STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345432	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 9/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN NORTH CAROLINA BAPTIST HOME	**213 RICHMOND HILL DRIVE ASHEVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 2 residents reviewed for resident assessments (Resident #26). Findings included: Resident #26 was admitted to the facility on 03/13/23.

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 640

Continued From Page 1

Review of the facility's resident census dated 09/11/23 revealed that Resident #26 resided in a room that was licensed only (meaning neither Medicare nor Medicaid certified).

Review of Resident #26's medical record on 09/12/23 revealed an admission MDS assessment dated 03/20/23 and a Medicare Part-A end of stay PPS (Prospective Payment System) assessment dated 04/01/23.

During an interview on 09/13/23 at 2:15 PM, the MDS Coordinator explained that Resident #26 had a Medicare Part A skilled stay from 03/14/23 to 04/01/23 at which point she resided in a Medicare/Medicaid certified room. She stated when Resident #26's skilled stay ended, she was transferred to a room that was licensed only. The MDS Coordinator stated a discharge MDS assessment should have been completed when Resident #26's skilled stay ended on 04/01/23.

During an interview on 09/14/23 at 4:52 PM, the Administrator stated it was his expectation for staff to follow the MDS guidelines and complete assessments within the regulatory timeframes.

F 641

Accuracy of Assessments
CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to accurately code a Minimum Data Set (MDS) assessment in the area of antipsychotic medication use for 1 of 5 residents reviewed for unnecessary medications (Resident #36).

Findings included:

Resident #36 was admitted to the facility 10/25/21 with diagnoses including non-Alzheimer's dementia and psychotic disorder.

Review of Resident #36's Physician orders revealed an order dated 12/30/22 for Quetiapine (an antipsychotic medication) 50 milligrams (mg) twice a day.

Resident #36's Medication Administration Record (MAR) for June 2023 revealed she received Quetiapine as ordered.

The quarterly Minimum Data Set (MDS) dated 07/01/23 revealed Resident #36 was severely cognitively impaired and did not receive antipsychotic medication in the 7-day look back period.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 2 An interview with the MDS Coordinator on 09/14/23 at 10:12 AM revealed Resident #36's quarterly MDS should have been coded to reflect she received antipsychotic medication and it was overlooked. An interview with the Director of Nursing (DON) on 09/14/23 at 10:29 AM revealed she expected the MDS to be coded accurately. An interview with the Administrator on 09/14/23 at 4:49 PM revealed he expected the MDS to be coded accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN NORTH CAROLINA BAPTIST HOME	213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigaiton survey was conducted on 09/11/23 through 09/15/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID#9EVT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/11/23 through 09/15/23. Event ID# 9EVT11. The following intakes were investigated: NC00203643, NC00197533, NC00197833, NC00203575, NC00203330, and NC00195222. One of the seventeen complaint allegations resulted in deficiency. Substandard Quality of Care was identifed at: CFR 483.12 at tag F607 at a scope and severity of F. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		10/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident was treated with dignity and respect when Nurse Aide (NA) #2 was observed speaking to a resident in a disrespectful manner for 1 of 1 resident reviewed for dignity (Resident #60). The findings included: Resident #60 was admitted to the facility on 08/03/2022, transitioned to Hospice care on	F 550	F550 #1 Resident #60 no longer resides at the facility. Nurse Aide #2 is no longer employed at the facility. #2 Facility residents have the potential to be affected by the deficient practice. The Social Worker conducted interviews on 10/05/23 with facility residents to ascertain	

