PRINTED: 01/03/2019 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED	
		345418	B. WING	<del> </del>	11/	29/2018	
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  1984 US HIGHWAY 70  SWANNANOA, NC 28778			
(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 SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 565 SS=D	and participate in resident participate in resident group, if one exists, reasonable steps, who make residents are upcoming meetings (ii) Staff, visitors, or resident group or farthe respective group (iii) The facility must person who is approgroup and the facility providing assistance requests that result if (iv) The facility must resident or family groups concerning is in the facility.  (A) The facility must response and rations (B) This should not be facility must implement request of the resident in family groups concerning is in the facility must implement facility must implement of the resident in family groups.	sident has a right to organize sident groups in the facility. Provide a resident or family with private space; and take ith the approval of the group, and family members aware of in a timely manner. Other guests may attend mily group meetings only at a list invitation. Provide a designated staff and responding to written from group meetings. Consider the views of a coup and act promptly upon recommendations of such assues of resident care and life to be able to demonstrate their ale for such response. The construed to mean that the cent as recommended every ent or family group.  Sident has a right to have other resident eet in the facility with the representative(s) of other	F 56	Disclaimer:		12/27/18	
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

Electronically Signed 12/22/2018

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.

DF DEFICIENCIES CORRECTION	IDENTIFICATION NI IMBED:			(X3) DATE SURVEY COMPLETED
	345418	B. WING		11/29/2018
ROVIDER OR SUPPLIER				·
E HEALTH CARE CENT	ER			
SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
Continued From pag	e 1	F 565		
and staff interviews to an ongoing grievance concerning call bell re implement a respons concern regarding so	he facility failed to address e of the resident council esponse and failed to e to a resident council oggy rolls.		Submission of this plan of correct not constitute admission or agree the provider of the truth or the fact alleged or conclusions set forth it Statement of Deficiencies. The procession is submitted solely be required by the provision of feder state law.	ement by cts n the lan of cause it is
from May 2018-Nove seven months a cond was voiced by reside monthly meeting. Th	ember 2018 noted that four of cern with call bell response ent council members in the		F565 – Resident / Family Group Response CFR(s): 483.10(f)(5)( (7)	
being turned off and right back and staff of the concern, an inser assistants on 05/08/1 should be answered not be turned off unti June 8th, 2018-Resid assistants were takin lights. In response to was done with nursin appropriate call light increased "rounding" August 10th, 2018-R assistants were turni residents they would come back. In responsite they would come back.	staff stated they would be lid not return. In response to rvice was done with nursing 18 to tell them call bells timely and that lights should I resident needs were met. It dents stated nursing 19 too long to answer call 19 the concern, an inservice 19 assistants on 6/8/18 on 19 response times and 19 on units. 19 lesidents stated nursing 19 ng off call bells and telling 19 return and staff did not 19 less, an inservice was done 19 less on 8/10/18 about 19 less were met. 19 lesidents stated they were 18 lesidents 19 les		(1) Plan for correcting specific ar concern identified, include the properties of that led to the concern:  On 12/22/18, Administrator and I reviewed Resident Council meeting minutes for timeframe May 2018 November 2018 pertaining to sognand call light response times. The Manager implemented the use of bags per resident council reques 11/30/18 to prevent rolls from besoggy on resident trays. The DC implemented a call bell action play further investigate the root cause multiple call bell concerns. Reside Council attendees were informed resolution of the grievances on 1 Documentation of resolution and communication to attendees was in the Resident Council meeting.  On 12/22/18 the DON educated staff (both clinical and non-clinical staff (both cli	ocess  DON ing to ggy rolls e Dietary f bread t on come DN/Admin an to e of dent d of the 2/21/18. s included minutes.
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag resident council mee and staff interviews t an ongoing grievance concerning call bell r implement a response concern regarding so  The findings included  1. Review of resider from May 2018-Nove seven months a conc was voiced by reside monthly meeting. The response included: May 4th, 2018-Resid being turned off and right back and staff of the concern, an inser assistants on 05/08/2 should be answered not be turned off unti June 8th, 2018-Resid lights. In response to was done with nursir appropriate call light increased "rounding" August 10th, 2018-Resid assistants were turni residents they would come back. In response with nursing assistant answering call lights light on until resident November 9th, 2018 waiting too long for coresponse, on 11/9/18	TORRECTION  345418  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  resident council meeting minutes and resident and staff interviews the facility failed to address an ongoing grievance of the resident council concerning call bell response and failed to implement a response to a resident council concern regarding soggy rolls.  The findings included:  1. Review of resident council meeting minutes from May 2018-November 2018 noted that four of seven months a concern with call bell response was voiced by resident council members in the monthly meeting. These concerns and the facility	A BUILDING  345418  ROVIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  resident council meeting minutes and resident and staff interviews the facility failed to address an ongoing grievance of the resident council concerning call bell response and failed to implement a response to a resident council concern regarding soggy rolls.  The findings included:  1. Review of resident council meeting minutes from May 2018-November 2018 noted that four of seven months a concern with call bell response was voiced by resident council members in the monthly meeting. These concerns and the facility response included:  May 4th, 2018-Residents stated call bells were being turned off and staff stated they would be right back and staff did not return. In response to the concern, an inservice was done with nursing assistants on 05/08/18 to tell them call bells should not be turned off until resident needs were met. June 8th, 2018-Residents stated nursing assistants were taking too long to answer call lights. In response to the concern, an inservice was done with nursing assistants on 6/8/18 on appropriate call light response times and increased "rounding" on units.  August 10th, 2018-Residents stated nursing assistants were turning off call bells and telling residents they would return and staff did not come back. In response, an inservice was done with nursing assistants on 8/10/18 about answering call lights timely and to leave the call light on until resident needs were met.  November 9th, 2018-Residents stated they were waiting too long for call bell response. In response, on 11/9/18 an inservice was done with	ROWIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH GEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYMO INFORMATION)  Continued From page 1  Continued From page 1  resident council meeting minutes and resident and staff interviews the facility failed to address an ongoing grievance of the resident council concerning call bell response and failed to implement a response to a resident council concern regarding soggy rolls.  The findings included:  1. Review of resident council meeting minutes from May 2018-November 2018 noted that four of seven months a concern with call bell response was voiced by resident council members in the monthly meeting. These concerns and the facility response included:  May 4th, 2018-Residents stated dall bells were being turned off and staff stated they would be right back and staff did not return. In response to the concern, an inservice was done with nursing assistants were taking too long to answer call lights. In response to the concern, an inservice was done with nursing assistants were taking too long to answer call lights. In response to the concern, an inservice was done with nursing assistants on 8/10/18 about answering call light response, an inservice was done with nursing assistants on 8/10/18 about answering all light on units resident each were met.  November 9th, 2018-Residents stated they were waiting too long for call bells were well into come back. In response, an inservice was done with nursing assistants on 8/10/18 about answering call lights timely and to leave the call light on units resident needs were met.  November 9th, 2018-Residents stated they were waiting too long for call bells aware done with nursing and the facility response. In response, on 11/9/18 an inservice was done with resident redeal were met.  November 9th, 2018-Residents stated they were waiting too long for call bell sends on the staff (both clinical and non-clinical staff (both clinical and non-clinical staff (both clinical and non-clinical staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345418	B. WING _			11/	29/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
V & HE / II I	E HEALTH CARE CENT	ED		19	984 US HIGHWAY 70		
ASHEVILL	LE REALTH CARE CENT	ER		S	WANNANOA, NC 28778		
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F 565	was held with member Eight of eight residen in the resident counci bell response was an	30 AM-11:30 AM a meeting ers of the resident council. ts present and participating il meeting reported that call ongoing issue. In addition,	F	565	on until the need is met and to always leave one staff member on the hall at a times to answer call bell lights. On 12/22.18 the Administrator implemente call bell audit on all three shifts to ascertain where the issues exist so the	ed a	
	ever heard about their esponse was staff experied staff continudidn't ask what the reif it was an emergence sometimes didn't com	ed to turn off the call bell, sidents concern was (to see cy) and left the room and ne back. Residents reported			facility can better strategize what interventions to put in place. Beginning on 12/22/18, a dedicated staff member will be assigned on the daily assignme sheets who is responsible for answerin lights during that shift.	nt ng	
	on 11/29/18 at 3:00 f stated she assisted the the monthly meetings concerns to appropria Activity Director state resident council meet from the prior month	PM the Activity Director ne resident council during to take notes and report ate department heads. The d at the beginning of each ting she reviewed concerns			It is the facility's practice for the Activiti Director to facilitate and communicate Resident Council grievances to ensure prompt resolution. Recent turnover in t Activities Director position led to a laps communication as to who manages Resident Council grievances, which led failure of the facility's practice of monitoring and responding to resident grievances timely.	he e in	
	stated the concern at resident council in Ma 2018 and November the Director of Nursin stated the response f the resident council cresponse had been s  On 11/29/18 at 3:30 F Director of Nursing st Nursing addressed the by resident council in August 2018. The fo Nursing stated staff w	pout call bells reported by ay 2018, June 2018, August 2018 had been reported to g. The Activity Director rom nursing management to oncerns about call bell taff education.			(2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Ad-hoc Resident Council meeting held 12/21/18 by Activities Director to determine if any other residents had unresolved concerns. Residents (Residents present included: #12; #9; #284; #43) were in attendance at the resident council meeting. No other new grievances noted during meeting. Residents were informed of the use of bread bags and the implementation of Call bell action plan.	I on / the	

