PRINTED: 02/16/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GIVENS HEALTH CENTER SUMMARY STATEMENT OF DEPICIENCIES (1904 DATE 1905 DATE 190		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES REACH DEPICIENCY MUST BE PIRECEDED BY PILL PREPIX REQUILATION ORLISE DEPICIENCY MUST BE PIRECEDED BY PILL PREPIX REQUILATION CONTROL DEPICIENCY MUST BE PIRECEDED BY PILL PREPIX REQUILATION CONTROL DEPICE PILL PREPIX REQUILATION CONTROL DEPICE PILL PREPIX TAG F 641 Accuracy of Assessments F 641 SSEE CFR(s): 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This RECOULREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the presence of an indiveiling Foley catheter (Resident #31) and #43) for 3 of 15 sampled residents and Level Preadmission Soreoning and Resident Review (PASRR) determination for 1 of 1 resident identified as PASRR Level II (Resident #17). The findings included: Preadmission Soreoning and Resident Review (PASRR) determination for 1 of 1 resident identified as PASRR Level II (Resident #17). The findings included: Preadmission Soreoning and Resident Review (PASRR) determination for 1 of 1 resident identified as PASRR Level II (Resident #17). The findings included: Preadmission Soreoning and Resident Review (PASRR) determination of 1 of 6 resident #17). The findings included: Preparation of 1 of 6 resident #17). Preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 7 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the preparation of 1 of 6 resident #18 and the pr			345328	B. WING			01/25/2018
FREETIX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FREETIX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FREETIX TAG CROSS-REPERENCED TO THE APPROPRIATE DEPLOIENCY) 11/26/18 FREAT TAG FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 FREEX FREEX FREEX FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 FREEX FREEX TAG FREEX FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 FREEX FREEX FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 FREEX FREEX FREEX FREEX TAG FREEX TAG FREEX TAG FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 11/26/18 FREEX FREEX FREEX TAG FREEX TAG FREEX TAG FREEX TAG FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 11/26/18 11/26/18 FREEX FREEX FREEX FREEX FREEX FREEX FREEX TAG FREEX TAG CROSS-REPERENCENT ON THE APPROPRIATE DEPLOIENCY) 11/26/18 11/26/18 FREEX TAG CROSS-REPERCNEDTO THE APPROPRIATE DEPLOENCY) 11/26/18 11/26/18 FREEX TAG TOBASH 11/26/18 FREEX TAG FREEX TAG THE RECULTORY THE REC					600 BARRETT LANE	DE	
SS=E CFR(s): 483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the presence of an indwelling Foley catheter (Resident #3) end no 58 et (MDS) assessment for the presence of an indwelling Foley catheter (Resident #30) end of 15 sampled residents and Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 resident identified as PASRR Level II (Resident #17). The findings included: 1. Resident #31 was admitted to the facility on 09/04/17 with diagnoses including Alzheimer's dementia. Review of Resident #31's progress notes dated 11/22/17 documented placement of a 16 French indwelling Foley catheter as a comfort measure as directed by Hospice. Review of the resident's care plan dated 11/24/17 noted the presence of a Foley catheter inserted for wound management, with interventions including maintaining the position of the catheter and tubing per routine nursing standards. Review of nursing notes for Resident #31's most current and tubing per routine nursing standards. Review of nursing notes for Resident #31's most current and experience on the residents were affected in a similar manner; the Leadership Team reviewed MDS's for all residents, ensuring that Hospice, PASRR and catheters were all oded correctly. No other MDS's were found to require	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	COMPLETION
Review of Resident #31's most current and other MDS's were found to require		S483.20(g) Accurace The assessment muresident's status. This REQUIREMEN by: Based on observati interviews, the facilit the Minimum Data S presence of an indw (Resident #31) and h and #43) for 3 of 15 II Preadmission Scro (PASRR) determina identified as PASRR The findings include 1. Resident #31 wa 09/04/17 with diagno dementia. Review of Resident 11/22/17 documente indwelling Foley cat as directed by Hosp medical orders date catheter care be per of the resident's care the presence of a Form wound managemen maintaining the posi tubing per routine no nursing notes for Re present time revealed	y of Assessments. Ist accurately reflect the IT is not met as evidenced on, record review and staff by failed to accurately code Set (MDS) assessment for the relling Foley catheter respice care (Resident #30 sampled residents and Level eening and Resident Review tion for 1 of 1 resident a Level II (Resident #17). d: s admitted to the facility on oses including Alzheimer's #31's progress notes dated and placement of a 16 French theter as a comfort measure ice. Review of the resident's d 11/22/17 directed Foley formed every shift. Review the plan dated 11/24/17 noted beloey catheter inserted for the time of the catheter and cursing standards. Review of the sident #31 from 11/22/17 to the do no documentation of	F 64	Plan of Correction for Tag F CFR:483.2 For each of the coding errors the survey, the MDS's were immediately and