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	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 550	Continued From page 2 07/26/2022 and expired on 11/6/2022. The quarterly Minimum Data Set (MDS) dated 08/07/2022 revealed Resident #60 had intact cognition and required extensive assistance with activities of daily living. During an interview on 09/13/2023 at 1:46 PM, Nurse Aide (NA) #1 stated she assisted NA #2 provide incontinence care for Resident #60 on 11/05/2022 around shift change. Resident #60 was total care and required 2 person-assist. Resident #60 had taken his clothes off, threw his diaper on the floor and had soiled himself. While providing care, NA #2 was yelling at Resident #60 and told him, he was stupid, he shouldn't be acting this way, he knew better and there was no need for his stupid shit. NA #1 further stated that it was a busy shift, and she did not have time to report the incident. NA #1 explained the following day, she reported the incident to the nursing supervisor. An interview was conducted with the Nursing Supervisor #1 on 09/13/2023 at 2:46 PM. The Nursing Supervisor stated NA #1 reported that NA #2 verbalized frustration towards Resident #60 and she used "foul language". Nursing Supervisor #1 was not sure what day this occurred but believed it was on a weekend in November 2022. Nursing Supervisor #1 indicated she reported the incident to the Administrator on the following day. On 09/14/2023 at 4:15 PM an interview was conducted with the Administrator. The Administrator stated the staff did not inform him about the incident involving NA #2 and Resident #60 in a timely manner. The incident occurred on	F 550	any further concerns from staff talking in a disrespectful manner. No further concerns were verbalized. #3 Facility staff were re-educated by the Administrator/Designee regarding Resident Rights. Any staff not receiving the education by 10/17/23 will complete prior to their next scheduled shift. All newly hired and agency staff will receive training during their on-boarding. The Administrator or Designee will conduct staff to resident interaction audits 5x/week for 4 weeks, then weekly for 8 weeks. #4 The Administrator will present the results of the audits to the Quality Assurance Performance Improvement (QAPI) members monthly x3 months or until a time determined by the QAPI members. The Administrator is responsible for ensuring the plan of correction is executed and on-going compliance is sustained. Completion Date: 10/17/23	

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F 550	Continued From page 3 11/05/2022 and he was notified on 11/08/2022. He also stated he expected all residents to be treated with dignity and respect.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582		10/17/23

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F 582	Continued From page 4 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide completed Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary notification review (Residents #9 and #21). The Findings Included: 1. Resident #9 was admitted to the facility on 08/10/23. Review of the medical record revealed a Notice of Medicare Non-Coverage (NOMNC) was discussed with Resident #9's Responsible Party (RP) on 08/23/23 which indicated Resident #9's Medicare Part A coverage for skilled services would end on 08/25/23. Resident #9 remained in	F 582	F582 #1 Residents #9 and #21 were provided information regarding the Skilled Nursing Facility Advanced Beneficiary notices (SNFABN) by the Social Worker on 10/06/23. Residents verbalized understanding. The Social Worker was re-educated by the Administrator on 10/04/23 regarding the protocol for the SNFABN. #2 Facility residents with Medicare as payor source have the potential to be affected by the deficient practice. The Social Worker reviewed resident notices on 10/05/23 to ascertain any further residents not receiving SNFABN since survey, no further issues identified.	

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F 582	Continued From page 5 the facility. Review of Resident #9's medical record revealed no evidence a SNF-ABN was also provided to Resident #9's RP. During an interview on 09/12/23 at 5:14 PM, the Social Worker explained he used to issue a SNF-ABN in conjunction with a NOMNC when a resident's Medicare Part A services ended but was instructed by the previous corporate representative that he only needed to issue a SNF-ABN when a resident returned to a lower level of care, such as an assisted living facility, and not when they remained in long-term care. The SW confirmed that Resident #9's RP was not issued a SNF-ABN when his Medicare skilled services ended on 08/25/23. During an interview on 09/14/23 at 4:42 PM, the Administrator confirmed he was aware SNF-ABNs were no longer being issued except under certain circumstances. He explained they had changed their process based on the guidance received by the previous corporation. 2. Resident #21 was admitted to the facility on 07/21/23. Review of the medical record revealed a Notice of Medicare Non-Coverage (NOMNC) was discussed with Resident #21's Responsible Party (RP) on 08/21/23 which indicated Resident #21's Medicare Part A coverage for skilled services would end on 08/21/23. Resident #9 remained in the facility. Review of Resident #21's medical record revealed no evidence a SNF-ABN was also	F 582	#3 The facility will utilize a tracking log to ensure residents requiring SNFABN receive per the requirement. The Administrator will complete an audit on delivery of SNFABN 5x/week for 4 weeks, then weekly for 8 weeks to ascertain regulatory compliance. #4 The Administrator will present the results of the audits to the Quality Assurance Performance Improvement (QAPI) members monthly x3 months or until a time determined by the QAPI members. The Administrator is responsible for ensuring the plan of correction is executed and on-going compliance is sustained. Date of Completion: 10/171/23	

