Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an initial survey and complaint investigation on December 5-9, 2016. The complaint investigations were initiated by Buncombe County Department of Social Services on November 21, 2016.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the physician for 1 of 5 sampled resident (Resident #5) with a diagnosis of obstructive sleep apnea was notified regarding orders for Continuous Positive Airway Pressure (CPAP) therapy. The findings are: Review on 12/5/16 of Resident #5's current FL2 dated 8/18/16 revealed: -Diagnoses included diabetes mellitus II, hypertension, congestive heart failure, edema, chronic obstructive pulmonary disease, pulmonary embolism with infarct (a blood clot in the lung resulting in a localized area of cell death), obstructive sleep apnea, and aortic valve disease with valve replacement surgery in July 2016.	D 273	Response to D273 (CPAP) (B) On 12/8/16 Resident # 5s primary care provider had been notified of the residents desire to use his CPAP machine and requested an order for its use. An order was received for a sleep study to be conducted and it took place on 1/4/17. The facility, primary care provider, and the DME Company are awaiting the results of the study. Once the results are received the primary care provider will make recommendations to the facility and DME Company to the proper kind of equipment, and its use with the resident. See Exhibit A1, A2. An audit of all residents' rooms will be conducted within the community. We will also audit for the proper equipment and/or use of any other in-house residents who are currently using a CPAP machines, the audit will be completed by 1/20/17. Going forward, any unresolved orders, not clarified within 24 hours, will require notification of the HCC.	

Division of Health Service Regulation

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

Executive Director
1-13-17

Reviewed and accepted
Susan Hake, RN
1/18/17

January 13, 2017

Susan Habel, Facility Survey Consultant

Adult Care Licensure Section

2708 Mail Service Center

Raleigh, NC 27699

Susan:

Please find the attached Plan of Correction with supporting documentation for the Statement of Deficiencies from the survey conducted 12/9/16. We hope that this plan will more than adequately address each and every deficiency noted and prevent any further future deficiencies.

Please note that we continue to add to our supporting documentation as we complete tasks and continue monitoring said deficiencies. I will email additional supporting documentation periodically as we move forward.

Sincerely,

Michael Ring

Executive Director

Division of Health Service Regulation

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Executive Director
1-13-17

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D 273	Continued From page 1 -There was an order for oxygen at 2 liters/minute continuously. -There was no order for CPAP (Continuous Positive Airway Pressure) therapy. Review of Resident #5's Resident Register revealed an admission date of 8/30/16. Observations on 12/5/16 at 12:20pm in Resident #5's room revealed: -The resident was wearing a nasal cannula connected to an oxygen concentrator. -There were several portable oxygen tanks properly stored in the room. -A CPAP machine was sitting on a bedside stand next to the resident's recliner with dust accumulation on the outside of the machine. (Continuous Positive Airway Pressure therapy is an important treatment for obstructive sleep apnea). -The reservoir on the machine was 1/3 filled with a clear liquid. -The clear plastic hose, connected to the reservoir, had an area that was bent and partially compressed. -There was no face mask connected to the distal end of the hose. -The machine was not plugged in. Interview on 12/5/16 at 12:25pm with Resident #5 revealed: -He had been diagnosed with obstructive sleep apnea 10 to 15 years ago and has had the CPAP machine since then. -He slept in his recliner because it was easier to breathe sitting up. -He did not sleep well at night. -During the move to this facility, a piece of the CPAP machine had been lost. -He had talked to the Licensed Practical Nurse	D 273	ongoing, the orders will be reviewed daily by our nursing and wellness staff. On 12/15/16, staff were in-serviced on the notification of the HCC/floor nurses when orders are in question. All charts will be audited and all residents with CPAP units will be reviewed by the HCC/or designee for proper orders, functioning units, and address any concerns by 1/20/17. These steps will ~~be~~ completed on or before ~~1/20/17~~. 1/12/17 [handwritten initials]	

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D 273	Continued From page 2 (LPN) at the facility, sometime in September 2016, and she told him she was "working on getting it fixed". -When he had his heart valve replaced in July 2016, the cardiologist had told him it was extremely important he use the CPAP machine. -The cardiologist had told the resident not using the CPAP machine would result in "damage to my brain, my heart and my lungs". Review of Resident #5's record revealed: -There was no information regarding the resident's use of a CPAP on the Assessment and Care Plans dated 8/25/16, 9/20/16 and 10/25/16. -There was no information regarding the resident's use of a CPAP documented in the staff notes. -An order written 9/20/16 by the Family Nurse Practioner (FNP) to "Please obtain equipment patient needs for his CPAP machine. Uses [name of company] for his oxygen." -Licensed Health Professional Support (LHPS) Evaluation dated 10/24/16 did not include "Monitoring of continuous positive air pressure devices (CPAP and BiPAP)" as a personal care tasks currently present. -An order written on 11/1/16, by the Physician's Assistant (PA) who had assumed the resident's care, for "Home Health oxygen services". -There were no notes located in the record that indicated the PA was aware the resident used a CPAP. Review on 12/6/16 of Resident #5's December 2016 electronic Treatment Administration Record (eTAR) revealed: -His blood pressure had been checked twice daily, at 8:00am and 8:00pm. -On 12/1/16, the 8:00am blood pressure was high at 142/78 and the 8:00pm was 116/61.	D 273		

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D 273	Continued From page 3	D 273		

-On 12/2/16, the 8:00am blood pressure was high at 138/74 and the 8:00pm was high at 140/72.
-On 12/3/16, the 8:00am blood pressure was high at 133/68 and the 8:00pm was high at 138/76.
-On 12/4/16, the 8:00am blood pressure was high at 140/78 and the 8:00pm was high at 146/76.
-On 12/5/16, the 8:00am blood pressure was high at 186/88 and the 8:00pm was high at 138/78.
-On 12/6/16, the 8:00am blood pressure was 107/67.

Normal blood pressure is considered 120/80 according to the National Institute of Health.

A telephone interview attempted on 12/7/16 at 3:15pm with Resident #5's FNP was not successful.

A telephone interview on 12/8/16 at 9:57am with Resident #5's cardiologist's office nurse revealed:
-It was extremely important the resident used his CPAP machine.
-CPAP therapy was beneficial in the treatment of hypertension, congestive heart failure, coronary artery disease, atrial fibrillation, diabetes, and reducing the risk of stroke.
-She would speak to the cardiologist and have him document his response to the resident not having access to a working CPAP machine.

Review of a statement dated 12/8/16 received from Resident #5's cardiologist revealed, "Obstructive sleep apnea, untreated, is a well-known contributor to cardiac morbidities."

Interview on 12/9/16 at 11:15am with the Health Care Coordinator (HCC) revealed:
-She was a Registered Nurse and had worked at the facility since 5/16/16.
-She was responsible for the overall clinical

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D 273	Continued From page 4 operation of the facility. -She completed assessments for potential residents prior to their moving into the facility. -She was responsible for completion of the LHPS forms and Care Plans for each resident.. -She had completed the pre-move in assessment for Resident #5 and was not aware he used a CPAP machine. -When Resident #5 arrived at the facility, the CPAP was not mentioned on any of the paperwork she received. -She was not aware of the order written 9/20/16 related to getting Resident #5 the equipment he needed for his CPAP machine. -She became aware of the CPAP machine when she heard an oxygen company employee talking with the LPN about it "sometime around the middle of November, I think." -She said she assumed, from the conversation, "the LPN had things under control but now realized she didn't". -The LPN's duties included medication administration several days each week, taking off new orders written by the physician, seeing residents on "doctor day," and following up with the physician if there were resident issues or concerns. -She would expect the LPN to immediately communicate with her if the LPN needed assistance with following up on physician orders. -She would call and let the PA know about Resident #5's CPAP machine. Interview on 12/9/16 at 12:05pm with the Executive Director revealed: -He was responsible for the day to day operations of the facility. -He expected the LPN to notify the HCC of any issues or concerns with resident care. -He expected the HCC would notify him of any	D 273		

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D 273	Continued From page 5 issues or concerns within her department. -He was not aware Resident #5 used a CPAP machine and did not have an order. -He did not know Resident #5's CPAP machine was non-functioning. A telephone interview attempted on 12/9/16 at 1:05pm with Resident #5's PA was not successful. Interview on 12/9/16 at 1:55pm with the LPN revealed: -She had been employed at the facility since 8/17/16. -When a resident moved in she was responsible for obtaining their vital signs, weight, the level of assistance they needed regarding activities of daily living, completing a skin assessment, determining their cognitive status and checking the admission FL2 against the electronic Medication Administration Record (eMAR) for accuracy. -There had not been information regarding Resident #5's CPAP on the FL2 dated 8/18/16. -She could not remember the first time she saw the CPAP machine in Resident #5's room. -The CPAP machine was brought to her attention, sometime in September 2016, by Home Health who told her the resident had a CPAP machine and wanted to start using it. -"He (Resident #5) came with the CPAP but when I asked him (after Home Health told her about it), he said he refused to wear it." -She had not asked him why he did not use the machine. -"Sometime in late October or the beginning of November 2016", she had asked the oxygen company to look at the resident's CPAP machine, which she stated they did. -The facility had requested an order from the PA	D 273		

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D 273	Continued From page 6 for supplies on 11/8/16 and information from the resident as to whether he had a sleep study done locally. -She did not inform the PA or the resident's cardiologist of his refusal to use the CPAP machine. -The refusal had not been noted in the resident's record. -Several days later, the oxygen company called the LPN to follow-up on the request for information regarding a local sleep study. -She had not spoken to the resident about it and the oxygen company stated they would follow-up with the hospital. -She spoke with the resident who told her his last sleep study was 10 to 15 years ago in another state, and this information was provided to the oxygen company. -The oxygen company told the LPN a sleep study determined the settings on his machine and the resident needed to have a sleep study ordered. -She had not spoken with the Resident's PA at the facility or cardiologist and no order had been received. -On 11/2/16, the resident had been seen by a podiatrist who wrote an order for diabetic shoe replacements and she had spent a lot of her time dealing with that order. -The resident kept asking her about the shoes and she had forgotten about the CPAP machine. -She had not discussed the CPAP machine issues with the HCC until today, when she had been asked about it. -She had not documented any information about the CPAP or dates, times or persons she had contacted in regard to the CPAP machine. -When asked what the status of the CPAP machine and the sleep study order was at this time, she stated, "It's up in the air unless someone else is involved".	D 273		

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D 273	Continued From page 7	D 273		

Continued From page 7

Interview on 12/9/16 at 2:00pm with the HCC revealed:
-Earlier the morning of 12/9/16, she had explained to Resident #5's PA what had been happening with the CPAP machine.
-The PA had provided an order for an "Overnight sleep study. DX (diagnosis)- history of obstructive sleep apnea) and it was in the process of being scheduled.
-Once the sleep study had been completed, the oxygen company would replace the missing part of his current machine or replace it with a new one.

____

The facility failed to contact the cardiologist and the Physician's Assistant when they became aware Resident #5, with diagnosis of obstructive sleep apnea, had been admitted with a non-functioning CPAP (Continuous Positive Airway Pressure) machine and without an order for CPAP therapy. CPAP therapy is beneficial in the treatment of the resident's hypertension, congestive heart failure, coronary artery disease, atrial fibrillation, diabetes, and in reducing the risk of stroke. The failure of the facility to obtain an order for CPAP therapy and provide the resident with a functioning CPAP machine, was detrimental to the health of the resident and constitutes a Type B Violation.

