PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C	
NAME OF PE	ROVIDER OR SUPPLIER	343313	1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	)1/25/2019	
NAME OF T	COVIDEIX OIX OOF FEIER			500 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVIL	LE		ASHEVILLE, NC 28804			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	00			
	conducted 01/22/19 to found in compliance v	ertification survey was o 01/25/19. The facility was with the requirement CFR Preparedness. Event ID#					
F 000	INITIAL COMMENTS		F 0	00			
F 578 SS=D	complaint investigation	ntnue Trmnt;FormIte Adv Dir	F 5	78		2/22/19	
	discontinue treatment	ht to request, refuse, and/or t, to participate in or refuse rimental research, and to e directive.					
	construed as the right the provision of medic	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or					
	requirements specifie subpart I (Advance Di (i) These requirement inform and provide wiresidents concerning medical or surgical tre resident's option, form (ii) This includes a wifacility's policies to im and applicable State I (iii) Facilities are perm	is include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. Iten description of the plement advance directives law.  Initted to contract with other information but are still					
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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

**Electronically Signed** 

02/18/2019

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	OF DEFICIENCIES CORRECTION	IDENTIFICATION NITIMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			C <b>01/25/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	01/20/2013	
				500 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHE\	/ILLE		ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 578	time of admission a information or articular has executed an admay give advance of individual's resident with State Law.  (v) The facility is no provide this information or she is able to receive a subject of the information to the information in the following facility failed to rescue a status were resulted.  1. A record review in readmitted to the famultiple hospitalization diagnor peripheral vascular and chronic kidney.  A review of the meditary information (UTI). The indicated that Residuare consult during information information information information information information in information information in information i	dual is incapacitated at the and is unable to receive plate whether or not he or she alwance directive, the facility directive information to the arepresentative in accordance at relieved of its obligation to action to the individual once he are must be in place to provide the individual directly at the action and staff interviews, the solve discrepancies regarding a sampled residents whose aviewed (Resident #44 and action 12/09/18, after the sign of the individual directly at the actions from 09/2018 to 10/2018, hission date of 06/28/18 with onese: diabetes mellitus, disease (PVD), hypertension,	F 5	The Plan of Correction is no construed as an admission or doing of liability. The facility regist to contest the survey find through informal dispute rescappeal proceedings or any are or legal proceedings. This play correction is not meant to est standard of care, contract ob position and the facility resert to raise all possible contention defenses in any type of civil or claim, action or proceeding. It contained in this plan of corresponding to the considered as a way potentially applicable peer response assurance or self-critical exaprivilege which the facility do and reserves the right to assurance or proceedings. The facility response, credible allegation compliance and plan of correspondents.	of any wrong reserves the adings olution, formal dministrative an of tablish any digation or eves the rights ons and or criminal Nothing ections aiver of any eview, quality mination es not waive ert in any al claim, accility offers ions of		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		345010	B. WING			C <b>01/25/2019</b>
	ROVIDER OR SUPPLIER	LLE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804			0.7.20.20.10
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	A review of Resident indicated there was a Scope of Treatment (she was a "Do Not R Medical Directive Upo 6/28/18 and signed b indicated she was a "order, dated 10/19/18 paper medical record a "Full Code" and rev Record revealed she of the paper medical was no DNR Golden MOST form.  A review of Resident minimum data set (Mindicated her cognition A review of the Advardated 12/17/18, indice DNR code status.  An interview was con Worker (SW) on 01/2 the interview, the follows.	#44's paper medical record in undated Medical Order for MOST) Form which stated esuscitate" (DNR) and the on Admission form, dated by the resident, further full Code." A physician's form which stated in the indicated Resident #44 was fiew of the Electronic Health for was a "Full Code." A review frecord further revealed there for was a significant change for was	F 5		ding es regarding the paper ewed and regarding or on cope of completed on caper chart, written in R Electronic Golden Rod t on ed and in 2/5/2019. ding es regarding ine paper and d and	
	MOST form, Medical Form, Full Code statusheet to match the M indicated that the pall the facility after the rehospital in December MOST form. She furtibelieved the DNR staresident was readmit	Directive Upon Admission us and no DNR Golden Rod OST form. The SW liative care nurse came to esident readmitted from the 2018 and initiated the		code status by Unit Coordinat DNR Order written in paper of 2/5/2019, DNR Electronic Ord on 2/5/2019. Care plan review reflects current code status or  2. Advance directive valida current residents was complet nursing admin staff to include Nursing (DON) and/or unit Co	or on 2/5/19: nart on ler entered wed and n 2/5/19.  ation audit of ted by Director of	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		,	
		345010	B. WING _				25/2019
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
				50	00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE		Α	SHEVILLE, NC 28804		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 578	Continued From page	e 3	F 5	578			
	speak to the Director	of Nursing (DON) regarding			and Staff Development Coordinator (S	DC)	
	the specifics of the D				on 1/26/2019. On 2/7/2019, Regional	- /	
	·				Nurse Consultant provided training on	the	
	An interview was cor	nducted with the DON on			new process to Nursing Home		
	01/24/19 at 11:28 AM	<ol> <li>During the interview, the</li> </ol>			Administrator, Social Worker, Minimum	ı İ	
	following information	was reviewed with the DON:			Data Set Nurse and Nursing Admin sta	ff	
		ated MOST form, Medical			to include Director of Nursing (DON)		
	-	ssion Form, Full Code status			and/or unit Coordinator and Staff		
		Rod sheet to match the			Development Coordinator (SDC)and a	ıy	
		ted that the staff should have			remaining IDT members. On 2/13/19		
	asked the resident w				Staff Development Coordinator (SDC) re-educated current licensed nursing si	toff	
		tatus and the staff should rsician to determine the			on the advance directive process. Curr		
	validity her code stat				licensed nursing staff will be re-educate		
	emergency. The DOI				prior to working next scheduled shift ar		
		een the palliative care			this education has been added to the n		
		sing staff led to the facility			hire orientation.		
	not having an order f	or DNR code status for					
	Resident #44. She fu	urther indicated that her			New admission/readmissions: the Soci	al	
	-	a physician order for the			worker or a licensed nurse will review t	he	
		should have been written,			advance directive with the family and		
	verified with a physic				resident. The completed advance		
		edical record updated to			directive will be given to the social		
	reflect the correct co	de status.			services director and the Director of	:11	
	An intorvious see	aducted with the			Nursing. The social services director w	_	
	An interview was cor	iducted with the 24/19 at 4:25 PM. The			place the advance directive paperwork the doctor s box for signature. The	111	
		ed that an order for the code			Director of Nursing will communicate to	,	
		d have been obtained and			the physician the request on the advan		
	_	medical record and the			directive and an order will be obtained		
	electronic health reco				placed in the medical record. The socia		
					services director or Minimum data set		
	2. Resident #25 was	admitted to the facility on			(MDS) nurse will update the care plans	to	
		e diagnoses that included			reflect current advance directives		
		of cervix, chronic obstructive			decisions. The interdisciplinary team (I	OT)	
		difficulty breathing) and atrial			will discuss and verify the status of the		
	fibrillation (irregular h	neartbeat).			advance directive during each resident		
					and family meeting.		
	Review of the signific	cant change MDS (Minimum					