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NAME OF PR	ROVIDER OR SUPPLIER		,	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E HEALTH CARE CENT	FR		19	984 US HIGHWAY 70			
ASIILVILL	L HEALIH CAKE CENT	LIX		S	WANNANOA, NC 28778			
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F 565	Continued From page	e 3	F !	565				
		cause she had not served as	. `		On 12/18/18, Administrator completed			
		ursing until August 2018 the			in-service education with department			
		or of Nursing stated with all			head team (including Activities Director	۲)		
		with management staff she			on (1) timely and proper follow up of	,		
	_	dent council concern about			Resident Council concerns and (2)			
		d been an ongoing concern.			ensuring to review previous interventio	ns		
	odii boli rooponoo na	a seen an engenig centeen.			and make sure to implement different			
	On 11/29/18 at 3:45 l	PM the Administrator stated			interventions if previous did not work, a	and		
	she started working at the facility August 2018.				(3).			
	The Administrator sta							
		I meeting and was aware of			(3) The monitoring procedure to ensur	e		
		concern about call bell			that the plan of correction is effective a			
	response reported in	the August meeting. The			that specific deficiency cited remains			
	Administrator stated	she did not realize call bell			corrected and / or in compliance with			
	response had been a	in ongoing concern and			regulatory requirements:			
	would expect a differ	ent intervention to address			Beginning 12/17/18, audits of resident			
	repeated resident co	uncil grievances.			council minutes / concerns (grievance	log)		
					will be conducted (we need to be check	king		
		t council meeting minutes			this weekly x 1 month at first) then			
		about soggy rolls had been			monthly x 3 months by Administrator for			
	reported 7/13/18 in the	ne resident council meeting.			proper follow up of concerns. Any not			
					issues during audits will be addressed	at		
		eting minutes dated 8/10/18			that time with the Activities Director or			
		d Service Director attended			respective department head.			
		residents dietary staff would			0 40/00/40 # 5055 # 4 4 5 5 5			
		draining vegetables better as			On 12/22/18 the DON educated that al			
	well as using bread b	pags for rolls.			staff (both clinical and non-clinical) sho			
	On 11/20/10 from 10	20 AM 44:20 AM a manatima			answer call lights and to ensure to leav	e it		
		:30 AM-11:30 AM a meeting ers of the resident council.			on until the need is met and to always leave one staff member on the hall at a	.II		
						111		
		its present and participating il meeting reported they had			times to answer call bell lights. On	d a		
		ggy rolls in the 7/13/18			12/22/18 the Administrator implemente call bell audit on all three shifts to	ua		
		ting and, in response, were			ascertain where the issues exist so the			
		ld put rolls in bread bags.			facility can better strategize what	•		
	•	its in the resident council			interventions to put in place. Beginning	ר		
		never saw any bread bags			on 12/22/18, a dedicated staff member			
	and continued to rece				will be assigned on the daily assignme			
					sheets who is responsible for answerin			

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	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		19	REET ADDRESS, CITY, STATE, ZIP CODE 184 US HIGHWAY 70 WANNANOA, NC 28778	<u>,,</u>	20/2010	
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F 565	stated she assisted the monthly meetings concerns to appropria Activity Director state rolls was brought up. The Activity Director steported to the forme dietary manager atter council meeting and place the rolls in bread place the rolls in bread that attended the 8/10 meeting no longer was former interim dietary served as the interim recently when another former interim dietary former dietary manage 8/10/18 resident cour or staff about using both The former interim dietary former dietary manages of one residen bread bag. The form manager/cook stated to use the bread bags didn't know.  On 11/29/18 at 3:45 form manager/cook stated to use the bread bags of the Administrator stated they would begin the resident council of and recalled the form stated they would begin the resident council of the resident council of the stated they would begin the stated they would begin the resident council of the	PM the Activity Director ne resident council during to take notes and report ate department heads. The d the concern about soggy by resident council 7/13/18. Istated the concern was r dietary manager and that nded the 8/10/18 resident reported dietary staff would ad bags.  PM a former interim dietary the former dietary manager 0/18 resident council orked at the facility. The manager/cook stated he dietary manager until er manager was hired. The manager/cook stated the ncil meeting) did not tell him read bags for all residents etary manager/cook stated ad bags and only were t that wanted his bread in a	F	565	lights during that shift.  Effective 12/27/18, audit findings for Resident Council Meeting Concerns where the person to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medica Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admission Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director) The QA Committee will review, discuss and implement any necessary changes indicated. The Call bell action plan wibe reported on and monitored in the monthly QAPI meeting until the QA committee and the resident council feethas been resolved. The DM will bring bread bag auditing tool to QA to report and monitor on monthly and until the Committee and resident council feels it has been resolved.  (4) The title of the person responsible implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Administrator.	I / ns s, s as II els it her		

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F 565 F 641 SS=E	bags in use. The Adbrought to her attent the former food serving resident council of pladministrator stated through on interventic concerns which wou bags to prevent sogg Accuracy of Assessment of CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment murresident's status. This REQUIREMEN' by:  Based on record revifacility failed to accur Data Set (MDS) to repreadmission Screen (PASRR) determinat (Resident #33, Resident #8, Resident #8, Resident #65) identifications included:  1. Resident #33 was 05/24/16 with diagnor A review of the annual assessment dated 0	ay and had not noticed bread iministrator stated until ion, she had forgotten about ice director telling the ans to use bread bags. The she expected staff to follow ons to address resident id have included use of bread gy rolls.  In of Assessments.  It is not met as evidenced view and staff interviews the rately code the Minimum effect the Level II ining and Resident Review ion for 7 of 9 residents ident #34, Resident #46, int #45, Resident #24 and fied as a PASRR Level II.  admitted to the facility on ionses of depression.  al Minimum Data Set (MDS) 1/16/18 indicated Resident	F 6	F641 – Accuracy of Assessments CFR(s):483.20(g)  (1) Plan for correcting specific area of concern identified, include the procest that led to the concern: On 11/28/18, Regional MDS Coordin made corrections to the following residents' MDS assessments to accurately reflect a Level II PASRR: #34; #46; #8; #45; #24; and #65. The were accepted by CMS on 11/28/18. It is the facility's practice for the SSD accurately code / submit resident date each resident's PASSR status. SSD not validating PASSR status within the	of ss ator #33; ey to sa on was se NC	/27/18	
	Preadmission Screet (PASRR) process to and/or intellectual dis	red by the state Level II ning and Resident Review have a serious mental illness sability. The results of this v are used for formulating a		MUST system at the time of assessn prior to MDS submission which led to deficient practice.  (2) The procedure for implementing to	o this		

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A CHEVILL	E HEALTH CARE CENT	TED.		1984 US HIGHWAY 70	
ASHEVILI	LE HEALTH CARE CENT	EK		SWANNANOA, NC 28778	
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PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
F 641	Continued From pag		F 64	1	
	determination of nee	d, determination of an		acceptable plan of correction for the	
	appropriate care sett	ing, and formulating a set of		specific deficiency cited:	
	I .	r services to help develop an		On 11/28/18, Social Services Directo	
	individual's plan of ca	are.		completed a 100% audit of all inhous	e
				residents of their PASRR levels and	
	On 11/27/18 at 9:17 AM an interview was			confirmed these were correct. All	
	conducted with the Social Worker (SW) who			residents that were affected by defici	
	stated she was responsible for coding Section			practice were corrected by the Social	
	A1500 and missed coding Resident #33 was determined as PASRR Level II on the annual			Services Director on this date.	
		ted 01/16/18. The SW stated		On 11/20/10 the Copiel Convince Dire	actor
				On 11/28/18, the Social Services Director contacted the State of North Carolina	
	she was new to the responsibility for coding PASRR and did not realize Resident #33 was			Department of Health for up to date	13
		R Level II. The SW stated		guidelines on PASRR assignments p	er
		ubmit a modification to the		Level II guidelines vs Level I. In addi	
		ment dated 01/16/18 to		she downloaded the manual to review	
		3 was determined as PASRR		order to better recognize the Level II	
	Level II.			PASRR identifiers. On 12/19/18, the	
				Administrator educated Social Service	es
	On 11/27/18 at 10:09	AM an interview was		Director on the following expectations	s 1)
	conducted with the ir	nterim Director of Nursing		upon admission to double check the	
	(DON) who stated he	er expectation was that the		PASRR to ascertain if follow-up is ne	eded
	I .	ment dated 01/16/18 would		2) to maintain a PASRR log with all	
		y coded to reflect Resident		current resident's most up-to-date PA	ASRR
		as PASRR Level II. The		printouts via NC Must.	
		er expectation that the Social		(3) The monitoring procedure to ensu	
		t a modification to the annual		that the plan of correction is effective	
		ted 01/16/18 to indicate		that specific deficiency cited remains	
	Resident #33 was de	etermined as PASRR Level II.		corrected and / or in compliance with	
	On 11/27/19 at 12:59	PM an interview was		regulatory requirements:  Beginning 12/24/18, the Administrator	r or
		dministrator who stated her		designee will audit the PASRR book	
	expectation was that			new admission PASRRs ones weekly	
	•	1/16/18 would have been		four weeks; then twice a month for or	
		ndicate Resident #33 was		month; then once a month for one me	
		Administrator stated her		Any issues discovered will be correct	
		the Social Worker would		that time.	<del></del>
	submit a modification				
		1/16/18 to indicate Resident		Beginning 12/24/18, MDS Coordinate	or or

