CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0934-0391 SUBTINENT CO-INSTRUCTIONS IDENTIFICATION NUMBER: IDENTIFICATION CENTER	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED		
AND FLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMMULTED 346174 IN WING STREET ADDRESS, CITY, STATE, ZIP CODE C MAKE OF PROVIDER OR SUPFLER STREET ADDRESS, CITY, STATE, ZIP CODE TOTAL YOU CORA ROAD ASHEVILLE, NO 23801 SUMMAY STATISMENT OF DEVENDENCES STREET ADDRESS, CITY, STATE, ZIP CODE TOTAL YOU CORA ROAD PROVIDER OR SUPFLER SUMMAY STATISMENT OF DEVENDENCES PROVIDER TWAY STATISMENT OF DEVENDENCES PROVIDER TWAY STATISMENT OF DEVENDENCES COMMUTICE PROVID RECOLLTORY OR LSG IDENTIFINIS INFORMATION TAG PROVIDER TWAY STATISMENT OF DEVENDENCES COMMUTICE PROVID NITTAL COMMENTS ID PROVIDER TWAY STATISMENT OF DEVENDENCES COMMUTICE COMMUTICE F 000 INITIAL COMMENTS F 000 F 000 A33.25 (F323) at J. III Inmediate Jeopardy began on 06/15/14 when Residuation of compliance at all from all ft when the sling her was sitting on ripped and she fell onto the floor. F 000 F 000 A 57.5 (F320) at J. III Inmediate Jeopardy began on 06/15/14 when F 000 F 000 A 57.5 (F320) at J. III Inmediate Jeopardy began on 06/15/14 when F 000 A 57.5 (F320) at J. IIII Inmediate Jeopardy began on 06/15/14 when F 000 A 57.5 (F320) at J. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	CENTER	S FOR MEDICARE &	MEDICAID SERVICES							
C 07/11/2014 NMEC OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE C 07/11/2014 ASHEVILE NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, 2P CODE Y WCTORIA ROAD ASHEVILE NURSING & REHABILITATION CENTER C ONLOWER SPAN OF CONSECTION IS				(X2) MUL	TIPI	LE CONSTRUCTION				
349174 P. WING 077711/2014 INMUE OF PROVIDER OF SUPPLIER STREET AUDRESS CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 OTHER ADDRESS. CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 OTHER ADDRESS. CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 OTHER ADDRESS. CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 OTHER ADDRESS. CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 OTHER ADDRESS. CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 OTHER ADDRESS. CITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28801 F 000 INITIAL COMMENTS F 000 PROVIDER OR SPONDART Code Provide ADDRESS, STATE, ADDRESS, CITY, STATE, ZIP CODE BY UCTORA ROAD BASED ADDRESS, DITY, STATE, ZIP CODE BY UCTORA ROAD ASHEVILE, NO: 28001 CODE BY UCTORA ROAD BY UCTO	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i	COMF	PLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE ASHEVILLE NURSING & REHABILITATION CENTER STREET ADDRESS. CITY, STATE, ZIP CODE IVAID SUMMANY STREMENT OF DEPICIENCIES STREET ADDRESS. CITY, STATE, ZIP CODE IVAID SUMMANY STREMENT OF DEPICIENCIES PRETX TAG SUMMANY STREMENTON OF DEPICIENCIES D F000 INITIAL COMMENTS PRETX F000 INITIAL COMMENTS F000 F000 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>С</td></t<>								С		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CYT. STATE, 2P CODE ASHEVILLE, NC 38801 SWMMARY STATEMENT OF DEPCIENCIES (EAC) DORIGINATION CENTER IN VICTORI AROAD ASHEVILLE, NC 38801 (D1) PHERK TAG EXAMPLEY STATEMENT OF DEPCIENCIES (EAC) DORIGINATION MUST ER PRECEDE OF NULL (ECC) CORRECTIVE ACTION SUBJECT AND			345174	B. WING			07	/11/2014		
ASHEVILLE, NC 28801 (VA) ID PRETIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIANCE) MAIST EE PRECIDE Y FULL RECOUNTORY ON USE 0: PRECIDE Y RECOUNTORY ON USE 0: PRECIDE Y FULL RECOUNTORY ON USE 0: PRECIDE Y FULL RECOUNTORY ON USE 0: PRECIDE Y RECOUNTORY ON USE 0: PRECOUNTORY ON USE 0: PRECIDE Y RECOUNTORY ON USE 0: PRECIDE Y	NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		-		
CASHEDUCE, NC 28001 Display the period of the						91 VICTORIA ROAD				
Multip Heart REMANSARY STREEMENT OF DESCRIPTION (ECAD DESCRIPTION MUST BE RESCRIPTION) Description (ECAD DESCRIPTION ACTION MUST BE DESCRIPTION ACTION MUST BE DESCRIPTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION (ECAD DESCRIPTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION (ECAD DESCRIPTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION (ECAD ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTION (ECAD ACTION ACTI	ASHEVILL	E NURSING & REHABIL	ITATION CENTER		ASHEVILLE, NC 28801					
Precinity TxG IEACH CORRECTIVE ACTION BROUD BE REGULTIONY OR LSC DENTIFYING INFORMATION) PRECIN TAG IEACH CORRECTIVE ACTION BROUD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 000 INITIAL COMMENTS F 000 483.25 (F323) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had a fail from a lift when the sling he was sitting in ripped and he fell on the floor. Immediate Jeopardy began for Resident #17 had fail from a lift when the sling she was sitting on ripped and she fell into a recline-or, inmediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fail from a lift when the sling the was strong in ripped and he fell to the floor. The Cuality Assurance Committee failed to immediate jeopardy began on 06/15/14 when Resident #18 had fail from a lift when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fail from a lift when the facility provided and implemented an acceptable credible alting in ripped and he fell to the floor. The Cuality Assurance Committee failed to immediate Jeopardy began on resident #17 on 06/23/14 when Resident #17 had a fail from a lift when the sling she was stiling on ripped and he fell to the floor. The Cuality Assurance Committee failed to immediate Jeopardy began on resident #17 on 06/23/14 when Resident #17 had a fail from a lift when the sling she was stiling on ripped and he fell to informediate Jeopardy began on resident #17 on 06/23/14 when Resident #17 h		SUMMARY ST		ID	-	J	(X5)			
Ind Description of the latent intermediated of the latent of laten							BE	COMPLETION		
F 000 INITIAL COMMENTS F 000 483.25 (F323) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was caceptable credible allegation of compliance. The facility remains out of compliance at lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling she was effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling in the vas stiting on ripped and she was stiting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was stiting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was stiting on ripped and she fell into a recliner chari. Immediate Jeopardy was removed on 07/11/14 at 7:00 FM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance. The facility remains out of compliance at lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate Jeopardy be ensure monitoring of systems put into place are effective.	TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG				DATE		
 483.25 (F323) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at alower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemente an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with polerthal for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. 										
 483.25 (F323) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at alower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemente an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with polerthal for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. 										
Immediate Jeopardy began on 06/15/14 when Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he floor. The Quality Assurance Committee failed to immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had fall from a lift when the sling set was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 no 06/23/14 when Resident #17 no 06/23/14 when the facility remains out of compliance at lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.	F 000	INITIAL COMMENTS		F	00	0				
Immediate Jeopardy began on 06/15/14 when Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he floor. The Quality Assurance Committee failed to immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had fall from a lift when the sling set was sitting on ripped and she fell into a recliner chair. Immediate Jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 no 06/23/14 when Resident #17 no 06/23/14 when the facility remains out of compliance at lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
Resident #18 had a fall from a lift when the sling he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 00/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recident chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance thar immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		483.25 (F323) at J.								
he was sitting in ripped and he fell onto the floor. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fail from a lift when the sling she was sitting on ripped and she fell lint a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minima harm that is not immediate jeopardy be sure monitoring of systems put into place are effective.		Immediate Jeopardy	began on 06/15/14 when							
Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate jeopardy began on 106/15/14 when Resident #14 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate jeopardy began of Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy began for Resident #17 had she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		he was sitting in rippe	ed and he fell onto the floor.							
when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began of no fighed may fail from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy began an acceptable credible allegation of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.			•							
fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediateJeopardy began for Resident #17 on 06/23/14 when Resident #17 had fall from a lift when the sling oh was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemente an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		-								
provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 no 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
 (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 non 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. 			-							
potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		· ·								
immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.			-							
systems put into place are effective. Example three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was slitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
three and four are at scope and severity of E. 485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
485.75 (F520) at J. Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.			-							
Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
Immediate Jeopardy began on 06/15/14 when Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		485.75 (F520) at J.								
Resident #18 had fall from a lift when the sling he was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		. ,	began on 06/15/14 when							
was sitting in ripped and he fell onto the floor. The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.			•							
The Quality Assurance Committee failed to immediately identify and implement a comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
comprehensive action plan to prevent recurrence. Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		•								
Immediate Jeopardy began for Resident #17 on 06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		immediately identify a	and implement a							
06/23/14 when Resident #17 had a fall from a lift when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		comprehensive action	n plan to prevent recurrence.							
when the sling she was sitting on ripped and she fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		Immediate Jeopardy	began for Resident #17 on							
fell into a recliner chair. Immediate jeopardy was removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		06/23/14 when Resid	ent #17 had a fall from a lift							
removed on 07/11/14 at 7:00 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		-								
provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.		· ·	•							
(a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective.										
immediate jeopardy) to ensure monitoring of systems put into place are effective.			-							
systems put into place are effective.										
		systems put into place	e are effective.							
				_						

Electronically Signed

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

08/04/2014

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _				C / 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER					
				A	SHEVILLE, NC 28801		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=G			F	157			8/10/14
	7 483.10(b)(11) NOTIFY OF CHANGES				Resident #17 - The physician was noti by the Director of Nursing (DON) regarding the resident □s' change in	fied	

Facility ID: 923265

	-	ND HUMAN SERVICES MEDICAID SERVICES					INTED: 12/10/2014 FORM APPROVED IB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED	
		345174	B. WING _				C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER	•		SI	TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	_E NURSING & REHABIL	ITATION CENTER	91 VICTORIA ROAD					
				A	SHEVILLE, NC 28801		1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 157	Continued From page	e 2	F 1	157				
F 137	 F 157 Continued From page 2 continued complaints of left knee pain for 1 of 2 residents who had a falls from lifts (Resident #17); and failed to notify the physician that nursing staff was unable to administer a resident's medications (Resident #18); and failed to notify the physician of a resident's discontinuation of skilled therapy services (Resident #14) for 2 of 3 sampled residents. The findings included: 1. Resident #17 was admitted to the facility on 01/30/14 with diagnoses which included generalized weakness, arthritis, high blood pressure, diabetes, thyroid disease and depression. The most recent quarterly Minimum Data Set (MDS) dated 04/26/14 indicated Resident #17 had no short or long term memory problems, was cognitively intact for daily decision making and was totally dependent on staff for 			157	condition related to pain and the re- the x-ray and MRI on 7/7/14. Resid 17 continues to receive pain medic per physicians order, no further x-ra- tests had been ordered. The care plan was reviewed and up by the MDS as needed and staff we educated. Resident #17 was discharged to home on 7/28/14. Resident# 18 - The physician was n of the resident change in condition pm on 6/16/14 by a licensed nurse which time the physician reviewed resident s labs and did not give an further orders. At 7:17 pm, the resident s change of condition continued and the on-call physician notified by the licensed nurse. New orders were received to transfer to hospital for evaluation. All licensed	dent # ations ays or odated ere notified at 1:20 at the yy was v the		
	PM indicated a chang Resident #17 was be chair with a mechanic at the left front corner Resident #17 fell bac approximately 6 inchen noted. A review of a nurse's AM indicated a late e Resident #17 was co and was given as nee A review of a physicia	note dated 06/23/14 at 2:59 ge of status which revealed ing lifted out of a recliner cal lift and the lift pad ripped r. The notes indicated k into the chair es with no apparent injury note dated 06/24/14 at 7:46 ntry note for 6:00 AM that mplaining of left knee pain eded (PRN) pain medication. an's order dated 06/24/14 at ray of left knee due to pain.			Nurses staff have been re-educated the change of condition policy whic includes notifying the primary physio on-call physician, and the Administ Nurse on call by DON and SDC be 7-17-14 and 8-9-14. Resident#14 is currently receiving the services per physician order. She happropriate wheelchair for her need care plan has been updated and al licensed Nurses staff has been re-educated. Any resident having a change in con- can be affected by this practice. Therefore, the Regional Clinical Nurse and the DON audited	d on h cian or rative tween herapy has the ds. He	/ ; r	

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 3 of 168

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C
	ROVIDER OR SUPPLIER	040114		STREET ADDRESS, CITY, STATE, ZIF	07/11/2014
	NOVIDER ON SUIT LIEN			91 VICTORIA ROAD	CODE
ASHEVILI	E NURSING & REHABIL	LITATION CENTER		ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE
F 157	Continued From page	e 3	F 15	57	
F 137	A review of a radiolog 5:44 PM indicated lef fractures but moderat knee. A review of a nurse's AM revealed at 1:00 to verbalize that her I especially with activit The notes further rev knee had no redness swelling. A review of a physicia 06/25/14 indicated th the facility medical dia asked to see Resider of severe left knee pa Resident #17 fell into using a lift and the fa above the level of the revealed Resident #1 floor first and she suc pain and today at the had significant tenden knee region and prox foreleg on her left leg no significant swelling	gy report dated 06/24/14 at it knee x-ray indicated no te osteoarthritis in the left note dated 06/25/14 at 1:35 AM Resident #17 continued eft knee was painful or sore y and the area was guarded. ealed Resident #17's left		 24-hour report on 7/17/14 60 days to ensure that changes in condition by the nursing staff and t and RP were notified of t condition. The Therapy Department nursing department in the meeting and morning clir when a resident is being Therapy. The therapy De the physician to update of progress and to obtain an discharge from therapy s Licensed therapist and al nursing staff were re-edu procedure on 8/4/14. Between 7-17-2014 to 8/ and SDC re-educated all staff regarding the facility notification of a change in condition. The Federal R regarding Notification of 0 Condition was provided t Nurses staff for education between 7/17/14 and 8/9 orders are copied each d 	a were addressed hat the physician he change in t will notify the e Medicare nical meeting discharged from epartment will call on the resident s n order for service. All Il licensed licated on this 9/14 The DON licensed Nurses y policy on n a resident s egulation Change in o all licensed nal purposes /14. Physician □
	Oxycodone by mouth hours on a PRN basis notes also indicated I due to severe pain or diagnosis, assessme Resident #17 had a h	nistory of severe		medical records clerk and the DON for follow-up. Al record are audited daily f charting and the nurses a return to the facility to co on the medication record named re-education was	Il medication for missed are called to mplete charting I. The above 100% or the
	degenerative joint dis followed by orthoped chronic right knee pa	ic surgery because of		licensed nursing staff tha attended the in-service w re-education is complete	vill not work until

Facility ID: 923265

If continuation sheet Page 4 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/10/2014 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345174	B. WING				C / 11/2014
	ROVIDER OR SUPPLIER	LITATION CENTER		91	TREET ADDRESS, CITY, STATE, ZIP CODE 1 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	bone survey of the le possible fractures an evaluation before dec needed. A review of a physicia 2:00 PM indicated x leg due to pain and c milligrams (mg) by m by mouth every 6 hou A review of a physicia with no time indicated obtain left leg x-rays /fibula (calf bone) and views on each. A review of a nurse's PM revealed Resider physician and continu- pain. The notes furth were received for sch x-ray of full leg and h A review of a radiolog indicated moderate of and no acute fracture lesions in the left fem A review of a nurse's 10:25 AM revealed Resi recliner from a lift and femur, and tibia/fibula further revealed Resi complain of left leg po scheduled for pain was	an had requested a complete ft lower leg to assess for d would await x-ray ciding further intervention if an's order dated 06/25/14 at ray full left hip and whole left hange Oxycodone to 5 outh twice a day and 5 mg urs PRN for pain. an's order dated 06/25/14 d an order clarification to of the hip, tibia (shin bone) d femur (thigh bone) with 2 note dated 06/25/14 at 2:52 nt #17 was assessed by the used to complain of left knee her revealed physician orders heduled pain medication and ip. gy report dated 06/25/14 steoarthritis of the left hip a, dislocation or destructive nur. note dated 06/26/14 at tesident #17 had a fall into a d x-ray results of her left hip, a were negative. The notes dent #17 continued to	F	157	The DON, RN Supervisor, QA Nurse audit for Changes in Condition utilizi the 24-hour report Monday thru Frida six months to assure continued compliance. The Medical Record cle will audit the charts on a quarterly ba and make any changes on the face s that need to be made. She will then replace the face sheet with the updat one in the medical record. The result these audits will be taken to the QAP Meeting monthly by the DON x 6 mon or until compliance is achieved.	ng y for rk sis heet ed s of I	

If continuation sheet Page 5 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _			
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL	ITATION CENTER		9	91 VICTORIA ROAD		
				4	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	9 5	F '	157	-		
	PM indicated Resider of left knee pain and i obtained from pain m	note dated 06/27/14 at 3:25 ht #17 continued to complain moderate relief was edication. There was no notes that the physician was					
	indicated a Magnetic x-ray of left knee state	an's order dated 07/07/14 Resonance Imaging (MRI) us post injury due to ange of motion and normal					
	indicated a clarification without contrast due t	an's order dated 07/07/14 on order for MRI of left knee to injury with severely notion and normal x-rays.					
	PM revealed Residen	note dated 07/08/14 at 1:17 at #17 was out of the facility due to severely decreased					
	without contrast dated facsimile (faxed) date	in the top left corner of the					
	 Moderate to severe (middle) compartmen contusions. The medial meniso that provides structure extruded (pushed out tear of the extruded b Findings suggest a 	eus (a semicircular cartilage al integrity to the knee) is) and there is a probable					