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F 582	Continued From page 6 provided to Resident #21's RP. During an interview on 09/12/23 at 5:14 PM, the Social Worker explained he used to issue a SNF-ABN in conjunction with a NOMNC when a resident's Medicare Part A services ended but was instructed by the previous corporate representative that he only needed to issue a SNF-ABN when a resident returned to a lower level of care, such as an assisted living facility and not when they remained in long-term care. The SW explained 08/21/23 was the date he discussed the NOMNC with Resident #21's RP but she had actually remained on Medicare Part-A skilled services through 09/06/23. He confirmed Resident #21's RP was not issued a SNF-ABN when her Medicare skilled services ended on 09/06/23. During an interview on 09/14/23 at 4:42 PM, the Administrator confirmed he was aware SNF-ABNs were no longer being issued except under certain circumstances. He explained they had changed their process based on the guidance received by the previous corporation.	F 582		
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		10/17/23

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F 607	Continued From page 7 §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and review of the facility's abuse policies and procedures the facility failed to develop an abuse policy that included procedures related to screening, training, prevention, identification, investigation, protection, reporting/response, and coordination with QAPI to address allegations of abuse. The findings included: The facility's Abuse Policy titled Elder/Dependent Adult Abuse Assessment and Reporting, dated July 2011 revealed "all alleged violations involving mistreatment, neglect, abuse, including injuries of unknown origin, will be reported immediately to the Department Supervisor who will forward the complaint to the Administrator". It is the policy of	F 607	F607 #1 The new ownership Abuse Policy and Procedure was implemented on 9/18/23 that includes screening, training, prevention identification, and coordination regarding Abuse. #2 Facility residents have the potential to be affected by the deficient practice. The Administrator and Business Office Manager audited all staff HR (Human Resource) files to ascertain they signed the abuse Policy. Any file not containing the signature of Abuse Policy reciept recieved education and provided attestation.	

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F 607	Continued From page 8 the facility to report any suspected cases of elder abuse or dependent adult abuse. Employees subject to the reporting requirements include any employees who provides direct resident care and any other employee whose duties require him/her to regularly work directly with elders or dependent adults. The policy failed to include written procedures for screening potential employees, training of new and existing staff members, prevention, identification, reporting/response, coordination with QAPI and investigation of all types of abuse, neglect, and misappropriation of property. On 09/14/2023 at 4:15 PM an interview was conducted with the Administrator. The Administrator indicated the facility's abuse and neglect policies did not include screening, training, prevention, identification, investigation, protection, and reporting/response. He stated these were corporate policies and he could not verbalize why they did not contain the required elements. He further added he was aware of the abuse and neglect regulations.	F 607	All residents have the potential to be affected by the deficient practice, the Social Worker re-educated the residents regarding the Abuse Policy and Procedure to be completed by 10/09/23. The Abuse Policy and Procedure will be reviewed during the monthly Resident Council meetings. #3 Facility staff were re-educated by the Administrator/Designee regarding the Abuse Policy and Procedure. Any staff not receiving the education by 10/17/23 will complete prior to their next scheduled shift. All newly hired and agency staff will receive training during their on-boarding. The Administrator or Designee will conduct new hire and agency audits 5x/week for 4 weeks, then weekly for 8 weeks to ensure training is completed. #4 The Administrator will present the results of the audits to the Quality Assurance Performance Improvement (QAPI) members monthly x3 months or until a time determined by the QAPI members. The Administrator is responsible for ensuring the plan of correction is executed and on-going compliance is sustained. Completion Date: 10/17/2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/17/23