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	DF DEFICIENCIES CORRECTION	` IDENTIFICATION NUMBED: `		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345010	B. WING _				C / <b>25/2019</b>	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01	723/2013	
					00 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVI	LLE		Α	SHEVILLE, NC 28804			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 578	Continued From page	e 4	F 5	578				
	Data Set) dated 12/0	6/18 revealed Resident #25			The Director of nursing or the st.	aff		
	had moderate impair				development/unit coordinator nurse wi			
		•			review 5 new/readmissions weekly for			
		services progress notes			weeks (starting 2/4/19) and monthly fo	r 2		
		ted 01/03/19 that read in			months to validate that the advance			
		der hospice care and is a			directive and the orders are in place ar	nd it		
	DNR (Do Not attempt	t Resuscitation)."			reflects the correct information. New			
	Davious of Davidant #	tOFIs madical short on			admissions and re-admissions will be	200		
		#25's medical chart on nd 01/25/19 revealed a hard			reviewed daily (Monday to Friday) for oweek (1/28/19 - 2/1/19) by the Director			
	-	dical Orders for Scope of			Nursing, Staff development nurse or U			
	Treatment) form date				Coordinator to validate the completion			
		no hard copy of a physician's			the advance directive and communicat			
	order indicating code				of the advance directive to the			
					Interdisciplinary team.			
		‡25's electronic medical						
		01/24/19 and 01/25/19			4. Effective February 21, 2019 the			
		n of code status under her			Social Services Director or the Directo	r of		
	resident profile. Revi				Nursing will report the findings of the			
	· · · ·	ealed no order indicating			audits and reviews to the Quality			
	code status.				Assurance and Performance Committee for any additional monitoring or	эe		
	During an interview o	on 01/24/19 at 3:34 PM,			modification of this plan monthly for 3			
	_	checked both the medical			months. The Quality Assurance and			
	chart and electronic r				performance Improvement Committee			
		nt's code status. Nurse #3			can modify this plan to ensure the facil			
	_	25's electronic profile did			remains in compliance.	,		
		status. Nurse #3 explained			·			
		hould be obtained any time a			Nursing Home Administrator and Direct	tor		
		s changed and their medical			of Nursing are responsible for			
		nedical record updated to			implementation of the plan.			
	reflect the correct coo	de status.			Correction date: Feb 22, 2019			
	During an interview o	on 01/25/19 at 9:40 AM, the						
		tated it was her expectation						
	_	order indicating code status						
		ent's medical chart and their						
	electronic medical recorrect code status.	cord updated to reflect the						

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		345010	B. WING			C <b>01/25/2019</b>
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVI	LLE		STREET ADDRESS, CITY, STATE, ZIP CO 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 640 SS=D	CFR(s): 483.20(f)(1)- §483.20(f) Automater requirement- §483.20(f)(1) Encoding a facility completes a facility must encode the each resident in the final (i) Admission assession (ii) Annual assessment (iii) Significant change (iv) Quarterly review (v) A subset of items reentry, discharge, and (vi) Background (face is no admission assestive facility must be caped CMS System information contained in the MDS standard record layout and that passes standed that passes standed that passes standed and the State.  §483.20(f)(3) Transmant days after a facility and the State.  §483.20(f)(3) Transmant days after a facility encoded, accurate, at the CMS System, incomplete in the CMS System in the CMS System, incomplete in the CMS System in	ng data. Within 7 days after resident's assessment, a the following information for acility: ment. In tupdates. In tupdates. It is in status assessments. In tupon a resident's transfer, and death. In the same the same that it is in a formation, if there is a resident's assessment, able of transmitting to the action for each resident is in a format that conforms to but and data dictionaries, dardized edits defined by an ittal requirements. Within a complete is a resident's a must electronically transmit and complete MDS data to sluding the following: ment. In the in status assessment.	F 64	0		2/22/19

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345010	B. WING _			C 01/25/2019	
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVI	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 640	initial transmission of does not have an addisonate have a control of the for a State which has by CMS, in the formal approved by CMS. This REQUIREMENT by:  Based on record revision facility failed to compute discharge MDS (Minimite with the required time reviewed for Resident #1).  Findings included:  Resident #1 was additionate with the series of Resident #1 an admission assessing were no other MDS at transmitted after the Review of Resident #1 an urse note dated to Resident #1 discharge During an interview of Resident #1.	and death.  De-sheet) information, for an an amount of MDS data on resident that mission assessment.  Description of MDS data on resident that mission assessment.  Description of MDS or, an alternate RAI approved at specified by the State and at specified by the State and are sevidenced of the work of the second of the specified by the State and are sevidenced of the work of the second of the second of the specified by the State and are sevidenced of the work of the second of the second of the specified of the second of the seco	F 6	F640 Encoding/Transmitting FAssessment  1. Resident #1, Discharge Assessment submitted on 1/24 accepted on 1/30/2019 by Mini Set Nurse (MDS Nurse).  2. Casper□s Missing Asse Report pulled and reviewed by Data Set Nurse (MDS Nurse) of 1/29/2019 and Point Click Care Admit/Discharge To/From Report Set Nurse (MDS Nurse) of 1/29/2019. Any deficient items corrected by the Minimum Data (MDS Nurse).  3. Education provide to M Data Set Nurse (MDS Nurse) it Minimum Data Set Consultant 2/7/2019, regarding timely com	est/2019 and imum Data essment Minimum on essort to reflect or on were a Set Nurse linimum on Regional on epletion and		
	and a discharge asse			submission of Discharge Asses Minimum Data Set Nurse (MDS will provide weekly submission Nursing Home Administrator al Point Click Care □s Admit/Disc	S Nurse) report to long with		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345010	B. WING				C <b>25/2019</b>
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVIL	L		50	FREET ADDRESS, CITY, STATE, ZIP CODE  BEAVERDAM ROAD  SHEVILLE, NC 28804	<u>  U17</u>	25/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	Administrator stated hassessments to be convithin the required tine.  During an interview of Director of Nursing states assessments to be according to the states.	it the assessment.  n 01/24/19 at 4:19 PM, the ne expected for MDS ompleted and transmitted	F	540	To/From Report to validate discharge assessment submission is timely as scheduled. Nursing Home Administrate will pull Casper□s Missing Assessment Report monthly for 3 months to ensure discharge assessments are completed timely.  4. Effective February 21, 2019, the MDS Coordinator and Nursing Home Administrator will report the findings of audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facili remains in compliance.  Nursing Home Administrator and Direct of Nursing are responsible for implementation of the plan.	e the e	
F 641 SS=D	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revifacility failed to accurate (Minimum Data Set) at Hospice (Resident #2	of Assessments. t accurately reflect the is not met as evidenced ew and staff interviews the	F	641	F641 Accuracy of Assessments  1. Minimum Data Set Nurse (MDS Nurse) modified the assessment for resident #25 to reflect the correct coding	ng	2/22/19