Facility ID: 923265

If continuation sheet Page 6 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10 FORM APPRO OMB NO. 0938-		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING		C 07/11/2014		
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				91 VICTORIA ROAD			
ASHEVILL	E NURSING & REHABIL			ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE HE APPROPRIATE DAT		
F 157	Continued From non	- 0					
F 137	Continued From page	9 0	F 15	1			
	of the knee.						
		cular swelling within the					
		e muscle located on the front					
	of the thigh).						
	A further review of the	e MRI report with the faxed					
		2:46 PM revealed a hand					
		not signed which indicated					
		. Orthopedic referral to bone					
		n Monday 07/21/14 at 2:00					
	PM.						
	A review of a physicia	an's order dated 07/11/14 at					
		refer Resident #17 to a bone					
	and joint specialist or	n 07/21/14.					
	During an interview o	n 07/02/14 at 11:30 AM					
		ed on 06/23/14 she was					
		air in her room and called					
		er back to bed and Nurse					
	. ,	#15 went to go find a lift.					
		e (NA) #3 and NA#15 came					
		ith the lift and connected the					
		h corner of the sling to the o raise her up out of her					
		when they raised her up off					
		ont left corner of the sling					
		d apart and she fell from the					
	lift back into the reclin						
	explained when she	started to fall NA #15 was					
		on her left side and pushed					
		chair so she would fall into					
		alling on the floor. She					
	÷	the floor and she was in so					
	-	rying and NA #3 and NA #15					
		come to the room and they					
	chair back into bed.	lifted her from the recliner					

Facility ID: 923265

If continuation sheet Page 7 of 168

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOF	ED: 12/10/2014 RM APPROVED IO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED		
	345174	B. WING		0	C 7/11/2014		
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COE	DE			
		9	91 VICTORIA ROAD				
ASHEVILLE NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
 physician saw her or because she was had knee and since the phe ordered x-rays of she was told they we #17 further stated she with her left knee and MRI because she had before she fell from the pain medication daily During an interview of Nurse #2 she stated afternoon she was and screaming coming fm She explained she rates and the mechanical I lift back and Resident #17 was in that her left foot was and the mechanical I lift back and Resider She explained she a she could not find an bruising. She stated what what had happen had ripped at the left dropped approximate recliner. She further sitting in the recliner the mechanical lift affront corner of the sli sling. She explained when what what had happen had ripped at the she sitting in the recliner the mechanical lift affront corner of the sli sling. She explained when when when when when when when when	ere negative. She stated the a Wednesday 06/25/14 ving so much pain in her left vervious x-rays were negative her left hip and leg and and ere also negative. Resident e felt something was wrong d thought she should have a d not had pain in that knee he lift and now had to take y on a regular basis. on 07/08/14 at 9:34 AM with on 06/23/14 during the t the nurse's desk and heard om Resident #17's room. an into the room and her recliner chair screaming stuck between her recliner ift. She stated she pulled the at #17 stopped screaming. ssessed Resident #17 but by redness or swelling or she asked Resident #17 ened and she said the sling front corner and she ely 6 inches back down in the stated Resident #17 was with the sling still hooked to and Nurse #2 verified the left ng had totally ripped off the l Resident #17 had a left 06/24/14 and the results were the had x-rays of her left hip /14 and the results were d Resident #17 was ten discharged to go home discharge was put on hold	F 157					

Facility ID: 923265

If continuation sheet Page 8 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/10/2014 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345174	B. WING			07	7/11/2014
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	results until the DON request a MRI on 07/ was still complaining stated she called the verbal order to sched and Resident #17's a for this afternoon bec available appointmen During an interview o DON explained she ta 06/24/14 as part of he her fall from a lift and that her left knee was she told Nurse #2 to o order for a left knee x x-ray results were ney still complaining of pa 06/25/14 and the phy ordered full x-rays of also negative. She st made aware that Res complaining of left kn #2 to call the physicia physician should orde Resident #17 went to afternoon but she did were. During an interview o Resident #17's physic Medical Director verif Resident #17 after sh complained of severe confirmed Resident # her right knee due to was not aware Resident	te physician about x-ray told her to call him to 07/14 since Resident #17 of pain in her left knee. She physician and he gave a ule Resident #17 for an MRI ppointment was scheduled ause that was the next it date and time. n 07/08/14 at 5:16 PM the alked with Resident #17 on er investigation regarding the resident complained a hurting. The DON stated call the physician to get an t-ray. She explained the gative but Resident #17 was ain in her left knee on sician examined her and her left leg but they were tated on 07/07/14 she was	F	157			

Facility ID: 923265

If continuation sheet Page 9 of 168

CENTER STATEMENT	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER	•	STE	REET ADDRESS, CITY, STATE, ZIP CC	DE
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		VICTORIA ROAD SHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONHE APPROPRIATEDATE
F 157	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 157		

Facility ID: 923265

If continuation sheet Page 10 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING				_ 11/2014
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	(MDS) dated 03/24/14 had no short or long to cognitively intact for or was totally dependent activities of daily living A note written by the dated 06/16/14 at 8:0 entry note for a 7:00 // Resident #18 would re stimulus, his vital sign and he had no signs of The note revealed that AM medications were was unable to be away revealed Resident #1 to the first shift nurse. Nurse #5 was intervied PM. Nurse #5 stated of periods of unawake response to external unable to give Reside morning of 06/16/14. report to the oncomin condition but had not physician because the Resident #18. On 07/10/14 at 9:59 // interviewed. She state have episodes where acting as if he were in	terly Minimum Data Set 4 indicated Resident #18 erm memory problem, was laily decision making, and t on staff for most of his g (ADLs). night shift nurse, Nurse #5, 3 AM indicated it was a late AM assessment that not respond to external as were within normal limits, or symptoms of distress. at all of Resident #18's 6:00 held because Resident #18 akened. The note further 8's condition was reported weed on 07/08/14 at 6:22 Resident #18 had a history ening episodes and no stimuli. She verified she was ent #18 his medications the She indicated she gave g nurse of Resident #18's contacted the on-call is was not unusual for	F	157			

Facility ID: 923265

If continuation sheet Page 11 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER			11 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
F 157	PM. She stated she of and worked from 7 Al Resident #18 had a h on some days in whice deep sleep and would wake him. She stated his baseline, awake a Nurse #5 reported the on 06/16/14 that Nurse again," meaning he w medications. Nurse # checked on Resident oxygen saturation we stated she shook him rubbed his cheeks an let him sleep. Nurse # the resident later in he was still in what appe and would not waken stated his vital signs a within normal limits at had seen the resident before so did not cons condition for him. Nurse #1 stated she of 1:20 PM and informed were ordered for Res informed the physicia resident's condition the physician gave her or 06/17/14, but gave no Resident #18. A review of a nurse's PM indicated the physical Resident #18's contin	wed on 07/09/14 at 1:35 ame on duty on 06/16/14 M to 3 PM. She stated that istory of lethargic episodes the appeared to be in a d not wake up if you tried to l later he would be back to and talking. She stated when e resident's condition to her be #5 told her "He is doing it yould not wake up to take his 1 stated that after report she #18 whose vital signs and re within normal limits. She and held his face and d he did not awaken so she f1 stated she checked on er shift before lunch and he ared to be a deep sleep, or open his eyes. She and oxygen saturation were t that time. She stated she t in this state multiple times sider this to be a change in contacted the physician at d him of results of labs that ident #18 on 06/15/14. She n at that time of the nat morning. She stated the ders for additional labs for o further orders regarding note dated 06/16/14 at 1:20	F	157			

Facility ID: 923265

If continuation sheet Page 12 of 168

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	FOR OMB N	D: 12/10/2014 M APPROVED D. 0938-0391 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED C
		345174	B. WING			/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 157	 about the results of R ordered labs. The not informed the physicia repeated on 06/17/14 nurse's note indicated received from the phy nurse's note revealed medications were not held related to the res During an interview of physician indicated he Resident #18's period on Monday 06/16/14 resident had a history refusal of care, and th similar to this in the phy association with a urin physician stated that be notified of Resider nurse was unable to a medications. Resident #14 was 12/05/13 with pressur chronic obstructive phy of the FL2 form with a revealed she required nonambulatory, requi assistance for bathing receive physical thera needs related to weig The physician orders (PT) was ordered 5 tii weeks on 12/06/13 fo exercises and activitie 	esident #18's recently the further indicated Nurse #1 in the lab work would be Continued review of the d no new orders were visician. Further review of the l Resident #18's oral given and his meals were sident's somnolence. In 07/09/14 at 12:45 PM, the e was made aware of ds of unawakening episodes at 1:20 PM. He stated the of non-compliance with and hat he had had episodes ast, sometimes in nary tract infection. The he would have expected to at #18's condition when the administer his 6:00 AM admitted to the facility on re ulcers, diabetes, and ulmonary disease. Review a faxed date of 12/03/13 d skilled nursing care, was red personal care g and dressing, was to apy daily and had specialized iht. revealed physical therapy mes per week times 4 or gait training, therapeutic	F 15			

Facility ID: 923265

If continuation sheet Page 13 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 157	included a short term bed to 4 hours and a gait training with rollin The physician orders therapy (OT) was ord for 8 weeks on 12/06/ activities of daily living exercises, neuro re-e as needed, wheelcha treatment, nurse/care education. The evalue included a short term transfers with maximu appropriate device ar The admission Minim 12/12/13 coded her w assistance needed fo toileting. Walking and during this assessme as receiving PT and C was a discharge plan to the community. PT notes dated 12/17 family brought in a w appeared too small for pressure areas on lat 12/18/13, 12/19/13, 0 revealed attempts to facility to assist Reside more active in therapy appropriate equipmer facility management. On 01/06/14, the physical	ion completed on 12/06/13 goal to increase time out of long term goal to complete ag walker. revealed occupational ered 5 to 7 times per week (13 for therapeutic activity, g/self care, therapeutic ducation, thermal modalities ir management, manual giver education, and nursing lation dated 12/07/13 goal to complete wheelchair um assistance of one with ad safety. um Data Set (MDS) dated vith intact cognition, total r bed mobility, dressing, and d transfers did not occur nt period. She was coded DT. The MDS noted there for Resident #14 to return 7/13 revealed Resident #14's heelchair from home which or her and could cause eral hips. PT notes dated 1/01/14, and 01/02/14 utilize equipment in the lent #14 out of bed and	F	157			

If continuation sheet Page 14 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2014
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD		
				4	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	<u>9</u> 14	F	157	,		
_		, therapeutic activities,		101			
	neuromuscular re-edu						
	visit as needed.	I therapy, gait training, home					
		an progress notes dated					
		acility was having difficulty and the facility was working					
	0 0	r size wheelchair so she can					
		asis. Her plan was noted as					
		Γ to maximize function and /ities of daily living and					
	mobility. Physician p						
		lent #14 was making "very d OT as they were having					
		obilizing her. Her plan at this					
	The PT discharge su	mmary dated 01/27/14					
		ad not achieved her goals					
		priate equipment to allow pt out of bed)" and that the					
	facility was in the pro-	cess of obtaining appropriate					
	-	ntinued that therapy will for further skill. Discharge					
	instructions was for a	home exercise program.					
		ary was not signed by the vas no discharge order					
		an in the medical record.					
		discharge summary stated					
		ited to in bed activity and					
		cess the therapy gym at this I the facility was awaiting					
	approval for a bariatri	c wheelchair and the					
	-	y unable to sit at the edge of the air mattress required for					
		OT would re-evaluate when					
	the wheelchair arrives						

If continuation sheet Page 15 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	SURVEY PLETED
		345174	B. WING				C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From page	9 15	F	157			
	with PT but she was u she does not have a accommodate her. T doing some strengthe plan stated she was t endurance and streng wheelchair that can a did not indicate know aware skilled therapy discontinued. Physician progress not the chief complaint was significant concerns r bedridden status and evaluation by PT. The not want to be bed rice asking PT to evaluate "bariatric wheelchair to functional gains." The quarterly MDS da Resident #14 was con- transfer, walk, or do a day assessment perior normally used was not Physician orders date evaluate and treat Re- orders dated 05/22/14 times per week for 30 exercises, therapeution re-education, self car- management and models.	A so that the physician was services had been been determined to the					

		ID HUMAN SERVICES				FORM	APPROVED
STATEMENT O	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			LETED
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2014
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD		
					ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	. 16	_	157	7		
1 107		id not get her out of bed and		157			
	therapy stopped when	n she had no wheelchair to					
		e has a wheelchair now hat fits her. She stated she					
	-	nd 2:45 PM and returned to					
	bed around 4:15 PM.						
	On 07/01/14 at 3:01 F	PM Resident #14 was					
		erself in a wheelchair using					
		I. On 07/01/14 at 3:20 PM served in the therapy gym					
	doing arm exercises.						
	On 07/02/14 at 12:03	the social worker stated					
	that initially Resident	#14 did not come to the					
		nair. The resident's family or one from home however					
	-	did not fit the resident					
	properly.						
	Resident #14 stated of	on 07/02/14 at 2:57 PM that					
		when she first arrived. She					
	stated therapy had as wheelchair at home a	nd she had a friend bring					
	her wheelchair from h	nome to the facility. She					
	reported that therapy was too small.	determined that wheelchair					
		AM, the Administrator was d that the facility had been					
	looking for months to	-					
		ent #14. He stated the					
		e was using was loaned by urther stated that when the					
	new therapy company	y came in (beginning in April)					
		ger stated there was a larger t another facility he had					
	been at previously, so	o the facility obtained that					
	wheelchair for Reside	ent #14 to use.					

Facility ID: 923265

If continuation sheet Page 17 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 (I APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION G			LETED
		345174	B. WING			(07/	C 11/2014
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD			
ASILVILL				ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE		(X5) COMPLETION DATE
F 157	Continued From page	9 17	F 1	57			
	Continued From page 17 Interview on 07/03/14 at 4:15 PM with the rehab manager revealed a new therapy company began in the facility on 04/01/14. He became the rehab manager on 05/12/14. At that time he became involved in the morning management meetings. During the morning management meeting, there had been a discussion of a resident who needed an extra wide wheelchair. The rehab manager stated he was aware of one at another facility and suggested they try to borrow that wheelchair for her. The rehab manager stated they obtained the extra wide wheelchair the next day and Resident #14 began therapy again. An interview was conducted with OT and PT on 07/10/14 at 10:08 AM. Both OT and PT on 07/10/14 at 10:08 AM. Both OT and PT othe therapy company change in April 2014 and continued on with the new therapy company since April. OT stated that Resident #14 was unable to walk and she could not access the therapy gym due to no wheelchair available to fit her properly. She further stated that she was unable to do therapy and exercises at bedside due to her using an air mattress and sitting on the edge of the air mattress was a fall risk. Both OT and PT stated therapy services ended due to the facility not having the correct wheelchair for her to access the therapy gym. There was no indication in the medical record that Resident #14's physician was notified or involved in the discontinuation of skilled therapy services			F 157			
	and/or the attempts the obtain the appropriate treat her.	ne facility was making to e size wheelchair in order to					0/40//4
F 166	483.10(t)(2) RIGHT T	O PROMPT EFFORTS TO	F 16	66			8/10/14

Facility ID: 923265

If continuation sheet Page 18 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					1 APPROVEI . 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 07/11/2014		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD ISHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 166 SS=E	10			166				
	facility to resolve grie	ht to prompt efforts by the vances the resident may with respect to the behavior						
	by: Based on observatio interviews, and medic failed to monitor and of grievances regardi extended periods of t residents. (Resident The findings included 1. Resident #21 was 03/15/13 with diagnos gastroesophageal ref mellitus, other fractur depression. Residen most recent Minimum Set (MDS) dated 03/7 requiring extensive as person assist for mos (ADL). An interview was con AM with the Director of revealed that she has reported to her but do	#21 and #15). : admitted to the facility on ses including hypertension, lux disease, diabetes e, anxiety disorder and t #21 was assessed on the Data I9/14 as cognitively intact			The Administrator, Senior Administrato DON and Social Services Director met with Resident #15 and the resident's daughter,(RP) to review concerns/grievances on 7/28/14 to determine a resolution. The Senior Administrator explained to RP that she could voice her concerns to the Administrator, DON, RN Supervisor or Social Services Director or by filling out the grievance form available throughout the facility so that the concerns can be addressed by the appropriate departmet The facility Administrator gave his personal cell phone number to the RP who stated understanding. Resident #21 was interviewed on 7/28/ by the Administrator concerning past concerns/grievances. Resident #21 states that she is happy of her current treatment nurse and is treat with kindness, dignity and respect by current treatmer nurse as well as other staff members.	t it ent. 114 with ted		
	most of the grievance	opy to give to the be handling it. She stated is received have been reported the Assistant			Any resident that has a grievance or concern could be affected by this pract Therefore, all	ice.		