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(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 9 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to date opened food, remove expired food available for use, and indicate the expiration date of thawed milkshakes for 1 of 1 walk-in cooler; failed to date and cover food item in 1 of 1 walk-in freezer; failed to label and date food and beverage items, indicate the expiration date of thawed milkshakes, and remove expired food available for use in 2 of 2 nourishment rooms (upper and lower floor nourishment rooms). This practice had the potential to affect food served to residents. Findings included: 1. An initial tour of the walk-in cooler on 09/11/23 at 9:42 AM revealed the following: a. 5 thawed chocolate milkshakes sitting on a cart and 8 thawed milkshakes and 2 boxes of	F 812	F812 #1 The items identified during the survey in the walk-in in cooler and freezer, were discarded on 9/11/2023 by Dietary Manager. The items identified during the survey in the upper floor nourishment room refrigerator, and lower floor nourishment room were discarded on 9/12/2023 by the Director of Nursing. The Administrator completed re-education with the Dietary Manager on 9/12/23, the Dietary Manager verbalized understanding. #2 The Dietary Manager completed an audit of all nourishment rooms, refrigerators, and Freezers for any opened, undated, and/or expired items on 9/12/23. There	

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	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 812	Continued From page 10 thawed milkshakes each containing 50 milkshakes sitting on a shelf. The manufacturer instructions stamped on each carton of milkshake indicated the product was good for 14 days after thawed. None of the milkshakes had a date indicating when they were placed in the cooler to thaw or when they expired. b. an opened 5-pound container of pimento cheese dated as being opened on 09/01/23 c. an opened 5-pound container of pimento cheese with no open date d. an opened 5-pound container of coleslaw dated as being opened 08/24/23 2. An initial tour of the walk-in freezer on 09/11/23 at 9:50 AM revealed an opened 5-pound bag of french fries exposed to air with no open date. An interview with the Certified Dietary Manager (CDM) on 09/11/23 at 9:55 AM revealed the milkshakes should have a date of when they were placed in the walk-in cooler, and they were good for 14 days after being thawed. The CDM stated all items should be dated when they were opened, and pimento cheese and coleslaw were good for 7 days after being opened. She stated the french fries should have been covered with plastic wrap and dated when they were opened. The CDM stated items should be labeled and dated by the person who placed them in the cooler or freezer and all staff were responsible for checking for and removing expired items. She explained several of her staff had been out sick and that contributed to items not being labeled, stored correctly, or not being discarded when indicated. An interview with the Administrator on 09/14/23 at	F 812	were no further observations of any opened, undated, and/or expired items. #3 Facility staff were re-educated by the Administrator/Designee regarding Food Storage. Any staff not receiving the education by 10/17/23 will complete prior to their next scheduled shift. All newly hired and agency staff will receive training during their on-boarding. The Administrator or Designee will complete audits of food storage in the dietary department and nourishment rooms 5x/week for 4 weeks, then weekly for 8 weeks. #4 The Administrator will present the results of the audits to the Quality Assurance Performance Improvement (QAPI) members monthly x3 months or until a time determined by the QAPI members. The Dietary Manager is responsible for ensuring the plan of correction is executed and the Administrator responsible to ensure on-going compliance is sustained. Completion Date: 10/17/2023	

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	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 812	Continued From page 11	F 812		

4:49 PM revealed he expected all food and beverage items to be labeled, dated, and stored correctly. He stated he expected food to be used or discarded by the expiration date.

3. An observation of the upper floor nourishment room refrigerator on 09/11/23 at 3:37 PM revealed the following:

a. 2 thawed milkshakes sitting on a shelf. The manufacturer instructions stamped on each carton of milkshake indicated the product was good for 14 days after thawed. The milkshakes did not have a date of when they were placed in the refrigerator or when they expired.
b. an undated bowl of applesauce
c. 3 opened and undated 32-ounce containers of fortified nutrition shakes
d. an undated and unlabeled ham and cheese sandwich
e. an undated and unlabeled bowl of soup
f. 2 opened, undated, and unlabeled 8-ounce containers of cream cheese