____

A Plan of Protection was provided by the facility on December 9, 2016 and included the following:
-The facility notified the primary care provider of resident's desire to use the CPAP machine and to obtain order.
-An order had been received and the DME (durable medical equipment) provider had been contacted for a CPAP machine.
-An order for a sleep study was received which is

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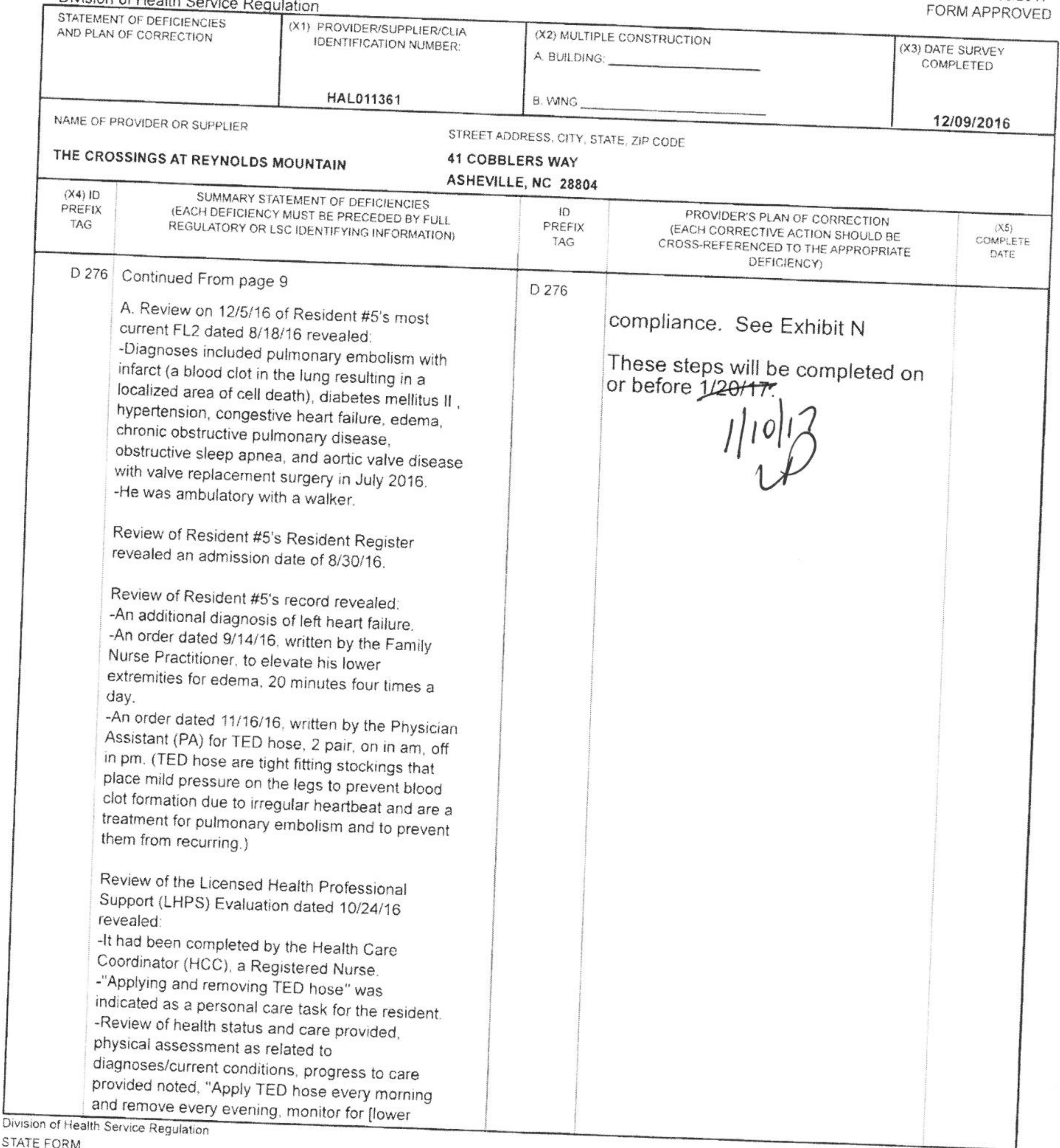
D 273	Continued From page 8 necessary for the resident to receive a CPAP machine. -Going forward, any unresolved orders, not clarified within 24 hours, will require notification of the HCC. -Staff were re-education on this. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2017.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure implementation of Thrombo-Embolic Deterrent (TED) hose for 2 of 2 sampled residents with cardiac diagnoses and edema of the lower extremities (Resident #2) and (Resident #5) with a past history of a pulmonary embolism with pulmonary infarct. The findings are:	D 276	Response to D276 (TED Hose) (B) We conducted an in-service on 12/6/16 and 12/7/16 to educate staff on how to record and notify any refusals to wear TED hose to the HCC to determine most appropriate course of action. See Exhibit B. An audit of all residents will take place by 1/17/17 to identify any residents who have orders for TED hose so we can properly document their use and process. See Exhibit M. Going forward, all orders for TED hose will be listed on the Medication Administration Record (MAR) or (TAR) Treatment Administration Record so the proper documentation of putting on the hose and removing the hose for those who need assistancecan be completed. The HCC and floor nurse staff will do random spot checks to assure	



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D 276	Continued From page 9 A. Review on 12/5/16 of Resident #5's most current FL2 dated 8/18/16 revealed: -Diagnoses included pulmonary embolism with infarct (a blood clot in the lung resulting in a localized area of cell death), diabetes mellitus II , hypertension, congestive heart failure, edema, chronic obstructive pulmonary disease, obstructive sleep apnea, and aortic valve disease with valve replacement surgery in July 2016. -He was ambulatory with a walker. Review of Resident #5's Resident Register revealed an admission date of 8/30/16. Review of Resident #5's record revealed: -An additional diagnosis of left heart failure. -An order dated 9/14/16, written by the Family Nurse Practitioner, to elevate his lower extremities for edema, 20 minutes four times a day. -An order dated 11/16/16, written by the Physician Assistant (PA) for TED hose, 2 pair, on in am, off in pm. (TED hose are tight fitting stockings that place mild pressure on the legs to prevent blood clot formation due to irregular heartbeat and are a treatment for pulmonary embolism and to prevent them from recurring.) Review of the Licensed Health Professional Support (LHPS) Evaluation dated 10/24/16 revealed: -It had been completed by the Health Care Coordinator (HCC), a Registered Nurse. -"Applying and removing TED hose" was indicated as a personal care task for the resident. -Review of health status and care provided, physical assessment as related to diagnoses/current conditions, progress to care provided noted, "Apply TED hose every morning and remove every evening, monitor for [lower	D 276	compliance. See Exhibit N These steps will be completed on or before ~~1/20/17.~~ 1/10/17	

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D 276	Continued From page 10 extremity] edema. Resident exhibits +2 pitting edema at this time". -Recommended changes and follow-up recommended to meet the resident's needs stated "Continue current plan of care treatment". Observation on 12/5/16 at 12:20pm of Resident #5 revealed: -The resident was sitting in a recliner in his room with his feet on the floor. -He was wearing white ankle socks, the tops of which were pressing into his severely edematous legs. -The resident was not wearing TED hose on either leg. -There were no TED hose observed in the room or bathroom. Interview on 12/5/16 at 12:25pm with Resident #5 revealed: -The staff usually put his TED hose on for him and he was unsure as to why they were not put on this morning. -He then stated, "No, I put them on myself." -He then said he is unable to put on the TED hose due to becoming short of breath. -He usually sits in his recliner with the foot rest up most of the time because of the swelling in his feet and lower legs. Review of the Resident #5's December 2016 electronic Treatment Administration Record (eTAR) revealed documentation by the Licensed Practical Nurse (LPN) the TED hose had been applied the morning of 12/5/16. Interview on 12/5/16 at 12:55pm with the Licensed Practical Nurse revealed: -She had put on Resident #5's TED hose that morning.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D 276	Continued From page 11	D 276		

-She did not know why they were not on at this time.
-She thought the staff may have taken them to be washed.
-She was unsure if he had a second pair to be used when the first pairs was being washed.
-She would make sure he was wearing his TED hose.

Interviews with three staff members between 12/5/16 and 12/9/16 revealed:
-They were aware Resident #5 had an order for TED hose.
-TED hose were listed on the Personal Care Logs they were carrying when interviewed.
-They had seen the resident but had not noticed if the TED hose were on him.
-No one had determined where the TED hose had been on 12/5/1

Telephone call on 12/9/16 at 1:05pm to the PA for Resident #5 was not returned prior to exit.

Observations of Resident #5 on 12/6/16 through 12/9/16 revealed the TED hose were on the resident.
B. Review of Resident #2's current FL2 dated 9/6/16 revealed:
-Diagnoses included atrial fibrillation (an irregular, often rapid heart beat that commonly causes poor blood flow), left hip replacement, peripheral artery disease, unstable gait, and edema of feet.
-A medication order for Lasix 20mg, one tablet daily, as needed, for edema, .
-An order for TED Hose, on in the morning and off at bedtime.

Review of Resident #2's record revealed no Licensed Health Professional Support (LHPS) Evaluation for the personal care task of applying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: **THE CROSSINGS AT REYNOLDS MOUNTAIN**

STREET ADDRESS, CITY, STATE, ZIP CODE: **41 COBBLERS WAY, ASHEVILLE, NC 28804**

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D 276	Continued From page 12 and removing TED hose. Review of staff notes dated 9/20/16 revealed: -"Resident noted to have +4 edema to bilateral feet. Both feet are cold to touch, mottled discoloration to bilateral feet and toes." -The resident's physician had been notified. -A return call had been received from the physician's office with instructions to send to the resident to the Emergency Room (ER) to evaluate for possible blood clot. Review of Resident #2's hospital discharge summary dated 9/20/16 revealed: -The ultrasound of the lower extremities had been negative for blood clot. -An appointment had been made with her physician for 9/21/16, "may want to discuss increase of Lasix." -A recommendation for elevation of feet and TED hose since they knew the resident was to be seen the next day by her own physician. Review of documentation from the physician appointment on 9/21/16 revealed an order for Lasix 40mg, once daily, for edema. Review of Resident #5's record revealed there had not been clarification by a facility nurse of the order written 9/21/16 for Lasix 40mg, once daily, for edema. Interview on 11/22/16 at 3:00pm with Resident #2 revealed: -Staff did not assist with applying TED hose in the morning. -She was told by her physician if her feet hurt she did not have to wear the TED hose. -She had only worn the TED hose "maybe a couple times."	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D 276	Continued From page 13 -She was not aware of her feet swelling. Observation on 11/21/16 at 3:05pm revealed: -The resident was not wearing her TED hose. -The TED hose were on top of the resident's desk in the living room area. Review of Resident #2's September 2016, October 2016, November 2016 and December 2016 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) on 12/6/16 revealed the TED hose order had not been transcribed to either record. Interview on 12/6/16 at 8:30am with the Health Care Coordinator (HCC) revealed: -Normally, the TED hose order would be on the eMAR or the eTAR. -The TED hose would also be listed on the Personal Care Logs the staff carry with them when on the floor. -"If staff become aware a resident is not following a doctor's order, they should notify the LPN or myself and we would make contact with the physician office." -"I was not aware the resident was not wearing the TED hose." Review of the current Personal Care Log for Resident #2 revealed TED hose was listed as a personal care need for Resident #2. Interview on 12/6/16 at 3:00pm with the Licensed Practical Nurse (LPN) revealed: -All clinical staff were responsible for checking the TED hose were on in the morning and off at bedtime. -The clinical staff included the HCC, the Nursing Assistants (NA's) and herself.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D 276	Continued From page 14 -Staff had not reported the resident refusing her TED hose. -She thought the NAs were applying TED hose every morning. -She was not aware there was not an order for the TED hose-She thought the resident may have brought them from home when she had been admitted. Confidential interviews with 5 staff members providing care for Resident #2 revealed: -"I have assisted the resident with getting her regular stockings on and off." -"I was not aware she was supposed to wear TED hose." - "I apply the TED hose when the resident will allow it, she refuses sometimes." - "Yes, I apply TED hose." - "I think she does those herself." Observation on 12/7/16 at 11:45am of Resident #2's feet revealed: -The resident was not wearing her TED hose. -Both feet were noted to have a small amount of puffiness visible. Interview with Resident #2 revealed: -She was not aware of any recent weight gain. -She was not aware of any swelling in her feet. -Staff had not offered to put her TED hose on this morning. -She could not recall when she last wore the hose. Telephone interview with Resident #2's Health Care Power of Attorney (HCPOA) on 12/7/16 at 3:15PM revealed: -She visits the resident regularly and takes the resident to her medical appointments. -She had observed the resident wearing her TED	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: THE CROSSINGS AT REYNOLDS MOUNTAIN

STREET ADDRESS, CITY, STATE, ZIP CODE: 41 COBBLERS WAY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 15	D 276		

hose "a few times".
-She had observed some swelling in the resident's feet and staff had told her the resident was receiving Lasix.
-She did not think the resident could apply her TED hose and thought staff were applying them.