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	the annual MDS assesshould have been concessident #33 was PA  2. Resident #34 was 04/20/18 with diagnor.  A review of the admis (MDS) assessment of Resident #34 was not Level II Preadmission Review (PASRR) promental illness and/or results of this screeniformulating a determination of an aformulating a set of reservices to help devertible care.  On 11/27/18 at 8:58 Acconducted with the Stated she was respondent as PASR MDS assessment data she was new to the repassed and did not redetermined as PASR and did not redetermined as PASR she would need to support a service of the support of the resident #34 Level II.	PM an interview was IDS Coordinator who stated essment dated 01/16/18 ded by the SW to reflect ISRR Level II.  admitted to the facility on ses of depression.  Ission Minimum Data Set ated 04/27/18 indicated to considered by the state in Screening and Resident cess to have a serious intellectual disability. The ing and review are used for nation of need, ppropriate care setting, and ecommendations for lop an individual's plan of	F	641	Regional Clinical Reimbursement Consultant will conduct random audit on less than 5 MDS Assessments prior submission to validate correct PASRR coding once weekly for 4 weeks, then twice a month for one month, then one month for one month.  Effective 12/27/18, audit findings of the PASRR audits will be reported by the Administrator to the QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacis Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Soc Services Director). The QA Committee review, discuss, and implement any necessary changes as indicated.  (4) The title of the person responsible implementing the acceptable plan of correction: The individual responsible for implementing the credible plan of correction is the Administrator.	r to ee a est, cial		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
	NAME OF PROVIDER OR SUPPLIER  ASHEVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 984 US HIGHWAY 70 SWANNANOA, NC 28778	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 641	(DON) who stated hadmission MDS asswould have been at Resident #34 was of The DON stated it viscoial Worker would admission MDS assindicate Resident #34 Level II.  On 11/27/18 at 1:06 conducted with the expectation was that assessment dated 0 accurately coded to PASRR Level II. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level II. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level II. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level II. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level II. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that submit a modification assessment dated 0 #34 was PASRR Level III. The expectation was that a modification assessment dated 0 #34 was PASRR Level III. The expectation was that a modification assessment dated 0 #34 was PASRR Level III. The expectation was that a modification assessment dated 0 #34 was PASRR Level III. The expectation was that a modification assessment dated 0 #34 was PASRR Level III. The expectation was that a modification assessment dated 0 #34 was PASRR Level III. The expectation was that a modification assessment dated 0 #34 was PASRR Leve	interim Director of Nursing ther expectation was that the dessment dated 04/27/18 courately coded to reflect determined as PASRR Level II. was her expectation that the disubmit a modification to the dessment dated 04/27/18 to 34 was determined as PASRR deministrator who stated her at the admission MDS 04/27/18 would have been indicate Resident #34 was determined as PASRR the administrator stated her at the Social Worker would be not the admission MDS 04/27/18 to indicate Resident	F 641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/201	8	
	NAME OF PROVIDER OR SUPPLIER  ASHEVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778	,		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	LETION	
F 641	formulating a set of services to help devicare.  On 11/27/18 at 9:44 conducted with the Stated she was resp A1500 and missed of determined as PASF MDS assessment dashe was new to the PASRR and did not determined as PASF she would need to sadmission MDS assindicate Resident #4 Level II.  On 11/27/18 at 10:12 conducted with the in (DON) who stated headmission MDS assindicates would have been according to the services of the services of the services to help devices the services of the services to help devices the services of the services to help devices the services of t		F 64	,			
	Social Worker would admission MDS assindicate Resident #4 Level II.  On 11/27/18 at 1:05 conducted with the A expectation was that assessment dated 0 accurately coded to	PM an interview was Administrator who stated her the admission MDS 7/10/18 would have been indicate Resident #46 was e Administrator stated her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
	NAME OF PROVIDER OR SUPPLIER  ASHEVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 641	assessment dated 0 #46 was PASRR Lev On 11/28/18 at 3:10 conducted with the M the admission MDS should have been concentrated with the M the admission MDS should have been concentrated was developed to the significant of the significant with a diagram of the significant with a	n to the admission MDS 7/10/18 to indicate Resident vel II.  PM an interview was MDS Coordinator who stated assessment dated 07/10/18 oded by the SW to reflect etermined as PASRR Level II.  admitted to the facility on nosis of depression.  ficant change Minimum Data ent dated 08/24/18 indicated a considered by the state in Screening and Resident ocess to have a serious intellectual disability. The sing and review are used for inination of need, appropriate care setting, and recommendations for elop an individual's plan of resident's record noted ASRR Level II Determination	F 64*	· · · · · · · · · · · · · · · · · · ·		
	stated she was responded to the state of the	Social Worker (SW) who consible for coding Section oding Resident #8 PASRR icant change MDS dated sated she was new to the was determined as PASRR ted she would need to submit significant change MDS 8/24/18 to indicate Resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345418	B. WING _			11/29/2018	
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778	•		
(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 COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	conducted with the ir (DON) who stated he significant change as would have been acc Resident #8 was det The DON stated it was SW would submit a richange assessment Resident #8 was det On 11/27/18 at 2:20 conducted with the Nother significant change 08/24/18 should have reflect Resident #8 was 03/11/13 with diagnode depression.  A review of the annual on one of the significant change of the state of the serious medisability. The results are used for formulating a set of riservices to help deversare. Review of the right Resident #45 had a light Determination Notifical control of the serious medisability. The results are used for formulating a set of riservices to help deversare. Review of the right Resident #45 had a light Determination Notifical control of the right and the significant resident #45 had a light Determination Notifical control of the right and the significant resident with the si	s PASRR Level II.  PM an interview was aterim Director of Nursing er expectation was that the esessment dated 08/24/18 curately coded to reflect ermined as PASRR Level II. as her expectation that the modification to the significant dated 08/24/18 to indicate ermined as PASRR Level II.  PM an interview was IDS Coordinator who stated as assessment dated as been coded by the SW to was PASRR Level II.  admitted to the facility on ses of anxiety and  al MDS assessment dated esident #45 was not ate Level II PASRR process antal illness and/or intellectual of this screening and review ing a determination of need, appropriate care setting, and ecommendations for elop an individual's plan of esident's record noted PASRR Level II ation made on 01/29/13.	F6				
	conducted with the S	PM an interview was W who stated she was g Section A1500 and missed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345418	B. WING		11/29/2018
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  641 Continued From page 12 coding Resident #45 PASRR Level II on the annual MDS dated 09/26/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #45 was determined as PASRR Level II. The SW stated she would need to submit a modification to the annual MDS assessment dated 09/26/18 to indicate Resident #45 was determined as PASRR Level II.  On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the annual assessment dated 09/26/18 would have been accurately coded to reflect Resident #45 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the annual assessment dated 09/26/18 to indicate Resident #45 was determined as PASRR Level II.  On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the annual assessment dated 09/26/18 should have been coded by the SW to reflect Resident #45 was PASRR Level II.  6. Resident #24 was admitted to the facility on 03/13/17 with diagnoses of depression and schizophrenia.  A review of the significant change MDS assessment dated 09/26/18 indicated Resident #24 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. The results of this	1	TREET ADDRESS, CITY, STATE, ZIP CODE 984 US HIGHWAY 70 WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 641	coding Resident #4 annual MDS dated was new to the resp and did not realize I as PASRR Level II. need to submit a massessment dated 0 #45 was determined. On 11/28/18 at 12:3 conducted with the expectation was that dated 09/26/18 wou coded to reflect Res PASRR Level II. The expectation that the modification to the a 09/26/18 to indicate determined as PASI Conducted with the the annual assessment dated 09/26/18 was PASRR Level II. The expectation that the modification to the a 09/26/18 to indicate determined as PASI Conducted with the the annual assessment dated 0 #45 was PASRR Level II. A review of the sign assessment dated 0 #24 was not consider PASRR process to and/or intellectual discreening and review determination of new appropriate care see as the sum of the sign assessment dated 0 #24 was not consider PASRR process to and/or intellectual discreening and review determination of new appropriate care see as the sum of the sign assessment dated 0 #24 was not consider PASRR process to and/or intellectual discreening and review determination of new appropriate care see as the sum of the sign as the sum of the	5 PASRR Level II on the 09/26/18. The SW stated she consibility for coding PASRR Resident #45 was determined The SW stated she would codification to the annual MDS 09/26/18 to indicate Resident d as PASRR Level II.  33 PM an interview was interim DON who stated her at the annual assessment all have been accurately sident #45 was determined as the DON stated it was her so SW would submit a annual assessment dated a Resident #45 was RR Level II.  10 PM an interview was MDS Coordinator who stated then the dated 09/26/18 should by the SW to reflect Resident evel II.  11 sadmitted to the facility on coses of depression and wificant change MDS 19/26/18 indicated Resident ered by the state Level II have a serious mental illness	F 641		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIC ALBUILDING				ATE SURVEY DMPLETED	
	345418	B. WING _			11/29/2018
	ER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
individual's plan of carecord noted Resided Determination Notifical On 11/27/18 at 12:20 conducted with the Same responsible for coding Resident #24 significant change M stated she was new coding PASRR and of was determined as Fastated she would neet the significant change 09/26/18 to indicate determined as PASR On 11/28/18 at 12:33 conducted with the irrespectation was that assessment dated 09 accurately coded to a determined as PASR was her expectation modification to the significant change of 11/27/18 at 2:20 conducted with the Material Resident #24 of 18 Resident #24 of 18 Resident #65 was	are. Review of the resident's at #24 had a PASRR Level II ration made on 04/04/18.  PM an interview was g Section A1500 and missed PASRR Level II on the DS dated 09/26/18. The SW to the responsibility for did not realize Resident #24 PASRR Level II. The SW red to submit a modification to realize Resident #24 was PASR Level II.  PM an interview was atterim DON who stated her the significant change PASIC PA	F 6	41		
	al MDS assessment dated				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag individual's plan of ca record noted Resided Determination Notific  On 11/27/18 at 12:20 conducted with the S responsible for codin coding Resident #24 significant change M stated she was new coding PASRR and of was determined as F stated she would nee the significant chang 09/26/18 to indicate if determined as PASR  On 11/28/18 at 12:33 conducted with the ir expectation was that assessment dated 09 accurately coded to re determined as PASR was her expectation modification to the si dated 19/26/18 to inc determined as PASR  On 11/27/18 at 2:20 conducted with the M the significant chang 09/26/18 should have reflect Resident #24  7. Resident #65 was 02/20/16 with diagno schizophrenia.	A 345418  ROVIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 individual's plan of care. Review of the resident's record noted Resident #24 had a PASRR Level II Determination Notification made on 04/04/18.  On 11/27/18 at 12:20 PM an interview was conducted with the SW who stated she was responsible for coding Section A 1500 and missed coding Resident #24 PASRR Level II on the significant change MDS dated 09/26/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #24 was determined as PASRR Level II. The SW stated she would need to submit a modification to the significant change MDS assessment dated 09/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the significant change assessment dated 09/26/18 would have been accurately coded to reflect Resident #24 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the significant change assessment dated 19/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the significant change assessment dated 09/26/18 should have been coded by the SW to reflect Resident #24 was PASRR Level II.  7. Resident #65 was admitted to the facility on 02/20/16 with diagnoses of depression and	A BUILDIN  345418  B. WING  ROVIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 individual's plan of care. Review of the resident's record noted Resident #24 had a PASRR Level II Determination Notification made on 04/04/18.  On 11/27/18 at 12:20 PM an interview was conducted with the SW who stated she was responsible for coding Section A 1500 and missed coding Resident #24 PASRR Level II on the significant change MDS dated 09/26/18. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #24 was determined as PASRR Level II. The SW stated she would need to submit a modification to the significant change MDS assessment dated 09/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the significant change assessment dated 09/26/18 would have been accurately coded to reflect Resident #24 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the significant change assessment dated 19/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the significant change assessment dated 09/26/18 should have been coded by the SW to reflect Resident #24 was PASRR Level II.  7. Resident #65 was admitted to the facility on 02/20/16 with diagnoses of depression and schizophrenia.	A BUILDING  345418  ROWDER OR SUPPLIER  LE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  individual's plan of care. Review of the resident's record noted Resident #24 had a PASRR Level II Determination Notification made on 04/04/18.  On 11/27/18 at 12:20 PM an interview was conducted with the ISW who stated she was responsible for coding Section A 1500 and missed coding Resident #24 PASRR Level II. The SW stated she was new to the responsibility for coding PASRR and did not realize Resident #24 was determined as PASRR Level II. The SW stated she was new to the responsibility for coding PASRR and lid not realize Resident #24 was determined as PASRR Level II. The SW stated she was new to the responsibility for coding PASRR and lid not realize Resident #24 was determined as PASRR Level II. The SW stated she was new to the responsibility for coding PASRR and lid not realize Resident #24 was determined as PASRR Level II. The DON stated her expectation was that the significant change assessment dated 09/26/18 would have been accurately coded to reflect Resident #24 was determined as PASRR Level II. The DON stated it was her expectation that the SW would submit a modification to the significant change assessment dated 19/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the significant change assessment dated 09/26/18 bould have been coded by the SW to reflect Resident #24 was determined as PASRR Level II.  T. Resident #65 was admitted to the facility on 02/20/16 with diagnoses of depression and schizophrenia.	A BUILDING  345418  ROYDER OR SUPPLER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEPICIONICES (EACH DEPICEMENT WILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  Continued From page 13  Continued From page 13  Continued Resident #24 had a PASRR Level II Determination Notification made on 04/04/18.  On 11/27/18 at 12:20 PM an interview was conducted with the SW who stated she was responsible for coding PASRR and did not realize Resident #24 was determined as PASRR Level II.  On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the significant change MDS dated will.  On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the significant change assessment dated 09/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/28/18 at 12:33 PM an interview was conducted with the interim DON who stated her expectation was that the significant change assessment dated 09/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/28/18 at 12:30 PM an interview was conducted with the interim DON who stated the expectation was that the significant change assessment dated 09/26/18 to indicate Resident #24 was determined as PASRR Level II.  On 11/27/18 at 2:20 PM an interview was conducted with the MDS Coordinator who stated the expectation that the SW would submit a modification to the significant change assessment dated 09/26/18 bin indicate Resident #24 was determined as PASRR Level II.  7. Resident #65 was admitted to the facility on 02/20/16 with diagnoses of depression and schizophrenia.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345418	B. WING _	<del></del>		11/29/2018
	ROVIDER OR SUPPLIER LE HEALTH CARE CENT	ER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778	•	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 641	to have a serious medisability. The results are used for formulation of an aformulating a set of reservices to help deverage. Review of their Resident #65 had a In Determination Notification Notification 11/27/18 at 12:20 conducted with the Seresponsible for coding Resident #65 annual MDS dated 0 was new to the responsible for coding Resident #65 annual MDS dated 0 was new to the responsible for coding Resident #65 annual MDS dated 0 was new to the responsible for coding Resident #65 annual MDS dated 0 was new to the responsible for coding Resident #65 annual MDS dated 0 was new to the responsible for coding Resident #65 was determined with the interpretation was that dated 01/08/18 at 12:33 conducted with the interpretation that the sexpectation that the sexpectation to the arrow of 11/27/18 at 2:20 conducted with the Modern was passed to 11/27/18 at 2:20 conducted with the Modern was passed	esident #65 was not ate Level II PASRR process antal illness and/or intellectual as of this screening and review sing a determination of need, appropriate care setting, and ecommendations for alop an individual's plan of esident's record noted PASRR Level II ation made on 03/09/16.  PM an interview was as a Section A1500 and missed PASRR Level II on the 1/08/18. The SW stated she ansibility for coding PASRR esident #65 was determined the SW stated she would diffication to the annual MDS 1/08/18 to indicate Resident as PASRR Level II.  PM an interview was a passed that in the annual assessment dated have been accurately dent #65 was determined as DON stated it was her SW would submit a annual assessment dated Resident #65 was at Resident #65 was as Resident #65 was R	F 6	41		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		(X3) DATE SURVEY COMPLETED
		345418	B. WING		11/29/2018
	A. BUILDING    NAME OF PROVIDER OR SUPPLIER		,		
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 641			F 64	11	
	Develop/Implement	Comprehensive Care Plan	F 68	56	12/27/18
	§483.21(b)(1) The faimplement a comprecare plan for each reresident rights set for §483.10(c)(3), that is objectives and timef medical, nursing, an needs that are ident assessment. The codescribe the followir (i) The services that or maintain the resident or maintain the resident and an equired under §483.24, §483 provided due to the under §483.10, inclutreatment	acility must develop and schensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable rames to meet a resident's diffied in the comprehensive ingrehensive care plan must ingrehensive care plan must ingrehensive ingrehensive care plan must ingrehensive care plan			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		IDENTIFICATION NUMBED:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
	ROVIDER OR SUPPLIER	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778			
(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 APPROP DEFICIENCY)	D BE COMPLETION	
F 656	entities, for this purpo (C) Discharge plans plan, as appropriate, requirements set fort section.  This REQUIREMENT by: Based on record rev facility failed to imple for 1 of 1 residents re (Resident #68), and it to reflect the Level II Resident Review (PA 9 residents (Residen Resident #46, Residen Resident #24, and Re PASRR Level II.  Findings included:  1. Resident #68 was 04/20/18 with a reading diagnoses which incl failure, chronic obstrut (COPD), insomnia, manxiety, visual loss of A Significant Change dated 08/06/18, indiccognition was intact.	in the comprehensive care in accordance with the h in paragraph (c) of this  It is not met as evidenced iew and staff interviews, the ment care plan interventions eviewed for smoking failed to develop a care plan Preadmission Screening and ASRR) determination for 7 of the #33, Resident #34, ent #8, Resident #45, esident #65) identified as  admitted to the facility mission dated, 10/24/18, with uded diabetes mellitus, heart factive pulmonary disease major depressive disorder, and tobacco use.  Minimum Data Set (MDS), sated Resident #68's The MDS indicated the	F 65	F656 – Develop / Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  (1) Plan for correcting specific area of concern identified, include the process that led to the concern: On 11/28/18 the Social Services Direst immediately corrected the following residents' careplans to reflect their lest PASRR status: Resident #68; #33, #46; #8; #45; #24; and #65. It's the facility's practice for the SSD accurately code/submit resident data each resident's PASSR status. SSD not informed on the new PASRR Authorization codes and had misider PASRRs on the MDS. Because these PASRRs were miscoded the carepla were incorrect, which lead to the definition procedures on including policy and procedures on	ector evel II #34;  to on was ntified se ns icient	
	two-person physical mobility. The MDS al was coded.  A review of the care	ensive assistance with assistance for transfers and so indicated tobacco use plan, dated 10/31/18, 68 was a smoker and		facilitating supervised smoking. One housekeeping staff member was not aware of all procedure(s) of facilitatin supervised smoking. Because of the of full understanding of the process, led to the deficient practice.	ng ir lack	