4. An observation of the upper floor nourishment room freezer on 09/11/23 at 3:50 PM revealed the following:

a. 2 unlabeled frozen meals
b. an unlabeled, undated frozen meal not contained in a box with multiple ice crystals
c. 2 opened, undated, and unlabeled 1.5-quart containers of ice cream
d. an opened, undated, and unlabeled pint of ice cream
e. an opened, undated, and unlabeled 20-ounce bottle of frozen diet soda

5. An observation of the cabinets in the upper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 12	F 812		

floor nourishment room on 09/11/23 at 4:00 PM revealed the following:

a. 2 opened and undated 16-ounce jars of peanut butter
b. an opened, undated, and labeled 26.5-ounce container of chocolate hazelnut spread

An interview with the Certified Dietary Manager (CDM) on 09/11/23 at 4:11 PM revealed the milkshakes should have a date of when they were thawed and were only good for 14 days after being thawed. She stated all food/beverages should have a label and date of when they were placed in the nourishment room and the person placing the item in the nourishment room was responsible for labeling and dating the item. The CDM stated a lot of families placed items in the nourishment room and did not label or date the items. She stated she wasn't sure of who was responsible for checking to ensure items were labeled and dated and discarded when expired.

An interview with the Administrator on 09/14/23 at 4:49 PM revealed he expected all opened food items to be labeled and dated. He stated dietary should check the nourishment rooms to make sure items were labeled and dated and to remove expired foods when they replenished supplies. The Administrator also stated the nursing department was responsible for labeling and dating items when they placed them in the nourishment rooms.

6. An observation of the lower floor nourishment room refrigerator on 09/11/23 at 4:19 PM revealed the following:

a. an opened, undated, and unlabeled 9-ounce

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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WESTERN NORTH CAROLINA BAPTIST HOME	213 RICHMOND HILL DRIVE ASHEVILLE, NC 28806

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F 812	Continued From page 13	F 812		

bottle of salad dressing
b. an opened container of what appeared to be peanut butter with no label or date
c. an unlabeled bag of carrots with an expiration date of 09/08/23
d. an unlabeled bag of carrots with a best-by date of 08/30/23
e. an undated and unlabeled plastic bag containing onions and peppers
f. an undated bowl of applesauce
g. an undated bowl of gravy
h. an unlabeled 5-ounce container of yogurt
i. an opened, undated, and unlabeled 8-ounce container of hummus
j. an unlabeled 15.2-ounce container of juice with an expiration date of 09/07/23
k. an unlabeled bag of cheddar cheese crackers with an expiration date of 07/24/23

7. An observation of the lower floor nourishment room freezer on 09/11/23 at 4:26 PM revealed the following:

a. 2 opened, undated, and unlabeled 1.5-quart containers of ice cream
b. an opened and unlabeled 10-ounce bag of avocado chunks

An interview with the Certified Dietary Manager (CDM) on 09/11/23 at 4:30 PM revealed all food/beverages should have a label and date of when they were placed in the nourishment room and the person placing the item in the nourishment room was responsible for labeling and dating the item. She stated a lot of families placed items in the nourishment room and did not label or date the items. She stated she wasn't sure of who was responsible for checking to ensure items were labeled and dated and

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	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 812	Continued From page 14 discarded when expired. An interview with the Administrator on 09/14/23 at 4:49 PM revealed he expected all opened food items to be labeled and dated. He stated dietary should check the nourishment rooms to make sure items were labeled and dated and to remove expired foods when they replenished supplies. The Administrator also stated the nursing department was responsible for labeling and dating items when they placed them in the nourishment rooms.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance	F 867		10/17/23

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F 867	Continued From page 15 indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities.	F 867		

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F 867	Continued From page 16 §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through	F 867		