Telephone interview on 12/8/16 at 11:05am with the nurse of the physician treating Resident #2 revealed:
-Their office did not write an order for TED hose.
-If the resident did not want to wear the TED hose then she would discuss with the physician.
-The Lasix was increased as a result of the hospital visit on 9/20/16.
-It was also increased because a family member (HCPOA) reported to the physician's office she had observed swelling and the staff had stated they had been administering Lasix.

Review of Resident #2's November 2016 eTAR revealed her weights ranged from 130 pounds to 134 pounds.

Review of Resident #2's December 2016 eTAR revealed one weight of 131 and one refusal to be weighed.

Review of a physician order dated 12/8/16 revealed:
-The TED hose were to be discontinued.
-The resident was to be weighed daily, if increases 2 pounds or more from one day to the next and has 1+ pitting edema give 20mg Lasix, if edema is 2+ or more give the 40mg of Lasix.

______

The facility failed to assure implementation of Thrombo-Embolic Deterrent (TED) hose for 2 of 2 sampled residents with cardiac diagnoses and edema of the lower extremities (Resident #2) and

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D 276	Continued From page 16 a past history of a pulmonary embolism with pulmonary infarct (Resident #5) placing the residents at risk for development of pulmonary embolism, pulmonary infarct and possible death. TED hose are tight fitting stockings that place mild pressure on the legs to prevent blood clot formation due to irregular heartbeat and are a treatment for pulmonary embolism and to prevent them from recurring.) The failure of the facility to assure these residents wore the TED hose was detrimental to the health of the residents and constitutes a Type B Violation. ______ A Plan of Protection was provided by the facility on December 6, 2016 and included the following: -Residents with orders for TED hose will be listed on the Medication Administration Record (MAR) and Treatment Administration Record (TAR) so the Medication Aide or a nurse will verify TED hose on and off and will sign off that the task has been completed. -Health Care Coordinator (HCC) to do random spot checks to assure compliance. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2017.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30	D 280	LHPS forms were completed on residents # 2 on 12/5/16 for #7 on 12/2/16 and #10 on 12/5/16. The facility shall conduct an audit of all resident charts by 1/17/17 to review the completeness of the LHPS's for each resident. HCC was in-serviced on 1/11/17 on the process, procedure, and requirements of the LHPS. See Exhibit K.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: THE CROSSINGS AT REYNOLDS MOUNTAIN

STREET ADDRESS, CITY, STATE, ZIP CODE: 41 COBBLERS WAY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 17 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a Licensed Health Professional Support (LHPS) assessment was completed on 4 of 5 sampled residents (Residents #2, #7 and #10) for the identified personal care tasks of ambulation using assistive devices, transferring semi-ambulatory and non-ambulatory residents and applying and removing Thrombo-Embolic Deterrent (TED) hose. The findings are: A. Review of Resident #10's current FL2 dated 9/6/16 revealed: -Diagnoses include right femur fracture, right wrist fracture, abnormality gait, history of falls, and mixed dementia. -Ambulation status was documented as semi-ambulatory.	D 280	Going forward the HCC shall ensure that the new residents will have a completed LHPS within the allowed 30 day date of admission and/or one will be completed as required if a resident develops a task and at least quarterly thereafter. All LHPS forms will be completed by ~~1/20/17~~ and will be monitored by the floor nurse staff and HCC to maintain current records ongoing. 1/10/17 [initials]	

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: **THE CROSSINGS AT REYNOLDS MOUNTAIN**

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D 280	Continued From page 18 -No assistive device had been documented. -Her bowel and bladder status was documented as incontinent. Review of Resident #2's Register revealed an admission date of 9/8/16. Review of Resident #10's Care Plan dated 9/12/16 revealed: -Her ambulation/locomotion status was not specified. -Her bowel status was documented as daily incontinence. -Bladder was documented as daily incontinence. -Activities of Daily Living: Ambulation/Locomotion and Transferring of the resident required extensive assistance. Review of Resident #10's record revealed no Licensed Health Professional Support (LHPS) form had been completed for the resident. Based on observations and record review, Resident #10 was determined not to be interviewable. Refer to interview on 12/9/16 at 10:45am with the Health Care Coordinator (HCC). B. Review of Resident #2's current FL2 dated 9/6/16 revealed: -Diagnoses of atrial fibrillation, left hip replacement, osteoarthritis, peripheral artery disease, rotator cuff tendonitis, unstable gait, and edema of feet. -Ambulation status was documented as non-ambulatory with a wheelchair. -The resident was incontinent of bladder. -An order for Thrombo-Embolic Deterrent (TED) hose, on in the morning and off at bedtime. (TED	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: THE CROSSINGS AT REYNOLDS MOUNTAIN

STREET ADDRESS, CITY, STATE, ZIP CODE: 41 COBBLERS WAY, ASHEVILLE, NC 28804

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D 280	Continued From page 19 hose are tight fitting stockings that place mild pressure on the legs to prevent blood clots due to irregular heartbeat and are a treatment for pulmonary embolism and to prevent them from recurring.) Review of Resident #2's initial Care Plan dated 9/7/16 revealed the resident required total assistance with ambulation and transferring. Review of a second Care Plan for Resident #2 dated 10/5/16 revealed the resident required extensive assistance with ambulation and limited assistance with transferring. Interview on 11/21/16 at 2:30pm with the Health Care Coordinator (HCC) revealed: -She was a Registered Nurse (RN) and had moved here from another state. -The LHPS assessments were new to her and she was still trying to "wrap her mind around all the tasks for evaluation of residents". -She was not aware ambulation, TED hose and transferring were LHPS task. -She would complete the LHPS for Resident #2 as soon as possible. Interview on 11/21/16 at 3:00pm with Resident #2 revealed: -Staff do assist her into her wheelchair and to meals with no problems. -Staff transfer her from bed into her chair and for toileting purposes with no problems. -She did not recall anyone checking her feet. -She was told by her physician if her feet hurt she did not have to wear her TED hose. -She had only worn the TED hose "maybe a couple times". -She was not aware of her feet swelling.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 20	D 280		

Review of an LHPS assessment dated 12/5/16 revealed:
-An assessment for ambulation and transferring non-ambulatory residents.
-Documentation of task as: "Resident non ambulatory, needs one person minimal assistance with all transfers, is able to follow commands and cues. Resident cannot ambulate independently using wheelchair, staff to assist."
-Recommendations documented as, "Continue to provide assistance to resident with assistance as needed."
-There was no assessment for TED hose.

Observation on 12/7/16 at 11:45am of Resident #2's feet revealed both feet with slight puffiness.

Telephone interview on 12/7/16 at 3:15PM with Resident #2's Health Care Power of Attorney (HCPOA) revealed:
-She visited the resident regularly and took the resident to her medical appointments.
-She had observed the resident wearing her TED hose "a few times".
-She had observed some swelling in the residents' feet and the staff had told her the resident was receiving Lasix but did not say how much.
-She did not think the resident could apply her TED hose and thought staff were applying them.

Refer to interview on 12/9/16 at 10:45am with the Health Care Coordinator (HCC).

C. Review of Resident #7's current FL2 dated 7/26/16 revealed:
-Diagnoses of osteoarthritis and hypertension.
-She was semi-ambulatory and continent of bowel and bladder.

