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

PRINTED: 08/23/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345418	B. WING			C 08/09/2018		
NAME OF PROVIDER OR SUPPLIER ASHEVILLE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778			00/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the		FC	000				
	complaint investigation	on. Event ID # P5CV11						
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	IRF	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.

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REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) INITIAL COMMENTS On August 8, 2018 and August 9, 2018, The Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an on-site revisit. The facility was found to be in compliance effective June 30, 2018.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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CAMPID C	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	Y, STATE, ZIP CODE	1 00/	03/2010
CALL DEPARTMENT SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	40005000	E LIE AL TIL OADE OFNT			1984 US HIGHWAY 70			
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		Home Licensure and on-site revisit. The fa	Certification conducted an acility was found to be in					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	ADODATOS							(X6) DATE

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