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F 867	Continued From page 17 (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey completed on 03/25/22. This was for three repeat deficiencies originally cited in the areas of accuracy of assessments, food procurement - store/prepare/serve, and infection control that were subsequently recited on the current recertification and complaint investigation survey of 09/15/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F641: Based on record review and staff interviews the facility failed to accurately code a Minimum Data Set (MDS) assessment in the area of antipsychotic medication use for 1 of 5 residents reviewed for unnecessary medications (Resident #36).	F 867	F867 #1 The Minimum Data Set (MDS) for resident #36 was corrected on 9/14/23 by the MDS Nurse. The items identified during the survey in the walk-in in cooler and freezer, were discarded on 9/11/2023 by Dietary Manager. The items identified during the survey in the upper floor nourishment room refrigerator, and lower floor nourishment room were discarded on 9/12/2023 by the Director of Nursing. The Administrator completed re-education with the Dietary Manager on 9/12/23, the Dietary Manager verbalized understanding. The contractors were provided education regarding Special Droplet Contact Precautions by the Maintenance Director on 9/12/23. The contractors verbalized understanding. #2 Facility residents have the potential to be affected by the deficient practice. On 10/06/23, the Minimum Data Set (MDS) Nurse audited resident MDS Assessments for the past 30 days to	

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	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 867	Continued From page 18 During the recertification and complaint investigation survey of 03/25/22, the facility failed to accurately code MDS assessments in the areas of unnecessary medications and falls. F812: Based on observations and staff interviews the facility failed to date opened food, remove expired food available for use, and indicate the expiration date of thawed milkshakes for 1 of 1 walk-in cooler; failed to date and cover food item in 1 of 1 walk-in freezer; failed to label and date food and beverage items, indicate the expiration date of thawed milkshakes, and remove expired food available for use in 2 of 2 nourishment rooms (upper and lower floor nourishment rooms). This practice had the potential to affect food served to residents. During the recertification and complaint investigation survey of 03/25/22, the facility failed to ensure dietary staff kept their hair covered during meal service. F880: Based on observations and staff interviews, the facility failed to ensure 2 of 2 facility contractors followed the "Special Droplet Contact Precautions" signage posted on the doors of residents' rooms by not donning and doffing Personal Protective Equipment (PPE) while entering and exiting 2 of 6 resident rooms on transmission-based precautions (TBP) for COVID-19. During the recertification and complaint investigation survey of 03/25/22, the facility failed to implement a Legionella (bacteria) prevention program and failed to ensure staff followed the facility's infection control policy and procedures related to hand hygiene.	F 867	ensure they were coded properly with prescribed Antipsychotics. No further missing coding was noted. The Dietary Manager completed an audit of all nourishment rooms, refrigerators, and Freezers on 9/12/23 to ascertain any further undated opened items. No further observations noted. Facility residents have the potential to be affected by the same deficient practice. The Director of Nursing and Maintenance Director completed rounds to ensure all contractors were adhering to the Special Droplet Contact Precautions, no further observations noted of non-compliance. Contractors verbalized understanding. #3 All staff were re-educated regarding the Quality Assurance Performance Improvement (QAPI) requirements. Any staff not receiving education by 10/17/23 will receive prior to their next scheduled shift. The Facility Management Team were re-educated by the Administrator on 10/06/23 regarding QAPI program requirements. The QAPI template was revised to include any current citations, audits, and statistics of audits with the QAPI Team Members. The next QAPI Meeting is scheduled for 10/16/2023. The Corporate Staff will audit Monthly QAPI meetings Monthly x3 months to ensure program guidelines are followed. #4 The Administrator will present the results of the audits to the Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 867	Continued From page 19 During an interview on 09/15/23 at 11:46 AM, the Administrator revealed one contributing factor to the repeat concerns with MDS was that the facility had contracted with an outside company to complete MDS assessments due to staff turnover. However, the since contracted company was based offsite, things got overlooked and the process had proved to be dysfunctional, so they brought it back in-house with the recent addition of the full-time MDS Coordinator. The Administrator explained that after the recertification survey of March 2022, staff were provided reeducation and they had noticed improvement with the systems the QA Committee had put into place for dietary and infection control through ongoing observations. The Administrator stated he felt the repeat concerns for dietary and infection control were the result of staff being tired from working overtime to cover shifts due to the recent rise in COVID outbreaks as well as the number of contracted employees hired by the new ownership coming in and out of the facility switching over the IT processes. The Administrator stated he felt things would improve with the Interdisciplinary Team the facility now had and hoped Administration with the new ownership would continue with the processes he has put into place to ensure ongoing compliance was achieved.	F 867	Performance Improvement (QAPI) members monthly x3 months or until a time determined by the QAPI members. The Administrator is responsible for ensuring the plan of correction is executed and on-going compliance is sustained. Completion Date: 10/17/2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		10/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 20	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 880	Continued From page 21 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure 2 of 2 facility contractors followed the "Special Droplet Contact Precautions" signage posted on the doors of residents' rooms by not donning and doffing Personal Protective Equipment (PPE) while entering and exiting 2 of 6 resident rooms on transmission-based precautions (TBP) for COVID-19. The findings included: The Special Droplet Contact Precautions (SDCP) signage, with a revised date of 02/09/22, noted staff should follow the instructions listed on the signage before entering the resident's room	F 880	F880 #1 The contractors were provided education regarding Special Droplet Contact Precautions by the Maintenance Director on 9/12/23. The contractors verbalized understanding. #2 Facility residents have the potential to be affected by the same deficient practice. The Director of Nursing (DON) and Maintenance Director completed rounds to ensure all contractors were adhering to the Special Droplet Contact Precautions, no further observations noted of non-compliance. Contractors verbalized	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. BUILDING _____ B. WING _____	C 09/15/2023