Event ID: 0W9Y11

Facility ID: 923265

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/20 /I APPROVE). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		SURVEY LETED
		345174	B. WING				_ 11/2014
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1	
	E NURSING & REHABI			91 V	VICTORIA ROAD		
ASHEVILL	LE NURSING & REHADI	ENATION CENTER		AS	HEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 166	Continued From page	e 10	F 16	86			
1 100	10	Jnit Manager had followed			grievances were audited by the Social		
		interviewing residents, family			Services Director, DON and the Corpo		
		s part of the investigation to			Nurse Consultant for		
		e. The Director of Social			the past 6 months on 7/16/14. All		
	Services stated she	-			grievances were found to have a		
	-	dents and from family			resolution.		
		lents having to wait for long			On 7/22/44 the Designal Olinical Num	_	
	•	ound care, preventing them tend activities and therapy.			On 7/22/14 the Regional Clinical Nurse re-educated the Administrator and	e	
		tend detivities and therapy.			department managers		
	On 07/02/14 at 4:53	PM an interview was			concerning the grievance resolution		
	conducted with Resid	dent #21. The resident			policies and procedures. From 7/17/14	Ļ	
		d multiple grievances			thru 8/9/14, the DON/SDC in-serviced		
		wait in bed for hours for			Housekeeping/Laundry staff,		
	-	e wound care. Resident #21			Maintenance/Floor tech staff, Dietary	fied	
		he had been told at 9:30 AM stay in bed and wait for			staff, all licensed Nursing staff, all certi nursing assistants, all certified medica		
		wound care and she was still			aides, all department heads (Dietary		
		Resident #21 stated she had			Manager, Maintenance Director,		
	been instructed to sta	ay in bed and keep water			Housekeeping/Laundry Supervisor,		
	•	ounds until Nurse #7 arrived.			Business Office Manager, Medical		
		this happened at least			Records Director, Marketing Director,		
		7, and she had complained writing to nurse aides, other			Social Services Director, Assistant Director of Nursing, Staff Development	+	
		rector of social services, and			Coordinator, Quality Assurance Nurse		
		of nursing/unit manager			Activity Director, Administrator, Therap		
		ent #21 stated nothing had			Director)Physical Therapist, Occupation		
	-	I had to wait all day for			Therapist, Speech Therapist,		
	wound care.				Occupational Therapist Assistant,		
		ducted on 0.7/0.3/14 of 0.25			Physical Therapist Assistant, Office Assistant, Human Resource Director,		
		nducted on 07/03/14 at 9:35 n Assistant (PA), who			regarding reporting to their immediate		
		th Nurse #7 each week to			supervisor any grievance/concern brou	ught	
		PA said Resident #21 had			to them by a resident or family membe		
	complained to her the	at she had not received her			Instructions on how		
	wound treatments tin	nely.			to report a concern or grievance is pos		
					on each unit on the wall by the nursing		
		nducted on 07/07/14 at 5:04			stations. All grievances will be given to		
	Pivi with the Director	of Nursing (DON). She			Administrator who will follow up with the	ie	

Facility ID: 923265

If continuation sheet Page 20 of 168

I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174 TION CENTER MENT OF DEFICIENCIES UST BE PRECEDED BY FULL	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/11/2014
TION CENTER	S S		
MENT OF DEFICIENCIES	9		
MENT OF DEFICIENCIES			
MENT OF DEFICIENCIES	4	91 VICTORIA ROAD	
		ASHEVILLE, NC 28801	
IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
) new DON for about 3 n given grievances to She said she had not n residents about a long time for wound was her expectation that wound care in a timely t filed a grievance about e for wound care, it would dived with the appropriate on 07/09/14 at 10:21 AM ently complained about wound care. Nurse #2 on resident complaints to nd to the administrator o wait hours for therapy ng for wound care. ation hadn't improved or r. on 07/09/14 at 10:30 AM ed to the administrator onts were complaining long for wound care. op the residents so they are not in pain, ivities are delayed some y wait for Nurse #7 to mitted to the facility on including acute omegaly, heart failure, The most recent	F 166		or is will e will sed by he in a vices are onths and ow- the ttee x h the
r na vteol cevororar cealait r ons	new DON for about 3 n given grievances to She said she had not a long time for wound was her expectation that yound care in a timely filed a grievance about e for wound care, it would we with the appropriate on 07/09/14 at 10:21 AM ently complained about yound care. Nurse #2 n resident complaints to no to the administrator of wait hours for therapy ng for wound care. tion hadn't improved or on 07/09/14 at 10:30 AM d to the administrator nts were complaining ong for wound care. os the residents so they are not in pain, vities are delayed some wait for Nurse #7 to nitted to the facility on including acute megaly, heart failure, The most recent) quarterly assessment Resident #15 was ired and usually able to	new DON for about 3 n given grievances to She said she had not a long time for wound was her expectation that yound care in a timely filed a grievance about a for wound care, it would we with the appropriate on 07/09/14 at 10:21 AM ently complained about yound care. Nurse #2 in resident complaints to no to the administrator o wait hours for therapy ng for wound care. tion hadn't improved or on 07/09/14 at 10:30 AM d to the administrator nts were complaining ong for wound care. os the residents so they are not in pain, vities are delayed some wait for Nurse #7 to nitted to the facility on including acute megaly, heart failure, The most recent) quarterly assessment Resident #15 was ired and usually able to	new DON for about 3 n given grievances to She said she had not residents about a long time for wound was her expectation that vound care in a timely filed a grievance about of rowound care, it would ved with the appropriate for wound care, it would vound care. Nurse #2 n resident complaints to of to the administrator o wait hours for therapy ig for wound care. tion hadn't improved or so there scidents so they are not in pain, vities are delayed some wait for Nurse #7 to mitted to the facility on including acute megaly, heart failure, The most recent) quarterly assessment Resident #15 was

Facility ID: 923265

If continuation sheet Page 21 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_		COMP	PLETED
		345174	B. WING				C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2014
				g	01 VICTORIA ROAD		
ASHEVILI	_E NURSING & REHABIL	ITATION CENTER		4	ASHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	41E	DATE
F 166	Continued From page	e 21	F	166			
	be understood.						
		reports revealed the family					
		#15 had filed the following					
	grievances:						
		04/09/14 by the family sident #15 had not being					
		every 2-4 hours. Family					
		ad observed him going for					
		hecked or turned when he					
		d. The grievance also					
	-	ember felt staff had been					
		Resident #15, causing him					
	excessive pain during	o Care. 06/06/14 by the family					
		e had observed Resident					
		ours to be changed on					
		nce also revealed the family					
		been physically rough with					
		g him excessive pain during					
	care.	06/06/11 (concrete from					
		06/06/14 (separate from member revealed family					
	member was unhapp						
		06/08/14 by the family					
		e had observed Resident					
		wn at the bottom of his bed,					
	unable to get up to th						
	-	vance revealed staff had not					
	he had not been able	up to top of bed to eat, and					
		06/10/14 by the family					
		sident #15's unplugged					
		incentrator had not been					
		ours which had resulted in					
		vithout oxygen for several					
	hours. The grievance	-					
		this occurring "7 or 8"					
	umes previously with	out resolution and staff was					

Facility ID: 923265

If continuation sheet Page 22 of 168

						FOR	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		PLETED
		345174	B. WING				C / 11/2014
NAME OF PI	ROVIDER OR SUPPLIER	·	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	LITATION CENTER		Å	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	Continued From page	a 22	E E	166			
1 100	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILE 345174 B. WING WE OF PROVIDER OR SUPPLIER 345174 B. WING WE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 166 Continued From page 22 still not checking his oxygen frequently enough. F An interview was conducted on 07/01/14 at 8:00 AM with the Director of Social Services. She revealed that she had written up and verbally informed other team members about grievances reported to her but did not investigate them. She said once she has received a grievance she logged it and made a copy to give to the department who would be handling it. She stated most of the grievances received had been nursing issues. She reported the Assistant Director of Nursing /Unit Manager (ADON/UM) had followed up on grievances by interviewing residents, family members and staff as part of the investigation to resolve the grievance. An interview was conducted on 07/01/14 at 4:46 PM with ADON/UM. She revealed the Social Worker had written grievances on forms and had given the forms to the department related to the grievance issue to be investigated. The ADON/UM also stated some grievances have been investigated by the nurse unit managers. The ADON/UM also stated some grievances have been investigated by the nurse unit managers. The ADON/UM stated she had at different times interviewed residents, family members and staff and had provided staff education related to grievance care issues. The ADON/UM said after she had completed interviews with residents, family members and staff she had discussed the findings with the complainant.		100				
	still not checking his	oxygen frequently enough.					
1							
	-	-					
	logged it and made a	copy to give to the					
	-	-					
	•						
	-	-					
	-	-					
	-						
	•	•					
	-						
		-					
	-						
	÷						
	-	-					
	-	-					
	-						
	AT OF DEFICIENCIES OF CORRECTION (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174 F PROVIDER OR SUPPLIER ILLE NURSING & REHABILITATION CENTER ILLE NURSING & REHABILITATION CENTER C SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 36 Continued From page 22 still not checking his oxygen frequently enough. An interview was conducted on 07/01/14 at 8:00 AM with the Director of Social Services. She revealed that she had written up and verbally informed other team members about grievances reported to her but did not investigate them. She said once she has received a grievance she logged it and made a copy to give to the department who would be handling it. She stated most of the grievances received had been nursing issues. She reported the Assistant Director of Nursing /Unit Manager (ADON/UM) had followed up on grievances by interviewing residents, family members and staff as part of the investigation to resolve the grievance. An interview was conducted on 07/01/14 at 4:46 PM with ADON/UM. She revealed the Social Worker had written grievances on forms and had given the forms to the department related to the grievance issue to be investigated. The ADON/UM stated she had at different times interviewed residents, family members and staff and had provided staff education related to grievance care issues. The ADON/UM said after she had completed interviews with residents, family members and staff she had discussed the findings with the complainant. She said if the complainant had agreed the grievance had been resolved the complainant. She said if the complaints from the family member of Resident #15. Wh					L	

Facility ID: 923265

If continuation sheet Page 23 of 168

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10 FORM APPR OMB NO. 0938	ROVI
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/11/2014	
		345174	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
				91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABI	LITATION CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPL HE APPROPRIATE DAT	(5) LETIO ATE
F 166	Continued From pag	e 23	F 16	5		
	aides from day shift a	about turning and changing				
	•	e basis. The ADON/UM				
		nterviewed the staff who had				
	worked with Residen	t #15 on the day mentioned				
	regarding the length	of time he was left without				
	care or the allegation	n of roughness. The				
	ADON/UM also state	ed she had not interviewed				
		r nurse aides, or other family				
		lar care issues or concerns.				
		grievances filed by the				
	•	sident #15 on 06/06/14, the				
		e had placed an inservice s station for all nurse aides to				
		ADON/UM stated she had not				
		who had worked with				
		day mentioned regarding				
	Resident #15 waiting					
	changed or the rough					
		DON/UM also stated she had				
	not interviewed other	r residents, other nurse				
	aides, or other family	/ members about similar care				
	issues or concerns.	The ADON/UM stated she				
	wasn't aware of the g	grievance dated 06/06/14				
	÷	care because it had been				
	-	nistrator. When shown the				
		e family member of Resident				
		ADON/UM stated she had				
	-	sheet at each nurse's station				
	for all nurse aides to	read and sign. The e had not interviewed the				
		d with Resident #15 on the				
		ding Resident #15 being left				
		unable to eat dinner. The				
		ed she had not interviewed				
		r nurse aides, or other family				
		lar care issues or concerns.				
		evance filed by the family				
	-	#15 on 06/10/14, the				
		e had gone and found the	1			

Facility ID: 923265

If continuation sheet Page 24 of 168

CENTER STATEMENT	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	FORM OMB NC (X3) DATE		
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		345174	B. WING		07/	/11/2014	
	ROVIDER OR SUPPLIER	ITATION CENTER	91	REET ADDRESS, CITY, STATE, ZIP CO VICTORIA ROAD SHEVILLE, NC 28801	DE		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 166	oxygen tubing had be heard complaints abo family member of Res stated she had place nurse's stations for al remind them to initial to make sure it is plug stated she had not in aides who had worke the incident. The AD not interviewed other aides, or other family issues or concerns. Interview with family 10 07/03/14 at 3:49 PM grievances, both oral past 6 months to com of care she had obse the facility, as well as #15 had to wait for ca care he received. Th although she submittu spoke to staff almost she felt the staff were problems more than the complaints fell on dea Follow up interview w Resident #15 on 07/1 family member had withen providing woun checking Resident #1 being left wet, withou where he couldn't eat administrator, to the fi	een unplugged and she had but this previously by the sident #15. The ADON/UM d an inservice sheet at the I nurse aides to sign to and date oxygen tubing and gged in. The ADON/UM terviewed the specific nurse d with Resident #15 during ON/UM also stated she had residents, other nurse member of Resident #15 on revealed she had filed many ly and in writing, during the splain about the roughness rved Resident #15 receive at the length of time Resident tre and the quality of the e family member stated ed repeated grievances and daily about these concerns, e never able to resolve the temporarily and she her af ears.	F 166				

Facility ID: 923265

If continuation sheet Page 25 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 07/11/2014		
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 166	grievances. The fami she was told they wou but nothing ever char stated she had to stay days to make sure he neglected because sh made changes after f member stated she h grievances after facili grievances with her, b were resolved. The fa- knew they had given some staff and had pi desks to remind staff nothing had changed frustrated. An interview was con PM with the DON. Sh new DON for about 3 given grievances to ir said she had not rece residents about rough DON was shown grie the ADON/UM that all rough. The DON con the grievances that th completed a thorough complaints of roughner esidents involved to described as rough tr stated she was aware Resident #15 had bee felt the grievances sh been more thoroughly.	ly member stated each time uld take care of the problem, aged. The family member y with Resident #15 most wasn't harmed or he didn't feel the facility staff her complaints. The family ad been asked to sign the ty staff reviewed the but she had never felt they amily member stated she customer service training to ut papers out at nurse's to provide prompt care but and she was extremely ducted on 07/07/14 at 5:04 he stated she had been the weeks and had only been hvestigate a week ago. She sived grievances from h treatment by the staff. The vances filed and written by leged the wound nurse was mmented after she had read he ADON/UM had not h investigation of the alleged ess by not interviewing determine what residents eatment. The DON also he the family member of l unhappy with the care en receiving and the DON he had filed should have	F	166				

Facility ID: 923265

If continuation sheet Page 26 of 168

	-	ND HUMAN SERVICES			PRINTED: 12/10/20 FORM APPROVI OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING _		C 07/11/2014		
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE COMPLETIC E APPROPRIATE DATE		
F 166 F 224 SS=H	members about staff over the grievances t them to investigate a findings. The Admini expectation was that thoroughly investigate which would include the resident involved on the same unit. 483.13(c) PROHIBIT	from residents and staff being rough he had turned o his clinical nursing staff for nd report back to him their strator stated his the ADON and DON would e all grievances about care interviewing individual staff, , and other residents living	F 1		8/10/14		
33-n	The facility must deve policies and procedu	elop and implement written res that prohibit t, and abuse of residents					
	by: Based on observation family interviews and staff failed to adminis physical and emotion who described the pri- rough, rude and pain oversee the provision residents who had co #7, #21, and #15). 1. Resident #19 was 07/19/13 with diagno- ulcers, wound infection	T is not met as evidenced on, staff and resident and record review, the facility ster wound care to meet the tal needs of 5 of 5 residents occess as unnecessarily ful. The facility failed to of wound care for 5 of 5 oncerns. (Resident #19, #20, admitted to the facility on ses including, pressure ons, and diabetes. The most a Set (MDS), a significant		A record review for residents #7, #21 and #15 was compleresidents are receiving treatron physician sorders. All residents affected were inter- the Regional Clinical Nurse of regarding the care they received the current treatment process treatment physicians orders reviewed by the DON, ADON Regional Clinical Nurse and RN Supervisor from 7/15/14 7/19/14 and have been found	eted. All nents per dents had a eted. rviewed by on 7/29/14 ved during s. The s have been J, The the weekend through		

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 27 of 168

						IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING			С
		345174	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		7/11/2014
				91 VICTORIA ROAD	ODE	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER		ASHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETIO
F 224	Continued From page	e 27	F 22	4		
		dated 05/04/14, revealed		appropriate for these reside	ents. All	
		gnitively intact, able to		physician orders were cla		
	understand and be ur			and approved by the Medic		
				After all interviews were co		
	Interview with Reside	nt #19 on 07/02/14 at 2:58		facility sent a 24-hr and a 5	-day abuse	
		n she felt pain at all times		report to the North Carolina		
		d especially during wound		Registry concerning the pre	evious wound	
		ind care provided by Nurse		care nurse.		
		painful. Resident #19				
		7 provided wound care, it felt		Any other resident with a tr		
	as though the wound			can be affected by this prac		
		et the gauze or packing into ed Nurse #7 is not gentle		Therefore, the Regional Cli reviewed all treatment orde		
	with the wound when	•		in the facility from 7/15/14 t		
	Resident #19 stated v	-		and they have been found	-	
		, including the wound care		appropriate for these reside		
	physician's assistant,	-		physician orders were clari		
		as it is when Nurse #7		and approved by the Medic		
		Resident #19 stated when				
		ound care, it felt as though		All Licensed Nursing Staff I	nave been	
	-	er, and the other staff that		have re-educated on dignit		
	provided wound care	provided it in a way that		gentleness and pain manage		
	caused pain but it did	not feel like they were trying		wound care on 7/17/14 and	l 8/9/14 by the	
		dent #19 stated she cries		DON and the Staff Develop	oment	
		f all the times she's been		Coordinator (SDC).		
	-	sident #19 stated she had			· ••	
		uch it hurt like the wound		A Qualified Clinical Educat	-	
		nd to stop, but Nurse #7 had		was been obtained to provi		
		nt #19 that the wound had to		in-service training in all asp		
	didn't stop. Resident	et the gauze in, and she #19 stated she had		care, including physician		
	-	e roughness shown by Nurse		products and accurate doc		
		arlier to the director of social		all licensed nurses and me		
		ad asked to not be treated		These in-service were cond		
		a result, Nurse #7 had not		8-01-14 to 8-9-14.		
		for a few weeks. Resident				
		v weeks, however, Nurse #7		All licensed nurses have be	en	
		wound care for Resident		re-educated on the facility /		
		#19 stated no staff had		and Procedure and Preven	•	

Facility ID: 923265

If continuation sheet Page 28 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/201 MAPPROVE D. 0938-039	
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 07/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER		- I	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			VICTORIA ROAD SHEVILLE, NC 28801			
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 224	Continued From page	2 8	F 2	24				
		ed her to describe the		.27	and the nurse□s responsibility to resid	ent		
		by Nurse #7 when she			comfort during treatment and the			
		e roughness of Nurse #7,			reporting procedures to the Administra			
		had come to explain to her			or DON when abuse is alleged from 7-			
	Resident #19 stated s	oviding care for her again.			14 to 8-9-14 by the DON and the SDC			
		bout the rough way it felt			The Quality Assurance Nurse (QA Nur	se)		
		ded wound care because			will interview all interviewable resident			
		wouldn't make a difference.			who have a physicians			
					order for wound treatments to ensure t			
		#7 on 07/07/14 at 2:15 PM			are treated with dignity, respect, kindne			
	-	asked residents if the wound are. Nurse #7 stated she			and gentleness during their wound car and are assessed for pain as needed	e		
		wound doctor and floor			each month x 4 months prior to the			
	-	f the resident had said the			monthly QAPI Meeting. If any allegati	ons		
		rse #7 stated Resident #19			are made, they will be brought to the			
	-	It the excessive pain, but			Administrator and DON immediately for resolution. Results of these interviews			
	touched the bed.	s always in pain, even if she			be presented at the monthly QAPI meeting x	WIII		
	Interview with Unit Ma	anager (UM) on 07/07/14 at			4 months.			
		he had been told Resident						
	•	about Nurse #7 being rough						
	•	ut Resident #19 was so nt and said everything hurt,						
		iewed Resident #19 in						
	response to the comp							
		admitted to the facility on						
	-	ses including diabetes,						
		a, and hypertension. The						
		n Data Set (MDS) quarterly 5/15/14 revealed Resident						
		ntact, able to understand						
	others and able to be							
		ent #20 on 07/03/14 at 9:30						
		urse #7 provided wound						
	care, she worked ver	y quickly and very roughly.						