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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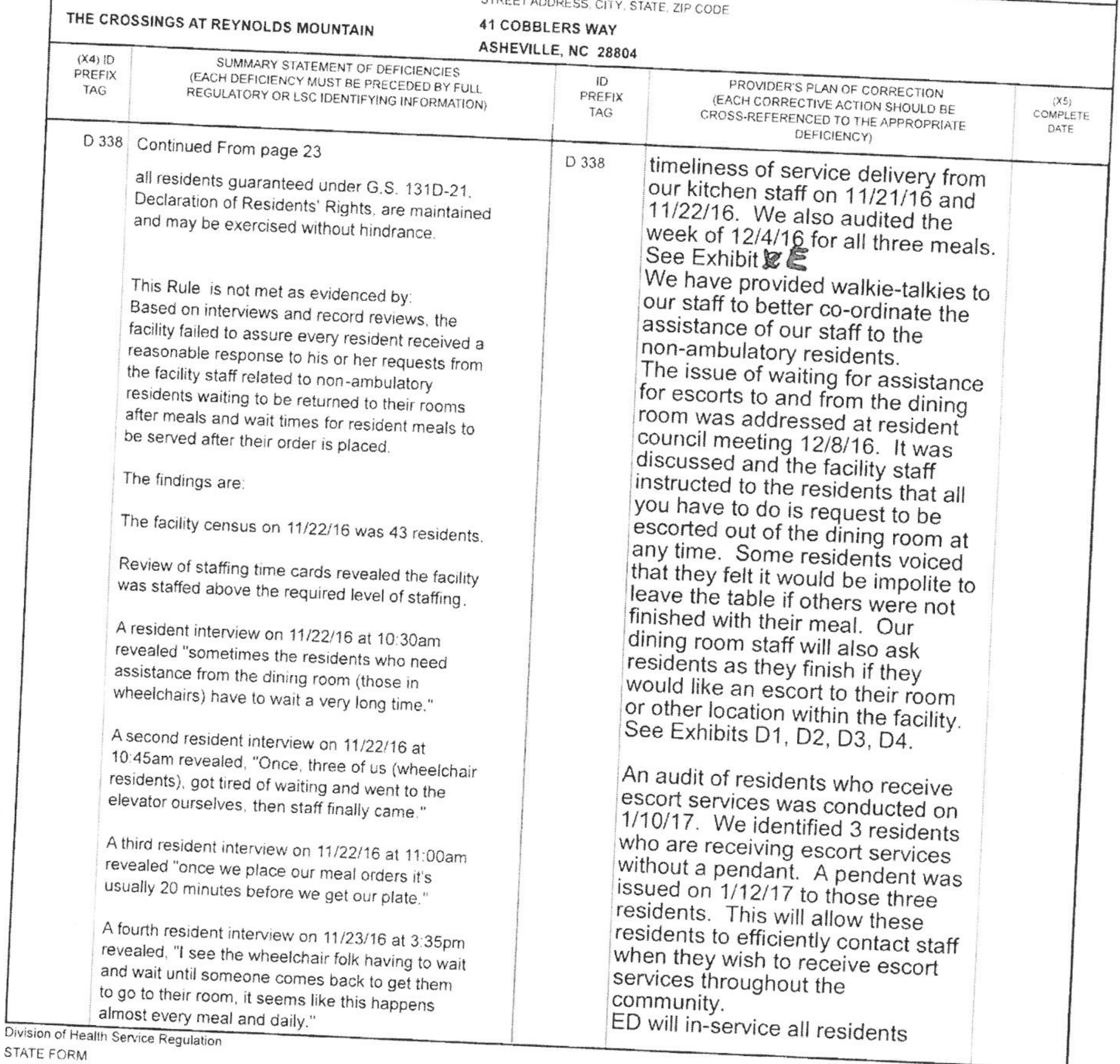
D 280	Continued From page 21 Review of the Care Plan for Resident #7 dated 8/2/16 revealed documentation the resident required total assistance ambulating using a walker and limited assistance with transferring and toileting. Review of the LHPS assessments dated 8/11/16 and 10/25/16 revealed: -The only personal care task identified had been inhalation of medication. - Ambulation with assistive device and transferring non-ambulatory residents were not included on either LHPS. Review on 12/6/16 at 11:00am of staff records revealed: -All direct care staff had completed the competency validation for LHPS tasks on 9/7/16. -The training had been completed by the HCC. Interview on 11/30/16 at 9:40am with Resident #7 revealed: -The staff assisted her with ambulation, transferring and toileting. -The staff "are great" and she had no problems getting staff assistance. Interview on 11/21/16 at 2:30pm with the Health Care Coordinator (HCC) revealed: -The LHPS assessments were new to her and she was still trying to "wrap her mind around all the tasks for evaluation of residents". -She was not aware ambulation, TED hose and transferring were LHPS task. -She would complete the LHPS for Resident #7 as soon as possible. Review of the LHPS assessment dated 12/2/16 revealed: -All task were reviewed by the HCC.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 22 -Recommendations were documented as: "Staff to provide assistance with transfers, resident requires one person minimal assist and was able to follow verbal commands and cues. Resident unable to ambulate in wheelchair R/T (related to) legal blindness. Staff to assist." Refer to interview on 12/9/16 at 10:45am with the Health Care Coordinator (HCC). D. Review of Resident #9's current FL2 dated 8/18/16 revealed: -Diagnosis included dementia, hypertension, depression, lupus, hypothyroid, gastrointestional reflux disease and respiratory problems. -Ambulation status documented as semi-ambulatory with a walker. -She was incontinent of bladder and continent of bowels. Review of Resident #9's record revealed no LHPS assessment. Based on observations and record review, Resident # 9 was determined not to be interviewable. Refer to interview on 12/9/16 at 10:45am with the HCC. Interview on 12/9/16 at 10:45am with the HCC revealed she just did not realize at the time that transferring, TED hose and ambulation required LHPS.	D 280		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338	Response to D338 (Resident Rights) We have audited meals for	



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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 23 all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure every resident received a reasonable response to his or her requests from the facility staff related to non-ambulatory residents waiting to be returned to their rooms after meals and wait times for resident meals to be served after their order is placed. The findings are: The facility census on 11/22/16 was 43 residents. Review of staffing time cards revealed the facility was staffed above the required level of staffing. A resident interview on 11/22/16 at 10:30am revealed "sometimes the residents who need assistance from the dining room (those in wheelchairs) have to wait a very long time." A second resident interview on 11/22/16 at 10:45am revealed, "Once, three of us (wheelchair residents), got tired of waiting and went to the elevator ourselves, then staff finally came." A third resident interview on 11/22/16 at 11:00am revealed "once we place our meal orders it's usually 20 minutes before we get our plate." A fourth resident interview on 11/23/16 at 3:35pm revealed, "I see the wheelchair folk having to wait and wait until someone comes back to get them to go to their room, it seems like this happens almost every meal and daily."	D 338	timeliness of service delivery from our kitchen staff on 11/21/16 and 11/22/16. We also audited the week of 12/4/16 for all three meals. See Exhibit E We have provided walkie-talkies to our staff to better co-ordinate the assistance of our staff to the non-ambulatory residents. The issue of waiting for assistance for escorts to and from the dining room was addressed at resident council meeting 12/8/16. It was discussed and the facility staff instructed to the residents that all you have to do is request to be escorted out of the dining room at any time. Some residents voiced that they felt it would be impolite to leave the table if others were not finished with their meal. Our dining room staff will also ask residents as they finish if they would like an escort to their room or other location within the facility. See Exhibits D1, D2, D3, D4. An audit of residents who receive escort services was conducted on 1/10/17. We identified 3 residents who are receiving escort services without a pendant. A pendent was issued on 1/12/17 to those three residents. This will allow these residents to efficiently contact staff when they wish to receive escort services throughout the community. ED will in-service all residents	

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: THE CROSSINGS AT REYNOLDS MOUNTAIN

STREET ADDRESS, CITY, STATE, ZIP CODE: 41 COBBLERS WAY, ASHEVILLE, NC 28804

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D 338	Continued From page 24 A fifth resident interview on 11/30/16 at 3:00pm revealed: - "Recently two staff came to take me to the lunch meal." -"One of them was called to assist someone else and then the one taking me to the elevator was called to help someone else." -"I was put on the elevator and left. The door kept opening and closing because I did not know which button to push." -"It was somewhat frightening, but now it would be OK because I would know to push the button." A sixth resident interview on 11/5/16 at 10:50am revealed the staff had forgotten to bring breakfast to the room and, "Eventually, I ended up with cold cereal and a banana and I don't even like cold cereal". Review of facility meal times revealed breakfast is served from 7:45am until 8:15am in the dining room. Additional resident interviews conducted between 12/6/16 and 12/7/16 revealed: -"There is not enough staff to serve everyone." -"It is very evident that they are low on staff." -"I have to wait 30-60 minutes for meals after I order." -"There are residents ready to go to their rooms after their meals and they have to wait for staff to get them for too long." -"The wait in the dining room to be served is too long and the food is sometimes cold." -"Sometimes there is only 1 dining staff and that delays everything." -"All staff work very hard and never stop, they just need more help." -"I am afraid the staff we have might leave	D 338	who have escort services. See Exhibit L. The ED, HCC, and LED will spot check with residents about the meal service and escort timesongoing. These steps will be completed on or before 1/20/17.	

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D 338	Continued From page 25 because they have to work non-stop." -"Staff are not rude, but sometimes I feel like they are not giving me their full attention when I am talking to them because they are so rushed." -"When staff do bring my plate ,they just put it on the table fast and then run on to the next person, very impersonal." Confidential staff interviews revealed: -"There might be a ten minute wait time to return residents who need assistance to their rooms, but never 30 minutes." -"We bust our butts and get it done." -"It is hard someday's but we get everything done and provide good care to our residents." -"I have never heard the residents complain about waiting to return to their rooms." -"It may take longer if we have to assist the resident once they get to their room." -"It is usually only a 2-3 minute wait unless a resident needs assistance before I go back to dining room" -"Maybe 10 minute wait to get back to their rooms, just depends if med tech is assisting or not." Interview on 11/23/16 at 4:45pm with the Executive Director revealed: -There were always 2 staff in the dining area to serve the residents. -The staff take each resident's order and then gives the order to the kitchen staff. -"I am surprised that residents are complaining about the wait time on the meals as they have not mentioned anything to me." -"We are in the process of trying to hire additional staff." -The personal care aides might take a little longer to return to the dining room to transport other residents if they have to provide personal care	D 338		

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

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D 338	Continued From page 26 such as toileting to a resident once returned to their room. Interview on 12/5/16 at 11:55am with a MA assigned to the dining room revealed: -There were two dietary aides and one care staff assigned to the dining room during meals. -Most of the residents in wheelchairs stayed in them while they ate. -She would assisted residents to/from their tables and help serve beverages. -She did not leave the dining room. -If a resident needed help, she would call on her walkie-talkie and have another nursing assistant come and take them back to their room. -How long a resident had to wait depended on what the other staff were doing. -It could be from 10 minutes to 20 minutes before someone came to get them. -If she needed to, she would call again for assistance so the resident didn't need to wait. Observation on 12/6/16 and 12/7/16 revealed: -Staff were using individual walkie/talkie call systems to notify staff when a resident was ready to be transported back to their rooms. -Staff arrived within 2 minutes of the notification.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility, (2) if orders are not clear or complete; or	D 344	D344 (Med Orders) The order for resident number 11 was clarified and received on 12/07/16. See Exhibit F. An audit of all PRN medications was conducted on 1/11/17. The facility has reviewed PRN medications and how to follow the physician's orders. See Exhibit O.	

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D 344	Continued From page 27 (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a medication order for hydralazine that was unclear and incomplete was verified and clarified in a timely manner with the prescribing practitioner for 1 of 7 sampled residents. (Resident #11.) The findings are: Review of Resident #11's current FL2 dated 11/21/16 revealed: -Diagnoses included hypertension, atrial fibrillation, and hemiplegia. -A medication order for Hydralazine 10mg, 1 tablet four times a day as needed. (Hydralazine is a medication used to dilate blood vessels and lower blood pressures.) Review of Resident #11's record revealed no subsequent order to verify or clarify the reason for administration of hydralazine, or at what level of hypertension the hydralazine was to be administered. Review of Resident #11's Medication Administration Records (MARs) for November and December 2016 revealed: . -No entry for blood pressures. -An entry for hydralazine 10mg, 1 tablet four times a day as needed for hypertension. -No hydralazine had been documented as	D 344	PRN medications were reviewed and clarified with the attending physician as need for more efficiency and understanding and placed on the MAR and/or TAR record. In the future, all PRN orders will be reviewed by the facility nursing staff for accuracy and completeness prior to sending to the pharmacy to fill. Going forward, any unresolved orders, not clarified within 24 hours, will require notification of the HCC, ongoing, the orders will be reviewed daily by our nursing and wellness staff. Staff were in-serviced on the notification of the HCC when orders are in question on 12/15/16. See Exhibits D1, D2, D3, D4. The HCC will spot audit MARs to review accuracy and the compliance of the orders. This will be completed by ~~1/20/17~~. 1/12/17	

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D 344	Continued From page 28	D 344		

administered on the MARs.

Observation of the morning medication pass on 12/6/16 at 9:10am revealed:
-Resident #11 received 5 oral medications and 1 eye drop.
-Two of the 5 oral medications administered to Resident #11 were for the treatment of high blood pressure, Norvasc and hydrochlorothiazide.
-No hydralazine was administered to Resident #11.
-Resident #11's blood pressure was not checked during this morning medication pass.

Review on 12/6/16 at 9:15am of Resident #11's medications on hand revealed:
-A bubble pack of hydralazine 10mg tablets, dispensed on 11/29/16 for 30 tablets, and no tablets used from the package.
-The hydralazine 10mg tablets were labeled, 1 tablet four times a day as needed for hypertension, with no parameters noted.

Interview on 12/6/16 at 10:40am with the pharmacist at the pharmacy provider revealed:
-They had an order for Resident #11's hydralazine 10mg, 1 tablet four times a day as needed for hypertension, but did not have any clarification about blood pressures at which to administer the hydralazine.
-Either the facility or the pharmacy could call the prescriber to request clarification of a medication order.
-The pharmacy had called Resident #11's physician "several times" to request clarification of the hydralazine orders.
-The physician's office had not called the pharmacy back.
-The pharmacy had also talked with two facility Medication Aides (MA), Staff D and Staff I, about

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D 344	Continued From page 29	D 344		

obtaining clarification for Resident #11's hydralazine.