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F 880	Continued From page 22 which included: "all healthcare personnel must: 1) clean hands before entering and when leaving the room, 2) wear a gown when entering room and remove before leaving, 3) wear N95 or higher level respirator before entering the room and remove after exiting, 4) wear protective eyewear (face shield or goggles), and 5) wear gloves when entering room and remove before leaving." A continuous observation on 09/12/23 from 9:50 AM to 10:00 AM of the lower C hall revealed Contractor #1 and Contractor #2 entered room C13 wearing only N95 masks that had SDCP signage posted on the room door and a PPE cart outside of it without sanitizing their hands or donning any personal protective equipment (PPE) per the instructions on the signage. Contractor #1 and Contractor #2 were observed exiting room C13 without sanitizing their hands or removing their mask and went directly across the hall to room C14, that also had SDCP signage posted on the door and a PPE cart outside of it, without sanitizing their hands or donning PPE. A joint interview with Contractor #1 and Contractor #2 and Medication Aide #1 was conducted on 9/12/23 at 10:03 AM. Medication Aide #1 stated the Contractors should be putting on gowns and gloves upon entering TBP rooms. She further revealed there were signs present on the doors and PPE carts outside of the rooms. Contractor #1 stated that no one informed him there were rooms on TBP for COVID-19 down that hall. An interview on 9/12/23 at 10:09 AM with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) revealed their expectation was the contractors should be	F 880	understanding. #3 Any facility contractors entering facility that may need to access any resident room in isolation will be provided education by the Assistant Director of Nursing (ADON) or Designee regarding required precautions prior to going on to the nursing units. Facility staff were re-educated regarding Special Droplet Contract Precautions by the Administrator or Designee. Any staff not receiving education by 10/17/23 will receive prior to their next scheduled shift. All newly hired and agency staff will receive training during their on-boarding. Random Audits will be completed by the Assistant Director of Nursing (ADON) or Designee regarding Personal Protective Equipment (PPE) when Isolation precautions in place 5x/week for 4 weeks, then weekly for 8 weeks. #4 The Director of Nursing will present the results of the audits to the Quality Assurance Performance Improvement (QAPI) members monthly x3 months or until a time determined by the QAPI members. The Director of Nursing is responsible for ensuring the plan of correction is executed and Administrator responsible to ensure on-going compliance is sustained. Completion Date: 10/17/2023	

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F 880	Continued From page 23 following the instructions on the TBP signage and wearing masks, gloves, and gowns prior to entering the rooms. An interview with the Administrator on 9/14/23 at 10:50 AM revealed his expectation was that contracted staff followed the same infection prevention policy that the rest of the staff did. The Administrator further revealed contractors were difficult to keep track of with coming in and out of the facility due to the new company communicating directly with the contract staff to switch out the facility's television service provider.	F 880		