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	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345010	B. WING _				C / <b>25/2019</b>	
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	20/2013	
					00 BEAVERDAM ROAD			
ACCORDI	US HEALTH AT ASHEVI	LLE			SHEVILLE, NC 28804			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From pag	e 8	F 6	641				
	Diagnoses (Resident of Daily Living (Residents reviewed for				on January 28th, 2019 (#23) and Janua 25th, 2019 (#52) February 10th, 2019 ( (#42 and #53) February 15th, 2019.			
	Findings included:  1. Resident #25 was	s admitted to the facility on			2. Sections A, G, I and O of the most recent Minimum Data Set, for current residents, for census date February 15	th.		
	04/18/18 with multiple diagnoses that included malignant neoplasm of cervix, chronic obstructive				2019; will be audited for accuracy by the Director of Nursing and or Staff			
	pulmonary disease ( fibrillation (irregular h	trouble breathing) and atrial neartbeat).			Development nurse. Opportunities corrected by the MDS Coordinator.			
	#25 revealed an entr part, Resident #25 re with referral order for Review of Resident # hospice documentati admitted to Hospice Review of the signific 12/06/18 indicated R expectancy of less the of the MDS revealed Resident #25 was not Hospice care. A rev Area Assessment (C dated 12/06/18 read place for end of life of cervical cancer."	#25's medical chart revealed on that indicated she was services on 12/06/18.  cant change MDS dated esident #25 had a life nan 6 months. Further review under Section O, O0100K of coded as receiving riew of the cognition Care AA) associated with the MDS in part, "hospice services in eare related to diagnosis of			3. Minimum Data Set Nurse (MDS Nurwill be re-educated by the Regional Minimum Data Set Consultant by February 7th 2019, regarding the importance of accurately coding the Minimum Data Set (MDS), specifically, Level II PASRR, ADLs, Diagnoses and Hospice. Regional MDS Consultant or Director of nursing will audit section A, and O by comparing the current documentation in the medical record regarding Level II PASRR, ADL documentation, active diagnoses and if the resident is receiving hospice service for 3 Minimum Data Sets per week for weeks then monthly for 2 months to ensure accuracy.	G, I f es 4		
	MDS Coordinator co admitted to hospice s added "that was why change MDS assess Coordinator stated si	on 01/24/19 at 3:20 PM, the infirmed Resident #25 was services on 12/06/18 and I completed the significant ment." The MDS he missed coding Section O, Resident #25 was receiving			Regional MDS Consultant or Director of Nursing will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and	of		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345010	B. WING				C <b>01/25/2019</b>	
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVI	LLE		500 BE	ADDRESS, CITY, STATE, ZIP CODE AVERDAM ROAD //ILLE, NC 28804		01/23/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 641	Director of Nursing stassessments to be at assessments to be at assessment and assessment at a set of recommendation of need and a set of recommendation as a set of recommendation and a set of recommendation and a set of recommendation and as a set of recommendation and as a set of recommendation and as a set of recommendation and as a set of recommendation	would submit a  In 01/24/19 at 4:35 PM, the lated she expected for MDS occurately coded.  Inited to the facility on ediagnoses that included  23's electronic medical mad a Level II PASRR listed ofile.  Ision Minimum Data Set 8 revealed Resident #23 by the state Level II hing and Resident Review have a serious mental illness lability. The results of this was used for formulating a d, appropriate care setting endations for services to	F 6	per car ren Nui of N	rformance Improvement Committed modify this plan to ensure the farmains in compliance.  rsing Home Administrator and Dir Nursing are responsible for plementation of the plan.  rrection date: Feb 22, 2019	cility		
	to reflect Resident #2	ction for the admission MDS 3 was a Level II PASRR. on 01/24/19 at 4:35 PM, the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345010	B. WING		01/25	5/2019	
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEV	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 07/20	1 0 1120 10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 641	assessments to be a  During an interview AD stated she review paperwork and kept with a Level II PASR screening review recexpiration date. The had a Level II PASR 08/28/18. She state included in an email AM informing variou #23's admission and which included her Ladded the MDS Cod a second email sent Resident #23's elect updated to reflect he PASRR.  3. Resident #42 was 12/07/18 with diagnodiabetes, and Alzhei A review of the Adm (MDS) assessment of Resident #42 was confurther revealed Resanticoagulant, antiar during the assessment odded for these medical review of the medical review of the second review of the Adm (MDS) assessment of the second review of the Adm (MDS) assessment of the second review of the Adm (MDS) assessment of the second review of the	stated she expected for MDS accurately coded.  on 01/25/19 at 10:05 AM, the wed new admission track of residents admitted at so that she could submit quests prior to the PASRR at AD confirmed Resident #23 R upon her admission on the MDS Coordinator was sent on 08/28/18 at 11:09 s facility staff of Resident at pertinent billing information acvel II PASRR number. She ordinator was also included in on 09/03/18 indicating aronic medical record was ar new limited-stay Level II seadmitted to the facility on access including: depression, amer's disease.  Insisted to the facility on the properties of the modern and the period with no diagnoses are period with no diagnoses.	F 64				
	01/25/19 at 8:30 AM these correctly and a errors. She further scaught it and she wi	revealed she missed coding admitted they were coding stated she should have II correct. She stated did not nissed this information.					

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,			(X3) DATE COMP	SURVEY LETED
ACCORDIUS HEALTH AT ASHEVILLE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 641  Continued From page 11  During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The DON stated she had been signing the MDS without a thoroughly reviewing the MDS  WASHEVILLE, NC 28804  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE)  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX CACH CORRECTIVE ACTION SHOULD BE COMPLIANCE  PREFIX TAG		345010	B. WING					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 641  Continued From page 11  During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The DON stated she had been signing the MDS without a thorough review and stated in the future she would be thoroughly reviewing the MDS			LLE	•	50	00 BEAVERDAM ROAD		
During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The DON stated she had been signing the MDS without a thorough review and stated in the future she would be thoroughly reviewing the MDS	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
During an interview on 01/25/19 with the Administrator he stated it was his expectation that the MDS be accurately coded.  4. Resident #53 was admitted to the facility on 08/03/18 with diagnoses including: hypertension, cervical vertebra fracture, non-Alzheimer's dementia, and edema.  A review of the quarterly MDS assessment dated 12/29/19 indicated that Resident #53 had severely impaired cognition.  A review of the medical record revealed Resident #53 was receiving Norco and Oxycodone for pain, Xanax for anxiety, and Risperidone for agitation. There were no diagnoses coded for these medications on the MDS.  An interview with the MDS Coordinator revealed on 01/25/19 at 8:30 AM she missed coding these correctly and admitted they were coding errors. She further stated she should have caught it and she will correct. She stated she did not know why she had missed this information.  During an interview on 01/25/19 at 9:55 AM with the Director of Nursing (DON) she stated she expected the MDS to be accurately coded. The	F 641	During an interview of the Director of Nursin expected the MDS to DON stated she had without a thorough reshe would be thorough assessments before. During an interview of Administrator he state the MDS be accurated.  4. Resident #53 was 08/03/18 with diagnost cervical vertebra fract dementia, and edemand and edemand the MDS be accurated. A review of the quarted 12/29/19 indicated the severely impaired confus was receiving Not pain, Xanax for anxiet agitation. There were these medications on An interview with the on 01/25/19 at 8:30 A correctly and admitted She further stated she will correct. She she had missed this in During an interview of the Director of Nursing and with the on During an interview of the Director of Nursing and with the Director of Nursing and	on 01/25/19 at 9:55 AM with a g (DON) she stated she to be accurately coded. The been signing the MDS eview and stated in the future gally reviewing the MDS they were submitted.  on 01/25/19 with the ed it was his expectation that ely coded.  admitted to the facility on ses including: hypertension, sture, non-Alzheimer's a.  erly MDS assessment dated at Resident #53 had gnition.  cal record revealed Resident orco and Oxycodone for end diagnoses coded for a the MDS.  MDS Coordinator revealed AM she missed coding these and they were coding errors. The should have caught it and stated she did not know why information.	F	541			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345010	B. WING			C <b>01/25/2019</b>
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	<b>,</b>	01/20/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From page 12 thorough review and stated in the future she would be thoroughly reviewing the MDS assessments before they were submitted.		F 64	11		
	During an interview Administrator he sta the MDS be accurat 5. Resident #52 wa	on 01/25/19 with the ted it was his expectation that ely coded.  s readmitted to the facility on				
	12/27/18 (original admission date was 08/04/05) with diagnoses including: Alzheimer's disease, non-Alzheimer's dementia, Parkinson's disease.					
	Resident #52 was c	1/03/19 indicated that ognitively intact. The MDS sident #52 was coded as				
	01/24/19 at 5:30 PM misunderstood the country with supervision. She every resident in the supervision. She fur corrected with each assessment. The M	coding instructions for eating e stated she had been coding e facility as needing ther stated this is being resident quarterly DS Coordinator stated this overed very recently and they				
	the Director of Nursi expected the MDS t DON had been sign thorough review and would be thoroughly assessments before	they were submitted.				
	During an interview	on 01/25/19 with the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345010	B. WING			01/	25/2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVIL	LE	•	50	TREET ADDRESS, CITY, STATE, ZIP CODE 00 BEAVERDAM ROAD SHEVILLE, NC 28804		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 F 656 SS=D	the MDS be accurate	ed it was his expectation that		641 656			2/22/19
	implement a compreheare plan for each reserved at the following (i) The services that a or maintain the reside physical, mental, and required under §483.24, §483. provided due to the reunder §483.24, §483. provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized sere abilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv) In consultation with resident's representation (A) The resident's prefuture discharge. Factorial plants and resident's prefuture discharge.	cility must develop and tensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive aprehensive care plan must grant to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse \$1.10(c)(6)\$. ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and efference and potential for					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345010	B. WING		C 01/25/2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVII	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
P 656	local contact agencie entities, for this purpo (C) Discharge plans i plan, as appropriate, requirements set forth section.  This REQUIREMENT by: Based on observation interviews, the facility plan to reflect the Lev Screening and Resid determination for 1 of identified as PASRR implement care plan an air mattress as stated 22 residents (Resider comprehensive care)  Findings included:  1. Resident #23 adm 08/28/18 with multiple bipolar disorder.  Review of the admissing (MDS) dated 09/04/11 received antidepression the 7-day assessment.  Review of Resident #0 n 12/11/18, revealed psychotropic medicate was developed for PAReview of Resident #7 record on 01/23/19 at record on 01	ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the in in paragraph (c) of this  is not met as evidenced Ins, record review and staff failed to develop a care well II Preadmission ent Review (PASRR) In resident (Resident #23) Level II and failed to interventions by not utilizing ated in the care plan for 1 of int #44) reviewed for plans.  In the diagnoses that included  Is ion Minimum Data Set Is revealed Resident #23 In medication daily during at period.  In the was a care plan for ion use but no care plan	F 65	F656 Develop/Implement Comprehe Care Plan  1a. Resident #23: PASRR II Care initiated on 1/25/2019 by Minimum Daset Nurse (MDS Nurse) and validated Director of Nursing.  1b. Resident #44: Air Mattress apto bed on 1/24/2019 by Central Supp Coordinator and validated by Nursing Home Administrator. Director of Nursiconfirmed care plan intervention was place as outlined by the Care Plan.  2a. 100% audit of Care Plans for Residents with pressure ulcers was completed by nursing admin staff to include Director of Nursing (DON) and unit Coordinator and Staff Developmed Coordinator (SDC) to ensure interver in place on 2/8/19. Any opportunities were corrected by nursing admin staff include Director of Nursing (DON) and unit Coordinator and Staff Developmed Coordinator (SDC)  2b. 100% audit of Any Resident was audited ensure that MDS and Care plan	Plan ata d by  plied dy sing in  d/or ent ent ofto d/or ent