If continuation sheet Page 29 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING _			07/11/2014		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-	
ASHEVILI	HEVILLE NURSING & REHABILITATION CENTER				1 VICTORIA ROAD SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Resident #20 stated I and laughing with oth wound care to her. R never asked her what was in pain during the #20 would interrupt N that she was hurting I stop but say I'm about through," and would I #20 stated Nurse #7 m while providing wound speak to her, she spot Interview with Nurse a revealed she usually care hurt during the care would report it to the nurse after the care if care was painful. Nur recall Resident #20 co pain during wound ca during the care becau and the wounds. Nur didn't like her providir care was painful and in general. 3. Resident #7 was au 12/11/07 with diagnos chronic airway obstru hypothyroidism. The Set quarterly assess revealed Resident #7 impaired for daily dec or long term memory understand and to be Interview with Reside	Nurse #7 was always talking er staff while providing tesident #20 stated Nurse #7 ther pain level was or if she e care, but when Resident urse #7's talking by yelling her, Nurse #7 wound not at through, I'm about keep on scrubbing. Resident rarely spoke to her at all d care, but when she did oke very harshly and rudely. #7 on 07/07/14 at 2:15 PM asked residents if the wound are. Nurse #7 stated she wound doctor and floor the resident had said the rse #7 stated she did not complaining about excessive re but she expected pain use of the nature of the care se #7 stated many residents and care for them, but wound residents didn't like the care	F2	224				

Facility ID: 923265

If continuation sheet Page 30 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
		345174	B. WING			C 07/11/2014		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
				9	1 VICTORIA ROAD			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER		A	ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 224	people because she f #7 stated Nurse #7 w room without knocking hall while she was in provide wound care th Resident #7 stated sh administrator about N rude when providing w stated she had told th #7 had come in her ro jerked her covers off, off her boot and yelled #7 stated she would t she gradually awaker scrub her wound with Resident #7 stated sh how much it hurt, and #7 would tell her that bleed, that Nurse #7 r and it was good for it Nurse #7 never asked care. Resident #7 state provided wound care, nearly the amount of provided the wound c Interview with Nurse # revealed she usually care hurt during the c would report it to the nurse after the care if care was painful. Nur recall Resident #7 con pain during wound ca during the care becau and the wounds. Nur didn't like her providin	be providing care for older nad no patience. Resident ould come flying into her g, yell out to people in the Resident #7's room, and hat was excessively rough. he had complained to the lurse #7 being rough and wound care. Resident #7 he administrator that Nurse boom when she was sleeping, jerked her leg up, yanked d "Put that leg up!" Resident ry to keep her own leg up as hed, but Nurse #7 would excessive force and speed. he would cry, tell Nurse #7 l ask her to stop, but Nurse it was good for the wound to needed to make it bleed, to hurt. Resident #7 stated d for her pain level during ated when any other nurse , it caused pain but not pain caused when Nurse #7	F	224				

Facility ID: 923265

If continuation sheet Page 31 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES					RINTED: 1 FORM AI MB NO. 0	PPROVED	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		X3) DATE SUF COMPLET	RVEY	
		345174	B. WING	B. WING			C 07/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP C	ODE	••••		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER							
				<u> </u>		CORRECTION		0(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE	
F 224	Continued From page in general.	31	F	224	1				
	in general.								
	03/14/13 with diagnost fracture, hypertension recent Minimum Data dated 03/19/14 revea	e to understand others and							
	PM revealed Nurse # providing wound care hatefully. Resident # regularly to get out of saying rude things an disrespect. Resident #7 " that hurts! " whe wound care, but Nurs going. Resident #21 s	o be understood by others. nterview with Resident #21 on 07/02/14 at 4:53 PM revealed Nurse #7 was very rude while providing wound care, cussing and talking hatefully. Resident #21 stated she told Nurse #7 regularly to get out of her room because she was saying rude things and treating her with disrespect. Resident #21 stated she told Nurse #7 " that hurts! " when she hurt her during wound care, but Nurse #7 would laugh and keep going. Resident #21 stated she had complained about the care of Nurse #7 to several nurses.							
	revealed she usually a care hurt during the c would report it to the nurse after the care if care was painful. Nur recall Resident #21 cd pain during wound ca during the care becau and the wounds. Nur didn't like her providin	#7 on 07/07/14 at 2:15 PM asked residents if the wound are. Nurse #7 stated she wound doctor and floor the resident had said the rese #7 stated she did not omplaining about excessive re but she expected pain use of the nature of the care se #7 stated many residents of care for them, but wound residents didn't like the care							
	10/24/11 with diagnos	admitted to the facility on ses including acute rdiomegaly, heart failure,							

If continuation sheet Page 32 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345174	B. WING			C 07/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
				9	91 VICTORIA ROAD			
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		A	ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION) T				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 224	dated 06/13/14 revea severely cognitively in be understood and us Interview with family r 07/03/14 at 3:49 PM r wound care being pro- different staff member witnessed Nurse #7 b Resident #15 than an members. The family would grab Resident is very roughly, causing pain. The family men Nurse #7 to stop and gently, but Nurse #7 h him that way. The far reported the roughness facility social servicess to the wound care phy but nothing had been Interview with Nurse #7 revealed she usually care hurt during the c would report it to the nurse after the care if care was painful. Nur recall the family mem complaining about ex care but she said the #15 complained frequ and so she had learned complaints. Nurse #7 didn't like her providin care was painful and	e. The most recent IDS) quarterly assessment led Resident #15 was mpaired and usually able to sually understood. member of Resident #15 on revealed she observed ovided to Resident #15 by rs frequently, and she had being a lot rougher with y of the other staff member stated Nurse #7 #15, turn him and pull in Resident #15 to cry out in nber stated she had told to move Resident #15 more had said she had to move mily member stated she had ss several times to the director as well as directly ysician's assistant (WPA) done about it. #7 on 07/07/14 at 2:15 PM asked residents if the wound are. Nurse #7 stated she wound doctor and floor the resident had said the rse #7 stated she did not	F	224				
	care but she said the #15 complained frequ and so she had learn complaints. Nurse #7 didn't like her providin	family member of Resident iently about care in general ed to ignore most of her 7 stated many residents ing care for them, but wound						

Facility ID: 923265

If continuation sheet Page 33 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			C 07/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91	1 VICTORIA ROAD			
				A	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG			ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Continued From page	33	F 2	224				
	Interview with facility (DSS) on 07/01/14 at heard different reside #7 being rough and ru when she was told of she had informed the Nursing/Unit Manage of Nursing (DON), an morning meeting, whi The DSS further state who investigated all c Interview with ADON/ revealed she had reco different residents' co being rude to them ar care. The ADON/UM complaints with the D each morning during ADON/UM stated she staff had different way she received the com being rough or rude, s education with Nurse to do further investiga Interview with the Reg 7/02/14 at 10:25 AM r chronic complaints fro the care they received said she had reported facility administrator.	Director of Social Services 8:00 AM revealed she had nts complain about Nurse ude. The facility DSS stated complaints about Nurse #7, Assistant Director of r (ADON/UM), the Director d the Administrator during ch they had each morning. ed that it was the ADON/UM oncerns regarding nurses. UM on 07/01/14 at 4:46 PM eived information about mplaints about Nurse #7 nd rough with them during stated she discussed the ON and the Administrator morning meeting. The e understood that different ys of doing things, so when plaints about Nurse #7 she would do some #7 so that she didn't need						
	Services which she hadministrator about.	cility Director of Social ad also informed the an's assistant (PA) on						

Facility ID: 923265

If continuation sheet Page 34 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/10/2014 / APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PR					E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345174	B. WING		C 07/11/2014				
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	t			
	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD				
					ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE	
F 224	quite a few residents loud, and rude. When residents complained received from Nurses she asked Nurse #7 a say she didn't think sl rough with the residen Follow up interview w at 12:18 PM revealed patterns of resident c know who did. The A and Administrator alw resident complaint be each day at the morn stated all department meeting each mornin Administrator would a new grievances, and grievances being inve Interview with the DO revealed her expecta or family member exp staff member being re care, the staff member moved from care of re and staff person nam additional information would also interview of care from that staff m members who worked member in question. thoroughly investigate resident or family mem-	revealed she had heard report Nurse #7 was rough, n asked what she did when to her about the care they #7, the PA stated each time about it and Nurse #7 would he was being rude or too nts. with ADON/UM on 07/07/14 I she had not looked for omplaints and she did not ADON/UM stated the DON vays knew about every ecause they were discussed ing meeting. The ADON/UM heads were also at that g, and at each meeting, the ask for information on any what was the status of any estigated. WN on 7/7/14 at 4:30 PM tions that when any resident pressed concern about a pugh or rude while providing er would immediately be esidents while the resident ed were interviewed to get to The DON stated she other residents who received ember, and other staff	F	224	4				

Facility ID: 923265

If continuation sheet Page 35 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			C 07/11/2014		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			I VICTORIA ROAD SHEVILLE, NC 28801			
(X4) ID PREFIX TAG				K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	family members about rough or rude during of had been working in t Interview with Adminis PM revealed his exper resident or family men about a staff member care, his clinical team thoroughly investigate talking to that and oth staff members, and lo expressed concerns i administrator stated h monitoring to be done even if the investigate rough care. The adm unaware of any grieva expressed by a reside the treatment by a sta been thoroughly invest the resident or family Interview with Nurse a revealed several diffe complained to her about and verbally rude to the had done, Nurse #2 s report the rudeness a and she knew severa grievances with the D had also gone directly the DON to report tha numerous complaints #7 being rough and ru care and had been to the complaints.	t any staff member being care. The DON stated she he facility for three weeks. strator on 07/07/14 at 5:42 ectation that when any mber expressed concern being rough when providing , led by the DON would e the complaint, including er residents, that and other ooking for patterns of n the area. The us also expected follow up e on the named staff person on revealed no evidence of inistrator stated he was ance that had been ent or family member about off member that had not stigated to the satisfaction of member. #2 on 07/09/14 at 10:21 AM rent residents had out Nurse #7 being rough hem. When asked what she tated she had told them to nd roughness to the DSS, I of them had filed SS. Nurse #2 stated she y to the Administrator and to	F2	224				

If continuation sheet Page 36 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION				(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 224 F 241 SS=H	revealed she had bee residents about the w Nurse #7 during wour every day Nurse #7 w least one resident wo they had received. N the ADON/UM and th complaints before an the frequency of resid 483.15(a) DIGNITY A INDIVIDUALITY The facility must prom manner and in an env	en complained to by several vay they were treated by nd care. Nurse #1 stated vorked with residents, at puld complain about the care lurse #1 stated she had told e facility DSS about the d knew they were aware of dent concerns. ND RESPECT OF	F 22 F 24		8/10/14
	full recognition of his This REQUIREMENT by: Based on observatio interviews, and record failed to provide would sensitive to resident et needs for 5 of 5 resid #19, #20, and #21). T knock and ask for pel rooms for 7 of 7 resid #12, #22, #24, #25, a seated a resident at a and stood over the re resident for 1 of 1 res The findings included 1. Resident #19 was	is not met as evidenced in, staff, resident, and family d review, the facility staff and care in a manner that was emotional and physical lents (Residents #7, #15, The facility staff failed to rmission to enter resident lents (Residents #7, #11, and #27). The facility staff a counter instead of a table esident while feeding the sident (Resident #1).		A record review for residents #19 #7, #21, and #15 was completed. residents are receiving treatments physician orders. All residents had pain assessment completed by the DON,SDC, and RN Supervisor on 7/29/14. The wound care physicia have been reviewed by the DON, and, the Regional Clinical Nurse a weekend RN Supervisor from 7/18 through 7/19/14 and have been found to be appropriate these residents. All physicians of were clarified, reviewed and appro- the Medical Director.	All s per d a new e n orders ADON and the 5/14 e for orders oved by

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 37 of 168

		MEDICAID SERVICES				O. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY IPLETED	
		045474	B. WING			С	
		345174				7/11/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
ASHEVILI	E NURSING & REHABIL	LITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETIC	
F 241	Continued From page	e 37	F 24	1			
		a Set (MDS), a significant		Maintenance/Floor Tech Staff	. Dietarv		
		dated 05/04/14 revealed		Staff, all Licensed Nursing St	-		
	•	gnitively intact, able to		Certified Nursing Assistants ,			
	understand and be u			Medication Aides, all Departn			
				(Dietary Manager, Maintenan			
	Interview with Reside	ent #19 on 07/02/14 at 2:58		Housekeeping/Laundry Supe			
	PM revealed althoug	h she felt pain at all times		Business Office Manager, Me	edical		
	-	d especially during wound		Records Director, Marketing I			
		and care provided by Nurse		Social Services Director, Ass	istant		
	#7 was exceptionally	painful. Resident #19		Director of Nursing, Staff Dev	elopment		
	stated when Nurse #	7 provided wound care, it felt		Coordinator, Quality Assuran	ce Nurse,		
	as though the wound	was pinched together		Activity Director, Administrato	r, Therapy		
	extremely tightly to ge	et the gauze or packing into		Director)Physical Therapist, C	Dccupational		
		ed Nurse #7 was not gentle		Therapist, Speech Therapist,			
	with the wound when	she provided care.		Occupational Therapist Assis			
		when Nurse #7 provided		Physical Therapist Assistant,			
		t #19 screamed and cried		Assistant, Human Resource I			
		elt Nurse #7 didn't care that		re-educated by the DON from			
		ever stopped or checked on		8/9/14 addressing knocking a			
		ated she couldn't tolerate		announcing when entering a			
	· ·	could do was to scream but		room. Interviews by the Soci			
		keep pinching and scrubbing.		Director and the Activity Director			
		when any other nurse		alert and oriented residents p			
	-	, including the wound care		began on 7/17/1 4 which spec			
		, it was painful but not		about knocking on doors. Res			
		as it is when Nurse #7		being assisted with dining by			
	•	. Resident #19 stated when		Nursing Assistant (C.N.A.) se	aleu next to		
		ound care, it felt as though		the resident.			
		er, and the other staff that provided it in a way that		Any other resident with a trea	tment order		
	-	as though they were trying to		can be affected by this practic			
		nt #19 stated she cried		Therefore, the Regional Clinic			
		ght when it wasn't time for		reviewed all treatment orders			
		e of all the times she had		in the facility from 7/15/14 thr			
		7. Resident #19 stated she		and was found to be appropri	-		
		w much it hurt like the		residents. All physician orders			
		ched and to stop, but Nurse		clarified, reviewed and approv			
		Resident #19 that the		Medical Director.			
	wound had to be don		1			1	

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 38 of 168

		ND HUMAN SERVICES			FOR	D: 12/10/20 M APPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	E SURVEY PLETED C
		345174				U /11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
	E NURSING & REHABI			91 VICTORIA ROAD		
ASHEVILL		LITATION CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 241	Continued From page	e 38	F 24 ²	1		
1 271			F 24		by the	
	#19 stated she had c	p or take breaks. Resident		Any resident can be affected practice. Therefore, interview	•	
		Nurse #7 several months		Social Services Director and	•	
		Director of Social Services		Director with 12 alert and orie	•	
	(DSS) and had asked	d to not be treated by Nurse		residents per week began on	7/17/1 4	
		Nurse #7 had not provided		which specifically		
		weeks. Resident #19		ask about knocking on doors.		
		eks, however, Nurse #7 had		observation audit will be com	pleted	
	• ·	und care for Resident #19 stated no staff had talked to		weekly x 4 weeks evaluating performance of knocking on c	toors prior to	
	-	describe the wound care		entering rooms.		
		7 when she complained				
		of Nurse #7, and no staff		Any resident requiring feeding	g assistance	
	member had come to	o explain to her why Nurse		can be affected by this praction	ce.	
		e for her again. Resident		Therefore, the Registered Die		
		topped complaining to staff		and the MDS Team audited a		
		felt when Nurse #7 provided		needing feeding assistance o	n 8/4/14.	
	wound care because wouldn't make a diffe			The Licensed Nursing Staff w	oro	
		sience.		educated on dignity, respect		
	Interview with Nurse	#7 on 07/07/14 at 2:15 PM		gentleness during treatments		
		asked residents if the wound		7/17/14 to 8/9/14 by the DON		
	care hurt during the	care. Nurse #7 stated she wound doctor and floor		Staff Development Coordinate		
		f the resident had said the		A Qualified Clinical Education	Manager	
		irse #7 stated Resident #19		was been obtained to provide		
		ut the excessive pain, but		in-service training in all aspec		
		as always in pain, even if she		care, including physician⊡s o		
	touched the bed.			provision of care technique, v		
	Interview with Assist	ant Director of Nursing/Unit		all licensed nurses and medic		
		l) on 07/07/14 at 12:18 PM		These in-service were conduct		
		en told Resident #19 had		8-01-14 to 8-9-14.		
		urse #7 being rough during				
		ident #19 was sensitive to		All licensed nurses have beer	า	
		everything hurt, so she had		re-educated by the DON and		
		dent #19 in response to the		7/17/14 to 8/9/14 on the facili		
	complaints.			Abuse Policy and Procedure		
				Prevention and the nurse s r	esponsibility	

