		ID HUMAN SERVICES			FOF	M APPROVED 0. 0938-0391	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345432	B. WING_		09	C 09/19/2018	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
WESTERN	I NORTH CAROLINA BA	PTIST HOME		213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000			
	There were no defici investigation complet JSPK11.	encies cited on a complaint ed 9/19/18. Event ID					
		SUPPLIER REPRESENTATIVE'S SIGNATU		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.

PRINTED: 10/01/2018

		ID HUMAN SERVICES			FOR	M APPROVED	
				PLE CONSTRUCTION	(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345432	B. WING		R 09/19/2018		
		DTIOT LIONE		STREET ADDRESS, CITY, STATE, ZIP CODE 213 RICHMOND HILL DRIVE			
WESTERN	NORTH CAROLINA BA			ASHEVILLE, NC 28806			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 000	INITIAL COMMENTS		F 00	00			
	Health Service Regul	cation conducted a revisit.					
		SUPPLIER REPRESENTATIVE'S SIGNATU	IRE	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.

PRINTED: 10/01/2018

		Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			COM	PLETED
		A. BUILDING:		R		
	NH0541		B. WING		09/19/2018	
AME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
ESTERN	NORTH CAROLINA BA	APTIST HOME	HMOND HILL DRIVI	E		
			LLE, NC 28806			(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	
L 000	INITIAL COMMENTS		L 000			
	Service Regulation , and Rertification con	2018, The Division of Health Nursing Home Licensure ducted a revisit. The facility ompliance effective 8/23/18.				