	F DEFICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345418	B. WING _			1	1/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				1984 U	JS HIGHWAY 70		
ASHEVILI	LE HEALTH CARE CE	NTER		SWAN	NANOA, NC 28778		
(X4) ID	SUMMAR	/ STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
F 656	Continued From p	age 17	F 6	656			
	interventions inclu	ded: she required a smoking		(2	) The procedure for implementing	the	
		sion while smoking.			cceptable plan of correction for the		
		G			ecific deficiency cited:		
	A review of a nurs	ing progress note in the		Or	n 11/28/18 the Services Director at	udited	
	medical record of	Resident #68, dated 11/8/2018,		10	00% of the careplans for PASRR		
		of Resident #68 smoking in		co	prrections if needed. All careplans	were	
	_	nsafely. The resident was		I	orrect and up to date as of this date		
	l · · · ·	sed smoke times until a new		I .	2/20/18 the Administrator and DON		
	smoke evaluation	was obtained.			udited all care plans of residents w		
	A	andrina Onfoto Onno and dated		I	noke and updated / corrected any		
		noking Safety Screen, dated  Resident #68 had cognitive			I necessary care plans at that time		
	· ·	deficits, and manual dexterity		I	n 11/28/18 the Administrator educa aff on Resident #68's smoking care		
		ety screen further revealed the			terventions and expectations of fol		
	1 *	noking apron as adaptive			e careplan. In addition, she educa	-	
		at supervision of the resident			e staff on expectations of staff while		
		screen indicated that the plan			cilitating supervised smoking with		
		to assure the resident was safe		I	sidents on this date.		
	while smoking.			Or	n 12/19/18 the administrator educa	ated	
				the	e IDT team and charge nurses abo	out	
		esident #68 were made in the			e importance of creating, implement		
	_	n 11/27/18 to 11/28/18 and		I	nd follow through of each resident's		
		dent #68 was not wearing the		1 -	an per it's interventions and goals.		
		e time and was observed		I .	/30/18 the Administrator created a		
	smoking unsuperv	rised two times.			plemented a Supervised Smoking		
	On 11/20/19 at 10	:22 AM on interview was			nder that outlined the following: 1)	20d O/	
		:23 AM an interview was e MDS Coordinator. She			sidents who needed to be supervis ny adaptive equipment that was to		
		smoking care plan should have			sed per resident 3) facility smoking		
		Resident #68 with constant			nd procedures 4) facility smoking	policy	
		smoking apron when smoking.		I	greements 5) information on how to	)	
		5 - F			operly and safely use smoking apr		
	On 11/29/18 at 01	:25 PM an interview was			e blankets and extinguishers. On	•	
	conducted with the	e Director of Nursing (DON).		I .	/30/18 and on 12/5/18 the Adminis	strator	
		her expectation was that the		he	eld in services to educate staff on t	his	
		king should have been followed		bir	nder and how to utilize it.		
		vith constant supervision and a					
	smoking apron wh	en smoking.			) The monitoring procedure to ens at the plan of correction is effective		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345418	B. WING			44,	00/0040
NAME OF D	ROVIDER OR SUPPLIER	343410	5	6.	TREET ADDRESS, CITY, STATE, ZIP CODE	11/2	29/2018
NAME OF T	NOVIDEN ON 3011 EIEN				984 US HIGHWAY 70		
ASHEVILI	E HEALTH CARE CENT	ER			WANNANOA, NC 28778		
(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 APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	e 18	F	656			
		PM the administrator			that specific deficiency cited remains		
		ectation was that the			corrected and / or in compliance with		
	1	nould have been followed for			regulatory requirements:		
		nstant supervision and a			Beginning 12/20/18, the Administrator	or	
	smoking apron when				designee will begin auditing the		
		-			supervised smoking times to ensure		
	2. Resident #33 was	admitted to the facility on			residents careplans are being followed	by	
	05/24/16 with diagnoses including depression.				staff per its interventions: three times p		
					week for four weeks; then twice a weel	(	
	A review of PASRR L				for four weeks, then once a week for fo		
		33 was determined as			weeks. The Administrator or designee		
	PASRR Level II.				also auditing careplans to ensure smoke careplans are current and being facilitations.	-	
		an with an initiation date of			as such.		
	I .	view date of 01/18/19			Beginning 12/24/18, MDS Coordinator	or	
		o comprehensive care plan			Administrator will conduct random audi	t of	
	_	ls and identified care plan			no less than 5 care plans to ensure		
	1	ented for PASRR Level II for			PASRR status is correctly reflected one		
	Resident #33.				weekly for 4 weeks, then twice a month		
	0:- 44/07/40 -+ 0:47	A.B.A iA i			for one month, then once a month for o	ne	
	On 11/27/18 at 9:17 /				month.		
	I .	ocial Worker (SW) who onsible for creating a care			Effective 12/27/18, audit findings of the	,	
		el II for Resident #33 with			care plan and smoking audits will be		
	·	d interventions. The SW			reported by the Administrator to the QA	/PI	
	_	are that Resident #33 was			committee monthly (Quality Assurance		
		R Level II and did not create			committee consists of: Administrator,		
	a comprehensive car	e plan with measurable			DON, ADON(s), Medical Director,		
		ns. The SW stated she			Pharmacist, Dietitian / Dietary Manage	r,	
	would create a comp	rehensive care plan for			MDS Coordinator, Admissions		
	PASRR Level II for R	esident #33.			Coordinator, Maintenance Director,	ĺ	
					Housekeeping Supervisor, Activities		
		AM an interview was			Director, and Social Services Director)		
		terim Director of Nursing			The QA Committee will review, discuss		
	, ,	e SW was responsible to			and implement any necessary changes	as	
	I -	sive care plan for PASRR			indicated.		
		#33 with measurable goals			(4) The title of the server server 31. (		
	and interventions. The expectation was that	the SW would create a			(4) The title of the person responsible f implementing the acceptable plan of	וט	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345418	B. WING		,	11/29/2018	
	ROVIDER OR SUPPLIER  LE HEALTH CARE CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE  1984 US HIGHWAY 70  SWANNANOA, NC 28778				
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	comprehensive care Resident #33.  On 11/27/18 at 12:58 conducted with the Ad SW was responsible care plan for PASRR with measurable goal Administrator stated it SW would create a corpassive passive	PM an interview was dministrator who stated the to create a comprehensive Level II for Resident #33 is and interventions. The ner expectation was that the emprehensive care plan for esident #33.  admitted to the facility on ses including depression.  evel II determination 34 was determined as  an with an initiation date of view date of 01/8/19 o comprehensive care plan is and identified care plan ented for PASRR Level II for AM an interview was ocial Worker (SW) who ensible for creating a care il II for Resident #34 with d interventions. The SW are that Resident #34 was R Level II and did not create e plan with measurable ins. The SW stated she rehensive care plan for	F 6	correction: The individual responsible fo implementing the credible placorrection is the Administrate.	an of		