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF D	ROVIDER OR SUPPLIER	0.00.0			TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	25/2019
TVAIVIL OF T	NOVIDER OR GOLT EIER				00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	LE					
				Α	ASHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	During an interview o MDS Coordinator revelectronic medical recal Level II PASRR. SID Director (AD) usually resident was admitted. The MDS Coordinato Resident #23 had a Lhad completed the action of the MDS and therefore developed.  During an interview on Director of Nursing stresident #23's care procomprehensive and in During an interview on AD stated she review paperwork and kept to	n 01/25/19 at 3:20 PM, the iewed Resident #23's cord and confirmed she had ne added the Admissions informed her when a d with a Level II PASRR. If stated she was unaware evel II PASRR when she dmission MDS dated re, a care plan was not n 01/25/19 at 9:40 AM, the ated it was her expectation plans would be include a Level II PASRR.	Fé	356	appropriately coded. Audit was conducted by nursing admin staff to include Director of Nursing (DON) and/unit Coordinator and Staff Developmer Coordinator (SDC) and any opportunitic corrected.  3. Minimum Data Set Nurse (MDS Nurse) and Nursing Admin Team to include Director of Nursing (DON) and/unit Coordinator and Staff Developmer Coordinator (SDC) re-educated by the Regional Minimum Data Set Consultar on 2/7/2019, regarding accuracy of Ca Plan interventions. During weekly Risk Meeting, all new interventions for prevention of skin breakdown will be reviewed weekly by IDT. DON will randomly Audit 3 charts weekly for prevention of skin breakdown and PAS II care plans and intervention implementation weekly for 4 weeks the	nt des or or or ot re c	
	screening review requests prior to the PASRR expiration date. The AD confirmed Resident #23 had a Level II PASRR upon her admission on 08/28/18. She stated the MDS Coordinator was included in an email sent on 08/28/18 at 11:09 AM informing various facility staff of Resident #23's admission and pertinent billing information which included her Level II PASRR number. She added the MDS Coordinator was also included in a second email sent on 09/03/18 indicating Resident #23's electronic medical record was updated to reflect her new limited-stay Level II PASRR.  2. A record review revealed Resident #44 was readmitted to the facility on 12/09/18 with the				<ul> <li>Monthly for 2 months.</li> <li>4. Effective February 21, 2019, the Nursing Admin Team to include Director Nursing (DON) and/or unit Coordinator and Staff Development Coordinator (Swill report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any addition monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvem Committee can modify this plan to ensithe facility remains in compliance.</li> <li>Nursing Home Administrator and Director Nursing are responsible for</li> </ul>	or of DC) d onal nent ure	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345010	B. WING _				C / <b>25/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	1 11 1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 01/	23/2013
					0 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE			SHEVILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From pag	e 16	F 6	656			
		diabetes mellitus, peripheral			implementation of the plan.		
	on her right and left b	(D), three stage 2 pressures outtock and sacrum, ronic kidney disease.			Correction date: Feb 22, 2019		
	minimum data set (Mindicated her cognitic limited assistance wire assistance for bed mindicated for bed mindicated for bed mitted assistance for bed mindicated for bed mitters, and had thould be and was coded. A review of the pression 01/02/19 indicated for felieving mattress and plan, dated 01/16/19 mattress was added. A review of the pression assessment (CAA), or Resident #44 developments.	obility, extensive assistance hysical assistance for ree new Stage 2 pressure d as not refusing care.  ure ulcer care plan, initiated d the resident had a pressure d the revision of the care, further indicated that an air due to her wounds.					
	The CAA further rever doctor visits and productor visits and productor care only and services, but she refure the transfers and bat staff to turn and positive reposition herself in the A review of the MDS dated 01/17/2019, in air mattress applied a with turning.	caled she was refusing all cedures and she wanted d was offered hospice used hospice. The CAA d extensive assistance with hing and refused to allow cion her and refused to bed even with verbal cues.  Nurse's Risk Meeting Note, dicated Resident #44 had an and she was non-compliant  Note, dated 01/17/2019,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, , ,	TE SURVEY MPLETED
		345010	B. WING			C 01/25/2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEV	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page 17		F 65	6		
	breakdown related to	44 was at risk for skin o refusal of care as eak down and overall				
	01/22/19 at 03:04 PM never had an air mat further indicated that healed. She stated the	nducted with Resident #44 on M. She indicated that she tress placed on her bed. She her wounds were almost that she could reposition				
	refused repositioning observation was made	did not indicate that she g. During the interview, an de of Resident #44's bed and no air mattress on her bed, de pressure relief.				
	Development Coordi AM. She indicated th	nducted with the Staff nator on 01/24/19 at 11:44 lat Resident #44 did not have further indicated that lurn herself.				
	Coordinator on 01/24 Coordinator indicates have been added to until it arrived at the that she jumped the the resident in her ro check to see if the ai She stated that she error, which was dat stated that she chart	nducted with the MDS 4/19 at 5:12 PM. The MDS d the air mattress should not the pressure ulcer care plan facility. She further indicated gun and went down to see from on 01/17/19 and did not or mattress was on her bed. Charted a risk meeting note in ed 01/17/19. She further ed the note in error because not on the resident's bed.				
	Administrator indicat	nducted with the 24/19 at 4:25 PM. The ed that Resident #44's care dressed that the air mattress				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 . BOILD!			,	c
		345010	B. WING _			01/	25/2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVIL	LE		500	REET ADDRESS, CITY, STATE, ZIP CODE  D BEAVERDAM ROAD  SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 656 F 695 SS=D	was implemented upon An interview was com Nursing (DON) on 01 indicated that Reside not have been documente air mattress was indicated that Reside be delivered on the nevendor.  Respiratory/Tracheos CFR(s): 483.25(i)  § 483.25(i) Respirator tracheostomy care are	n it arrived at the facility and on arrival.  ducted with the Director of /24/19 at 4:45 PM. The DON nt #44's air mattress should tented on the care plan until in the facility. The DON also nt #44's air mattress would ext day from a closer  tomy Care and Suctioning		656			2/22/19
	needs respiratory car care and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this sul This REQUIREMENT by: Based on observation interview, staff interviethe facility failed to obtresidents reviewed with Findings included:  Resident #52 was read 12/27/18 (original admithed to diagnoses included)	e, including tracheostomy tioning, is provided such professional standards of tensive person-centered tts' goals and preferences, opart.  is not met as evidenced  ans, record review, resident tews, and physician interview that an oxygen orders for 1 of 1 th oxygen (Resident #52).  admitted to the facility on mission date was 08/04/05) ing: hypertension, cerebrovascular accident,			F695 Respiratory/Tracheostomy Care and Suctioning  1. Resident #52 physician notified, a oxygen order updated by unit coordination 1/25/2019.  2. 100% Audit of all residents receiv oxygen was completed by Unit Coordinator on 1/25/2019, no other residents found to be affected at this tir.  3. Education provided to licensed st	ring me.	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345010	B. WING			C <b>1/25/2019</b>	
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVII	LE		STREET ADDRESS, CITY, STATE, ZIP COD 500 BEAVERDAM ROAD ASHEVILLE, NC 28804			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	A review of the significate (MDS) assessmenthat Resident #52 was required the use of oxervations made of the control of the physicistor oxygen use.  Observations made of the control of the physicistor oxygen use.  Observations made of the control oxygen use.  Observations made of the control oxygen when the conduct with Resident #52 rewinder with Resident #52 rewinder with Nurse #4 reveals oxygen when he want locate a physician or oxygen when he want locate a physician or oxygen to have a physician review conduct with the Director of Nowsher expectation of the control oxygen to have a physician review conduct with the physician review that the staff notify his for oxygen use.  An interview conduct with the administrator	cant change Minimum Data nt dated 01/03/19 indicated s cognitively intact and cygen.  an orders revealed no order  on 01/22/19 at 9:22 AM and a revealed Resident #52 to via nasal cannula at 4 liters  ed on 01/24/19 at 5:27 PM realed he receives oxygen liters per minute.  ed on 01/25/19 at 12:23 PM ed Resident #52 wears ts it. Nurse #4 could not der for oxygen.  ed on 01/25/19 at 1:25 PM ursing (DON) revealed it for all residents receiving riscian order for the gen.  ed on 01/25/19 at 1:48 PM realed it was his expectation or or on call staff for order	F 69	regarding Oxygen use and or Development Coordinator (SI 2/13/2019. Current licensed r will be re-educated prior to we scheduled shift and this eduction been added to the new hire of Central Supply Coordinator will of residents, weekly whom ox supplies are distributed. Nursite team to include Director of Not and/or unit Coordinator and Since Development Coordinator (SI review list weekly for orders. If admin to include Director of Note (DON) and/or unit Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of for 4 weeks then monthly for the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensure accuracy of Oxygen of the staff Development Coordinator (SI randomly audit 3 residents were ensured to include Director of No.	pursing staff pricing next ation has rientation. Fill provide list tygen ing adminursing (DON) Staff (DC) will Nursing Jursing or and Staff (DC) will eekly to reders weekly 2 months.  2019, the de Director of pordinator (SDC) audits and nece and liny additional this plan utility Improvement and to ensure ince.		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345010	B. WING		C 01/25/2019
	ROVIDER OR SUPPLIER	ILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 01/23/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 761 F 761 SS=D	CFR(s): 483.45(g)(h §483.45(g) Labeling Drugs and biological labeled in accordance professional principle appropriate accessor instructions, and the applicable.  §483.45(h) Storage §483.45(h)(1) In accessional laws, the fact biologicals in locked temperature controls personnel to have accessor instructions, and the applicable.  §483.45(h)(1) In accessor in locked temperature controls personnel to have accessive to have accessive to have accessive to have accept when package of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distrib quantity stored is middle between the package drug distributed in the readily detected. This REQUIREMEN by:  Based on observation interviews the facility multi-dose tuberculir	of Drugs and Biologicals is used in the facility must be see with currently accepted es, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and compartments under proper s, and permit only authorized	F 76		
	of 1 Novolog insulin days and failed to di vial that was expired	rators and failed to discard 1 vial that was expired for 31 scard 1 of 1 Levemir insulin for 22 days and was 1 or 2 medications carts.		medication refrigerator on 1/23/2019 to Director of Nursing (DON). Medication replaced with newly delivered Medication-hand.	is