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 39 of 168

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/201 MAPPROVE D. 0938-039
STATEMENT (DF DEFICIENCIES				CONSTRUCTION		PLETED
		345174	B. WING				C 11/2014
NAME OF P	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
				91	VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	LITATION CENTER		AS	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From page		F 24	41			
		admitted to the facility on			to resident comfort during treatment an	id	
		ses including diabetes,			the reporting procedures to the		
	depression, dementia most recent Minimum	a, and hypertension. The			Administrator and DON.		
		t dated 05/15/14 revealed			Housekeeping/Laundry staff,		
		gnitively intact, able to			Maintenance/Floor Tech Staff, Dietary		
		able to be understood.			Staff, all Licensed Nursing Staff, all		
					Certified Nursing Assistants , all Certified	ed	
	Interview with Reside	ent #20 on 07/03/14 at 9:30			Medication Aides, all Department Head	ls	
		urse #7 provided wound			(Dietary Manager, Maintenance Directo	or,	
		y quickly and very roughly.			Housekeeping/Laundry Supervisor,		
		Nurse #7 was always talking			Business Office Manager, Medical		
		er staff while providing Resident #20 stated she			Records Director, Marketing Director, Social Services Director, Assistant		
		7, cuss at her, and beg her			Director of Nursing, Staff Development		
		would keep going. Resident			Coordinator, Quality Assurance Nurse,		
	#20 got tearful when				Activity Director, Administrator, Therap		
	frightened of the pain	the residents must feel who			Director)Physical Therapist, Occupatio	nal	
	-	ent from Nurse #7 and are			Therapist, Speech Therapist,		
		cry out. Resident #20 stated			Occupational Therapist Assistant,		
		d her what her pain level			Physical Therapist Assistant, Office		
		bain during the care, but vould interrupt Nurse #7's			Assistant, Human Resource Director w re-educated by the DON and SDC from		
		she was hurting her, Nurse			7/17/14 to 8/9/14 concerning the	1	
		it say "I'm about through,			responsibility of announcing and knock	ina	
		nd would keep on scrubbing.			on resident doors before entering. All	-	
	Resident #20 stated	Nurse #7 rarely spoke to her			employees will be re-educated upon hi		
		wound care, but when she			The staff were re-educated by the DOM		
		spoke very harshly and			and SDC from 7/17/14 to 8/9/14 regard	ling	
	rudely.				assisting residents during their dining		
	Interview with Nurse	#7 on 07/07/14 at 2:15 PM			experience in a dignified manner.		
		asked residents if the wound			The Quality Assurance Nurse (QA Nurs	se)	
		are. Nurse #7 stated she			will interview all interviewable resident		
	-	Physician's Assistant (PA)			who have a physicians		
		the care if the resident had			order for wound treatments to ensure		
	-	inful. Nurse #7 stated she			they are treated with dignity, respect,		
		nt #20 complaining about			kindness and gentleness		
	excessive pain during	g wound care but she			during their wound care treatment and	are	

Facility ID: 923265

If continuation sheet Page 40 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT (· ,		(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	·
				91 VICTORIA ROAD	
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 241	Continued From page		F 24		ab month
	nature of the care and stated many resident	the care because of the d the wounds. Nurse #7 s didn't like her providing und care was painful and he care in general.		assessed for pain as needed ea x 4 months prior to the monthly QAPI meeting. If an allegations are made, they will be brought to the Admin and	ny
	12/11/07 with diagnost chronic airway obstru hypothyroidism. The Set (MDS) quarterly a	a admitted to the facility on ses including diabetes, iction, neuropathy, and most recent Minimum Data assessment dated 05/19/14		DON immediately for resolution. of the interviews will be presented Interviews by the Social Service and the Activity Director with 12 oriented residents	ed. Is Director alert and
	impaired for daily dec	was moderately cognitively vision making with no short problems and able to understood.		per week began on 7/17/1 4 whi specifically ask about knocking These interviews will be conducted weekly x 6 months at taken to the monthly QAPI meet	on doors. nd results
	PM revealed her opin someone who should people because she if #7 stated Nurse #7 w room without knockin hall while she was in	nt #7 on 07/02/14 at 5:15 non that Nurse #7 was not be providing care for older had no patience. Resident rould come flying into her g, yell out to people in the Resident #7's room, and		Social Services Director x 6 months. An observative will be completed weekly x 4 we evaluating performance of knocking on doors prior to en rooms and will be submitted to the Committee for review	tering
	Resident #7 stated sh Administrator about N rude when providing stated she had told th #7 had come in her ru jerked her covers off, off her boot and yelle tears in her eyes, Res try to keep her own le awakened, but Nurse with excessive force a Nurse #7 was taking by being mean. Resi	hat was excessively rough. he had complained to the Nurse #7 being rough and wound care. Resident #7 he Administrator that Nurse boom when she was sleeping, jerked her leg up, yanked d "Put that leg up!". With sident #7 stated she would eg up as she gradually #7 would scrub her wound and speed and she felt out her frustrations on her dent #7 stated she would y much it hurt, and ask her to		and recommendations. The assisted feeding residents of areas will be monitored by the M Coordinators/RN Supevisor durin times x twice daily x 6 months for appropriateness of staff while ass the resident to eat. The RN Supervisor will round daily durin to assess assistance with eating resident rooms. Results will be taken to the monthly QAPI m the MDS Coordinators for review recommendations x 6 months.	ADS ing meal or ssisting ig a meal g in neetings by

Facility ID: 923265

If continuation sheet Page 41 of 168

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 // APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILLE NURSING & REHABILITATION CENTER				91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 241	for the wound to bleer make it bleed, and it w Resident #7 stated sh enter her room at all b would be hurt and trea Resident #7 stated sh facility continued to se care for her and other already in pain. Resid she became extremel even entered her roor was treated. Resider asked for her pain lev Resident #7 stated sh encouraged Resident frustration during the stated when any othe care, it caused pain b pain caused when Nu care. Interview with Nurse a revealed she usually care hurt during the c would report it to the and floor nurse after t said the care was pain did not recall Resident excessive pain during expected pain during nature of the care and stated many residents care for them, but wo residents didn't like th 3.b. Record review re admitted to the facility on 08/17/12 with diag	d, that Nurse #7 needed to was good for it to hurt. he hated to have Nurse #7 because she knew she ated roughly and rudely. he felt very angry that the end Nurse #7 to provide relderly patients who were dent #7 stated further stated y upset any time Nurse #7 m because of the way she it #7 said Nurse #7 never el during care and in fact he felt Nurse #7 laughed and #7 to express her pain and wound care. Resident #7 r nurse provided wound ut not nearly the amount of rise #7 provided the wound #7 on 07/07/14 at 2:15 PM asked residents if the wound are. Nurse #7 stated she Physician's Assistant (PA) he care if the resident had nful. Nurse #7 stated she t #7 complaining about wound care but she the care because of the d the wounds. Nurse #7 s didn't like her providing und care was painful and	F	241			

If continuation sheet Page 42 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING			C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 241	review of resident #7' dated 05/19/14 revea moderately cognitively making. Resident #7 was inter PM in her room. At a Aide (NA) #19 flung th the resident's room w permission to enter. If does not knock anym told staff to knock. A with Resident #7 at 3: lightly tapped Resider room without gaining was observed to place first bed in the room w the room. Resident #7 her feel when staff do permission to enter th it has made her feel s because she might be dressed. On 07/02/14 at 12:50 concerning knocking rooms. She stated sh Resident #7's room o the resident to enter. should knock and wai the resident's room at she needed to knock. On 06/30/14 at 3:52 F interviewed. She state knocked on the door a enter. She said she o	s Minimum Data Set (MDS) led she was assessed as y intact for daily decision viewed on 06/30/14 at 2:45 pproximately 2:55 PM Nurse he door open and entered ithout knocking or gaining Resident #7 stated staff ore and she said she had also, during the interview 22 PM the Activity Director nt #7's door and entered the permission to enter. She the activity calendar on the which was vacant and left 7 was asked how it made on to knock and wait for he room. Resident #7 stated mall and embarrassed a undressed or getting PM NA #19 was interviewed before entering resident he had not knocked on r gained permission to enter nd Resident #7 had told her PM the Activity Director was	F	241			

If continuation sheet Page 43 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/10/2014 M APPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED		
		345174	B. WING			07	C 7/ 11/2014
NAME OF PF	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				91	VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		A	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From page	e 43	F2	241			
	conducted with the D She stated she would resident's door and w entering the room. 3.c. Resident #7 was on 08/17/12 with diag diabetes, lung diseas most recent quarterly dated 05/19/14 indica short or long term me cognitively intact for of Section M of the MDS other skin problems li During an observation at 2:13 PM Nurse #7 nurse gathered suppl a treatment cart in the Resident #7's room a next to her. The door open but the privacy so that Resident #7 w hallway and there wa Nurse #7 and Nurse # room without knockin announce they were not ask for permission #4 announced to Res privacy curtain open a they were ready to do left heel. Resident #7	AM an interview was irector of Nursing (DON). d expect staff to knock on a vait for a response before a re-admitted to the facility poses which included e, and thyroid disease. The Minimum Data Set (MDS) ated Resident #7 had no emory problems and was daily decision making. S indicated Resident #7 had isted as infection of foot. In of wound care on 07/01/14 who was the wound care ies for a dressing change at e hallway outside of and Nurse #4 was standing r of Resident #7's room was curtain was partially pulled was not visible from the s no roommate in the room. #4 walked into Resident #7's g on the door, did not entering the room and did in to enter the room. Nurse sident #7 as she pulled the at the foot of the bed that to a dressing change on her 7 stated "you should have came in." Nurse #7 stated					
	to Resident #7 that sl heard them talking in door and knew they v	he thought the resident had the hallway outside of her					

Facility ID: 923265

If continuation sheet Page 44 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	SURVEY
		345174	B. WING	ING .		C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	07	/11/2014
					91 VICTORIA ROAD		
ASHEVILLE NURSING & REHABILITATION CENTER				ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	she guessed they cou Nurse #4 held Reside #7 washed her hands changed the dressing Nurse #7 then discard hands and left Reside During an interview o Resident #7 she state #7 to just walk in her the door. She explain well and had been na She stated when Nurs into her room she was dressing changed on had just gotten off the herself together. She aggravated when Nurs in that she told them to dressing change to ge stated it made her fee unacceptable when N without knocking or d enter her room. During an interview o Nurse #7 she stated s supposed to knock or she entered resident not knock on Resider she was talking with N outside of Resident # Resident #7 already # to do her dressing cha	the dressing changed but uld go ahead and do it. ent #7's left leg while Nurse s, put on gloves and g on Resident #7's left heel. ded supplies, washed her ent #7's room. In 07/01/14 at 2:40 PM with ed it was routine for Nurse room without knocking on ned she had not been feeling suseated earlier in the day. se #7 and Nurse #4 came is not ready to have the her left heel because she e toilet and was trying to get e stated she was so rse #4 and Nurse #7 walked to go ahead and do the et it over with. Resident #7 el bad and was it totally lurse #7 entered her room id not ask for permission to in 07/02/14 at 12:35 PM with she was aware she was in the resident's door before rooms. She verified she did at #7's door yesterday before dressing change because Nurse #4 in the hallway 7's door and she thought knew they were getting ready	F	241			

If continuation sheet Page 45 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		COMPLETED	
						С	
		345174	B. WING			07/	11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	91 VICTORIA ROAD		
ASHEVILLE NURSING & REHABILITATION CENTER				ASHEVILLE, NC 28801			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORY OR I	REGULATORY OR LSC IDENTIFYING INFORMATION)		1	DEFICIENCY)	AIE	
			-				
F 241	Continued From page	45	E	241	1		
1 271				241			
		sident doors and announce events of a resident room.					
		iff should ask permission to					
		and should explain to the					
	resident what they ne	•					
	4. Resident #21 was	admitted to the facility on					
	03/14/13 with diagnos	ses including diabetes,					
		n, and anxiety. The most					
		Set quarterly assessment					
		led Resident #21 was					
		e to understand and to be					
	understood by others						
	Interview with Reside	nt #21 on 07/02/14 at 4:53					
		7 was very rude while					
	providing wound care						
	hatefully. Resident #	21 stated she told Nurse #7					
		her room because she was					
	saying rude things an	-					
		#21 stated she told Nurse					
		she hurt her during wound					
		ould laugh and keep going. she had complained about					
	the care of Nurse #7	-					
	Interview with Nurse	#7 on 07/07/14 at 2:15 PM					
		asked residents if the wound					
		are. Nurse #7 stated she					
		Physician's Assistant (PA)					
		the care if the resident had					
		nful. Nurse #7 stated she					
	excessive pain during	nt #21 complaining about					
		the care because of the					
		d the wounds. Nurse #7					
		s didn't like her providing					
	-	und care was painful and					
	residents didn't like th						

Facility ID: 923265

If continuation sheet Page 46 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 241	Continued From page	e 46	F 24	1	
	10/24/11 with diagnost respiratory failure, ca and acute renal failur Minimum Data Set (M dated 06/13/14 revea severely cognitively in be understood and us Interview with family 0 07/03/14 at 3:49 PM wound care being pro- different staff member witnessed Nurse #7 to Resident #15 than ar members. The family would grab Resident very roughly, causing pain. The family mer did not cry out, wince else provided wound him in such pain. The had told Nurse #7 to #15 more gently, but to move him that way she had reported the the facility Social Ser directly to the Physici nothing had been dor Interview with Nurse # revealed she usually care hurt during the co would report it to the and floor nurse after said the care was paid did not recall the family the family and not recall the family for the family did not recall the family for the family for the family did not recall the family for the family for the family family did not recall the family for the family family for the family fami	rdiomegaly, heart failure, e. The most recent IDS) quarterly assessment iled Resident #15 was mpaired and usually able to sually understood. member of Resident #15 on revealed she observed ovided to Resident #15 by rs frequently, and she had being a lot rougher with by of the other staff / member stated Nurse #7 #15, turn him and pull in I Resident #15 to cry out in nber stated Resident #15 , and jump when anyone care, and it hurt her to see e family member stated she stop and to move Resident Nurse #7 had said she had roughness several times to vices Director as well as an's Assistant (PA) but			

Facility ID: 923265

If continuation sheet Page 47 of 168

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345174	B. WING		C 07/11/2014
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE
ASHEVILLE NURSING & REHABIL			91 VICTORIA ROAD	
	ITATION CENTER		ASHEVILLE, NC 28801	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE CROSS-REFERENCED	
 #15 complained frequand so she had learning complaints. Nurse #7 didn't like her providing care was painful and in general. 6. During an observation and the floor technicia 100 resident hallway machine. The floor technicia 100 resident norm number partially open without did not ask for the resident room. The floor technica to either Resident #25 in bed in the room and the foot of the resider and then walked behin of the room and into the floor term and loard was moderately in making and a review quarterly MDS dated short term and long te was severely impaired decision making. During an observation the floor technician with floor making and a review floor was partially oper door and did not ask floor was partially oper door and did not ask floor was floor was partially oper door and floor wa	e 47 family member of Resident iently about care in general ed to ignore most of her 7 stated many residents ing care for them, but wound residents didn't like the care ation on 06/30/14 at 10:41 an was cleaning floors on the with an electric buffing echnician walked behind the e hallway and then into r 108 whose door was knocking on the door and sident's permission to enter echnician also did not speak 5 or Resident #11 who were d operated the machine at ht's beds, between the beds nd the buffing machine out he hallway. A review of recent quarterly Minimum d 04/19/14 indicated she ng term memory problems mpaired for daily decision Resident #11's most recent 04/29/14 indicated she had erm memory problems and d in cognition for daily	F	241	

Facility ID: 923265

If continuation sheet Page 48 of 168

	-	ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/10/2014 ORM APPROVED NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING				C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ASHEVILI	E NURSING & REHABIL	LITATION CENTER						
				4	ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	Continued From page in bed in the room an	e 48 Id operated the machine at	F	241				
		nt's beds, between the beds						
		ind the buffing machine out the hallway. A review of						
	Resident #22's most	recent annual MDS dated						
		ne had no short or long term Id was cognitively intact for						
		g, and a review of Resident						
		arterly MDS dated 05/14/14						
		short term or long term Id was cognitively intact for						
	daily decision making							
	During an observatio	n on 06/30/14 at 10:58 AM						
	•	alked behind the floor						
	-	resident room 104 whose						
		en without knocking on the for the resident's permission						
		esident #12 was alone in the						
		floor technician did not rated the machine at the						
		beds, between the beds and						
		he buffing machine out of the						
		Ilway. A review of Resident arterly MDS dated 05/13/14						
	indicated she had she	ort term and long term						
	daily decision making	nd was severely impaired for g.						
	During an observatio	n on 06/30/14 at 11:06 AM						
	the floor technician w	alked behind the electric						
	•	resident room 101 whose en without knocking on the						
	door and did not ask	for the resident's permission						
		esident #27 was alone in the						
		floor technician did not erated the machine at the						
	foot of the resident's	beds, between the beds and						
	then walked behind t	he buffing machine out of the						