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING		(X3) DATE SURVEY COMPLETED		
345418	B. WING		11/29/2018	
ER		1984 US HIGHWAY 70	=	
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
atterim Director of Nursing e SW was responsible to sive care plan for PASRR #34 with measurable goals be DON stated her the SW would create a plan for PASRR Level II for  PM an interview was dministrator who stated the to create a comprehensive Level II for Resident #34 Is and interventions. The her expectation was that the comprehensive care plan for tesident #34.  admitted to the facility on ses including anxiety and schizophrenia.  Level II determination 46 was determined as  an with an initiation date of eview date of 01/13/19 to comprehensive care plan Is and identified care plan les and identified care plan ented for PASRR Level II for  AM an interview was locial Worker (SW) who consible for creating a plan for PASRR Level II for	F 656			
		A BUILDING  345418  B. WING  TER  TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  PREFIX TAG  TAG  F 656  TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  F 656  TER  TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  F 656  TER  TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  F 656  TER  TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  F 656  TAGE TAGE TAGE TAGE TAGE TAGE TAGE TAG	IDENTIFICATION NUMBER:  345418  345418  STREET ADDRESS, CITY, STATE, ZIP CODE  1984 US HIGHWAY 70  SWANNANOA, NC 28778  IPREFIX  FACE CONTINUES  TAG  PREFIX  PREFIX  TAG  PREFIX  FACE COORSE-REFERENCED TO THE APPR  DEFICIENCY)  E 20  Re 20  Re 3W was responsible to sive care plan for PASRR  #34 with measurable goals to create a plan for PASRR Level II for PASRAL deministrator who stated the to create a comprehensive care plan for tesident #34.  admitted to the facility on sees including anxiety  and schizophrenia.  Level II determination  46 was determined as  an with an initiation date of eview date of 01/13/19  no comprehensive care plan is and identified care plan ented for PASRR Level II for  AM an interview was docial Worker (SW) who onsible for creating a plan for PASRR Level II for easurable goals and	

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345418	B. WING		11/29/2018
	ROVIDER OR SUPPLIER LE HEALTH CARE CEN	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1984 US HIGHWAY 70  SWANNANOA, NC 28778	,20.20.10
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIO
F 656	Level II and did not plan with measurable The SW stated she comprehensive car Resident #46.  On 11/27/18 at 10: conducted with the (DON) who stated to create a comprehence and interventions. The expectation was the comprehensive car Resident #46.  On 11/27/18 at 1:05 conducted with the SW was responsible care plan for PASR with measurable go Administrator stated SW would create a PASRR Level II for 5. Resident #8 was	vas determined as PASRR create a comprehensive care ble goals and interventions. would create a e plan for PASRR Level II for  12 AM an interview was interim Director of Nursing the SW was responsible to nsive care plan for PASRR at #46 with measurable goals The DON stated her at the SW would create a e plan for PASRR Level II for  5 PM an interview was Administrator who stated the e to create a comprehensive R Level II for Resident #46 bals and interventions. The d her expectation was that the comprehensive care plan for	F 65	, , , , , , , , , , , , , , , , , , ,	
	indicated Resident Level II. Review of	SRR Level II determination #8 was determined as PASRR the resident's record noted PASRR Level II Determination in 03/04/16.			
	there was no comp measureable goals	e plan dated 09/06/18 revealed rehensive care plan with and identified care plan mented for PASRR Level II for			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345418	B. WING			11/	29/2018
	ROVIDER OR SUPPLIER	TER	·	1984 US H	DDRESS, CITY, STATE, ZIP CODE IIGHWAY 70 ANOA, NC 28778		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	conducted with the stated she was resp plan for PASRR Lev measurable goals a stated she was unaudetermined as PASI a comprehensive cargoals and intervention would create a compassive compassive compassive care plan for PASRR Level II for II on 11/28/18 at 5:26 conducted with the SW was responsible care plan for PASRI measurable goals a Administrator stated SW would create a PASRR Level II for II on 16. Resident #24 was 03/13/17 with diagnoschizophrenia.  A review of the PAS indicated Resident #24 Determination Notifical A review of the care there was no comprehensive poals.	O PM an interview was Social Worker (SW) who onsible for creating a care el II Resident #8 with and interventions. The SW ware that Resident #8 was RR Level II and did not create are plan with measurable ons. The SW stated she orehensive care plan for Resident #8.  PM an interview was Administrator who stated the exto create a comprehensive R Level II for Resident #8 with and interventions. The her expectation was that the comprehensive care plan for	F	556			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	' '	DATE SURVEY COMPLETED
		345418	B. WING			11/29/2018
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778	•	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	conducted with the stated she was resp plan for PASRR Lev measurable goals at stated she was unaw determined as PASR a comprehensive cat goals and intervention would create a comprehensive cat goals and intervention stated SW was responsible care plan for PASRR with measurable goals and would create a comprehensive cat goals and would create a comprehensive cat goals and would create a comprehensive cat goals and cat g	D PM an interview was Social Worker (SW) who onsible for creating a care el II Resident #24 with and interventions. The SW ware that Resident #24 was RR Level II and did not create re plan with measurable ons. The SW stated she orehensive care plan for Resident #24.  PM an interview was Administrator who stated the et to create a comprehensive R Level II for Resident #24 als and interventions. The her expectation was that the comprehensive care plan for	F 65	56		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
	ROVIDER OR SUPPLIER LE HEALTH CARE CEN	TER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 984 US HIGHWAY 70 WANNANOA, NC 28778	•	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 656	plan for PASRR Lev measurable goals at stated she was unaw determined as PASR a comprehensive car goals and intervention would create a comprehensive car goals and intervention would create a comprehensive car goals and intervention would create a comprehensive determined by the second with the second would create a conducted with the second would create a comprehensive would create a comprehensive would create a comprehensive work and work and would create a comprehensive work and	onsible for creating a care el II Resident #45 with and interventions. The SW ware that Resident #45 was RR Level II and did not create re plan with measurable ons. The SW stated she orehensive care plan for Resident #45.  PM an interview was Administrator who stated the e to create a comprehensive R Level II for Resident #45 als and interventions. The her expectation was that the comprehensive care plan for	F 656			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
	345418	B. WING _			11/	29/2018
ROVIDER OR SUPPLIER  E HEALTH CARE CENTI	ER		19	84 US HIGHWAY 70		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFII TAG		•		(X5) COMPLETION DATE
measurable goals and stated she was unaway determined as PASRI a comprehensive care goals and intervention would create a comprehensive care goals and intervention would create a comprehensive and the second create at the second conducted with the Additional states of the second conducted with the Additional states of the second create and second creat	d interventions. The SW are that Resident #65 was R Level II and did not create e plan with measurable as. The SW stated she rehensive care plan for resident #65.  PM an interview was diministrator who stated the to create a comprehensive Level II for Resident #65 and interventions. The are expectation was that the comprehensive care plan for resident #65.  ards/Supervision/Devices (2)  Inter that - sident environment remains zards as is possible; and sident receives adequate trance devices to prevent  This is not met as evidenced ans, record review, and staff as, the facility failed to inpervision and a smoking ag for 1 of 1 residents ed smoking (Resident #68).			<ul><li>(1)(2)</li><li>(1) Plan for correcting specific area of concern identified, include the process that led to the concern:</li></ul>		12/27/18
A review of the facility	's undated smoking policy					
	CORRECTION  ROVIDER OR SUPPLIER  E HEALTH CARE CENTI  SUMMARY ST. (EACH DEFICIENC' REGULATORY OR LE  Continued From page measurable goals and stated she was unawa determined as PASRI a comprehensive care goals and intervention would create a compre PASRR Level II for Ro  On 11/28/18 at 5:26 F conducted with the Ac SW was responsible to care plan for PASRR with measurable goal Administrator stated h SW would create a co PASRR Level II for Ro Free of Accident Haza CFR(s): 483.25(d)(1)(1)  §483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha  §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation and resident interview provide continuous su apron for safe smokin reviewed for supervis  The findings included	CORRECTION  JAS418  ROVIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 25  measurable goals and interventions. The SW stated she was unaware that Resident #65 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #65.  On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #65 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #65.  Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	CORRECTION  345418  B. WING  ROVIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 25  measurable goals and interventions. The SW stated she was unaware that Resident #65 was determined as PASRR Level II and did not create a comprehensive care plan with measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #65.  On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #65 with measurable goals and interventions. The Administrator stated her expectation was that the SW would create a comprehensive care plan for PASRR Level II for Resident #65.  Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents.  The facility must ensure that - §483.25(d)(2)Each resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observations, record review, and staff and resident interviews, the facility failed to provide continuous supervision and a smoking apron for safe smoking for 1 of 1 residents reviewed for supervised smoking (Resident #68).  The findings included:	A BUILDING	CONTIDER OR SUPPLIER  E HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCES  ENGLIA CONTROLLS DENTIFYING INFORMATION)  COntinued From page 25  measurable goals and interventions. The SW stated she would create a comprehensive care plan for PASRR Level II for Resident #65.  On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #65.  With measurable goals and interventions. The SW would create a comprehensive care plan for PASRR Level II for Resident #65.  On 11/28/18 at 5:26 PM an interview was conducted with the Administrator who stated the SW was responsible to create a comprehensive care plan for PASRR Level II for Resident #65.  The facility must ensure that - \$483.25(d)(1)(2)  \$483.25(d) (1)(1) The resident environment remains as free of accidents. The facility failed to provide continuous supervision and a sistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:  Based on observations, record review, and staff and resident interviews, the facility failed to provide continuous supervision and a smoking apron for safe smoking for 1 of 1 residents reviewed for supervised smoking (Resident #68).  The findings included:  DEFICIENCY)  SYMANMANOA, NC 28778  SWANNANOA, NC 28778  SWANNANOA, NC 28778  SWANNANOA, NC 28778  SWANNANOA, NC 28778  PREPTX  SWANNANOA, NC 28778  PREPTX  SWANNANOA, NC 28778  PREPTX  PREPTX  PREPTX  SWANNANOA, NC 28778  PREPTX  PREPTX	A BUILDING  345418  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  11/1  SIMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  CACHOLOGY  SWADNANAOA, NC 28778  PRECIVE (CACHOLOGY)  P