transmitted During the survey, it was not and Care Plans were in place properly addressed the care identified residents; therefore modification of the CAA's an were required. Each of the coding errors the identified during the survey of an MDS coordinator or interivassistant who were both new facility, within the first 60-80 employment. Despite, a thore knowledge and experience of and the Assessment / MDS were nevertheless new to the processes, residents, EHR, assessment Software, contributed in the coding. To verify that there were no dinaccuracies on the identified MDS, and to ensure no othe were affected in a similar matheadership Team reviewed for residents, ensuring that Hos	s noted during modified to CMS. ted that CAA's te and needs of the e, no d CarePlans at were were input by im MDS to the days of rough on the RAI process, they e facility and MDS ibuting to the other d areas of the er residents anner, the MDS's for all pice, PASRR	1/26/18
	ADODATOR				other MDS's were found to r	•	(VC) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/14/2018

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING _			01	/25/2018
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				60	00 BARRETT LANE		
GIVENS H	EALTH CENTER			Α	SHEVILLE, NC 28803		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 641	Continued From pag	ge 1	F 6	641			
	, .	Data Set (MDS) assessment			modification.		
		ealed in Section H (Bladder			In light of this deficiency we have		
	T	k mark under appliances for			reviewed our processes, and have		
	an indwelling cathet	er.			evaluated improvements that will provi		
					better access to information for coding		
		25/18 at 6:09 AM of Resident			Attending physicians are now noting th		
	_	d care revealed the presence			life expectancy on the referral orders for		
		lary catheter, the collection straw colored urine collecting			Hospice. We are providing easier acce to the PASRR system, and further train		
	in the bag.	straw colored urine collecting			on EHR and MDS assessment softwar		
	in the bag.				has occurred. On 1/24, The DON and	C	
	Interview on 01/25/	18 at 3:30 PM with the MDS			Administrator discussed the need for		
		d, for MDS assessment data,			accuracy in coding with the MDS		
		resident charts or staff			coordinator, and with her assistance		
	provided her with ne	eeded data. She stated a part			developed needed changes to process	es	
	time nurse updated	care plans and sometimes			to better facilitate accurate coding. On		
	would fill out MDS a	ssessments, with her			1/24, The MDS Coordinator was provide	led	
	assigned tasks base	ed on deadlines and workload.			education by the Medical Records		
		review of Section H of			Coordinator Regarding finding Hospice	;	
		S assessment revealed no			Certifications in the EHR and how the		
		ment the indwelling urinary			certification procedures differ between		
	_	rt time nurse would have been			Hospice providers. This training also		
		ewing this section of the MDS.			included accessing of other attachmen		
		hat nurse was not present , she was not sure if the nurse			and consults in the EHR, and verification		
	_	elephone order or if she looked			of PASSR status using the the PASSR system so that it can be compared to E		
	1	tronic record. She stated that			for accuracy in coding. These changes		
		picked up on this and coded it			will improve ease of access to		
	as such.	sicked up on the and coded it			information, reducing the chance of		
					miscoding, and will also facilitate doub	ie	
	Interview on 1/25/18	3 at 5:41 PM was conducted			checking the accuracy of our medical		
	with the Administrat	or and Director of Nursing			records and of the coding by the MDS		
	present. The Admir	nistrator stated his expectation			coordinator and nursing leadership. Ou	ır	
	that MDS assessme	ents were to be accurate.			Nurse Consultant has been scheduled		
					evaluate and assess the MDS procedu	res	
		is admitted to the facility on			and accuracy and identify any further		
	07/23/15 with diagn	oses including dementia.			training needs. The improved procedur	es,	
					training, and monitoring by nursing		
	Review of Resident	#30's hospice certification			leadership and the consultant is expec	ted	

	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	345328	B. WING		01/25/2018
	•		STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	,
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
lan of treatment be certification (18. A physicial certification deally ill with a life if her illness who of the reside led her to be relied her distributions) of the Minimum Date (19.04/17 revettions) of the Min	ant dated 11/17/17 revealed a period of 11/17/17 through an's addendum note attached ocumented the resident as fe expectancy of six months were to run its normal course. In the care plan dated 11/29/17 eceiving hospice care. #30's most current significant at Set (MDS) assessment alled Section J (Health DS assessment for prognosis ection O (Special Treatments, grams) of this MDS document hospice care. 8 at 3:30 PM with the MDS document hospice care. 8 at 3:30 PM with the MDS documenting any prognosis are MDS and hospice care the stated her review of the expectance of the section Z) for Resident #30 ampleted these sections for the tated hospice notes were ally available when she needed to the two difficult to get hospice to which she was not formation on the MDS. She pending MDS not yet change in the hospice status the prognosis was still not do a review of the resident's lowed the hospice certification	F 64	to continue to positively impact to accuracy, consistency, and come of the MDS assessments. In order to prevent reoccurrence type of error in the future, the DO Designee will verify the accuracy MDS coding of Section A1500, SO-0100k, and H-0100 of every assessment of all residents prior submission for a period of sixty and randomly thereafter. The DO report her findings to the QAPIC for ongoing monitoring and over the QAPIC Committee determines ongoing, consistent compliance achieved.	pleteness e of this ON and/or y for the J-1400, r to (60) days ON will Committee sight until s that