Interview on 12/6/16 at 11:10am with the facility's Health Care Coordinator (HCC) revealed:
-She believed the medication orders for Resident #11 were verified when she was admitted on 11/30/16.
-She would try to find the documentation regarding the verification.
-A nurse (HCC or LPN) was supposed to clarify all medication orders that were unclear or incomplete.

Interview on 12/6/16 at 11:30am with a representative from the physician's office revealed:
-No one at the facility had ever called about Resident #11 for any reason.
-The pharmacy had called twice, once yesterday (12/5/16), and once today (12/6/16) about clarifying the hydralazine.

Interview on 12/6/16 at 12:20pm with Staff D, Medication Aide (MA), revealed:
-He called Resident #11's physician last Thursday, 12/1/16, about clarification of her hydralazine.
-The physician's office did not return the call.
-Staff D could not explain why the physician's office did not have a record of his call.
-Usually the physician calls back within a day.
-He was not too concerned about the physician not calling back because Resident #11 was scheduled to see the house doctor or nurse practitioner on her next visit, (12/6/16.)

Interview on 12/6/16 at 2:50pm with Staff I, MA, revealed:
-She did not call the physician, but told the nurses

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D 344	Continued From page 30 about the need for order clarification for Resident #11's hydralazine, i.e. the HCC or the LPN. -She would not know how to give the hydralazine without blood pressure parameters. Interview on 12/6/16 at 3:05pm with Staff H, MA, revealed: -She was not aware of Resident #11's as needed order for hydralazine. -"We would have to get blood pressures to give it," (the hydralazine). Interview on 12/7/16 at 4:00pm with Resident #11's responsible party revealed: -Resident #11's recent hospitalization was due to a hemorrhagic stroke. -Resident #11 had a history of spikes in her blood pressure. -Resident #11 has had some confusion since her stroke. Interview on 12/9/16 at 11:35am with Resident #11 revealed: -Facility staff had checked her blood pressure, but she was not sure how often. -The MA had never administered any medications after checking her blood pressure. -She believed her blood pressures had been good since she's been in the facility. Review of Resident #11's record revealed: -The facility obtained an order on 12/7/16 for heart rate and blood pressures twice daily for 7 days, and discontinue the hydralazine. -Prior to 12/7/16, Resident #11 did not have an order for routine blood pressure checks. -On admission, the resident's blood pressure on 11/30/16 (no time specified) was 124/72. -The resident's blood pressure was elevated at 136/88 on 12/1/16 at 1pm.	D 344		

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D 344	Continued From page 31 -The resident's blood pressure was elevated at 138/72 on 12/5/16 at 11am. -The resident's blood pressure was elevated at 138/78 on 12/6/16 at 7:34pm. -The resident's blood pressure was elevated at 140/74 on 12/7/16 at 8am. The National Institute of Health defines a normal blood pressure as 120/80. Review of facility's policy "when a clarification is needed from the physician" revealed: -"Write the order request/clarification and fax to the physician." -"Place the clarification on the pending faxes clipboard mounted near the fax machine." -"Call the physician's office to alert a fax was sent." -"Make a notation on the Daily Log and if necessary, flag the MAR." -"Continue calling and faxing each shift until the order has been clarified." -"Once received, remove the unsigned clarification from the pending faxes clipboard and destroy."(Obtain a signed order from the physician via fax.) -"Note: A strong sense of urgency must be maintained to receive any necessary clarifications."	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358	D358 (Medication Administration) (B) An audit of all PRN medications was conducted on 1/11/17. The facility has reviewed PRN medications and how to follow the physician's orders. Some PRN medications were clarified with perimeters.	

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D 358	Continued From page 32 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure medications (Lasix and Timoptic) were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #2 and #11) . The findings are: A. Review of Resident #2's current FL2 dated 9/6/16 revealed: -Diagnoses included atrial fibrillation and edema of the feet. -A medication order for Lasix 20mg, once daily, as needed for edema. (Lasix is a potent diuretic used to treat congestive heart failure and fluid retention.) Review of staff notes written on 9/6/16 by the Licensed Practical Nurse's (LPN) revealed: -"Resident [#2] noted to have +4 edema to bilateral feet. Both feet are cold to touch, mottled discoloration to bilateral feet and toes." -The resident's physician had been contacted. -A return call from the physician's office with instructions to send Resident #2 to the emergency room to evaluate for a possible blood clot. Review of Resident #2's hospital discharge summary dated 9/20/16 revealed: -Ultrasounds of the lower extremities were negative for blood clot.	D 358	and placed on the MAR record. See Exhibit P. In the future all PRN orders will be reviewed by the facility nursing staff for accuracy and completeness prior to sending to the pharmacy to fill. Going forward, any unresolved orders, not clarified with 24 hours, will require notification of the HCC, ongoing, the orders will be reviewed daily by our nursing and wellness staff. Staff were in-serviced on the notification of the HCC when orders are in question on 12/15/16. See Exhibits D1, D2, D3, D4. The HCC will spot audit MARs to review accuracy and the compliance of the orders. This will be completed by ~~1/20/17~~. 1/12/17	

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D 358	Continued From page 33 -Recommendations for elevation of feet and TED hose. -"The resident has an appointment with her physician on 9/21/16, "may want to discuss increase of Lasix." Review of Resident #2's record revealed: -A subsequent physician order dated 9/21/16 for Lasix 40mg daily, as needed for edema. -An order dated 10/27/16 to obtain the Resident's weight three times a week on Monday, Wednesday and Friday. Review of documented weights on the electronic Treatment Administration Record (eTAR) for Resident #2 revealed: -In November 2016, weights ranged from 130 pounds to 134 pounds. -In December 2016, one weight of 131 pounds had been recorded and one refusal. Review of Resident #2's September 2016 electronic Medication Administration Records (eMAR) revealed: -An entry for "Lasix 20mg, take one tablet by mouth every day as needed for edema" was printed on the eMAR. -There was no documentation Lasix 20mg had been administered to the resident. -The order dated 9/21/16 for "Lasix 40mg, take one tablet by mouth every day as needed for edema" had not been entered on the September 2016 eMAR Review of Resident #2's October 2016 eMAR revealed: -An entry for "Lasix 40mg, one tablet by mouth every day as needed for edema". -There was no documentation Lasix 40mg had been administered to the resident.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 34 Review of Resident #2's November 2016 eMAR revealed: -An entry for "Lasix 40mg, one tablet by mouth every day as needed for edema". -There was no documentation Lasix 40mg had been administered to the resident. Review of Resident #2's December 2016 eMAR from 12/1/16 to 12/9/16 revealed: -An entry for "Lasix 40mg, one tablet by mouth every day as needed for edema". -There was no documentation Lasix 40mg had been administered to the resident. Interview on 12/6/16 at 2:45pm with a Medication Aide (MA) revealed: -She did not recall administering any Lasix to Resident #2. -She would check resident's feet and ankles when administering medications and note any edema. -She recalled one time when Resident #2 had "maybe +4 edema and refused the Lasix". -"I think she was sent out to hospital at that time, not sure." -"We always check legs and feet when assisting with bathing or when weighing residents." Interview on 12/6/16 at 3:00pm with the Licensed Practical Nurse (LPN) revealed: -The staff were to report any weight gains and/or edema to her for follow-up. -All staff were responsible for checking Resident #2 for edema when they provided personal care and anytime they are assisting in her room. -The MAs had been instructed by the HCC on how to determine the degree of edema in the feet and legs. -She was unsure if Lasix had been administered	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 35	D 358		

to the resident, but staff had not reported any signs of edema for the resident to her.
-She had documented 4+ edema on 9/20/16 but could not recall if she had administered the Lasix.
-The resident was sent to the emergency room for possible blood clot.
-She thought the tests were negative and the resident' physician had seen the resident the day following emergency room discharge.

Interview on 12/7/16 at 11:45am with Resident #2 revealed:
-She was not aware of any recent weight gain.
-She did not check her feet routinely for swelling.
-The staff did not check her feet for welling.
-She was not sure if she had been given Lasix since admission to the facility.

Observation on 12/7/16 at 11:45am of Resident #2"s feet revealed both feet with slight puffiness.

Observation on 12/7/16 at 11:15am of the medications available for administration revealed:
-One bubble package containing 30 tablets of "Lasix 20mg, as needed for edema, once daily".
-The dispense date on the medication card indicated 30 tablets had been sent to the facility on 9/6/16.
-There were 30 tablets remaining in the medication package.
-There were no Lasix 40mg tablets available for administration.
-There was no sticker on the Lasix 20mg bubble package indicating the order had been changed, refer to chart.

Telephone interview on 12/7/16 at 3:15pm with Resident #2's Health Care Power of Attorney revealed:
-She visits the resident regularly and takes the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: **THE CROSSINGS AT REYNOLDS MOUNTAIN**

STREET ADDRESS, CITY, STATE, ZIP CODE: **41 COBBLERS WAY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 36 resident to her medical appointments. -She had observed the resident wearing her TED hose "a few times" . -She had observed some swelling in the resident's feet and when asked, the staff had told her the resident was receiving Lasix but did not say how much. -The physician was aware of some reported swelling and raised the Lasix to 40mg "sometime back." -She trusted the staff to monitor for swelling and to administer the Lasix as needed. Interview on 12/7/16 at 3:35pm with the Health Care Coordinator (HCC) revealed: -She was unsure why Resident #2's Lasix order had been increased to 40mg. -If the resident had brought any Lasix with her at admission it would have been repackaged by the pharmacy. -She had spoken with the pharmacy today and they had not repackaged any Lasix for the resident. -If there were no Lasix missing from the bubble package, then there would not have been any administered. -She had contacted the physician on 12/6/16 to get more specific perimeters for administering the "as needed" Lasix. Telephone interview on 12/8/16 at 11:05am with the nurse at Resident #2's physician's office revealed: -The Lasix was increased to 40mg as a result of the hospital visit on 9/20/16. -She would try to speak with the physician related to the facility calling yesterday and wanting more specific perimeters for the Lasix prn. -She would expect that Lasix would be administered for "any" edema in the resident's	D 358		

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D 358	Continued From page 37 feet. -"We assumed she was getting the Lasix 20mg because the family member had reported some edema in her legs." Review of physician's orders dated 12/8/16 revealed : -The resident was to be weighed daily. -"If (weight) increases 2 pounds or more from one day to the next and has 1+ pitting edema, give 20mg Lasix, if edema is 2+ or more give the 40mg of Lasix. B. Review of Resident #11's current FL2 dated 11/21/16 revealed: -Diagnoses included hypertension, atrial fibrillation, and hemiplegia. -A medication order for Timoptic eye drops, 1 drop twice daily for glaucoma. (Timoptic is used to lower intraocular pressure in residents with glaucoma.) -A medication order for brimonidine eye drops, 1 drop into right eye 3 times a day. (Brimonidine is used to lower intraocular eye pressure in residents with glaucoma.) Review of Resident #11's record revealed: -No subsequent order to clarity the strength of the Timoptic drops, or which (or both) eyes to place the drops. -A history of glaucoma noted on a progress note dated 11/8/18 from another facility. Review of Resident #11's Medication Administration Records (MARs) for November and December 2016 revealed: -No entry for Resident #11's Timoptic drops. -An entry for brimonidine eye drops, 1 drop into right eye three times a day. -The brimonidine eye drops had been initialed as administered three times a day since Resident	D 358		