Facility ID: 923265

If continuation sheet Page 49 of 168

		ID HUMAN SERVICES				FORM	/ APPROVED
		MEDICAID SERVICES					0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDI	- UN			С
		345174	B. WING				11/2014
NAME OF PI	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
	E NURSING & REHABIL	ITATION CENTER		9	91 VICTORIA ROAD		
ASILVILL				4	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
					DEFICIENCY)		
F 241	Continued From page room and into the hall recent annual MDS de Resident #27 had no memory problems and daily decision making During an interview of floor technician stated facility for 3 months. orientation and training technician but stated training to knock on re aware he was suppose residents to give perm their room. During an interview of Environmental Service responsible for hiring services staff which in He explained the floo knocked on resident's asked and waited for he took the electric but room. He stated it was environmental service doors and wait for the they entered the room expectation for them to and what they needed room before they entered During an interview of	e 49 lway. A review of the most ated 06/17/14 indicated short term or long term d was cognitively intact for n 07/03/14 at 9:42 AM the d he had only worked in the He verified he received ng for his job as a floor he did not remember esident doors and was not sed ask and wait for nission before he entered n 07/03/14 at 9:46 AM the es Director stated he was and training environmental noluded the floor technician. r technician should have permission to enter before uffing machine into their as his expectation for es staff to knock on resident e resident to respond before n and it was also his to announce who they were d to do in the resident's ered the room. n 07/03/14 at 10:23 AM with		241	DEFICIENCY)		
	Resident #27 he state when the floor technic	ed he had not paid attention					
	During an interview of	n 07/06/14 at 3:45 PM with					

Facility ID: 923265

If continuation sheet Page 50 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/10/2014 RM APPROVED IO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345174	B. WING			0	C 7/11/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CODE			
				91 VICTORIA RO	AD			
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER		ASHEVILLE, NO	C 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF COR H CORRECTIVE ACTION S 3-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 241	anyone to enter her n door first because so dressed or was in the privacy. She further to knock and tell her came in her room esy them before. During an interview of Resident #22 stated technician had not kn resident doors before the buffing machine t explained she had als speak to her or her ro the room. She stated knock on her door an enter before they can she was taking a batt needed privacy. She residents who lived o able to communicate explained she though knock on the door of to voice their needs a themselves and tell th to enter the room. Sh just common courtest done because she wa coming into her room who they were or wha 7. Resident #1 was a 12/13/04. The most recent Mini dated 05/16/14, code	e 50 ted she did not like for oom without knocking on the metimes she was getting bathroom and wanted stated she expected for staff who they were before they becially if she had not seen in 07/07/14 at 10:39 AM with she had noticed the floor tocked on her door or other the entered their room with o clean the floors. She so noticed that he did not bommate when he came into d she expected for staff to d wait for permission to ne in because sometimes n or getting dressed and further stated many of the n the 100 hallway were not their needs. Resident #22 at all staff should definitely residents who were unable and staff should introduce he resident why they needed he stated she felt that was y and it should always be anted to know why staff were e sepecially if she didn't know at they were planning to do.	F 2	241				

If continuation sheet Page 51 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER		- I		REET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	extensive assistance On 07/01/14 at 12:26 assisted dining room eating. Resident #1 w wheelchair close to the in bowls, was located PM, Nurse Aide (NA) where he was sitting stood next to Resider the resident's small si the resident's head/fa as the NA's waist. N/ one bowl of food after to him as he sat in his counter. Once he was of food, then she har (2) which he drank ind stood and he sat in his counter. Observation there was a square ta seated at one side of chairs around the roo After Resident #1 finits with NA #19 revealed at a table if one was a resident. When aske Resident #1 at a table working another hall at in the dining room. S have sat with Resider assisted him to eat. Interview with the Dire	s. He was coded as needing with eating. PM, Resident #1 was in the where other residents were was seated in a low ne counter. His tray, all food on the counter. At 12:27 #19 placed a towel in his lap by the counter. NA #19 nt #1 and fed him. Due to tature and low wheelchair, ice was at the same height A #19 proceeded to feed him r another while standing next is wheelchair next to the is finished eating all 3 bowls inded him his cups of fluids dependently all while she is wheelchair by the room's as during this time revealed able with only one resident the table and 4 empty	F 2	41			
	at 11:26 AM revealed	-					

If continuation sheet Page 52 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		PLETED
		345174	B. WING			C 11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	HAHON CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 241	assisting them to eat.		F 24	41		
F 244 SS=E	483.15(c)(6) LISTEN/ GRIEVANCE/RECOM		F 24	14		8/10/14
	must listen to the view grievances and recom and families concernit operational decisions life in the facility. This REQUIREMENT by: Based on record revi interviews, the facility raised by the resident answering call bells q Findings included: Record review of the dated 10/07/13 revea previous months that answered in a timely the dated 11/04/13 reveal regarding the length of during third shift for cal Record review of the dated 02/03/14 reveal regarding waiting too	Inmendations of residents Ing proposed policy and affecting resident care and is not met as evidenced ew and resident and staff failed to act upon concerns council regarding not uickly. Resident Council minutes led residents' concerns from call bells were not being manner. Resident Council minutes led residents' concerns of time residents had to wait are. Resident Council minutes led residents' concerns		No specific resident was named in th citation. Any resident residing in the facility car affected by this concern. The Social Services Director met with the Resident Council President regarding process of identifying concerns for follow-up in resident council and on the call bell response times or 7/29/14. All Department Managers w re-educated by the Regional Clinical Director regarding grievance resolutio 7/22/14. Housekeeping/Laundry Staff, Maintenance/Floor Tech Staff, Dietary Staff, all Licensed Nursing Staff, all Certified Nursing Assistants , all Certi Medication Aides, all Department Hea (Dietary Manager, Maintenance Direc Housekeeping/Laundry Supervisor,	n be the ere n on îied ds	
		led residents' concerns		Business Office Manager, Medical Records Director, Marketing Director,		

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 53 of 168

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2 FORM APPRO\ OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE
	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD	
//0///2///2/				ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETI IE APPROPRIATE DATE
F 244	Continued From page	- 53	F 24	4	
	provided by nurses a			Social Services Director, As	eietant
		ווע וועושב מועבש.		Director of Nursing, Staff De	
	Record review of the	Resident Council minutes		Coordinator, Quality Assura	•
	dated 05/05/14 revea	led residents' concerns		Activity Director, Administrat	
		long for nursing care,		Director)Physical Therapist,	-
	especially during thire	d shift.		Therapist, Speech Therapis	
				Occupational Therapist Assi	
		Resident Council minutes		Physical Therapist Assistant Assistant, Human Resource	-
	regarding call bell res			re-educated by the DON be	
				to 8/9/14 regarding grievand	
	Interview with the fac	ility Director of Social		including follow-up on reside	
		7/01/14 at 8:00 AM revealed		concerns. The Administrator	is now
		Director (AD) attended the		keeping the	
	-	uncil meetings. When		Grievance Logs and distribu	
		brought up by residents at were handled at the facility,		grievances to the Departme for follow-up. The Social Ser	
		d that at each meeting the		Director and Activity Director	
	concerns from the pr			concerns from Resident Cou	
	reviewed to see if res	-		Administrator for	
	improvement during f	the month. The facility DSS		logging and resolution after	each resident
		s from Resident Council		council meeting. Re-educat	ion on
		form, which went to the		answering call lights in a	an hatwaar
		nanage. The facility DSS esidents had expressed		timely manner will be done of 7/17/14 to 8/9/14 by the Adr	
		ise time, waiting too long for		the DON.	
	-	consistency and quality of			
	nursing care had not			The Social Service Director	and Activity
	-	e facility DSS stated the		Director will interview 12 res	
	-	plaints at every Resident		week x 6 months for	
		e facility DSS further stated		timely response to answerin	
		nvolving nursing were given tor of Nursing/Unit Manager		The Social Service Director results of these audits to	
	(ADON/UM) to invest	v		QAPI monthly x 6 months fo	r review and
				recommendation. The Resi	
	Interview with the AD	ON/UM on 07/01/14 at 4:46		minutes will be submitted to	
		I never been informed of any		QAPI monthly for review and	b
		ce made by the Resident		recommendation.	
	Council in the years	she had worked as nursing			

Facility ID: 923265

If continuation sheet Page 54 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			I VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 244	05/15/13 with diagnost depression, demential most recent Minimum assessment dated 05 #20 was cognitively in others and able to be Interview with Reside AM revealed she had Council meeting in the stated that residents If facility DSS and the A residents had to wait nursing and nurse aid during the past year. when the Resident Co problem had improve on one shift, but not co stated when they did times, it was only tem the residents who atte had expressed their b for care was the way facility. Resident #20 remember a Resident residents had not exp bell response and nur Resident #20 stated t up each month at the had never changed a ever would. Resident complaints about nurs	mitted to the facility on ses including diabetes, a, and hypertension. The Data Set (MDS) quarterly /15/14 revealed Resident ntact, able to understand understood. nt #20 on 07/04/14 at 9:30 attended every Resident e last year. Resident #20 had complained to the D about the length of time for care and the quality of le care at every meeting Resident #20 stated that buncil minutes stated the d, it meant it had improved on others. Resident #20 see improvement of wait porary. Resident #20 stated ended the Resident Council belief that waiting a long time it would always be in the stated she could not t Council meeting when pressed concerns about call rse aide care in the last year. he concerns were brought meeting, but the problems nd she didn't have hope they	F 2	244			
		d all the monthly Resident					

Facility ID: 923265

If continuation sheet Page 55 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 12/10/201 MAPPROVE O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONS	TRUCTION	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING			07	7/11/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		-
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			ORIA ROAD ILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 244	stated the residents v	h the facility DSS. The AD who attended the Resident	F	244			
F 246 SS=E	meeting, including ca	NABLE ACCOMMODATION	F	246			8/10/14
	services in the facility accommodations of in	ndividual needs and when the health or safety of					
	by: Based on observatio interviews, and facility failed to accommodal sampled residents by equipment in order to #14 was not provided appropriate size to al gym and Resident #1	low her to go to the therapy 7 was not provided a of the appropriate size to		redi slin bed liste 7/29 Res app acc Res	sident #14 was provided a press ucing mattress, a shower gurney, g, a walker, a wheelchair and a l-side commode. All of the equip ed above was provided on or befo 5/14. sident # 17 was provided an propriate lift sling on 7/03/14 to commodate her weight needs. sident was discharged home from lity on 7/28/14.	, a ment pre	
	12/05/13 with pressur obstructive pulmonar specialized needs rel the FL2 form with a fa	admitted to the facility on re ulcers, diabetes, chronic y disease and had ated to weight. Review of axed date of 12/03/13 d skilled nursing care, was		Any equ prad dep deta equ spe	/ resident requiring specialized uipment can be affected by this ctice. Therefore, the therapy partment audited all residents to ermine equipment needs and obt uipment when the need for ecialized equipment was identified e plans were updated by the MDS	I. All	

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 56 of 168

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2 FORM APPRO OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, 2	•
	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD	
				ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETI TO THE APPROPRIATE DATE IENCY)
F 246	Continued From page	2 56	E 2	246	
	assistance for bathing receive physical thera	g and dressing, and was to		as needed and Housek Staff, Maintenance/Floo Dietary Staff, all Licens all Certified Nursing Ass	or Tech Staff, ed Nursing Staff,
	(PT) was ordered 5 ti on 12/06/13 for gait to exercises and activitie	mes per week for 4 weeks raining, therapeutic		Certified Medication Aic Heads (Dietary Manage Director, Housekeeping Supervisor, Business C	des, all Department er, Maintenance J/Laundry
	needed. The evaluat included a short term	ion completed on 12/06/13 goal to increase time out of long term goal to complete		Medical Records Direct Director, Social Service Assistant Director of Nu	or, Marketing es Director,
	gait training with rollin	ng walker.		Development Coordina Assurance Nurse, Activ Administrator, Therapy	vity Director,
	therapy (OT) was ord for 8 weeks on 12/06	lered 5 to 7 times per week /13 for therapeutic activity, g/self care, therapeutic		Therapist, Occupationa Speech Therapist, Occu Assistant, Physical The	l Therapist, upational Therapist
	exercises, neuro re-e as needed, wheelcha	ducation, thermal modalities ir management, manual		Office Assistant, Human Director were were edu	n Resource
		egiver education, and nursing uation dated 12/07/13		by the DON.	
	included a short term	goal to complete wheelchair um assistance of one with		The Therapy Departme Admission Nurse and th re-educated by the Reg	ne DON were jional Clinical
	12/12/13 coded her w	num Data Set (MDS) dated vith intact cognition, total		Nurse on 7-23-14 regar equipment needs of ner residents. All Therapy S	wly admitted Staff were
	toileting. Walking and during this assessme	or bed mobility, dressing, and d transfers did not occur ent period. She was coded OT. The MDS noted there		in-serviced to refer any to the Administrator on Therapy Manager.	
	•	for Resident #14 to return		The DON, RN Supervis will audit 4 residents pe to assure equipment ne	er week x 6 months
	family brought in a will appeared too small for pressure areas on late	7/13 revealed Resident #14's heelchair from home which or her and could cause teral hips. PT notes dated esident was transferred to a		Audits will be submitted committee by the DON recommendation for 6 r	for review and

Facility ID: 923265

If continuation sheet Page 57 of 168

Event ID: 0W9Y11

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _			C
		345174	B. WING				_ 11/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			01 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	,	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 246	Continued From page	57	F	246			
	U	t was also too small for her. /13 stated that the small					
		ed with the rehab manager					
		nagement was working on					
		hair for the resident. PT revealed that the therapist					
		e rehab manager regarding					
	the status of a wheel Resident #14. The re	hab manager reported he					
	had price quotes but	ordering a chair was under					
		nanagement. PT notes led there was no wider					
	wheelchair in the facil	ity for Resident #14 to use					
	and that she was very work on standing in the	eager to get out of bed and ne parallel bars.					
	On 01/06/14, the phy continue 5 times per	sician ordered skilled PT to					
		, therapeutic activities,					
	neuromuscular re-edu	-					
	visit as needed.	I therapy, gait training, home					
		nmary dated 01/27/14 Id not achieved her goals					
	"due to lack of approp	priate equipment to allow pt					
		ut of bed)" and that the cess of obtaining appropriate					
	seating. The note co	ntinued stating that therapy					
	would reassess if indi	cated. Discharge home exercise program.					
		lischarge summary stated ited to in bed activity and					
		cess the therapy gym at this					
	time. The note stated	I the facility was awaiting					
	approval for a bariatri resident was currently	c wheelchair and the / unable to sit at the edge of					
		lary to the air mattress					

Facility ID: 923265

If continuation sheet Page 58 of 168

	-	ID HUMAN SERVICES				FORM	APPROVED	
	<u>S FOR MEDICARE & I</u> DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
-	CORRECTION	IDENTIFICATION NUMBER:	l` í				LETED	
				_		(c	
		345174	B. WING			07/	11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER						
				4	ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		(X5) COMPLETION DATE	
					DEFICIENCY)			
F 0.40			_					
F 246	· · · · · · · · · · · · · · · · · · ·		F	246				
	required for multiple skin ulcers. The note stated OT would re-evaluate when the wheelchair arrived.							
		ated 05/09/14 revealed gnitively intact and did not						
		any locomotion during the 7						
	· · · ·	od. The mobility device						
	normally used was no	oted as a wheelchair.						
	Physician orders date	ed 05/22/14 included OT to						
	-	sident #14. OT physician						
		4 included OT to treat 3						
	times per week for 30 exercises, therapeutic	c activities, neuromuscular						
	re-education, self care							
	management and mo	dalities as needed.						
	On 06/30/14 at 10:41	AM, Resident #14 stated						
	that for awhile they di	d not get her out of bed but						
		heelchair from another						
	-	e stated she generally got nd returned to bed around						
	4:15 PM.							
	0= 07/04/44 =+ 0:04 5	NA Decident #14						
	On 07/01/14 at 3:01 F	PM Resident #14 was erself in a wheelchair using						
		l. On 07/01/14 at 3:20 PM						
		served in the therapy gym						
	doing arm exercises.							
	On 07/02/14 at 12:03	PM, the social worker						
	stated that Resident #	#14 did not come in the						
	-	air. The resident's family or						
	-	one from home however did not fit the resident						
	properly.							
	Resident #14 stated of	on 07/02/14 at 2:57 PM that						