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	' '	ATE SURVEY OMPLETED
		345010	B. WING			C <b>01/25/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZIP CODE		01/25/2019
TO WILL OF T	NOVIDER OR COLL FIER			500 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVII	LE .		ASHEVILLE, NC 28804		
	I					
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	e 21	F 7	61		
	I .	multi-dose tuberculin t once opened the product		2. Other 2 medication carts a treatment carts were reviewed Nursing Admin Team to include Nursing (DON) and/or unit Coc and Staff Development Coordin (SDC), and no other expired its identified on 1/23/2019.	by the e Director of ordinator nator	
	Medications (revised facility shall not use of drugs or biologicals. A returned to the disper destroyed.  On 01/23/19 at 10:11 tuberculin purified pro #321478 and a manu 06/2020 was observed the medication refrige tuberculin vaccine was remained in the medi resident use. Nurse #	policy entitled Storage of 04/2007) indicated the outdated or deteriorated All such drugs were to be		3. Education provided to licer by Staff Development Coordinate regarding medication storage of 2/12/2019. Current licensed nur will be re-educated prior to work scheduled shift and this educate been added to the new hire orienthe Nursing Admin Team to incomplete Director of Nursing (DON) and Coordinator and Staff Developing Coordinator (SDC) will random carts per week to ensure there expired medications present. A undits will be conducted for 4 will monthly for 2 months.	ator (SDC) on ursing staff rking next tion has ientation. clude /or unit ment nly audit 2 are no Weekly	
	Nurse #1 stated becahad not been dated whot be determined whould expire. Nurse # undated tuberculin vamedication refrigerate  On 01/23/19 at 10:21 conducted with the D who verified that the multi-dose vial was ouse in the medication stated the tuberculing	AM an interview was irector of Nursing (DON) tuberculin vaccine pened and ready for resident refrigerator. The DON vaccine should have been as per facility policy. The		4. Effective February 21, 20 Nursing Admin Team to include Nursing (DON) and/or unit Cod and Staff Development Coordin will report the findings of the au reviews to the Quality Assurance Performance Committee for an monitoring or modification of th monthly for 3 months. The Quality Assurance and performance In Committee can modify this plan the facility remains in complian  Nursing Home Administrator ar of Nursing are responsible for	e Director of prdinator (SDC) udits and ce and ny additional nis plan rality mprovement n to ensure nce.	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345010	B. WING _				C (25/2040
NAME OF PI	ROVIDER OR SUPPLIER	0.00.0		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 01/	25/2019
					0 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVII	LLE			SHEVILLE, NC 28804		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	e 22	F 7	61			
		uctions was good for 30			implementation of the plan.		
	tuberculin vaccine wa could not be determin expire. The DON stat	he DON stated because the as not dated when opened it ned when the vaccine would ed she did not have a eck for out dated medication igerator.			Correction date: Feb 22, 2019		
	conducted with the Adexpectation was that located in the medical been dated when operecommendation and Administrator stated by vaccine was not date.	AM an interview was dministrator who stated his the tuberculin vaccine tion refrigerator would have ened per manufacturer's facility policy. The because the tuberculin d when opened it could not the vaccine would expire.					
	b. A review of the ma recommendation for I that once opened the discarded after 28 da	Novolog insulin vial indicated product was to be					
	Medications (revised facility shall not use o	y policy entitled Storage of 04/2007) indicated the outdated or deteriorated All such drugs were to be nsing pharmacy or					
	vial was observed op and remained on 1 of for resident use. Nurs insulin was opened a remained on the Wes ready for resident use insulin was good for 2	AM 1 of 1 Novolog insulinened and dated 11/26/18 f 2 medication carts ready se #2 verified the Novolog and dated 11/26/18 and with Wing medication cart fee. Nurse #2 stated Novolog 28 days once opened and all days been discarded.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
		345010	B. WING		01/25/2	2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVI	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	,	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE CO	(X5) DMPLETION DATE
F 761	Continued From pag	e 23	F 76	1		
	Wing medication car when she took contro of her shift. Nurse #2 administered Novolo vial.  On 01/23/19 at 11:22 conducted with the E who verified the Nov and dated 11/26/18 a use on the West Winstated the Novolog ir instructions was goo and was expired. The expectation was that	g insulin using the expired  I AM an interview was Director of Nursing (DON) olog insulin vial was opened and was ready for resident g Medication cart. The DON insulin vial per manufacturer's d for 28 days once opened e DON stated her staff would have removed insulin vial from the West				
	conducted with the A expectation was that the expired Novolog 11/26/18. The Admin insulin was good for c. A review of the marecommendation for that once opened the discarded after 42 da A review of the facilit Medications (revised facility shall not use drugs or biologicals. returned to the disped destroyed.	Levemir insulin vial indicated e product was to be ays.  y policy entitled Storage of 04/2007) indicated the butdated or deteriorated All such drugs were to be				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COM	E SURVEY PLETED
		345010	B. WING			C / <b>25/2019</b>
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVI	LLE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		1 020.20.10	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 761	and remained on 1 of for resident use. Nur insulin was opened a remained on the Weready for resident us insulin was good for was expired and sho Nurse #2 stated she Wing medication car when she took controf her shift. Nurse #2 administered Levem vial.  On 01/23/19 at 11:20 conducted with the E who verified the Leve and dated 11/20/18 a use on the West Winstated the Levemir in instructions was goo and was expired. The expectation was that	pened and dated 11/20/18 of 2 medication carts ready se #2 verified the Levemir and dated 11/20/18 and st Wing medication cart e. Nurse #2 stated Levemir 42 days once opened and ould have been discarded. had not checked the West t for expired medications of of the cart at the beginning extra stated she had not ir insulin using the expired  I AM an interview was Director of Nursing (DON) emir insulin vial was opened and was ready for resident ng Medication cart. The DON insulin vial per manufacturer's d for 42 days once opened	F 76			
F 812 SS=E	conducted with the A expectation was that the expired Levemir 11/20/18. The Admin insulin was good for	O AM an interview was administrator who stated his a staff would have discarded insulin vial that was dated iistrator stated Levemir 42 days once opened. Store/Prepare/Serve-Sanitary (2)	F 81	2		2/22/19