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D 358	Continued From page 38 #11's admission on 11/30/16. Observation of the morning medication pass on 12/6/16 at 9:10am revealed: -Resident #11 received 5 oral medications and 1 eye drop. -The eye drop administered was brimonidine. -No Timoptic eye drops were administered. Review on 12/6/16 at 9:15am of Resident #11's medications on hand revealed: -No Timoptic drops of either strength (0.25% or 0.5%) available to administer. -A bottle of brimonidine eye drops, labeled 1 drop into right eye three times a day. Interview on 12/6/16 at 10:40am with the pharmacist at the pharmacy provider revealed: -They did not have a prescription on file for Resident #11's Timoptic. -They received the FL2 dated 11/21/16 from the facility, but were waiting on clarification in order to dispense the Timoptic. -Either the facility or the pharmacy could call the prescriber to request clarification of a medication order. -The pharmacy had called Resident #11's physician "several times" to request clarification of the Timoptic orders. -The physician's office had not called the pharmacy back. -The pharmacy had also talked with two facility Medication Aides (MA), Staff D and Staff I about obtaining clarification for Resident #11's Timoptic. Interview on 12/6/16 at 11:10am with the facility's Health Care Coordinator (HCC) revealed: -She believed the medication orders for Resident #11 were verified when she was admitted on 11/30/16.	D 358		

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D 358	Continued From page 39 -She would try to find the documentation of the verification. -A nurse (HCC or LPN) was supposed to clarify and verify all medication orders that were unclear or incomplete. Interview on 12/6/16 at 11:30am with a representative from the physician's office revealed: -No one at the facility had ever called about Resident #11 for any reason. -The pharmacy had called twice, once yesterday (12/5/16), and once today (12/6/16) about clarifying the Timoptic. -Their physician would not have approved the Timoptic eye drops because he did not order them for Resident #11. Interview on 12/6/16 at 12:20pm with Staff D, Medication Aide (MA), revealed: -He called Resident #11's physician last Thursday, 12/1/16, about clarification of her Timoptic. -The physician's office did not return the call. -Staff D could not explain why the physician's office did not have a record of his call. -Usually the physician called back within a day. -He was not too concerned about the physician not calling back because Resident #11 was scheduled to see the house doctor or nurse practitioner on her next visit, (12/6/16.) Interview on 12/6/16 at 2:50pm with Staff I, MA, revealed she did not call the physician, but told the nurses (the HCC or the LPN) about the need for order clarifications for Resident #11's Timoptic. Interview on 12/6/16 at 3:05pm with Staff H, MA, revealed she was not aware Resident #11 had an	D 358		

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D 358	Continued From page 40 order for Timoptic eye drops. Interview on 12/7/16 at 3:05pm with the facility's HCC revealed: -They had gotten Resident #11's Timoptic order filled on 12/6/16 from a discharge summary dated 11/8/16. -The order had been dispensed from the back up pharmacy. Observation on 12/7/16 at 3:10pm of Resident #11's medications revealed an open bottle of Timoptic 0.5% labeled, "1 drop into right eye twice daily for glaucoma," with a dispense date of 12/6/16. Interview on 12/7/16 at 4:00pm with Resident #11's responsible party revealed: -The resident was using the eye drops for glaucoma. -The Timoptic had recently been added to her drug regimen while she was in the hospital. -The Timoptic was added because her insurance would not pay for the combination eye drop she had used previously. Interview on 12/9/16 at 11:35am with Resident #11 revealed: -She had only been getting one eye drop since she had been at the facility, and she usually received two eye drops. -She was not sure of the names of the eye drops she was receiving. -She did not ask the staff why she was only receiving one eye drop. Review of facility's policy "when a clarification is needed from the physician" revealed: -"Write the order request/clarification and fax to the physician."	D 358		

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 41	D 358		

-"Place the clarification on the pending faxes clipboard mounted near the fax machine."
-"Call the physician's office to alert a fax was sent."
-"Make a notation on the Daily Log and if necessary, flag the MAR."
-"Continue calling and faxing each shift until the order has been clarified."
-"Once received, remove the unsigned clarification from the pending faxes clipboard and destroy."(Obtain a signed order from the physician via fax.)
-"Note: A strong sense of urgency must be maintained to receive any necessary clarifications."

The facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (#2 and #11). Failure to administer Resident #2's Lasix as ordered resulting in the resident accumulating significant fluid in her lower extremities (+4 edema.) This significant edema required Resident #2 to obtain an emergency evaluation in the local hospital to rule out blood clots in the lower extremities. The facility failed to verify a medication order for Resident #11 and resulted in her not receiving Timoptic eye drops for treatment of her glaucoma for 6 days. Uncontrolled or inadequately treated glaucoma is one of the leading causes of blindness in the United States. The facility's failure to administer Resident #2's Lasix and Resident #11's Timoptic as ordered was detrimental to the health of Residents #2 and #11 and constitutes a Type B Violation.

Plans of Protection were provided by the facility on 12/6/16 and 12/7/16 and included the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

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THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D 358	Continued From page 42 -All routine and as needed medications will be given according to physician orders. -Any condition change will be addressed immediately by assessing resident, review of MAR for pertaining prn medications and report promptly to HCC, physician, responsible party and documented in the chart. -Prior to admission, the HCC will review the FL2 to verify medication orders. -Forty-eight hours prior to move in, the FL2 will be faxed to the pharmacy. -If the pharmacy needs further clarification or notes an incomplete order, the pharmacy manager will e-mail the HCC. -On the day of move in, care staff in charge will verify FL2 to the MAR/treatment administration record(TAR) to confirm accuracy. -If any questions arise, we will contact the physician. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2017.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the	D 375	D375 (self-administration of meds) For resident number 4 we obtained orders on 12/5/16 for the resident to self-administer the nitro pill and hydrocortisone cream. The antibiotic ointment was removed from the room. A self-medication review was conducted and completed with resident number 4 on 12/6/16. See Exhibits G1, G2. Upon admission each resident will be assessed for the possibility of managing their own medications.	

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 43 medication label. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to obtain a physician's order and to assess the resident's ability to self administer medications for 1 of 3 residents sampled who self-medicated. (Resident #4.) The findings are: Review of Resident #4's current FL2 dated 7/22/16 revealed: -Diagnoses included coronary artery disease, coronary artery bypass graft, peripheral vascular disease, and a history of aortic valve replacement. -Two medication orders for aspirin 81mg daily, and pentoxifylline 400mg 1 tablet three times a day. (Low dose aspirin is used to prevent blood clots, and pentoxifylline is used to improve blood flow.) -There was no order for nitroglycerin in any form. A tour of the facility on 12/5/16 at 11:22am revealed: -Resident #4 occupied a private room. -A bottle of Nitrostat (nitroglycerin) 0.4mg sublingual tablets sitting on the bathroom sink. (Nitrostat is a medication used to treat angina, pain from an inadequate flow of blood to the heart.) -A one ounce tube of hydrocortisone 1% cream sitting on the bathroom sink. (Hydrocortisone cream is a topical steroid used to treat rashes and itching on the skin.) -A one ounce tube of triple antibiotic ointment sitting on the bathroom sink. (Triple antibiotic	D 375	At this meeting the facility will discuss the policies of the facility concerning any personal medications and their use. The facility will conduct room sweeps beginning on 1/11/17 and monthly thereafter, to locate any OTC/PRN medications and educate each resident about OTC/PRN medications and what our procedure is to manage them. See Exhibit H. Any PRN/OTC medication will be reviewed by our nursing staff and addressed with the resident and physician to the most appropriate outcome. Room sweeps and PRN/OTC medications will be monitored by the HCC/and or Designee monthly. This will be in compliance by ~~1/20/17~~. 1/12/17	

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NAME OF PROVIDER OR SUPPLIER: THE CROSSINGS AT REYNOLDS MOUNTAIN

STREET ADDRESS, CITY, STATE, ZIP CODE: 41 COBBLERS WAY, ASHEVILLE, NC 28804

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D 375	Continued From page 44 ointment is used to prevent infections in minor cuts and abrasions of the skin.) -Both the cream and ointment were a brand from a local chain pharmacy. -Approximately 1/3 of the cream and ointment from the tubes had been used. -Approximately 1/4 of the bottle of 25 Nitrostat 0.4mg tablets were taken from the bottle. -There was no prescription label on the Nitrostat 0.4mg tablets, the hydrocortisone cream, or the triple antibiotic ointment. Review of Resident #4's record revealed no subsequent orders for Nitrostat, hydrocortisone cream, nor triple antibiotic cream. Review of Resident #4's electronic Medication Administration Records (eMARs) for October 2016, November 2016, and December 2016 revealed no entries for Nitrostat tablets, hydrocortisone cream, or the triple antibiotic ointment. Interview on 12/5/16 at 11:25am with Resident #4 revealed: -He used the creams for itching "occasionally." -He used the Nitrostat tablets. "sometimes 2 to 3 times a day, I've had bypass surgery." -The Nitrostat tablets helped "when I feel tired." Interview on 12/5/16 at 4:10pm with the Health Care Coordinator (HCC) revealed: -Resident #4's family had brought in medications before and they were told not to bring in outside medications. -"We (staff) have taken medications out of his room, (no specific medications identified.)" -The facility's policy on self-administration was "to have the physician write an order for the resident to self-medicate, and I (the HCC) had to evaluate	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 375	Continued From page 45	D 375		

the resident to self-medicate."

Interview on 12/6/16 at 11:55am with the HCC revealed:
-She had not assessed Resident #4 for self-medication.
-She was not aware Resident #4 had Nitrostat or the creams in his room.

Interview on 12/6/16 at 3:10pm with Resident #4's family member revealed:
-Resident #4 had aortic valve replacement.
-Resident #4 had been using the Nitrostat tablets for over 20 years, "he knows how to take them."
-Resident #4 brought the bottle of Nitrostat he is using now from home, when he was admitted to the facility in August 2016.
-Resident #4 had some bug bites that itched and he used the creams on the bug bites.
-Resident #4 brought the creams in his room himself.
-Resident #4 wasn't aware he needed a doctor's order for the creams because you can buy them without a prescription.
-Resident #4 was "used to taking care of himself."
-Resident #4 recently got a prescription for the Nitrostat from his primary care doctor and had it filled at a local chain pharmacy.

Interview on 12/7/16 at 11:20am with the facility's Licensed Practical Nurse (LPN) revealed:
-She was not aware Resident #4 had any Nitrostat in his room.
-"The families should tell us," (when they bring medications into the facility.)
-Resident #4's physician told us he had written an order for the Nitrostat 0.4mg, and the family member had pick it up, (no time specified.)

A second interview on 12/7/16 at 11:25am with

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
D 375	Continued From page 46 Resident #4 revealed: -He took nitroglycerin (generic Nitrostat) "every once and a while." -He was not sure how often he used his nitroglycerin (NTG). -The NTG "relieved my chest pain when I'm feeling tired." -He brought the NTG from home, "it doesn't require an order, you can buy it without a prescription." -His cardiologist told him how to take the NTG years ago. -He had more NTG in his room. -He bought the hydrocortisone cream and triple antibiotic cream himself from a local chain pharmacy. -"I use the creams for itching." Observation on 11:30am on 12/7/16 of the extra NTG in Resident #4's room revealed: -A large plastic prescription bottle with three small 25 count glass bottles of Nitrostat 0.4 inside. -The label on the large plastic bottle read, "Take one tablet sublingually every 5 minutes for chest pain as needed," with a dispense date of 10/2/15. -The resident had another unlabeled glass bottle of Nitrostat 0.4mg 100 tablets, and about a third of the tablets remained in the bottle. Interview on 12/7/16 at 11:40am with a facility housekeeper revealed: -She worked from 8am to 4pm daily. -She worked primarily on the 3rd floor where Resident #4's room was located. -If she saw medications in any resident's room, she would report it to the MA on duty. -She had never observed any medications in Resident #4's room. Review on 12/6/16 of Resident #4's record	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
D 375	Continued From page 47	D 375		

revealed:
-An e-mail request from the facility on 12/5/16 at 4:28pm that stated, "Patient has been self-administering nitro tabs, they need an order saying he can do this-also they need a order stating patient can self-administer hydrocortisone cream."