If continuation sheet Page 59 of 168

-					FC	TED: 12/10/2014 DRM APPROVED NO. 0938-0391	
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C		
	345174	B. WING				07/11/2014	
ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
E NURSING & REHABIL	ITATION CENTER		91	1 VICTORIA ROAD			
			Α	SHEVILLE, NC 28801			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
she started in therapy stated therapy had as wheelchair at home a her wheelchair from h reported that therapy was too small. On 07/03/14 at 9:54 <i>A</i> interviewed and state been looking for mon accommodate Reside current wheelchair sh wheelchair that was k He further stated that company came in (be rehab manager state wheelchair at another previously, so the fac for Resident #14 to u evidence of the facilit appropriate sized whe #14's needs the follow a. an email to a supp requesting a bariatric inches and 18 inches b. an email from the s stating 40 inches sou c. an email from the s with a picture of a hig additional information d. an undated compu- brand of extra wide w inches, 28 inches and e. a computer print of same brand of extra wide width up to 30 inches f. an email dated 04/1	y when she first arrived. She sked her if she had a and she had a friend bring home to the facility. She determined that wheelchair AM, the Administrator was ed that the the facility had ths to find a wheelchair to ent #14. He stated the ne was using was a coaned by another facility. when the new therapy eginning in April) the new d there was a larger bariatric r facility he had been at illity obtained that wheelchair se. When asked to provide y's attempts to obtain an eelchair to meet Resident wing was provided: ly company on 01/13/14 wheelchair 40 inches by 22 high. supply company on 01/13/14 nded way too wide. supply company on 01/30/14 h back wheelchair with no n attached. ter print out of a specific /heelchair with widths of 26 d 30 inches. ut dated 04/17/14 of the wide wheelchair with a seat 18/14 from a facility	F	246				
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E NURSING & REHABIL SUMMARY ST (EACH DEFICIENC) REGULATORY OR Continued From page she started in therapy stated therapy had as wheelchair at home a her wheelchair from h reported that therapy was too small. On 07/03/14 at 9:54 / interviewed and state been looking for mon accommodate Reside current wheelchair sh wheelchair that was I He further stated that company came in (be rehab manager state wheelchair at anothe previously, so the fac for Resident #14 to u evidence of the facilit appropriate sized wh #14's needs the follow a. an email to a supp requesting a bariatric inches and 18 inches b. an email from the s stating 40 inches sou c. an email from the s stating 40 inches sou c. an email from the s stating 40 inches sou c. an email from the s stating 40 inches sou c. an email from the s stating 40 inches sou c. an email from the s stating 40 inches sou c. an email from the s stating 40 inches sou f. an email dated 04/7 corporate staff who w	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345174 ROVIDER OR SUPPLIER LE NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 59 she started in therapy when she first arrived. She stated therapy had asked her if she had a wheelchair at home and she had a friend bring her wheelchair from home to the facility. She reported that therapy determined that wheelchair	SPOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345174 B. WING ROVIDER OR SUPPLIER IDENTIFICATION NUMBER: A. BUILDI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 59 she started in therapy when she first arrived. She stated therapy had asked her if she had a wheelchair at home and she had a friend bring her wheelchair from home to the facility. She reported that therapy determined that wheelchair was too small. F : commodate Resident #14. He stated the current wheelchair she was using was a wheelchair that was loaned by another facility. He further stated that when the new therapy company came in (beginning in April) the new rehab manager stated there was a larger bariatric wheelchair at nother facility be had been at previously, so the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the facility obtained that wheelchair for Resident #14 to use. When asked to provide evidence of the supply company on 01/13/14 requesting a bariatric wheelchair to meat Resident #14's needs the following was provided: a. an e	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X) PROVICENSUPPLIERCLIA D2) MULTIPLE CONSTRUCTION A BUILDING	MENT OF HEALTH AND HUMAN SERVICES OMB SFOR MEDICARE & MEDICALO SERVICES OMB OF DEFICIENCIES (1) PROVIDERBURFLERCLA DESTIFICATION NUMBER 345174 B. WING A BULDING A BULDING	

Facility ID: 923265

If continuation sheet Page 60 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING _			
		345174	B. WING				C 11/2014
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				9	91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		4	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 246	wheelchairs found via Interview on 07/03/14 manager revealed a r in the facility on 04/01 manager on 05/12/14 involved in the morning m had been a discussion an extra wide wheelch stated he was aware suggested the facility her. The rehab mana extra wide wheelchair #14 began therapy ag An interview was com 07/10/14 at 10:08 AM they had worked with therapy company cha continued on with the April. OT stated that walk and she could no due no wheelchair wa properly. She further to do therapy and exe using an air mattress the air mattress was a stated therapy service not having the correct access the therapy gy 2. Resident #17 was 01/30/14 with diagnos generalized weakness pressure, diabetes, th	were two examples of a internet. • at 4:15 PM with the rehab hew therapy company began 1/14. He became the rehab • At that time, he became ing management meetings. hanagement meeting, there in of a resident who needed hair. The rehab manager of one at another facility and borrow that wheelchair for ager stated they obtained the r the next day and Resident gain. ducted with OT and PT on 1. Both OT and PT stated Resident #14 prior to the inge in April 2014 and new therapy company since Resident #14 was unable to ot access the therapy gym as available to fit her stated that she was unable ercises at bedside due to her and sitting on the edge of a fall risk. Both OT and PT es ended due to the facility t wheelchair for her to ym. admitted to the facility on ses which included s, arthritis, high blood	F	246			
	Data Set (MDS) dated						

Facility ID: 923265

If continuation sheet Page 61 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL	ITATION CENTER		9	1 VICTORIA ROAD		
				Α	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 246	Continued From page	S 61		- 4 0			
1 240			F.	246			
problems, was cognitively intact for daily decision making and was totally dependent on staff for transfers.							
	A review of a care pla	n with a revised date of					
	04/30/14 indicated a	problem statement that					
		d assistance with activities					
	use a full body lift to t	uded a handwritten note to ransfer with 2 people.					
		note dated 06/23/14 at 2:59					
	-	ge of status which revealed					
		ing lifted out of a recliner cal lift and the lift pad ripped					
		The notes indicated					
		k into chair approximately 6					
	inches and there was	no apparent injury noted.					
	A review of a purchas	e order dated 06/30/14					
	-	e full body slings were					
	ordered from a supply	y company.					
	During an interview o	n 07/02/14 at 11:30 AM					
	•	ed on 06/23/14 she had a					
		e entire left front corner of					
		ng on ripped apart and she ir. She stated another sling					
		om for Nurse Aide (NA) #3					
	and NA #15 to put he	r back to bed. She					
		but her back to bed on					
		stay in bed for 8 days until ing that was large enough to					
		e further explained while she					
		b lay in the same position					
	most of the time beca	use she could not turn					
		ide and could only turn					
		right side. She stated she g in bed for so long and was					
		er overall strength had					

Facility ID: 923265

If continuation sheet Page 62 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_		COMF	PLETED
		345174	B. WING				C 11/2014
345174 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE ASHEVILLE NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE ASHEVILLE NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX F 246 Continued From page 62 F 246 decreased and she felt her ability to care for herself had declined. F 246 During an interview on 07/08/14 at 9:34 AM with Nurse #2 she stated on 06/23/14 Resident #17 had a fall from a mechanical lift when the sling that she was sitting on ripped at the left front corner and she dropped approximately 6 inches down in a recliner chair. She explained Resident #17 was in bed for 8 days after her fall because the nurse aides (NAs) told her they did not have a lift sling that was large enough to lift her from her bed into her recliner chair. She further explained Resident #17 required an extra large lift sling but they only had a limited number of extra large slings because NAs usually left lift slings under							11/2014
				9	1 VICTORIA ROAD		
ASHEVILL				A	SHEVILLE, NC 28801		
				x	PROVIDER'S PLAN OF CORRECTION	F	(X5) COMPLETION
					CROSS-REFERENCED TO THE APPROPRI		DATE
	1						
F 246	Continued From page	62	F	246			
decreased and she felt				210			
		,					
	During an interview o	n 07/08/14 at 9:34 AM with					
	Nurse #2 she stated of	on 06/23/14 Resident #17					
	down in a recliner cha	air. She explained Resident					
		-					
		-					
		•					
		ansferred them back to bed					
		sier for them. She stated she					
		sling to be ordered for e she had been told the					
		was auditing lift slings and					
	she thought he had o	rdered new slings.					
	During an interview o	n 07/08/14 at 9:37 AM with					
	NA #3 she confirmed						
		17 when the sling ripped on					
		nt #17 fell into the recliner e transferred Resident #17					
	back to bed after the	fall but they could not lift					
	Resident #17 out of b	ed the next day because					
	-	ing that was large enough to ht the nurses were aware.					
	-	sident #17 was in bed for 8					
	days before an extra-	large sling was available to					
	get her out of bed.						
	During an interview o	n 07/11/14 at 3:06 PM the					
	DON stated lift slings	were not assigned to					
	residents and they we	ere stored in the linen closet					

If continuation sheet Page 63 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 246 F 281 SS=D	stated it was her expe lift slings to be kept a NAs should report to not have a sling large resident. She further to notify the Maintena order lift slings so resibed. During an interview of Maintenance Director staff could not get Re her fall on 06/23/14 b sling large enough to ordered 4 extra-large his routine monthly of slings were delivered 483.20(k)(3)(i) SERV PROFESSIONAL ST. The services provide must meet profession This REQUIREMENT by: Based on resident an record review, the fac reordered eye medica order to avoid missed sampled residents. (The findings included Resident #13 was ad	they were laundered. She ectation for different sizes of vailable in the facility and their nurse when they did e enough to transfer a stated she expected nurses ance Director so he could sidents did not have to stay in n 07/11/14 at 5:23 PM the r stated he was not told that esident #17 out of bed after ecause they did not have a lift her. He confirmed he lift slings when he placed rder on 06/30/14 and those to the facility earlier today. ICES PROVIDED MEET ANDARDS d or arranged by the facility hal standards of quality.	F 24		an be the all nsure

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 64 of 168

	-	ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 12/10/2014 ORM APPROVEI NO. 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		OATE SURVEY
		345174	B. WING				C 07/11/2014
	ROVIDER OR SUPPLIER	LITATION CENTER		91	TREET ADDRESS, CITY, STATE, ZIP CODE 1 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	quarterly assessment that Resident #13 had cognitively intact. A care plan dated 04/ problem for Resident secondary to glaucom Medication as ordere During an interview w 06/30/14 at 11:35 AW her eye drops for glau administered over the A record review of the Record (MAR) for Re- June, 2014 revealed 0.005 % was to be in: night for glaucoma. F had been signed and 06/28/14 thru 06/30/1 it was circled on the M An interview with Nur PM revealed that on she was the nurse withose nights for Resid circled the Latanopro and it meant the med because, the medicate An interview with Nur PM revealed that she evening shift, and she and circled the Latanopro	e Minimum Data Set (MDS) t dated 04/22/14 revealed d been identified as /30/14 revealed an identified #13 of impaired vision na. An intervention included: d. with Resident #13 on 1 Resident #13 stated that ucoma had not been e weekend. e Medication Administration esident #13, for the month of that Latanoprost solution stilled in each eye every further review revealed that it circled for the dates of 14 and no explanation of why MAR. rse #13 on 07/01/14 at 3:35 06/28/14 and 06/29/2014 ho initialed the MAR on dent #13. She revealed she st eye drops on the MAR, lication was not given tion was not available. rse #14 on 07/01/14 at 3:40	F	281	available. All medications were availa The DON and SDC re-educated all licensed nursing staff between 7/17/' and 8/9/14 regarding the process for obtaining medications when order and for using the back-up pharmacy located locally. Nursing staff were educated betweer 7/17/14 and 8/9/14 regarding notifyin physician and DON when a medication unavailable. The QA Nurse and RN Supervisor widdily MAR audits for issues regarding missing documentation on the medication record. The audits wild done daily x 8 weeks and brought to monthly QAPI meeting by the DON for review and recommendations.	14 red g the on is II do J I be the	

If continuation sheet Page 65 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		ICTORIA ROAD IEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 281	Continued From page medication from phare		F 281		
	12:30 PM revealed he Latanoprost eye drop significant enough to would not raise the pr eyes. He did state that	Physician on 07/02/14 at e did not feel missing the s for 3 days would be impact Resident #13, and ressure in Resident #13's at if Resident #13 missed 30 s he would worry about the			
F 309 SS=G	on 07/03/14 at 8:50 A who was passing med medication was due, I available, was respon clarifying any orders f pharmacy. She furthe not receive the medic report it to the pharma revealed it is her expe should have been ord responsible for that m pass, and there shoul communication about medication to the pha was expected to follow	sible for communicating and for the medication with the er stated if the nurse does ation right away she should acy and the DON. She ectation that the medication lered by the nurse nedication during her med ld have been the specific need for the irmacy. She stated the nurse w up with pharmacy if the rrived at the facility that RE/SERVICES FOR	F 309		8/10/14
	provide the necessary or maintain the higher mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment			

Facility ID: 923265

If continuation sheet Page 66 of 168

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 / APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9	1 VICTORIA ROAD		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER		A	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	: 66	F 3	309			
	by: Based on observation physician and staff int identify and assess th Resonance Imaging (initial x-rays were neg continued to complain fell from a lift for 1 of 2 from lifts (Resident #1 The facility failed to re drinking straw for 1 of (Resident #12). The findings included 1. Resident #17 was a 01/30/14 with diagnos generalized weakness pressure, diabetes, th depression. The mos Data Set (MDS) dated Resident #17 had no problems, was cogniti making and was totall transfers. A review of a care pla 04/30/14 indicated a p Resident #17 required of daily living and incl use a full body lift to th A review of a nurse's PM indicated a chang	assess for the use of a 3 sampled residents admitted to the facility on ses which included s, arthritis, high blood yroid disease and t recent quarterly Minimum d 04/26/14 indicated short or long term memory ively intact for daily decision y dependent on staff for n with a revised date of problem statement that d assistance with activities uded a handwritten note to			The physician was notified by the Dire of Nursing (DON) regarding resident # change in condition related to pain and the results the x-ray and MRI 5-8-14 and 5-19-14. Resident # 17 continued to receive pain medications per physician order and no further x-rays or tests had been ordered. Resident #17 was discharged home on 7/28/14. Resident # 12 was reassessed by the Speech Therapist on 7/18/14 and was deemed safe to use a straw to assist with drinking fluids. The care plan was updated by the MDS Coordinator on 7-30-14 and staff was re-educated from 7-18-14 to 8-9-14. Th no straw alert was removed from the MAR, tray card and Physician telephon order All residents may be affected by this issue. A Numerical Pain Scale form requiring a numerical score and license nurses initials every shift was added to each resident's medication administrati record and will be completed for all residents every shift to better assess and document a change in pain. Any resident requiring special needs at meals or change in condition related to pain can be affected.	17 s of s l ne ed on nd	

Event ID: 0W9Y11

Facility ID: 923265

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 12/10/2014 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		LETED
		345174	B. WING			C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		01 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	Continued From page	e 67	F 309			
F 309	at the left front corner Resident #17 fell bac inches and there was A review of a nurse's AM indicated a late e Resident #17 was co and was given as nee A review of a nurse's PM indicated Residen the Director of Nursin resident 's status rela The notes revealed R DON that her left kne requested for Nurse # for a left knee x-ray. physician's order was monitor for increased pain medication. A review of a physicia 1:30 PM indicated x-r	cal lift and the lift pad ripped r. The notes indicated k into chair approximately 6 s no apparent injury noted. note dated 06/24/14 at 7:46 ntry note for 6:00 AM that mplaining of left knee pain eded (PRN) pain medication. note dated 06/24/14 at 1:25 nt #17 was interviewed by ig (DON) to follow up on the ated to her fall from a lift. Resident #17 stated to the	F 309	The RD and the MDS Team rev audited all residents with adapt equipment or specialty needs for accuracy on 7/18/14. Re-education was done by the SDC between 7/18/14 and 8/9/ licensed nursing staff members concerning resident □s special □ meals. Physician orders were re follow-up and care plans were re follow-up and care plans were re needed. A Pain Scale requiring a numer is being completed for all reside shift utilizing the Numerical Pain better assess and document a pain. Any resident exhibiting sy pain will have a pain assessme completed. The physician will b of change in condition related to clinically appropriate. Re-educated done by the DON and SDC bet 7/18/14 and 8/9/14 for all licens and medications aides concern new pain scale. The nurse will issue on the 24-hour report for	ive DON and 14 for all needs for eviewed for updated as rical score ents every n Scale to change in mptoms of int be notified o pain as ation was ween sed nurses ing the place the	
	5:44 PM indicated lef fractures but moderat knee. A review of a nurse's	t knee x-ray indicated no te osteoarthritis in the left note dated 06/24/14 at 6:44 esults revealed no fracture or		during the next morning meetin Residents will be reviewed for s needs or change of condition re pain in the clinical morning meeting for follow-up a	g. special elated to	
	indicated Resident #1 Administrator were no continue to observe f	esent. The notes further 17 and the DON and otified of x-ray results and		recommendations. A referral to and Speech Therapist will be made as needed to determine in needs for meals are needed or continue to be appropriate. Any resident admitted requiring equipment or special needs will	f special will ı adaptive	

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 68 of 168

ATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		ISTRUCTION	(X3) DATE SL	JRVFY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLE	
						c c	
		345174	B. WING			07/11	/2014
NAME OF PR	ROVIDER OR SUPPLIER		- I	STREE	TADDRESS, CITY, STATE, ZIP CODE	•	
				91 VIC	TORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		ASHE	VILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	-	(X5) COMPLETIO DATE
F 309	Continued From page	<u> 68</u>	F 30				
1 000		AM Resident #17 continued	F 50	-	voisian ⊐a talanhana		
		eft knee was painful or sore			nysician⊡s telephone der written. A communication form w	ill	
		y and the area was guarded.			e completed by the nurse receiving th		
		cated Resident #17's left			hysicians order and		
	knee had no redness				ill be forwarded to the RD, DON and	the	
	swelling.	-			DS Team. The physician s order and		
	-			co	ommunication form will be brought to	the	
		an's progress note dated			orning meeting to ensure that the		
		e physician who was also			opropriate departments have been		
	•	rector documented he was		nc	otified.		
		t #17 because of the onset		-			
		in. The notes revealed			The audit of the adaptive equipment v		
		her recliner while staff was I was from about 6 inches			e completed weekly x 4 weeks and th onthly x 3 months	en	
	-	recliner. The notes further			the RD and MDS Team.		
		7 stated her left leg hit the		-	ne pain scale will be audited daily x 2		
		Idenly developed left knee			eeks and then weekly x 12 weeks and		
		time of the examination she			ill be taken to the		
	had significant tender	ness in the distal thigh,			onthly QAPI meeting by the DON x 3		
		imal (central point) of her			onths for review. The Director of		
	• •	but there was no deformity,			ursing (DON) will review all residents		
		or redness of the skin but			entified as having a change in conditi		
		luced range of motion. The			lated to pain on a daily basis to ensu		
		lent #17 had been receiving twice a day and every six			at assessment and the plan of care a		
		s for pain. The progress			eing implemented as well as physicial otification.		
		Resident #17 was in distress			Janoadon.		
		left knee. A section titled		Tr	ne QAPI Committee will review a		
	diagnosis, assessmer				Immary of the findings of the		
	Resident #17 had a h	•			oservations related to pain		
	degenerative joint dis				ssessments and adaptive equipment.		
	followed by orthopedi				ecommendations for additional chang	ges	
	chronic right knee pai				ill be made as needed		
		in had requested a complete		by	/ the committee.		
	-	ft lower leg to assess for					
	possible fractures and						
	evaluation before dec	ciding further intervention if					