	nued From pagalan of treatmer be certification deally ill with a life of the residence of the months	TION IDENTIFICATION NUMBER: 345328 OR SUPPLIER	A BUILDING 345328 B. WING COR SUPPLIER CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The property of the state of the sessions of the state of the sessions of the state of hospice care. We of Resident #30's most current significant the Minimum Data Set (MDS) assessment 12/04/17 revealed Section J (Health tions) of the MDS assessment for prognosis hecked no. Section O (Special Treatments, dures and Programs) of this MDS sment did not document hospice care. We won 01/25/18 at 3:30 PM with the MDS linator revealed for, MDS assessment data, ither looked at resident charts or staff led her with needed data. She stated she esponsible for documenting any prognosis Section J of the MDS and hospice care Section O. She stated her review of the signature page (Section 2) for Resident #30 led she had completed these sections for resident. She stated hospice notes were times not readily available when she needed them and that it was difficult to get hospice status, without which she was not tted to enter information on the MDS. She la review of a pending MDS not yet mitted noted a change in the hospice status sident #30, but the prognosis was still not ed. She stated a review of the resident's poincir record showed the hospice certification was not scanned into the resident's record 11/23/18 and that this form should not have	OR SUPPLIER CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DIAGONAL PROPERTY AND THE STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THE ADDITION OF THE STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THE ADDITION OF LSC IDENTIFY INFORMATION OF LSC IDEN

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345328	B. WING		01/25/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	, , , , , , , , , , , , , , , , , , , ,	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 641	with the Administra present. The Admithat MDS assessm 3. Resident #43 w. 10/30/13 with diagr disease, heart failur A record review of Minimum Data Set Resident #43 was to O-Special Treatment hospice care. A review of the Host Treatment revealed receiving hospice services are the MDS Coordina 4:40 PM regarding #43's significant chareflect hospice care Coordinator stated	8 at 5:41 PM was conducted tor and Director of Nursing nistrator stated his expectation ents were to be accurate. as admitted to the facility noses including Parkinson's re, depression, and edema. the significant change (MDS) dated 9/14/17 indicated not coded under Section nts and Programs as receiving spice Certification and Plan of that Resident #43 began services on 8/31/17.	F 64	.1		
	hospice care and w MDS Coordinator's MDS would require Resident #43 was on 1/24/18 at 5:21 conducted with the The DON stated it significant change accurately to reflect hospice care.	sident #43 was receiving was missed for coding. The stated the significant change a correction to reflect receiving hospice care. PM an interview with was Director of Nursing (DON). was her expectation that the MDS would have been coded t Resident #43 was receiving				
		PM an interview was Administrator. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING _			1/25/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 600 BARRETT LANE ASHEVILLE, NC 28803			
(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 ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	the significant chan coded accurately to receiving hospice of 4. Resident #17 wa 11/18/16 with diagn disorder, anxiety d	d it was his expectation that ge MDS would have been oreflect Resident #43 was are. It is admitted to the facility on oses including bipolar sorder, and depression. In #17's annual Minimum Data thent dated 11/01/17 indicated of considered by the state on Screening and Resident rocess to have a serious or intellectual disability. The ning and review are used formination of need, appropriate care setting, and recommendations for yelop an individual's plan of as PASRR Level II and RR Level II. The MDS Resident #17. The MDS Resident #17 was RR Level II by reviewing the stated she would need to on to the annual MDS dated Resident #17 was PASRR	F	541			
	who stated her expe	Director of Nursing (DON) ectation was that Resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345328	B. WING		01/25/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 641	Resident #17 was de The DON stated her	e 5 urately coded to reflect termined as PASRR Level II. expectation was that the uld submit a modification to	F 64	1	