Continued review of Resident #4's record revealed:
-On 12/5/16 at 5:45pm Resident #4's physician sent a reply, "patient may use nitroglycerin sublingual tablets as needed via self-administration and per prescription parameters stated on the bottle."
-A second order on 12/5/16 at 5:45pm stated, "patient may apply topical hydrocortisone cream (self administration) as needed.
-No mention of an order for triple antibiotic ointment.

On 12/9/16, the facility obtained orders from Resident #4's physician that stated:
-"Nitroglycerin 0.4mg SL (Under tongue) every 5 minutes as needed for chest pain for 90 days, 100 tablets, not to exceed 3 doses, if pain persists, seek medical attention."
-The start date of the NTG was 11/10/16.
-"Hydrocortisone topical 1% cream, apply topical daily as needed for itching for 30 days."
-The start date of the hydrocortisone cream was 12/9/16.
-There was no mention of the triple antibiotic ointment.

Interview on 12/9/16 at 11:45am with the facility's Executive Director revealed:
-They would check with Resident #4's physician about the triple antibiotic ointment.
-Resident #4 told the Executive Director "he didn't

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 375	Continued From page 48 need an order for the antibiotic ointment, you can buy it over with counter." -Resident #4 was an officer in the military, and "if you don't outrank him, he won't listen to you." Review of the facility's policy on self administration of medications revealed: -The resident who wishes to manage their own medication is evaluated for self-administration prior to or upon move in. -The resident is re-evaluated monthly to ensure their continued ability to self manage their medications. -The results of the evaluation will be discussed with the resident and their family and/or legal representative. -The community will know and follow the state laws and regulations governing self-administration/administration of medications. -The monthly self-medication evaluation will be completed by the HCC or designee.	D 375		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 5 of 5 sampled residents (Residents #1, #2, #7, #10 and #13) who required assistance with toileting were treated with respect, consideration and dignity and received a reasonable response in a timely manner to their calls for assistance.	D911	D911 (Residents Rights) The staff was provided walkie-talkie units to communicate with each other and to be more efficient with communicating their needs to assist residents in a timely fashion. We audited call response times on 12/7/16. See Exhibit E. An in-service was conducted on 12/15/16 and 1/5/17 to address the call system, response times, and resident rights. See Exhibits D1, D2, D3, D4. The Executive Director will audit call response times in the facility weekly and review any issues.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

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D911	Continued From page 49 The findings are: Observation on 11/22/16 beginning at 11:45am until 12:06pm on third floor of the facility revealed: -No staff were in the hallway or at the nurse's station during the 21 minute observation period. -Doors to the medication room and nurse's room located at the nurse's station area were locked and no one responded to multiple knocks on the doors. -A staff member did respond when the Adult Home Specialist asked a resident to push the pendant call bell the resident was wearing. Review of the facility census revealed there were 14 residents residing on the third floor Confidential third floor resident interviews revealed: -"Staff are usually not on the floor during meal times." -"Usually no one is at the nurses station." -"Sometimes it is hard to find staff if you need something." Interview on 11/22/16 at 11:49am with a resident in her room revealed: -"Usually there are no staff in the hallway." -When asked what she would do if she required assistance the resident responded, "push my button and wait." Observation on 11/22/16 at 12:01pm of a resident pushing her pendant for assistance revealed a Medication Aide (MA) arrived at the resident's room at 12:06pm. Interview on 11/22/16 at 12:07pm with a MA revealed:	D911	The HCC and the nursing staff will spot check satisfactory resident responses ongoing and report any concerns to the Executive Director. See Exhibits J1, J2, J3, J4. This violation will be corrected on 1/20/17.	

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D911	Continued From page 50	D911		

-He was assigned to work on the third floor.
-He was assisting the staff on the second floor with taking residents to the lunch meal which "usually takes about 10 minutes".
-Staff usually assist each other to get residents ready for meals and transport them down to the dining room.
-There were 4 of 14 residents on third floor who were on every 2 hour checks for toileting assistance.
-He thought there were adequate staff assigned to each hall to meet the resident's needs in a timely manner.

A. Review of Resident #2's current FL2 dated 9/6/16 revealed:
-Diagnoses included atrial fibrillation, left hip replacement, osteoarthritis, peripheral artery disease, rotator cuff tendonitis, unstable gait, ulnar neuropathy of left upper extremity, and edema of feet.
-Ambulation status had been documented as non-ambulatory.
-The Resident was incontinent of bladder.

Review of Resident #2's original Care Plan dated 9/7/16 revealed she required total care with toileting, ambulation and transfers.

Review of a second Care Plan for Resident #2 dated 10/5/16 revealed she required extensive assistance with toileting and ambulation and limited assistance with transferring.

B. Review of Resident #7's current FL2 dated 7/26/16 revealed:
-Diagnoses included osteoarthritis, hypertension and hyperlipidemia.
-She was semi-ambulatory and continent of bowel and bladder.

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D911	Continued From page 51 Review of Resident #7's Care Plan for dated 8/2/16 revealed: -She required total assistance with ambulation and limited assistance with transfers and toileting. -She was semi-ambulatory with use of a wheelchair. -Her skin had been noted as normal with a note stating she was at risk for skin breakdown related to her incontinence and being non-ambulatory. Prevention was noted as every 2 hour repositioning and toileting. Review of Resident #7's record revealed: -A staff note dated 8/23/16, documented redness and an open wound on her tailbone. -An order dated 9/1/16 for a gel cushion for wheelchair due to decrease mobility placing her at risk for skin breakdown. Interview on 11/30/16 at 9:40am with Resident #7 revealed: -Staff do check on her every two hours for toileting. -She "sometimes" has to wait for assistance after she pushes her pendant "but that is OK" -She was not aware of any skin breakdown or other problems since the wound on her tailbone had healed. C. Review of Resident #1's current FL2 dated 8/30/16 revealed: -Diagnoses included decreased cognition and unspecified dementia. -He was continent of bladder and incontinent of bowel. Review of the Care Plan for Resident #1 dated 9/5/16 revealed he required supervision with toileting and transfers and limited assistance with	D911		

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: **THE CROSSINGS AT REYNOLDS MOUNTAIN**

STREET ADDRESS, CITY, STATE, ZIP CODE: **41 COBBLERS WAY, ASHEVILLE, NC 28804**

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D911	Continued From page 52	D911		

ambulation.

Interview on 11/23/16 at 10:30am with a family member for Resident #1 revealed:
-"Once, I found [Resident's name] sitting in the dark with his pants off and a wet diaper on the floor."
-"Another time, I found [Resident's name] lying on top of the covers, fully dressed and in the dark at 9:00pm when he needed to be prepared for bed."
-"I worry about his needs being met when I am not there."
-"There have been times when I walk the halls and cannot find staff available to answer questions."
-"The staff are lovely, but there is not enough to attend to all the needs of the residents."

D. Review of Resident #13's current FL2 dated 8/9/16 revealed:
-Diagnoses included diabetes, kidney stones, prior CVA (a stroke), sleep apnea, peripheral neuropathy.
-He was documented as non-ambulatory with wheelchair and required total care.

Review of Resident #13's Care Plan dated 8/16/16 revealed he required total assistance with toileting and extensive assistance with ambulation, bathing, dressing, grooming and transfer.

Interview on 11/23/16 at 2:35pm with Resident #13 revealed he sometimes required 2 person assistance, depending on which staff were working the floor.

E. Review of Resident #10's current FL2 dated 9/6/16 revealed:
-Diagnoses include right femur fracture, right

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D911	Continued From page 53	D911		

wrist fracture, abnormality gait, history of falls, mixed dementia, history of urinary tract infection, insomnia and vitamin D deficiency.
-Ambulation status was documented as semi-ambulatory.
-No assistive device had been documented.
-Her bowel and bladder status was documented as incontinent.

Review of the Resident Register revealed an admission date of 9/8/16.

Review of Resident #10's Care Plan dated 9/12/16 revealed:
-Her ambulation/locomotion status was not specified.
-Her bowel status was documented as daily incontinence.
-Bladder was documented as daily incontinence.
-Activities of Daily Living: Ambulation/Locomotion and Transferring of the resident required extensive assistance.

Based on observations and record review, Resident #10 was determined not to be interviewable

Confidential interviews with 5 residents related to wait times after the pendant button was pushed for personal care needs revealed:
-"During meal time I usually wait a minimum of 10-15 minutes once the pendant button is pushed."
-"About 7-10 days ago, a worker told me the reason the wait time was so long was because someone called in sick and there was no one assigned to this floor." (Upon review, no staff were noted to be out sick during that period of time.)
-"There are times I wait 40 minutes and push the

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D911	Continued From page 54 pendant a second time and many times it is at least 20 minutes." -"The workers always apologize and tell me how sorry they are for the delay and they were assisting another resident." -"I have wet my brief on a few occasions because they do not come when I push the pendant button and that is not a good feeling." -"I have begun to call staff before I know I need assistance for toileting so maybe I will not have an accident." -"Sometimes staff will come and push my pendant button (turn it off) and then say I will be right back to assist you and sometimes do not come back." -At one time a staff said, "See it only took me 20 minutes this time (to come back)." -"Staff work very hard and I hate to complain to anyone, but [named Executive Director] told me they were trying to hire more people." -"Sometimes they will answer the call button and assist me to the toilet and say they will be right back but don't." -'Sometimes it is a long time before they come back and sometimes I have to pull the call cord in the bathroom to remind someone to come back and assist me off the toilet." -"I have noticed the response time at night is sometimes longer, maybe 30 minutes a few times and when you have to go, you have to go." -"I do sometimes have to wait a long time but it is OK, because I know they are short staffed and I do not want to bother anyone." -"Sometimes I ring the bell for pain medication at night and it takes them 5-10 minutes sometimes." -"I do not need a lot of assistance but when I do I will pull all three call areas in my apartment and that way they know they better come quick." -"A couple of times, when I was not feeling well, I informed the staff I would be eating in my room,	D911		

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D911	Continued From page 55	D911		

they forgot me and I had to call them after waiting until 6:00pm to remind them I had not been served dinner."

Confidential interview with a family member revealed:
-"Things were really good in the beginning with staff and personal care needs but as they have added more residents it seems the wait times have increased."
-"I rarely see staff on the floor when I visit."
-"When the family interviewed with the Health Care Coordinator (HCC) we asked about wait times for resident care. I was told, by the HCC, the expectation was 2-3 minutes when the resident called for assistance, which is one of the reasons we chose this facility."
-The resident told the family member they sometimes had to wait "20-30 minutes" before staff responded to their call request.

Confidential interviews with three staff revealed:
-The staff gather before the shift begins and have a plan in place for the care of the residents.
-Staff stay busy all the time and there is not enough time to get to all the needs of the residents.
-The bathing is time consuming and staff cannot get to the other residents.
-The response time to the call bells is always a fast response 2-5 minutes.
-Staff are exhausted and more staff is needed.
-"This is a good staff team."