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY IPLETED
		345010	B. WING _		0.	C I/ <b>25/2019</b>
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVI	LLE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	ı ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	Continued From pag	e 25	F8	12		
	state or local authorit (i) This may include of from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and food (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accords standards for food se This REQUIREMENT by: Based on observation facility failed to cover contained vanilla put orange slices and fait peppers that were medate of 12/30/18 that reach-in refrigerators The findings included  1. Observations of th 8:55 AM to 9:15 AM, spoiled foods were se reach in refrigerators in reach-in refrigerators	red satisfactory by federal, ies. red satisfactory by federal, ies. red sod items obtained directly subject to applicable State sulations. res not prohibit or prevent roduce grown in facility compliance with applicable d-handling practices. res not preclude residents is not procured by the facility.  If prepare, distribute and revice safety. If is not met as evidenced residenced and staff interviews, the red two dessert trays that adding cups and cups of red to discard a bag of green oldy and had an expiration were stored in 2 of 2 observed in the kitchen.  It:  Re kitchen, on 01/22/19 from revealed uncovered and reviced in the kitchen's two. Tobservation of food stored or #1 revealed two dessert inch on 01/22/19, had 8 lices of oranges without a reainder of the dessert cups liding without a covering.		F812 Food Procurement Store/Prepare/Serve  1a. Moldy Peppers and outdat carrots were immediately discard 1/22/2019. Consultant Registered Dietician (RD) conducted in-servi all kitchen staff 1/22/2019 regardi storage.  1b. Desserts were covered pr distribution on 1/22/2019.  2. Kitchen rounds completed be Consultant Registered Dietician (RD)/Dietary staff on 1/22/2019, r items identified as deficient.  3. Education given to all dietar regarding food storage by Consul	ed on d ce with ing food rior to  by no other	

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			(X3) DATE COMP	SURVEY LETED			
		345010	B. WING			1	25/2019
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017.	23/2019
					0 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	.LE			SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 26	F 8	312			
	molded green pepper substance in the bag 12/30/18.  An interview was con	with an expired date of ducted with the Dietary			Registered Dietician (RD) on 1/22/2019 Education given to all dietary staff regarding proper covering of food items upon delivery to floor by Dietary Managand/or Consultant Registered Dietician (RD) on 1/22/2019. Dietary Manager w	s ger	
	indicated that the refr storage were checked and signs of spoilage her expectation was t should have been three	/22/19 at 9:15 AM. The DM igerators, freezer, and dry d daily for expiration dates. She further indicated that the molded green peppers own away because of the 30/19 and the dessert cups			audit kitchen weekly for expired items. Dietary Manager will randomly audit me service delivery carts one time per week to ensure all items are covered when served, weekly for 4 weeks then month for 2 months.	ek	
	An interview was con Administrator on 01/2 Administrator indicate that food stored in the checked daily for exp spoilage and there sh				4. Effective February 21, 2019, the Dietary Manager will report the findings the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facili remains in compliance.  Nursing Home Administrator and Direct of Nursing are responsible for implementation of the plan.	ee	
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)(		F 8	867	Correction date: Feb 22, 2019		2/22/19
	§483.75(g)(2) The qu assurance committee (ii) Develop and imple	-					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI			، ا	С
		345010	B. WING				25/2019
NAME OF PI	ROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 017.	20/2013
				5	00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVIL	LLE		4	ASHEVILLE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 867	Continued From page	e 27	F	867			
	· ·	is not met as evidenced					
	by:	is not met as evidenced					
	_ ·	ns, record reviews, and staff			F867 QAPI/QAA Improvement Activitie	es	
		s Quality Assessment and					
		nmittee failed to maintain			F640 Encoding/Transmitting Resident		
	implemented procedu				Assessment		
		committee had previously					
		ilure related to two recited			1. Resident #1, Discharge		
		e originally cited following the			Assessment submitted on 1/24/2019 a		
	recited deficiencies w	rtification survey. The			accepted on 1/30/2019 by Minimum Da Set Nurse (MDS Nurse).	ita	
		resident assessments and			Set Nuise (MDS Nuise).		
		biologicals. The continued			2. Casper□s Missing Assessment		
		uring two federal surveys of			Report pulled and reviewed by Minimu		
		of the facility's inability to			Data Set Nurse (MDS Nurse) on		
	sustain an effective C	Quality Assurance Program.			1/29/2019 and Point Click Care ☐s		
					Admit/Discharge To/From Report to ref	lect	
	Findings included:				discharges for the 30-days prior on		
					1/29/2019. Any deficient items were		
	This tag is cross refer	renced to:			corrected by the Minimum Data Set Nu	rse	
	1 a 492 20 Encoding	g/Transmitting Resident			(MDS Nurse).		
		on record review and staff			3. Education provide to Minimum		
		failed to complete and			Data Set Nurse (MDS Nurse) by Regio	nal	
		MDS (Minimum Data Set)			Minimum Data Set Consultant on	i i a i	
	_	e required time frame for 1			2/7/2019, regarding timely completion	and	
	of 1 resident (Resider	nt #1) reviewed for Resident			submission of Discharge Assessments		
	Assessments.				Minimum Data Set Nurse (MDS Nurse	)	
					will provide weekly submission report to		
	During the annual rec				Nursing Home Administrator along with	1	
	04/19/18 the facility w				Point Click Care ☐s Admit/Discharge		
	complete and transmi	_			To/From Report to validate discharge		
	assessments for two	residents.			assessment submission is timely as scheduled. Nursing Home Administrat	or	
	   b_483.45	Drugs and Biologicals:			will pull Casper s Missing Assessmen		
		ns, record review, and staff			Report monthly for 3 months to ensure		
		failed to discard 1 of 2			discharge assessments are completed		
	multi-dose tuberculin				timely.		
		and available for use in 1 of			,		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345010	B. WING		C 01/25/2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804	1 01/20/2010
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 867	of 1 Novolog insulin v days and failed to dis vial that was expired use on 1 of 2 medical.  During the annual rec 04/19/18 the facility w discard 2 opened Nowwere not dated when.  During an interview of Administrator stated so to correct the deficient recertification survey breakdown was a result in Administrative staff corporate ownership. was committed to put address the repeated QA committee would	ators and failed to discard 1 ial that was expired for 31 card 1 of 1 Levemir insulin for 22 days and available for ion carts.  Description survey of the care cited for failure to yolog insulin FlexPens that	F 86	4. Effective February 21, 2019 MDS Coordinator and Nursing Hom Administrator will report the findings audits and reviews to the Quality Assurance and Performance Comm for any additional monitoring or modification of this plan monthly for months. The Quality Assurance amperformance Improvement Committ can modify this plan to ensure the faremains in compliance.  F761 Label/Store Drugs & Biological 1. Expired medications immediated removed from medication cart and medication refrigerator on 1/23/2019 Director of Nursing (DON). Medication replaced with newly delivered Mediconhand.  2. Other 2 medication carts and 2 treatment carts were reviewed by the Nursing Admin Team to include Director (SDC), and no other expired items identified on 1/23/2019.  3. Education provided to licensed by Staff Development Coordinator (regarding medication storage on 2/12/2019. Current licensed nursing will be re-educated prior to working scheduled shift and this education in been added to the new hire orientat The Nursing Admin Team to include Director of Nursing (DON) and/or un Coordinator and Staff Development	ne s of the nittee 3 d d dee acility als tely 9 by dons cations actions are ector of ator nurses (SDC) g staff next has done.