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345418	B. WING			447	20/2049
NAME OF P	ROVIDER OR SUPPLIER	0.01.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>1 117.</u>	29/2018
TVAINE OF T	KOVIDER OR OUT FEER				984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER			WANNANOA, NC 28778		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
F 689	Continued From pag	e 26	F	689			
	and procedure include	led that any resident that			apron to use during smoke times.		
	required supervision				Additionally, on 11/28/18, the DON and	j	
	restrictions would on	ly be allowed to smoke under			Administrator completed in-service		
	direct supervision of	staff and that all smoking			training with staff regarding the supervi	sed	
		oment, if care planned as			smokers process to ensure that Reside	ent	
	such, must be used v	while smoking.			#68 only smoked while supervised per care plan.		
	Resident #68 was ac	Imitted to the facility 04/20/18			It's the facility's practice to abide by all		
	with a readmission d	<u>-</u>			supervised smoking guidelines includir	ıa	
		uded diabetes mellitus, heart			providing continuous supervision and t		
	failure, chronic obstru	uctive pulmonary disease			provide any adaptive equipment neede	ed.	
	(COPD), insomnia, n	najor depressive disorder,			Some staff were not aware of the need		
	anxiety, visual loss o	f left eye, and tobacco use.			provide continuous 1:1 smoking for the supervised smokers and the need for t		
	A Significant Change	Minimum Data Set (MDS),			apron for resident #68. Because of this		
	dated 08/06/18, indic				lack of knowledge, this led to the defici		
		The MDS also indicated			practice.	J. I.	
	tobacco use was coo				produce:		
					(2) The procedure for implementing the	ا د	
	A review of the care	plan, dated 10/31/18,			acceptable plan of correction for the		
		68 was a smoker and			specific deficiency cited:		
	interventions in place	e included: required a			On 11/28/18, the DON and Administrat	or	
	smoking apron and s	supervision while smoking.			completed in-service training with staff		
					regarding the supervised smokers		
		progress note in the			process. This training was repeated at		
	medical record of Re				the facility Staff meeting that occurred	on	
		d the resident was smoking			12/6/18.		
		nsafely. The resident was					
	·	d smoke times until a new			To ensure the safety of all supervised		
	smoke evaluation wa	as obtained.			smokers the following measure were		
	A	do a Cafata Canada data d			taken: 1) additional smoking aprons we	re	
		king Safety Screen, dated			purchased and placed in the smoking	2)	
		esident #68 had cognitive			area by the Administrator on 11/28/18, beginning on 11/28/18, all staff be	۷)	
		ficits, and manual dexterity  screen further revealed the			educated upon hire as to the smoking	ſ	
		king apron as adaptive			policy/process, 3) smoking manuals we	are	
		supervision of the resident			created by the administrator that outling		
		reen indicated that the plan			the smoking policy, a list of supervised		
		assure the resident was safe			and non-supervised smokers, any		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/20/2010	$\neg$
A OLUE V/II. I	E LIEALTH CARE CENT	ED.		1984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	N
F 689	Continued From page	e 27	F 68	9		
	while smoking.  An interview was con 11/26/18 at 03:26 PM on a smoking restrict of a cigarette lit and of indicated that she was until the nurse managestated that staff kept behind a door at the stated that a staff met the cigarettes and that 9:30 AM, 1:00 PM, 4: also stated that she in she went outside to swere provided. She find accidents or burns On 11/27/18 a contin from 04:17 PM to 04: observed holding her the designated smok Further observation in burn herself. Further Smoking Supervisor smoking area and was	ducted with Resident #68 on I. She indicated that she was ion because she had a half dropped it. She further is supervised for a month ger reassessed her. She the cigarettes and lighter nurses' desk. She further indicated had one lighter and lit at the smoking times were 00 PM, and 8:00 PM. She emoved her oxygen when imoke and that ash trays form smoking.  Luous observation was made 19 PM, Resident #68 was a cigarette while smoking in ing area without an apron. evealed the resident did not observation indicated #1 left the designated as out of the line of sight for		adaptive equipment that the smoke requires, and how to use the fire blar These manuals were placed on ear on 11/30/18 by the Administrator.  Staff were educated about this produced and manuals at the "All Staff" Meet held 12-6-18. The Social Services Director will be responsible for upd and replacing the list of smokers in book and updating the care plan of resident as changes occur.  (3) The monitoring procedure to enthat the plan of correction is effective that specific deficiency cited remain corrected and / or in compliance wiregulatory requirements:  Beginning 12/27/18, the Social Ser Director will audit supervised smok random shifts, the supervised smok manual and the care plans three tir week for four weeks, then once a very for 4 weeks, then once a quarter tir	ang liket. Ich unit  cess lings lating leach  sure live and lins lith  vices lers on king lines a liveek lines	
	_	(2) minutes to get another		one. Any issues noted will be corre immediately at that time.		
	#68 was observed be smoking area by Smo Smoking Supervisor a pron on Resident #6 smoking a cigarette li observation revealed left the smoking area the line of sight for Re	#2 placed the smoking 68. Resident #68 started t by Supervisor #2. Further that Smoking Supervisor #2 at 9:35 AM and was out of		The Social Services Director will re these audits to the QAPI committee monthly (Quality Assurance commi consists of: Administrator, DON, ADON(s), Medical Director, Pharm Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Admissions Coordinator, Maintenance Director, Housekeepi Supervisor, Activities Director, and Services Director). The QA Commi	e ttee acist, or, ng Social	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345418	B. WING			1/20/2019	
NAME OF PI	ROVIDER OR SUPPLIER	0.01.0		STREET ADDRESS, CITY, STATE, ZIP CO		1/29/2018	
				1984 US HIGHWAY 70			
ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page	e 28	F 68	9			
	more smoking materi observation, Residen	ials. Throughout the at #68 held the lit cigarette.		review, discuss, and implem necessary changes as indica			
	conducted with Smok stated that she took is smoking area at 9:30 a few days prior that supervised and watch was not aware of the which residents need revealed that she did needed the smoking the reason that she is unsupervised at the consupervised at the consupervised at the consupervised to find the information	AM an interview was king Supervisor #2. She Resident #68 out to the AM every day and was told Resident #68 had to be hed. She revealed that she smoking aprons regarding led to wear it. She further not think Resident #68 apron. She did not indicate left Resident #68 designated smoking area on e, nor did she indicate where in regarding which residents apron during supervised		(4) The title of the person reimplementing the acceptable correction: The individual responsible for implementing the credible placorrection is the Social Serv	e plan of or an of		
	conducted with the S indicated that she too smoke twice a week; issues with smoking; and lighter for her an She stated that Resid supervised because returned from the hos cigarette once or twic supervised meant so Resident #68 at all tir Resident #68 did not apron and that one til smoking. She further knowledge, another r who had to wear an at the reason that she let	resident was the only one apron. She did not indicate					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345418	B. WING _			11/29/2018
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	where to find the inforesidents required a supervised smoking.  On 11/29/18 at 10:04 conducted with the N Manager. She stated supervised smoker at cigarettes. She further was previously an unhowever, she fell asked cigarette and it rolled ground. She indicated deemed a supervised further indicated that to wear the smoking out to smoke, had to further revealed that residents were safe staff knew to meet sp smoking residents.  On 11/29/18 at 1:25 F conducted with the form	AM an interview was orth Hall Nursing Unit that Resident #68 was a nd was not safe to light er stated that Resident #68 supervised smoker; eep and dropped the on her smoking apron to the d that the resident was I smoker on 11/08/18. She Resident #68 was supposed apron and whoever took her light the cigarette. She she had to make sure mokers before they were d. She did not indicate how ecific needs of supervised	F 6	,		
	kept a running list of unsupervised resider smoking aprons and the nursing station fo access. At the time o interim Director of Nu stations and was una supervised and unsurames of residents the apron. The former in could not explain why					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION	(X3) DATE COMP	SURVEY
		345418	B. WING			11/	29/2018
	ROVIDER OR SUPPLIER	ER		1984	EET ADDRESS, CITY, STATE, ZIP CODE 4 US HIGHWAY 70 ANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 756 SS=E	was to communicate who are were supervisions and ensure (smoking apron) was  On 11/29/18 at 1:30 F conducted with the Adassumed the smoking smoking policy for supermokers. She indicate that the smoking supermoking area would represent the smoking area would represent the smoking area would represent the smoking apron on all smoking apron on all smoking apron.  Drug Regimen Review CFR(s): 483.45(c)(1)(1)(1)(1)(2)(1)(2)(2)(1)(3)(3)(4)(4)(4)(4)(4)(4)(5)(4)(5)(4)(5)(4)(5)(4)(5)(4)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	effectively to staff regarding sed and unsupervised proper adaptive equipment followed.  PM an interview was diministrator. She stated she gaupervisors followed the pervised and unsupervised ted that her expectation was ervisors assigned to the not leave the residents, who to smoke, unsupervised; nts' cigarettes; and place a residents who required a w, Report Irregular, Act On (2)(4)(5)  Immen Review.  Ing regimen of each resident east once a month by a view must include a review call chart.  PM an interview was diministrator. She stated she gaupervisors she stated she gaupervisors dividents, who do not she stated and unsupervised; nts' cigarettes; and place a residents who required a view must include a review call chart.  PM an interview was diministrator. She stated she gaupervisors followed the provised she stated upon. She acted by the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a she was a state of the pharmacist st be documented on a		756			12/27/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING _			11/3	29/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E HEALTH CARE CEN	TER		19	984 US HIGHWAY 70		
AOHEVIEL	L HEALIN OAKE OEK	ILK		S	WANNANOA, NC 28778		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From pag	ge 31	F 7	'56			
	· -	and the facility's medical					
		of nursing and lists, at a					
		nt's name, the relevant drug,					
		he pharmacist identified.					
		ysician must document in the					
		ecord that the identified					
		reviewed and what, if any,					
	action has been take	en to address it. If there is to					
		medication, the attending					
	_	cument his or her rationale in					
	the resident's medica	al record.					
	§483.45(c)(5) The fa	icility must develop and					
	maintain policies and	d procedures for the monthly					
	drug regimen review	that include, but are not					
	limited to, time frame	es for the different steps in					
		os the pharmacist must take					
		tifies an irregularity that					
	_	on to protect the resident.					
	This REQUIREMEN	T is not met as evidenced					
	by:						
		ecord review, review of			F756 □ Drug Regimen Review , Repo		
	_ ·	ndations and staff interview			Irregular, Act On CFR(s): 483.45(c)(1)(	2)	
		cknowledge or respond to 43			(4)(5)		
		ndations from September					
		018 which affected 2 of 5			(1) Plan for correcting specific area of		
	-	eviewed for medications.			concern identified, include the process		
	(Residents #59 and	#81)			that led to the concern:		
					On 11/28/18, the Inter Disciplinary Tea	ım	
	The findings include	a:			(IDT), along with the respective		
	0-44/00/40 - 4.0.40	DM the fermion in the			resident □s attending physician, review		
		PM the former interim			the pharmacy recommendations for the		
	•	that served in the role from			months of September 2018 and Octobe	er	
		s) stated, until asked by the			2018 for residents #59 and #81 and	:	
	_	ot aware of the system to			implemented those the providers were	IU	
		lations by the consultant			agreeance with.	_	
	· · ·	mer interim Director of			It s the facility's practice for the DON t		
	Nursing stated she o				provide the attending physician with the		
	pnarmacist (after the	e monthly drug reviews were			pharmacy recommendation monthly or	as	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` '	) DATE SURVEY COMPLETED	
		345418	B. WING _			11/:	29/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVII I	E HEALTH CARE CENT	FR		19	984 US HIGHWAY 70			
AOHEVIEL	L HEALIN GARE GERT			S	WANNANOA, NC 28778			
(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 756	to obtain the reviews. 11/28/18, the pharma September 2018 and by the former interim included 24 recomme September 2018 and the month of October recommendations, the sampled residents wi included the following a. On 10/22/18 the con 03/20/18 Resident Remeron for appetite her weight was 129 pweight is listed as 12 weight is recorded as receives Lexapro." Tasked, "Please evalu Remeron." b. On 9/23/18 the contat Resident #81 "renot have a current lip the resident record wonths." The consul "Please consider more on the next convenient thereafter." On 10/26/18 the consultance and the sesident #81 "was stimiligrams every more serum creatinine was	veyor) to discuss the process . After the interview on a cy recommendations for October 2018 were printed Director of Nursing. These endations for the month of 19 recommendations for 2018. Of these 43 ree were specific to 2 of 5 th medications reviewed and 3: consultant pharmacist noted at #59 "was started on estimulation. At the time, counds. Her ideal body 0 pounds. Her current at 138 pounds. She also the consultant pharmacist are continued need for consultant pharmacist noted accives Atorvastatin but does id evaluation documented in ithin the previous 12 thant pharmacist asked, nitoring a fasting lipid panel at lab day and annually sultant pharmacist noted that	F	756	needed for appropriate follow up. The interim DON was not aware of her role this process. Due to this the pharmacy recommendations did not get passed of the physician which lead to the deficient practice.  (2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:  To ensure that all residents pharmacy recommendations for the month of September 2018 and October 2018 we not missed, the DON along with the provider reviewed 100% of the recommendations and implemented all orders that provider agreed with into the resident □s EMR.  Consultant pharmacist educated the Do as to the importance and processes involved with addressing the pharmacist recommendations in a timely manner of 12/20/18. The DON educated the nursi management team to the new process addressing pharmacy recommendation on 12/2/18. This process is 1) the consultant pharmacist will email the recommendations to the DON monthly, the DON or designee will met with the provider to review the monthly recommendations within 5 days of receiving them via email, the DON or designee with then process all provider	nto nto t re e ON st n ng of s 2)		
	On 11/28/18 at 3:55 F pharmacist stated the changes in the Direct				approved recommendations into the individual resident s MAR, 3) the DON designee will then ensure the pharmac recommendations are scanned into the individual resident s EMR, 4) the print	l or y		