Interview on 11/22/16 at 3:10pm with a nursing assistant revealed:
-She had worked at the facility a little over 2 months.
-Some of her responsibilities were to assist with resident care, dressing, bathing, toileting,

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D911	Continued From page 56 transporting to meals, sometimes laundry. -She might sometimes be called to another floor to assist a staff person there but usually the MA would be on the floor to answer call bells. -She did think there was enough staff to meet the residents' needs timely. -She normally would answer call bells in under 3 minutes. Interview on 11/22/16 at 3:30pm with the Health Care Coordinator (HCC) revealed: -She was responsible for staff schedules. -The current census was 44 and she staffed a MA and a nursing assistant on each floor. -She had received no complaints from residents or their families related to delayed response times for personal care request. -Staff had not complained to her about needing additional staff to meet the resident's needs. -She was aware staff might leave their assigned floor to assist on another floor, leaving their assigned floor without coverage, but thought that had been "Ok'd " by their corporate office with someone at the state. -There are times the staff might have to leave their assigned floor especially around meal times to assist with getting residents on other floors to the dining room. -There was no written policy related to a staff member being on the floor at all times. -Breakfast was from 7:45am to 8:15am, lunch from 11:45am to 12:15pm and dinner from 4:45pm until 5:15pm. Review of the facility staff time cards and schedules for the previous two weeks on 11/22/16 revealed staffing requirements were met for the census of 44 residents on each shift. Interview on 11/22/16 at 4:45pm with the	D911		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D911	Continued From page 57 Executive Director revealed: -He was very surprised at the concerns voiced by the residents related to wait times for personal care assistance. -His door is always open for residents and no one had mentioned any of the concerns noted during the complaint investigation today. -He had spoken with someone on the state level who had stated staff could leave the floor to assist others. -He would have addressed the resident's concerns immediately had they been voiced to him by family or residents. -He takes these concerns very serious and they will be addressed immediately. -After he had been informed of the delay in answering call bells, he pulled the call bell response time report for the previous two weeks and there had been only one delayed response recorded on 11/20/16. Review of the call bell response time report on 11/22/16 revealed with the exception of the 11/20/16 delayed response noted by the Executive Director, all response times were logged within a 2-7 minute timeframe. Interview on 11/23/16 at 2:50pm with a nurse assistant revealed: -She feels there is adequate staff to meet the resident's needs. -She does not have to leave her assigned floor unless there is a MA available to cover the floor. Interview on 11/23/16 at 3:05pm with a MA revealed: -She is responsible for all the resident care needs, which includes answering the call bells. -She can usually respond to all call bells within 5-10 minutes.	D911		

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D911	Continued From page 58 -"There may have been a couple of times where it might have been 20 minutes, because I was assisting another resident." -"Sometimes the MA will assist with answering call bells." -"I think we have sufficient staff to meet all the resident needs." Interview on 11/23/16 at 3:15pm with the Licensed Practical Nurse (LPN) revealed: -Her role was to assist the HCC, backup medication aides, support physician calls or needs when they are in the building, and support for all staff. -She had not noticed any concerns related to delay in answering call bells. -It did get busy during meal times when staff were transporting residents to the dining room but staff had not reported any problems to her. Interviews on 12/5/16 with five residents revealed three residents had experienced delays (10 to 12 minutes) in having their call bells answered. Review on 12/6/16 of the call bell record for 11/28/16 through 12/5/16 revealed response times did not exceed six minutes. Interview on 12/9/16 at 12:09pm with the Executive Director revealed: -He was responsible for auditing the call bell response records. -He was not aware there were residents whose call bells had been turned off and staff left and did not return. -He would immediately address this with the staff and follow-up with the residents to assure their call bells are being answered properly. Interview on 12/5/16 at 11:55am with a	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

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THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D911	Continued From page 59 Medication Aide assigned to the dining room revealed: -There were two dietary aides and one care staff assigned to the dining room during meals. -Most of the residents in wheelchairs stayed in them while they ate. -She assisted residents to/from their tables and help serve beverages. -She did not leave the dining room. -If a resident needed help, she would call on her walkie-talkie and have another nursing assistant come and take them back to their room. -How long a resident had to wait depended on what the other staff were doing. -It could be from 10 minutes to 20 minutes before someone came to get them. -If she needed to, she would call again for assistance so the resident didn't need to wait.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations in the areas of facility management, health care, medication orders and medication administration and Residents' Rights.	D912	D912 (Resident Rights) The findings in 912 have been addressed in the previous citations. The HCC and the community ED will monitor for compliance as indicated in the previous citations. This deficiency will be in compliance ~~on 1/20/17~~.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 60 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure all care and services were provided to residents by management in accordance with all applicable local, state and federal regulations and codes related to health care, medication administration, medication orders and treating residents with respect and dignity. [Refer to Tag 980, G.S 131D-25 Implementation (Type B Violation).] 2. Based on observations, interviews and record reviews, the facility failed to assure the physician for 1 of 5 sampled resident (Resident #5) with a diagnosis of obstructive sleep apnea was notified regarding orders for Continuous Positive Airway Pressure (CPAP) therapy. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 3. Based on observations, interviews and record reviews, the facility failed to assure implementation of Thrombo-Embolic Deterrent (TED) hose for 2 of 2 sampled residents (Residents #2 and #5) with cardiac diagnoses and edema of the lower extremities. [Refer to Tag 276, 10A NCAC 13F .0902(c)(4) Health Care (Type B Violation).] 4. Based on observations, record reviews and interviews, the facility failed to assure medications (Lasix and Timoptic) were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #2 and #11) . [Refer to Tag 358, 10A NCAC 13F .1004(a)(1) Medication Administration (Type B Violation).]	D912		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D980	Continued From page 62 -He helped in the dining room several times a week and with activities as needed. -He assisted the Health Care Coordinator (HCC) with monthly medication turnover, chart audits and staff training. -He ran errands for the facility, completed paperwork reviews and audits to include the call bell response log. 1. Based on observations, interviews and record reviews, the facility failed to assure the physician for 1 of 5 sampled residents (Resident #5) with a diagnosis of obstructive sleep apnea was notified regarding orders for Continuous Positive Airway Pressure (CPAP) therapy. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 2. Based on observations, interviews and record reviews, the facility failed to assure implementation of Thrombo-Embolic Deterrent (TED) hose for 2 of 2 sampled residents (Residents #2 and #5) with cardiac diagnoses and edema of the lower extremities. [Refer to Tag 276, 10A NCAC 13F .0902(c)(4) Health Care (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to assure a Licensed Health Professional Support (LHPS) assessment was completed on 4 of 5 sampled residents (Residents #2, #7, #9 and #10) with identified personal care tasks ambulation using assistive devices, transferring semi-ambulatory and non-ambulatory residents and applying and removing TED hose. [Refer to Tag 280, 10A NCAC 13F .0903(c) LHPS.] 4. Based on interviews and record reviews, the facility failed to assure every resident received a	D980		

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	HAL011361	A. BUILDING: ______ B. WING ______	12/09/2016

NAME OF PROVIDER OR SUPPLIER: **THE CROSSINGS AT REYNOLDS MOUNTAIN**

STREET ADDRESS, CITY, STATE, ZIP CODE: **41 COBBLERS WAY, ASHEVILLE, NC 28804**

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D980	Continued From page 63 reasonable response to his or her requests from the facility staff related to non-ambulatory residents waiting to be returned to their rooms after meals and wait times for resident meals to be served after their order is placed. [Refer to Tag 338. 10A NCAC 13F .0909 Residents' Rights.] 5. Based on observations, record reviews, and interviews, the facility failed to assure a medication order for hydralazine which was unclear and incomplete, was verified and clarified in a timely manner with the prescribing practitioner for 1 of 7 sampled residents (Resident #11). [Refer to Tag 344, 10A NCAC 13F .1002(2)(a) Medication Orders.] 6. Based on observations, record reviews and interviews, the facility failed to assure medications (Lasix and Timoptic) were administered as ordered by a licensed prescribing practitioner for 2 of 7 sampled residents (Residents #2 and #11) . [Refer to Tag 358, 10A NCAC 13F .1004(a)(1) Medication Administration (Type B Violation).] 7. Based on observations, record review, and interviews, the facility failed to obtain a physician's order and to assess the resident's ability to self administer medications for 1 of 3 sampled residents (Resident #4) who self-medicated. [Refer to Tag 375, 10A NCAC 13F .1005(a)(1) Self-Administration Of Medications.] 8. Based on interviews and record reviews, the facility failed to assure 4 of 5 sampled residents (Residents #1, #2, #7 and #13) who required assistance with toileting were treated with respect, consideration and dignity and three additional residents received a reasonable	D980		

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D980	Continued From page 64 response in a timely manner to their calls for assistance. [Refer to Tag 911, G.S. 131D-21(1) Declaration of Residents' Rights.] ______ The facility failed to assure all care and services were provided to residents by management in accordance with all applicable local, state and federal regulations and codes related to health care, medication administration, medication orders and Residents' Rights related to receiving resonable responses to requests, being treated with respect and dignity and receiving adequate care and services. This failure put Resident #5, with a diagnosis of obstructive sleep apnea, at risk when they failed to notify the physician and obtain an order for CPAP (Continuous Positive Airway Pressure) therapy. Residents #2 and #5, with cardiac diagnoses and lower extremity edema and Resident #5 who had a pulmonary embolus with infarct (a blood clot in the lung resulting in a localized area of cell death) , were placed at risk due to inconsistent use of TED hose. (TED hose are tight fitting stockings that place mild pressure on the legs to prevent blood clot formation due to irregular heartbeat and are a treatment for pulmonary embolism and to prevent them from recurring.) Residents #2 and #11 were put at risk when Lasix, a diuretic, and Timoptic, used to treat Glaucoma and prevent blindness were not administered as ordered. These failures by the facility were detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. ______ A Plan of Protection was provided by the facility on December 9, 2016 and included the following: -Daily nursing stand-down meetings Monday-Friday and clinical shift meetings daily to start immediately. -Pulling daily call logs to review exceptions.	D980		

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D980	Continued From page 65 -Schedule multiple visits with the Regional Director of Clinical Services to assist in chart reviews and clinical education. -Interviewing for an additional LPN for 3:00pm to 11:00pm. -ED and Health Care Coordinator have begun to re-educate staff on charting and documentation. -Reviewing options for a third party contractor to handle/review LHPS. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2017.	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D980	Continued From page 61	D980		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure all care and services were provided to residents by management in accordance with all applicable local, state and federal regulations and codes related to health care, medication administration, medication orders and Residents' Rights related to receiving resonable responses to requests, being treated with respect and dignity and receiving adequate care and services.. The findings are: Interview on 12/9/16 at 12:05pm with the Executive Director revealed: -He was responsible for the day to day operation of the facility. -During the week, he was in the facility daily for 9 hours to 14 hours. -He periodically dropped in on the the weekends and occasionally conducted surprise visits after hours. -He met daily during the week with the department heads and also as needed throughout the day.	D980	D980 (Management)(B) The findings in 980 have been addressed in previous citations. The HCC and the community ED will monitor for compliance as indicated in the previous citations. This deficiency will be in compliance. ~~on 1/20/17~~ LD The administator will be engaged in the oversite of the community to include auditing clinical areas, resident interviews, in-servicing, coaching and monitoring the compliance of the regulations as set forth through DHHS. The administrator will follow-up with the Dept. heads through weekly meetings to discuss the review and compliance of the community. In addition, Harmony Senior Services will provide outside support with corporate staff as a resource and will monitor the community on a monthly basis. This deficiency will be in compliance on 1/12/17. LD	