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345010	B. WING			l	C
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVIL		5: *******	50	TREET ADDRESS, CITY, STATE, ZIP CODE  O BEAVERDAM ROAD  SHEVILLE, NC 28804	<u>  U1/</u>	25/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	29	F	867	Coordinator (SDC) will randomly audit carts per week to ensure there are no expired medications present. Weekly audits will be conducted for 4 weeks the monthly for 2 months.  4. Effective February (date of QA meeting), the Nursing Admin Team to include Director of Nursing (DON) and/unit Coordinator and Staff Development Coordinator (SDC) will report the finding of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.  Nursing Home Administrator and Director of Nursing are responsible for implementation of the plan.	en or t gs e	
F 883 SS=E	CFR(s): 483.80(d)(1)(1)( §483.80(d) Influenza immunizations §483.80(d)(1) Influenza policies and procedur (i) Before offering the each resident or the r	and pneumococcal  za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza	F	383	Correction date: Feb 22, 2019		2/22/19

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	· ,	TE SURVEY MPLETED
		345010	B. WING _			C 1/ <b>25/2019</b>
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVII	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		11/23/2013
(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 883	contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's me documentation that in following:  (A) That the resident was provided education and potential side efficient immunization; and (B) That the resident immunization or did not immunization or did not immunization due to refusal.  §483.80(d)(2) Pneumon must develop policies that—  (i) Before offering the immunization, each representative receive benefits and potential immunization;  (ii) Each resident is of immunization, unless medically contraindical already been immunical (iii) The resident or the has the opportunity to (iv)The resident's medocumentation that in following:  (A) That the resident was provided education.	mmunization is medically a resident has already been as time period; e resident's representative or refuse immunization; and dical record includes adicates, at a minimum, the cor resident's representative on regarding the benefits ects of influenza and receive the influenza and receive the influenza and procedures to ensure and procedures are ensured to the immunization is and or the resident has zeed; e resident's representative or refuse immunization; and	F 8	83		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345010	B. WING		,	C 1/ <b>25/2019</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	112012010
				500 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVI	LLE		ASHEVILLE, NC 28804		
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 883	Continued From page	e 31	F 88	33		
	(B) That the resident	either received the				
	. ,	nization or did not receive				
	•	munization due to medical				
	contraindication or re	fusal.				
	This REQUIREMENT	「 is not met as evidenced				
	by:					
		iews and staff interviews, the		F883 Infection Prevention & C	Control	
	•	ss the residents for eligibility				
		were offered the influenza		1. Residents #53, #42, #35		
		accinations upon admittance		contact via phone by the Nurs	-	
	-	of 5 residents reviewed for dent #42, #35 and #53).		Team to include Director of Nu (DON) and/or unit Coordinator		
	illillullizations (Nesic	dent #42, #35 and #35).		Development Coordinator (SD		
	Findings included:			2/2/2019 and preference/cons obtained.		
	The facility's policies	on influenza and		obtained.		
		nizations which were revised		2. 100% audit conducted b	v nursina	
	•	viewed. The pneumococcal		admin on consents/refusal and	-	
	_	ndicated all residents will be		administration on 2/2/2019 by	the Nursing	
		al vaccines. This policy		Admin Team to include Directo	-	
	indicated residents w	ill be offered the vaccine		Nursing (DON) and/or unit Co	ordinator	
	within 30 days of adn	nission to the facility unless		and Staff Development Coordi		
		ated or the resident has		(SDC). Any opportunities were	e corrected.	
	already been vaccina					
		ndicated all resident who		3. Flu/Pneumovax consent		
		traindications to the vaccine		added to the new admission p		
		uenza vaccine annually		checklist. Licensed nurses edu	-	
	between October 1st	and March 31st each year.		the Nursing Admin Team to inc Director of Nursing (DON) and		
	1 Docidont #42 was	admitted to the facility on		Coordinator and Staff Develop		
		ses including: depression,		Coordinator (SDC) on the con-		
	Alzheimer's dementia			new process upon admission		
				Current licensed nursing staff		
	Review of immunizati	ion record for Resident #42		re-educated prior to working n		
	revealed no pneumod			scheduled shift and this educa		
	immunizations had be			been added to the new hire or		
	administered or recei	ved.		The Nursing Admin Team to in	clude	
				Director of Nursing (DON) and		
	An interview with Nur	se #3 (Infection Control		Coordinator and Staff Develor	ment	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(	С
		345010	B. WING			1	25/2019
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	20/2010
				50	00 BEAVERDAM ROAD		
ACCORDI	US HEALTH AT ASHEVII	LLE		A	SHEVILLE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
					,		
F 883	Continued From page	e 32	F	883			
		t 9:10 AM revealed the		000	Coordinator (SDC) will review all new		
	·	the influenza vaccine. She			admits daily (Monday-Friday) for 1 wee	-k	
		did not know if Resident #42			(2/4/19 - 2/8/19) for consent forms and		
		umococcal vaccine or not.			follow-up. Director of Nursing (DON)		
	-	ould have been done, but			and/or unit Coordinator and Staff		
		The Infection Control Nurse			Development Coordinator (SDC) will		
		nsible for obtaining consent,			randomly audit 3 charts per week for		
	-	cines and maintaining			flu/pneumovax		
	surveillance data on a				consent/refusal/administration weekly	for	
		urse #3 explained the facility			4 weeks (starting 2/11/19) then monthl		
	policy for the pneumo	coccal vaccine was each			for 2 months.	-	
		sessed within 5 working days					
	of the resident's admi	ssion and for the influenza			4. Effective February 21, 2019, the		
	vaccine, residents wil	I be offered the influenza			Nursing Admin Team to include Director	or of	
	vaccine between Octo	ober 1st and March 31st of			Nursing (DON) and/or unit Coordinator		
	each year. In addition				and Staff Development Coordinator (S		
		and March 31st will be			will report the findings of the audits and	d	
		ithin 5 working days of			reviews to the Quality Assurance and	_	
	admission.				Performance Committee for any additi	onal	
	A :	divide di with the Discotor of			monitoring or modification of this plan		
		ducted with the Director of			monthly for 3 months. The Quality	oont	
		/25/19 at 9:51 AM regarding occal and influenza vaccines.			Assurance and performance Improven Committee can modify this plan to ens		
		that Nurse #3 would have			the facility remains in compliance.	ui <del>C</del>	
	·	s and documentation. She			the facility remains in compliance.		
	further stated she was				Nursing Home Administrator and Direc	tor	
		umococcal and influenza			of Nursing are responsible for		
		ocumentation system due to			implementation of the plan.		
		s and she had provided an					
		ction Control Nurse to use to			Correction date: Feb 22, 2019		
	facilitate this process	. She further stated she did					
		his audit tool had not been					
	utilized and the proce	•					
	An interview was con						
	Administrator on 01/2						
	_ ·	ion was for the nurses to					
	-	documentation as per the					
	facility policy.						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		345010	B. WING		01/25	/2019
	ROVIDER OR SUPPLIER	/ILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		1 01/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 883	08/03/18 with diagn	s admitted to the facility on oses including: hypertension, acture, non-Alzheimer's	F 88	3		
	revealed no pneum immunizations had An interview with N Nurse) on 01/25/19 resident had not ha	ation record for Resident #53 ococcal or influenza been documented.  urse #3 (Infection Control at 9:10 AM revealed the d the influenza vaccine. She				
	had received the pr The Infection Contr been done, but she stated she was resp administering the va surveillance data or	e did not know if Resident #53 neumococcal vaccine or not. of Nurse stated it should have had not done it. Nurse #3 nonsible for obtaining consent, accines and maintaining n all pneumococcal and Nurse #3 explained the facility				
	policy for the pneur resident would be a of the resident's ad vaccine, residents v vaccine between O each year. In additi- between October 1st offered the vaccine	nococcal vaccine was each ssessed within 5 working days mission and for the influenza will be offered the influenza ctober 1st and March 31st of on, residents admitted at and March 31st will be within 5 working days of				
	Nursing (DON) on ( the lack of pneumon Her expectation wa provided the vaccin further stated she w problem with the pri administration and of	onducted with the Director of 01/25/19 at 9:51 AM regarding coccal and influenza vaccines. Is that Nurse #3 would have es and documentation. She was aware there was a leumococcal and influenza documentation system due to es and she had provided an				

