated to ask the dof 4 weeks for existing that the facility is identifying at did not disclose their prior my. The results of that rought to the QA committee for review however if d, the person conducting the fill notify the DON and	F 52					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345174	B. WING			03/28/2015	
	ROVIDER OR SUPPLIER LE NURSING & REHABI	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 91 VICTORIA ROAD ASHEVILLE, NC 28801	P CODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIAT		
F 520	with the Administrate physician, and at lea Quarterly QA meetin least the Administrate physician, 3 other st X-ray and lab will also certified nurse aide of invited to attend each direct care to reside identify any potential safety. 03/27/2015 Staff will not be allow this in-service training Clinical Coordinator Coordinator Degan in beginning their shift policy, QA, and their all residents are more concerns are to be in Administrator or DOI 03/28/2015 Audit tools will proving patterns and will be meetings with interval been implemented the review of the intervence they are working and residents to ensure they are working and residents to ensure they are working and residents to ensure they are the needs by 03/27/2015 Audits will be done of the control of th	e place on a monthly basis or, DON, designated st 3 other staff members. gs will take place with at or, DON, designated aff members, and pharmacy, so be invited to attend. One or licensed nurse will be the QA meeting that provides nts to help the committee on concerns regarding resident are ved to work until they receive g, so on 03/27/15, the DON, and Staff Development on the revised smoking responsibility to ensure that nitored for safety and any reported immediately to the N for appropriate follow up. The a synopsis of trends or discussed at monthly QA rentions that should have noughout the month, so a nitions will be done to ensure the meeting the needs of the the safety of all residents that Interventions that are not requirements will be modified	F	520			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			C 03/28/2015
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 91 VICTORIA ROAD ASHEVILLE, NC 28801	ODE	33/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATI	(X5) COMPLETION DATE
F 520	results of the audits meeting. A line item department manager about QA items. 03/27/2015 Monthly QA summar to review and make enhance the safety of show trends or patter 03/27/2015 The next monthly QA 03/27/2015 The next monthly QA 03/27/2015 Immediate Jeopardy 7:45 PM when intervivesidents confirmed training on the facility procedures and the a resident was found policy. Record revier residents who smoke assessments and carconfirmed that all sm smokers were secure possession of safe's designated as safe's follow the new smok returning lighters to the smoked in the designated observed smoking with designated times and secured by staff.	ent manager meetings with discussed at the monthly QA will be added to the morning resheet to include questions dies will be posted for the staff suggestions on how to of every resident in areas that rns. A meeting is March 30, 2015. Was removed on 03/28/15 at diews with nursing staff and they had received inservice ye's new smoking policy and expected action to take when I to not follow the smoking was confirmed that all current to had updated smoking re plans. Observations aloking materials for unsafe end with only cigarettes in the mokers. Residents smokers were observed to ing policy in obtaining and the charge nurse and mated resident smokers were ith staff supervision in the	F 5	20		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 2/29/2045		
NAME OF PROVIDER OR SUPPLIER ASHEVILLE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 91 VICTORIA ROAD ASHEVILLE, NC 28801	· ·	3/28/2015		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 520	Assurance Committee implemented proceed interventions that the September of 2014. deficiencies which we September of 2014 of complaint follow-up were in the areas of maintenance service kitchen sanitation. If facility during two fee a pattern of the facility effective Quality Ass. The findings included Cross refer to: a. F253: House Services. Based on interviews, the facility the floor for 3 of 5 sto secure ceiling tiles bathrooms. During a recertiful object of 4 sampled definite of 5 sampled defin	es Quality Assessment and be failed to maintain dures and monitor these es committee put into place in This was for three recited bere originally cited in on a recertification and survey. The deficiencies housekeeping and es, activities of daily living and the continued failure of the deral surveys of record show ty's inability to sustain an urance Program. d: ekeeping and Maintenance observations and staff by failed to secure toilets to ampled bathrooms and failed as for 1 of 5 sampled fication/complaint survey of was cited for F253 for maintain wall unit air ties of Daily Living: Based on all record reivew and failed to provide nail care to 1 ependent residents. fication/complaint survey of was cited for F253 for sistance with eating and nail	F 5	20				

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F 520	plastic containers of and a container for co	pans ready for use free to label and date food refrigerator; failed to keep condiments, thickner, lean plastic wear free from by greasy residue and failed to stored ready for use. In failed to serve food under ons by not touching ready for use in failed to serve food under ons by not touching ready for use in failed to serve food under ons by not touching ready for residents meals. Ication/complaint survey of was cited for F371 for and change gloves prior to ready for the failed the areas of aintenance services, gend kitchen santiation had the ongoing monthly Quality for urance Committee on the food as through changes in services, and weekly the care but that it was a work ininistrator stated the focus 2014 wint survey had been on the	F	520				