	Resident #17's annual reflect PASRR Level On 01/23/18 at 5:09 F conducted with the Adexpectation was that assessment dated 11 accurately coded to redetermined as PASR stated his expectation Coordinator would sure	al MDS dated 11/01/17 to III. PM an interview was dministrator who stated his the annual MDS /01/17 would have been eflect Resident #17 was R Level II. The Administrator in was that the MDS bmit a modification to al MDS dated 11/01/17 to			
F 867 SS=E	CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct identifies REQUIREMENT by: Based on observation interviews, the facility Assurance Committee implemented proceduinterventions that the following the recertific of 2016 to correct a during the recertificat was cited again on the	seessment and assurance. ality assessment and must: ement appropriate plans of tified quality deficiencies; is not met as evidenced n, record review and staff 's Quality Assessment and	F 86	It is the policy and practice of the fac to maintain a quality assessment and assurance committee (QAA) consistir the outlined members that meet to ide issues with respect to which quality assessment and assurance activities necessary; and develop and impleme appropriate plans of action designed correct identified quality deficiencies. facility has policies and procedures	ng of entify are nt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345328	B. WING		0.	1/25/2018	
	STREET ADDRESS, CITY, STATE, ZIP CODE 600 BARRETT LANE ASHEVILLE, NC 28803						
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From page	e 6	F 86	67			
	continued failure of the surveys of record sho	of Assessments. The ne facility during two federal owed a pattern of the ustain an effective Quality		designed to maintain these g assurance monitoring, physic consultant reviews, and staff examples of the many compoutilized. Our Quality Assurance monit	cian reviews, training are onents		
	This tag is cross refe	rred to:		cited deficiency in the last ce survey on 1/22/18 involved F Accuracy of Assessments. The	rtification 641,		
	Based on observation interviews, the facility the Minimum Data Sepresence of indwellin #31), and hospice cat for 3 of 15 sampled in Preadmission Screer (PASRR) determination identified as PASRR. The Accuracy of Asseduring the December survey for failing to a resident with a cather Interview on 1/25/18 with the Administrato	essments was originally cited 8, 2016 recertification ccurately code the MDS for a ter. at 5:41 PM was conducted r, with the Director of		also cited in the Dec. 2016 si the QA monitoring that occur the Dec. 2016 survey indicate compliance and improvemen In light of most recent QAA of following steps have been and Quality Assurance Monitoring On 2/14/18 the four-poin correction to address F641 w to DHHS. The POC addresse plan of correction for the spe deficiency, 2) The procedure implementing the plan of corr The monitoring procedure to the POC is effective and the deficiency remains corrected compliance with the regulatio The title of the person respor	urvey, and red following ed t in this area. itation, the Ided to the g process. It plan of vas submitted ed 1) The ciffic for rection, 3) ensure that specific and/or in ons and 4) nsible for		
	expectation that MDS accurate and that the	e Administrator stated his assessments were to be facility's Quality Assurance prevented the inaccurate assessments.		implementing the acceptable Plan of Correction has been into the Quality Assurance sy facility. The facility Quality Asser Assurance Program (QAA) w re-assessed by the Administr Health Services Director on 2 following was noted: Attendees were appropr include: Administrator, Medic	integrated restem of the sement and rate rator and 2/12/18. The riate and		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY MPLETED
		345328	B. WING _			01/25/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 600 BARRETT LANE ASHEVILLE, NC 28803		
(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 AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 867	Continued From pag	e 7	F8	Director of Nursing, Const. Pharmacist, Infection Prev. Dining Director, and the S. Programming Director. • Agenda items were a ¿ An Agenda item was audit results for the most redeficiency, F 641 Accurace Assessments, and will renagenda until the next certi ¿ An Agenda item was evaluation of the QAA prothe cited deficiency, F 867 and will remain on the agenext certification survey. • A Performance Impro (PIP) was opened for the Assessment Citation, (F 6 • A Performance Impro (PIP) was opened for the citation (F867) • Frequency of meeting monthly, with QAPI sub Comeeting on a monthly bas or issues were identified with frequency. • The QAA committee was analyze trends/possible cand act accordingly to resof non-compliance and imquality of care. • Progress and results PIPs and Plan of Correction reported to the Corporate committee for further over	ventionist, the social Services / also reviewed: added to include recent cited by of main on the iffication survey. added to include ocess related to 7 QAA/QAPI, enda until the ovement plan Accuracy of 641) ovement plan QAA/QAPI gs is at least committee also sis – no changes with meeting will continue to ausal factors solve instances aprove overall of the ongoing on will be QAPI	