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED	
	345010	B. WING		C 01/25/2019	
ROVIDER OR SUPPLIER  JS HEALTH AT ASHEV	1000		STREET ADDRESS, CITY, STATE, ZIP CODE  500 BEAVERDAM ROAD  ASHEVILLE, NC 28804	1 01/25/2015	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
audit tool for the Infercialitate this process not understand why utilized and the process. An interview was conducted and the process. An interview was conducted and the process. Administrator on 01 revealed his expectatorized and facility policy.  3. Resident #35 was 06/21/18 with diagnical following joint replaced. Review of immunization revealed the influen on 10/19/18. Furthed documentation of the further revealed she had not had further revealed she had received the process. And interview with Nurse #3 stated it she had not done it stated she was respandinistering the vasurveillance data or influenza vaccines. Policy for the pneum resident would be an of the resident's adrivaccine, residents wascine between Occario.	ection Control Nurse to use to s. She further stated she did this audit tool had not been cess improved.  Inducted with the /25/19 at 3:17 PM. He ation was for the nurses to id documentation as per the did documentation as per the seation record for Resident #35 is a vaccine was administered in record review revealed note pneumococcal vaccine.  Inse #3 (Infection Control at 9:10 AM revealed the did the influenza vaccine. She is did not know if Resident #35 is eumococcal vaccine or not. The Infection Control Nurse is onsible for obtaining consent, accines and maintaining in all pneumococcal and Nurse #3 explained the facility inococcal vaccine was each sessesed within 5 working days mission and for the influenza otober 1st and March 31st of	F 88	33		
	SUMMARY S (EACH DEFICIEN REGULATORY OF  Continued From pag audit tool for the Infe facilitate this proces not understand why utilized and the proc  An interview was co Administrator on 01 revealed his expect provide vaccines an facility policy.  3. Resident #35 was 06/21/18 with diagn following joint replace Review of immunizar revealed the influen on 10/19/18. Furthe documentation of the An interview with Nt Nurse) on 01/25/19 resident had not had further revealed she had received the pn Nurse #3 stated it si she had not done it. stated she was resp administering the va surveillance data or influenza vaccines. policy for the pneum resident would be a of the resident's adr vaccine, residents of each year. In addition between October 1s	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 34 audit tool for the Infection Control Nurse to use to facilitate this process. She further stated she did not understand why this audit tool had not been utilized and the process improved.  An interview was conducted with the Administrator on 01/25/19 at 3:17 PM. He revealed his expectation was for the nurses to provide vaccines and documentation as per the	CONTIDENTIFICATION NUMBER:  345010  B. WING  COVIDER OR SUPPLIER  JS HEALTH AT ASHEVILE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 34  audit tool for the Infection Control Nurse to use to facilitate this process. She further stated she did not understand why this audit tool had not been utilized and the process improved.  An interview was conducted with the Administrator on 01/25/19 at 3:17 PM. He revealed his expectation was for the nurses to provide vaccines and documentation as per the facility policy.  3. Resident #35 was admitted to the facility on 06/21/18 with diagnoses including: aftercare following joint replacement surgery.  Review of immunization record for Resident #35 revealed the influenza vaccine was administered on 10/19/18. Further record review revealed no documentation of the pneumococcal vaccine.  An interview with Nurse #3 (Infection Control Nurse) on 01/25/19 at 9:10 AM revealed the resident had not had the influenza vaccine. She further revealed she did not know if Resident #35 had received the pneumococcal vaccine or not. Nurse #3 stated it should have been done, but she had not done it. The Infection Control Nurse stated she was responsible for obtaining consent, administering the vaccines and maintaining surveillance data on all pneumococcal and influenza vaccines. Nurse #3 explained the facility policy for the pneumococcal vaccine was each resident would be assessed within 5 working days of the resident's admission and for the influenza vaccine between October 1st and March 31st will be	TOWNER OR SUPPLIER  345010  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC. 28804  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 34  audit tool for the Infection Control Nurse to use to facilitate this process. She further stated she did not understand why this audit tool had not been utilized and the process improved.  An interview was conducted with the Administrator on 01/25/19 at 3:17 PM. He revealed his expectation was for the nurses to provide vaccines and documentation as per the facility policy.  3. Resident #35 was admitted to the facility on 06/21/18 with diagnoses including: aftercare following joint replacement surgery.  Review of immunization record for Resident #35 revealed the influenza vaccine was administered on 10/19/18. Further record review revealed no documentation of the pneumococcal vaccine. She further revealed she did not know if Resident #35 had received the pneumococcal vaccine or not. Nurse #3 stated it should have been done, but she had not done it. The Infection Control Nurse stated she was responsible for obtaining consent, administering the vaccines and maintaining surveillance data on all pneumococcal and influenza vaccines. Nurse #3 explained the facility policy for the pneumococcal and influenza vaccines was eased within 5 working days of the residents will be offered the influenza vaccine between October 1st and March 31st of each year. In addition, residents admitted between October 1st and March 31st will be	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
						С
		345010	B. WING _		1	01/25/2019
	ROVIDER OR SUPPLIER  US HEALTH AT ASHEVIL	LE		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BEAVERDAM ROAD ASHEVILLE, NC 28804		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 883	admission.  An interview was con Nursing (DON) on 01 the lack of pneumocod Her expectation was provided the vaccines further stated she was problem with the pneudministration and domultiple staff changes audit tool for the Infect facilitate this process not understand why the utilized and the process.  An interview was con Administrator on 01/2 revealed his expectation.	ducted with the Director of /25/19 at 9:51 AM regarding ccal and influenza vaccines. that Nurse #3 would have and documentation. She aware there was a umococcal and influenza cumentation system due to and she had provided an action Control Nurse to use to She further stated she didnis audit tool had not been se improved.	F8	83		