OL. VILLI	C . C	WEDIO/ ND CEITWICEC				<u> </u>	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345418	B. WING			11/	29/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		s	WANNANOA, NC 28778		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 756	Continued From page	e 33	F	756			
	' "	er 2018 the former Director	•		copies of the pharmacy recommendation	ne	
		ar with the system to obtain			will then be placed into a notebook in the		
	_	iew recommendations. The			DON office.	ic	
		st stated she sent an email			BOTT OFFICE.		
	•	r 2018 drug reviews were					
		e former Director of Nursing,			(3) The monitoring procedure to ensure	<u>.</u>	
		Director of Nursing. The			that the plan of correction is effective a		
		st stated she sent an email to			that specific deficiency cited remains		
	•	10/31/18 to inform her the			corrected and / or in compliance with		
	drug reviews were re	ady for review. The			regulatory requirements:		
	consultant pharmacis	st stated she spoke to the			Beginning within the range of 12/31/18	to	
	former interim Directo	or of Nursing around			1/10/19, the DON and Administrator wil	I	
		ain how to access the			audit all pharmacy recommendations to		
	_	ws via the pharmacy system			ensure they are addressed and proces	sed	
		11/18/18 to let her know the			in a timely manner monthly times 4		
	_	ws were completed. The			month, every other month times two		
		st stated on 11/20/18 she			months then quarterly times two. The		
	sent the November d	-			DON will report on these audits to the		
		ministrator because she mmendations had been			QAPI committee monthly (Quality Assurance committee consists of:		
		ner interim Director of			Administrator, DON, ADON(s), Medical		
		tant pharmacist stated she			Director, Pharmacist, Dietitian / Dietary		
		28/18 that the former interim			Manager, MDS Coordinator, Admission		
		idn't have access to the			Coordinator, Maintenance Director,		
	-	ws or that reviews from			Housekeeping Supervisor, Activities		
	_	October 2018 had not been			Director, and Social Services Director).		
	· ·	he consultant pharmacist			The QA Committee will review, discuss		
		ed to address the system to			and implement any necessary changes		
	I -	ews when she was back in			indicated.		
	the building again in	December 2018.					
					(4) The title of the person responsible	for	
		PM the administrator stated			implementing the acceptable plan of		
		t the facility August 2018.			correction:		
		ited up until 11/20/18 she			The individual responsible for		
		f about the pharmacy reports			implementing the credible plan of		
	-	y didn't receive a pharmacy			correction is the Director of Nursing.		
		rator explained she didn't					
		d she was talking about the					
	monthly drug reviews	s when she was asking about					

PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 756  Continued From page 34 the pharmacy reports. The administrator stated she had not seen monthly drug reviews until she received the email (with individual pharmacy reviews attached) on 11/20/18 from the consultant pharmacist. The administrator stated she printed the November pharmacy reviews and handed them to the former interim Director of Nursing to review. The administrator stated she expected monthly drug reviews to be addressed in a timely manner and didn't realize until 11/28/18 that the drug reviews for September 2018 and October 2018 had not been accessed or addressed.  On 11/29/18 at 12:00 PM the Family Nurse Practitioner (FNP) stated upon arrival to the facility that morning she was informed the monthly drug reviews for September 2018 and		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	` ′	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  ASHEVILLE HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (X4) ID PREFIX TAG  CONTINUED FROM IT TAGE  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 756  Continued From page 34 the pharmacy reports. The administrator stated she had not seen monthly drug reviews until she received the email (with individual pharmacy reviews attached) on 11/20/18 from the consultant pharmacist. The administrator stated she printed the November pharmacy reviews and handed them to the former interim Director of Nursing to review. The administrator stated she expected monthly drug reviews to be addressed in a timely manner and didn't realize until 11/28/18 that the drug reviews for September 2018 and October 2018 had not been accessed or addressed.  On 11/29/18 at 12:00 PM the Family Nurse Practitioner (FNP) stated upon arrival to the facility that morning she was informed the monthly drug reviews for September 2018 and			345418	B. WING		11	/29/2018
F 756  Continued From page 34 the pharmacy reports. The administrator stated she had not seen monthly drug reviews until she received the email (with individual pharmacy reviews attached) on 11/20/18 from the consultant pharmacist. The administrator stated she printed the November pharmacy reviews and handed them to the former interim Director of Nursing to review. The administrator stated she expected monthly drug reviews to be addressed in a timely manner and didn't realize until 11/28/18 that the drug reviews for September 2018 and October 2018 had not been accessed or addressed.  On 11/29/18 at 12:00 PM the Family Nurse Practitioner (FNP) stated upon arrival to the facility that morning she was informed the monthly drug reviews for September 2018 and			ΓER		1984 US HIGHWAY 70	·	
the pharmacy reports. The administrator stated she had not seen monthly drug reviews until she received the email (with individual pharmacy reviews attached) on 11/20/18 from the consultant pharmacist. The administrator stated she printed the November pharmacy reviews and handed them to the former interim Director of Nursing to review. The administrator stated she expected monthly drug reviews to be addressed in a timely manner and didn't realize until 11/28/18 that the drug reviews for September 2018 and October 2018 had not been accessed or addressed.  On 11/29/18 at 12:00 PM the Family Nurse Practitioner (FNP) stated upon arrival to the facility that morning she was informed the monthly drug reviews for September 2018 and	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
October 2018 had not been printed for review. The FNP stated the system had always worked smoothly up until recent nursing management changes. The FNP stated she depended on staff to alert her when the drug reviews were completed and ready for review and typically addressed the reviews within 30 days. The specifics of the drug reviews for September 2018 and October 2018 affecting Resident #59 and Resident #81 were reviewed with the FNP and the FNP stated the delay in addressing pharmacy reviews did not cause any harm to the residents.  F 810 SS=D CFR(s): 483.60(g)  §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and	F 810	the pharmacy report she had not seen moreceived the email (vereviews attached) or consultant pharmacishe printed the Novehanded them to the Nursing to review. Expected monthly dring a timely manner at 11/28/18 that the drug 2018 and October 2 or addressed.  On 11/29/18 at 12:00 Practitioner (FNP) stacility that morning monthly drug review October 2018 had not have the smoothly up until rechanges. The FNP to alert her when the completed and read addressed the reviews pecifics of the drug and October 2018 a Resident #81 were in the FNP stated the creviews did not cause Assistive Devices - I CFR(s): 483.60(g)  §483.60(g) Assistive The facility must process.	s. The administrator stated onthly drug reviews until she with individual pharmacy in 11/20/18 from the st. The administrator stated ember pharmacy reviews and former interim Director of the administrator stated she ug reviews to be addressed and didn't realize until ag reviews for September 2018 had not been accessed and on the same accessed a				12/27/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
	ROVIDER OR SUPPLIER	TER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778	,	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 810	by: Based on observation record review, the facup to two of two residevices. (Residents The findings included 1. Resident #20 was 09/21/13 with diagnor hypertension, non-Adepression, chronic disease, hypothyroid disease, vitamin D d The care plan for Refundation related to diet and vision loss, mechanically altered an extensive assist fassisted dining room. Observations of Resident in the control of the cont	ons, staff interviews, and cility failed to provide a sippy sidents reviewed for adaptive #20 and #47).  d:  admitted to the facility bees which included: Izheimer's dementia, anxiety, obstructive pulmonary lism, failure to thrive, heart eficiency, and weight loss. Isident #20 was last updated and the potential for weight variable oral intake, bland Resident #20 was on a lidiet of ground meats, was or meals, and ate in the lident #20 at 2 of 4 meals as not provided at the meal.	F 810	F810 – Assistive Devices – Eating Equipment / Utensils CFR(s): 483.60 (1) Plan for correcting specific area of concern identified, include the process that led to the concern:  On 11/28/18, the Dietary Director delivered sippy cups to resident #20 a Resident #47 at lunch. On 11/28/18, the Dietary Director and the regional nurs consultant reviewed adaptive equipment orders for resident #20 and #47 and modified their tray cards to reflect order for adaptive equipment (specifically, scups) to ensure they delivered with trata the meal time thereafter.  IDT team reviewed diet/equipment orders for residents #20 and #47 to ensure they dentified residents had needed assist devices, sippy cups, ordered and ensure they were printed on their tray cards. It's the facility's practice for all tray can and physician orders to match accordingly. Additionally, it is the facility practice for dietary staff to read the tray	ind he e eent ers ippy ays ders nose eed ured rds ity's	
	room. The tray card sippy cup should be There were 2, 4 oun mighty shake on the cup. The resident's hapilled juice on the capitr. Resident #20 h	ch in the assisted dining for Resident #20 noted a provided with the meal. ce juice containers and a tray and no cups or sippy nands were shaky and she lothing protector covering her and 19 dime sized spills on r at the end of the meal.		cards thoroughly and ensure all tray of instructions are followed including add adaptive equipment on the trays before they are served. The dietary staff did follow the tray card instructions thus no sippy cups were present on the tray at this lead to the deficient practice.  (2) The procedure for implementing the	ding re not o nd	

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CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID IN	J. 0930 <del>-</del> 0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345418	B. WING _			11/	/29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				19	984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		SI	WANNANOA, NC 28778		
(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)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 810	Continued From page 36		F 8	310			
				acceptable plan of correction for the			
	b. On 11/28/18 at 12:	:51 PM Resident #20 was			specific deficiency cited:		
		h in the assisted dining			On 11/28/18, the IDT (Regional nurse		
	room. Resident #20 \			Consultant; DON; MDS Coordinator;			
	eating ground chicke			Dietary Director; and Regional MDS			
	yogurt, mighty shake juices. There was no			Coordinator) completed a 100% audit of all residents' dietary orders and their	DΤ		
	time of the observation			respective tray cards to ensure they			
	stated the resident de			matched and that the tray cards had all			
	on the tray, but other			assistive devices clearly printed on their			
	for the resident. The			tray cards. Any issues identified during			
	noted a sippy cup sh			this audit were immediately corrected b	y		
	meal.				the DON on 11/28/18.		
	c. On 11/28/18 at 4:2	0 PM Resident #20 was			On 12/18.18 Administrator conducted		
	observed eating dinn			in-service education with Dietary Mana	ger		
	room. Resident #20 h			(DM) and Nurse administration team or			
	able to drink juice ind			the importance of checking orders daily	′		
	for Resident #20 note			for any assisted devices ordered to			
	provided with the me	di.			ensure they are pulled over into the tray card system. DM conducted in-service	у	
	d. On 11/29/18 at 8:4	6 AM Resident #20 was			education on 12/18/18 and 12/19/18 wi	th	
		akfast in the assisted dining			dietary staff regarding checking the tray		
		was being assisted with			card thoroughly every meal to ensure n		
	eating 2 boiled eggs,			assisted devices are left off of trays.			
		4 ounce juices. Resident #20			Nurse admin conducted in-service		
		a sippy cup and was able to			education with clinical staff emphasizing	•	
	drink without assistar	nce.			that they read tray card when delivering		
	   On 11/28/18 at 3⋅09	PM the Director of Therapy			trays on the hall to ensure all devices a present on the tray at time of delivery.	16	
		ne sippy cup was evaluated			Administrator educated Risk IDT to		
		ed into the communication			ensure ordered assisted devices are		
	book for the doctor to				discussed weekly in Risk Meeting to		
					confirm none are missed on the tray ca	rd	
		al record noted on 11/19/18			system.		
		ed the sippy cup for Resident					
	#20.				(3) The monitoring procedure to ensure		
	On 44/00/40 - 1.0.45	DM the Food Coming			that the plan of correction is effective as	nd	
	On 11/28/18 at 2:45 I	PIVI THE FOOD Service			that specific deficiency cited remains		

Facility ID: 952947

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED  11/29/2018	
		345418	B. WING				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		123/2010	
				1984 US HIGHWAY 70			
ASHEVILI	LE HEALTH CARE CEN	TER		SWANNANOA, NC 28778			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 810	Continued From page 37		F 810				
F 810	Continued From page 37 Director stated she expected the kitchen staff to send adaptive equipment on the resident's food tray as ordered by the physician. The Food Service Director stated she did not know why the sippy cup had not been sent at lunch on 11/26/18 and 11/28/18.  On 11/28/18 at 4:34 PM the Director of Nursing stated her expectation was for the resident to receive the adaptive equipment ordered by the physician.  On 11/28/18 at 5:19 PM the Administrator stated her expectation was for the adaptive equipment to be provided to the resident in accordance with the physician orders.  2. Resident #47 was admitted to the facility 03/13/13 with diagnoses which included: non-Alzheimer's dementia, Parkinson's, anxiety, depression, feeding difficulties, dysphagia, vitamin D deficiency, and gastroesophageal reflux.  The care plan for Resident #47 was last updated 09/21/18 and included the potential for weight fluctuation related to mechanically altered diet. Resident #47 was on a mechanically altered diet. Resident #47 was on a mechanically altered diet of ground meats, required supervision for meals, and ate in the assisted dining room.  Observations of Resident #47 at 2 of 4 meals noted a sippy cup was not provided at the meal. These observations included:  a. On 11/26/18 at 12:46 PM Resident #47 was observed eating lunch in the assisted dining room. The tray card for Resident #47 noted a sippy cup should be provided with the meal.		F 810	corrected and / or in compliance with regulatory requirements: Beginning 12/19/18, the dietary manager will audit tray line across varying meal times (breakfast, lunch, dinner) to validat that assisted devices are present on the required trays three times a week x four weeks; then twice a week x four weeks; then once a week x four weeks. Any issues noted during these audits will be immediately corrected by the Dietary Manager at that time. Starting 12/27/18, audit findings for adaptive equipment will be reported by the Dietary Manager to th QA/PI committee monthly (Quality Assurance committee consists of: Administrator, DON, ADON(s), Medical Director, Pharmacist, Dietitian / Dietary Manager, MDS Coordinator, Admissions Coordinator, Maintenance Director, Housekeeping Supervisor, Activities Director, and Social Services Director).			
				The QA Committee will review and implement any necessary needed.  (4) The title of the person respinglementing the acceptable procrection: The individual responsible for implementing the credible plant correction is the Certified Dieta Manager.	changes consible for clan of		

Facility ID: 952947

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		11/29/2018	
NAME OF PROVIDER OR SUPPLIER  ASHEVILLE HEALTH CARE CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 984 US HIGHWAY 70 SWANNANOA, NC 28778	11120/2010	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 810	b. On 11/28/18 at 12 observed eating lungroom. Resident #47 ground chicken, cornounce grape juices. A nursing assistant seen the resident us for Resident #47 not provided with the mode. On 11/28/18 at 4:: observed eating dim room. Resident #47 able to drink juice in for Resident #47 able to drink juice in for Resident #47 not provided with the mode. On 11/29/18 at 8: observed eating bre room. Resident #47 eating 2 boiled eggs ensure clear and 2, was provided juice in drink without assistated. On 11/28/18 at 3:08 stated the need for the book for the doctor to 11/28/18 at 2:45 Director stated she desend adaptive equip tray as indicated on	2:58 PM Resident #47 was ch in the assisted dining was being supervised eating n, cauliflower, roll, and 2, 4 No sippy cup was on the tray. (NA) stated she had never se a sippy cup. The tray card ted a sippy cup should be eal.  22 PM Resident #47 was ner in the assisted dining had a sippy cup and was dependently. The tray card ted a sippy cup should be eal.  46 AM Resident #47 was akfast in the assisted dining was being supervised with se, toast, waffle, oatmeal, 4 ounce juices. Resident #47 in a sippy cup and was able to ance.  PM the Director of Therapy the sippy cup was evaluated red into the communication	F 810			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING	<del></del> -	11/29/2018
NAME OF PROVIDER OR SUPPLIER  ASHEVILLE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778	,
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 810	and 11/28/18.  On 11/28/18 at 4:34 F stated her expectation receive the adaptive of the tray card.  On 11/28/18 at 5:19 F her expectation was f	PM the Director of Nursing in was for the resident to equipment as indicated on PM the Administrator stated or the adaptive equipment resident in accordance with	F 81		