If continuation sheet Page 69 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	A review of a physicia 2:00 PM indicated x-r leg due to pain and ch milligrams (mg) by mo by mouth every 6 hou A review of a physicia with no time indicated obtain left leg x-rays of /fibula (calf bone) and views on each. A review of a nurse's PM indicated Resider physician and continu pain. The notes furth orders were received medication and x-ray A review of a radiolog indicated moderate of and no acute fracture lesions in the left fem A review of a nurse's 10:25 AM indicated R recliner from a lift and femur, and tibia/fibula further indicated Resider of left knee pain and r obtained from pain mo	In's order dated 06/25/14 at ay full left hip and whole left hange oxycodone to 5 buth twice a day and 5 mg irs PRN for pain. In's order dated 06/25/14 an order clarification to of the hip, tibia (shin bone) I femur (thigh bone) with 2 note dated 06/25/14 at 2:52 at #17 was assessed by the red to complain of left knee er indicated physician for scheduled pain of full leg and hip. If y report dated 06/25/14 steoarthritis of the left hip , dislocation or destructive ur. note dated 06/26/14 at resident #17 had a fall into a I x-ray results of her left hip, were negative. The notes dent #17 continued to ain and medication as given. note dated 06/27/14 at 3:25 at #17 continued to complain	F	30	9		

Facility ID: 923265

If continuation sheet Page 70 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345174	B. WING				C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	A review of a physicia indicated a Magnetic x-ray of left knee statu severely decreased ra x-rays. A review of a physicia indicated a clarificatio without contrast due to decreased range of m A review of a nurse's PM indicated Resider for a MRI of left knee range of motion. A review of an x-ray r without contrast dated facsimile (faxed) date stamped at 12:46 PM report. The report ind impression: 1. Moderate to severe (middle) compartmen contusions. 2. The medial menisc that provides structure extruded (pushed out tear of the extruded b 3. Findings suggest a medial collateral ligar of the knee. 4. Moderate intramus vastus medialis (large of the thigh). A further review of MR of 07/11/14 at 12:46 F	an's order dated 07/07/14 Resonance Imaging (MRI) us post injury due to ange of motion and normal an's order dated 07/07/14 on order for MRI of left knee to injury with severely notion and normal x-rays. note dated 07/08/14 at 1:17 of #17 was out of the facility due to severely decreased eport titled MRI left knee d 07/08/14 at 2:30 PM had a e of 07/11/14 and time 1 in the top left corner of the dicated the following e osteoarthritis of the medial t associated with cus (a semicircular cartilage al integrity to the knee) is 0 and there is a probable	F	309	9		

Facility ID: 923265

If continuation sheet Page 71 of 168

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				M APPROVE <u>). 0938-03</u>	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	Сом	E SURVEY PLETED	
		345174	B. WING			C / 11/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILL	E NURSING & REHABII	LITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 309	Continued From page	e 71	F 30	9			
	to physician. Orthop	edic referral to bone and nday 07/21/14 at 2:00 PM.					
3: ⁻ an Du Re siti for Aid		an's order dated 07/11/14 at refer Resident #17 to a bone n 07/21/14.					
	Resident #17 explain	on 07/02/14 at 11:30 AM led on 06/23/14 she was lair in her room and called					
	for staff to transfer he Aide (NA) #3 and NA	er back to bed and Nurse #15 went to go find a lift. le (NA) #3 and NA#15 came					
	back into her room w hooks located on eac	ith the lift and connected the ch corner of the sling to the					
	chair. She explained the chair the entire fr	to raise her up out of her I when they raised her up off ont left corner of the sling					
	lift back into the reclin	d apart and she fell from the ner chair. She further started to fall NA #15 was					
	standing next to her of her back toward the of	on her left side and pushed chair so she would fall into alling on the floor. She					
	stated her left leg hit much pain and was c	the floor and she was in so crying and NA #3 and NA #15					
	got another sling and	o come to the room and they I lifted Resident #17 from the to bed. She explained the					
	Tuesday 06/24/14 an	rays of her left knee on id they were negative. She saw her on Wednesday					
	06/25/14 because sh in her left knee and s	e was having so much pain ince the previous x-rays					
	and leg and they wer	lered x-rays of her left hip e also negative. Resident e felt something was wrong					
	with her left knee and	d thought she should have a d not had pain in that knee					

Facility ID: 923265

If continuation sheet Page 72 of 168

		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/10/20 ⁷ FORM APPROVE MB NO. 0938-039	
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			3) DATE SURVEY COMPLETED	
		345174	B. WING			C 07/11/2014		
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				91 V	ICTORIA ROAD			
ASHEVILLI	E NURSING & REHABI	LITATION CENTER		ASH	HEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pag	o 72	F 3	00				
			F 3	09				
	pain medication daily	he lift and now had to take / on a regular basis.						
		on 07/08/14 at 9:34 AM with						
		on 06/23/14 during the						
		t the nurse's desk and heard om Resident #17's room.						
	She explained she ra							
		her recliner chair screaming						
		stuck between her recliner						
	and the mechanical I	ift. She stated she pulled the						
		t #17 stopped screaming.						
		ssessed Resident #17 but						
		y redness or swelling or						
	-	she asked Resident #17						
		ened and she said the sling front corner and she						
		ely 6 inches back down in the						
		stated Resident #17 was						
		with the sling still hooked to						
	-	nd Nurse #2 verified the left						
	front corner of the sli	ng had totally ripped off the						
		Resident #17 had a left						
	2	06/24/14 and the results were						
	•	he had x-rays of her left hip						
	negative. She stated	/14 and the results were						
	-	en discharged to go home						
		discharge was put on hold						
		nee pain. She explained she						
		ne physician about x-ray						
	results until the DON	told her to call him to						
		/07/14 since Resident #17						
	· •	of pain in her left knee. She						
		physician and he gave a						
		dule Resident #17 for an MRI						
	and Resident #17'S a	appointment was scheduled						
	for this afternoon ber	cause that was the next						

Facility ID: 923265

If continuation sheet Page 73 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345174	B. WING	_			C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	11/2014
i u une or i							
ASHEVILI	_E NURSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	9 Continued From page 73		F	309			
	DON explained she ta 06/24/14 as part of he her fall from a lift and that her left knee was she told Nurse #2 to co order for a left knee x x-ray results were neg still complaining of pa 06/25/14 and the phy ordered full xrays of h negative. She stated aware that Resident # left knee pain and she physician because sh should order an MRI. #17 went to get the M she did not know what During an interview of Resident #17's physic Medical Director verift Resident #17 after sh complained of severe confirmed Resident # her right knee due to was not aware Reside with her left knee or h her left knee before si explained he was ask making rounds in the on Wednesday 06/25 complaining of severe had decreased range He stated he first orde and those results wer ordered x-rays of her	sician examined her and her left leg but they were also on 07/07/14 she was made #17 was still complaining of the told Nurse #2 to call the he thought the physician She confirmed Resident IRI done this afternoon but at the results were. IRI done this afternoon but the fell from the lift. He the results were resident #17					

Facility ID: 923265

If continuation sheet Page 74 of 168

		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	NG_			C
		345174	B. WING			07/	11/2014
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		-	01 VICTORIA ROAD		
-				4	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	called by nursing staff exact date because the because the left leg a He stated that he had results of the MRI and so he could determine Resident #17. The pl expectation for the nu- eyes and ears when h stated he expected for with him when x-ray n resident continued to change in their condit communication could During a follow up inte PM the DON stated s of Resident #17's MR staff had called earlie The DON obtained a after she read the imp loud she stated the re- had a torn meniscus of physician needed to b 2. Resident #12 was a 09/23/08 with diagnost failure, altered mental disability, dysphagia (epilepsy, and cerebra A review of Resident a indicated a speech the 12/20/13 indicated Re- secondary to a declin decline in her cognitic skills. The clinical sum evaluation indicated F	 He stated he was next f but did not remember the ney wanted orders for a MRI nd hip x-rays were negative. not been called about the d was waiting for the results appropriate treatment for nysician stated it was his inses in the facility to be his ne was not there. He further r nurses to communicate esults came back or if the complain of pain or had a ion and he thought the be improved. erview on 07/11/14 at 3:06 he had not seen the results I but she thought nursing r that day for the results and oression of the report out eport indicated Resident #17 of her left knee and the be notified. admitted to the facility on ses which include kidney I status with intellect difficulty in swallowing), I palsy. #12's medical record erapy evaluation dated esident #12 had weight loss e in her ability to swallow, a on, and communication mary of the speech therapy Resident #12 was changed 	F	309			
		Resident #12 was changed					

Facility ID: 923265

If continuation sheet Page 75 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
AND I LAN OF	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			C
		345174	B. WING			07/	11/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page assistance with eating drinking straws. The quarterly Minimu 05/13/14 indicated Re impaired in cognition and was totally deper daily living (ADLs). A review of the physic 12/01/13 through 06/3 "mechanical soft diet snack at bedtime, and A review of the nurse Record (MAR) dated indicated "No Straw" A review of a care pla 06/04/14 indicated a p Resident #12 required listed approaches in p diet, no drinking straw precautions which con supervision with meal head of the bed eleva for 30 minutes after m Resident #12 was obs AM sitting up in her b	e 75 g of small bites, and no m Data Set (MDS) dated esident #12 was severely for daily decision making ident on staff for activities of cian's orders dated from 30/14 revealed an order for with full range of liquids, a d no straw." 's Medication Administration 12/01/13 through 06/30/14 for Resident #12. In with a revised date of problem statement that d assistance with ADLs and part for a mechanical soft vs, and swallowing insisted of the following: ls, encourage small bites, ited with meals and at least neals.		309	DEFICIENCY)		
	due to the cerebral pa set up by the Nursing consisted of scramble orange juice, and a ca Resident #12, with no	It use of her left arm/hand alsy, her breakfast tray was Assistant (NA) #13, which ed eggs, grits, a muffin, arton of milk with a straw. o staff in the room, drank the v and was observed to have n.					

Facility ID: 923265

If continuation sheet Page 76 of 168

	MENT OF HEALTH AN					FORM): 12/10/2014 // APPROVED). 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED		
		345174	B. WING				C 11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	CTION SHOULD BE COMPLI O THE APPROPRIATE DAT		
F 309	Nurse #3 was observ go into Resident #12' of a thickened shake observed to put the si- held the cup for Resid thickened shake throu Resident #12 was ob- PM, her lunch tray was straw placed into the which time she left the #12 was observed to while sucking the mill NA #13 was interview PM. She stated she w #12 was not suppose straw. Nurse #3 was interview PM. She stated she w #12 was not suppose straw. Nurse #3 was intervier PM. She stated she w #12 was not suppose straw. She further sta the "no straw" printed brought to her attention Speech Therapist (ST 07/01/14 at 2:37 PM. completed the evalua 12/20/13 was no long the ST's were under a 04/01/14. She indicat information, and/or ev Resident #12 and had she had been with the The Director of Nursin	ed on 07/01/14 at 8:34 AM s room with an 8 ounce cup and a straw. Nurse #3 was traw in the cup of shake and dent #12 to drink half of the ugh the straw. Served on 07/01/14 at 12:36 as set up by NA #13 with a resident's carton of milk at e resident's room. Resident have 1 episode of a cough a through the straw. red on 07/01/14 at 12:44 vas unaware that Resident d to be drinking through a ted she had never noticed on the MAR until it was on during the interview. T) #1 was interviewed on She stated the ST that tion on Resident #12 on er with the facility because a different contractor as of ed she had no orders, valuations regarding d not worked with her since e facility. ng (DON) was interviewed M. She stated she would	F	309	9			

Facility ID: 923265

If continuation sheet Page 77 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C	
		345174	B. WING				
	ROVIDER OR SUPPLIER .E NURSING & REHABIL	ITATION CENTER		91	REET ADDRESS, CITY, STATE, ZIP CODE VICTORIA ROAD SHEVILLE, NC 28801	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 312 SS=D	Continued From page 77 Resident #12 was not supposed to have a straw when it was printed on the MAR. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to			309 312			8/10/14
r 2 - 1	maintain good nutritio and oral hygiene. This REQUIREMENT by:	on, grooming, and personal is not met as evidenced ns, record review, and staff			Resident #12 is assisted with all meals	s at	
	with eating meals for	failed to provide assistance 1 or 3 sampled residents r activities of daily living			bedside. The RN Supervisor is monitor residents that require assistance with eating to ensure they a receiving needed assistance. Any resident requiring assistance with	-	
	Resident #12 was ad 09/23/08 with diagnor failure, altered menta	mitted to the facility on ses which include kidney I status with intellect (difficulty in swallowing),			meals can be affected. Therefore, The RD and the MDS Team reviewed the current assistive needs for all residents for accuracy on 7/14/14. T Care Plan was reviewed and updated as needed.	or	
	05/13/14 indicated Re impaired in cognition and was totally dependaily living (ADLs). The Resident #12 had implead and neck, left a	m Data Set (MDS) dated esident #12 was severely for daily decision making indent on staff for activities of the MDS further revealed paired range of motion of her rm, and both legs. The MDS e was not exhibited and she every day."			All Dietary Staff were re-educated by th RD for the Dietary Department betwee 7/14/14 and by the DON and SDC for the all licensed and certified nursing staff between 7/17/14 and 8/9/14 regarding provision of assistance with meals. The MDS Team, RN Supervisor and Weekend RN Supervisor will do audits the Assisted Dining Room 5	n he	

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 78 of 168

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		07	C 7/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 312	A review of Resident indicated a speech th 12/20/13 indicated Re secondary to a declin decline in her cognitic skills. The clinical sur evaluation indicated F to a mechanical soft of assistance with eating A review of a care pla 06/04/14 indicated a Resident #12 required listed approaches in p diet and swallowing p of the following: requi encourage small bites with meals and at lea meals. The care plan communication defici garbled, and staff wor Nursing Assistant (NA 07/01/14 at 8:08 AM bed, set up her break room. Resident #12 v carton of milk with sp gown, and onto the b revealed Resident #1 her right hand in an a approximately 35% o bed and approximate Nurse #3 was observ go into Resident #12'	#12's medical record erapy evaluation dated esident #12 had weight loss e in her ability to swallow, a on, and communication nmary of the speech therapy Resident #12 was changed diet and supervision to total g consisting of small bites. In with a revised date of problem statement that d assistance with ADLs and part for a mechanical soft orecautions which consisted res supervision with meals, s, head of the bed elevated st for 30 minutes after noted Resident #12 had a t, speech was unclear and uld anticipate her needs. A) #13 was observed on to set Resident #12 up in her fast tray, and leave the vas observed to drink her illage down her face, neck, ed. Further observations 2 to pick up her spoon with ttempt to feed herself with f her breakfast meal in her	F 312	x a week x 8 weeks to observe th residents needing assistance are receiving the needed assistance The audit will be taken to the mo QAPI meeting by the DON x 3 m review and recommendations	e nthly	

Facility ID: 923265

If continuation sheet Page 79 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD		
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 312	breakfast meal. NA #13 was observed set up Resident #12's room. Resident #12's room. Resident #12 w milk with spillage dow onto her bed. Further Resident #12 drank h lunch meal. The Director of Nursin 07/01/14 at 12:43 PM room at the doorway eating?" Resident #12 an incomprehensible NA #13 was observed pick up Resident #12 of the room. NA #13 was interview PM, she stated Resid but almost never ate eat only 15% to 25% she had always set u assisted her with eatin she would have to ch and bed linens after h would spill her milk ar she was unaware tha assistance with eating Nurse #3 was interview PM, she stated she w therapy had worked v	d on 07/01/14 at 12:36 PM to a lunch tray and leave the vas observed to drink her on her face, neck, shirt, and observations revealed er milk and ate 0% of her ng (DON) was observed on to stop at Resident #12's and ask "are you done 2 was observed to mumble response to the DON. d on 07/01/14 at 12:44 PM to s lunch tray and take it out red on 07/01/14 at 12:44 ent #12 would drink her milk her food and usually would of her meals. She indicated p her meal trays but had not ng. She further indicated ange Resident #12's clothes her meals because she nd food. She further stated t Resident #12 needed g. wwed on 07/01/14 at 12:50 ras aware that speech with Resident #12 to assist eat her meals but was	F	312			

Facility ID: 923265

If continuation sheet Page 80 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • •
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 312 F 314 SS=D	Speech Therapist (ST 07/01/14 at 2:37 PM. completed the evalua 12/20/13 was no long the ST's were under a 04/01/14. She indicat information, and/or ev Resident #12 and had she had been with the The Director of Nursir on 07/01/14 at 3:09 P unaware Resident #1 supervision with her r Resident #12's care p required supervision vith her r Based on the resident #1 PREVENT/HEAL PRI Based on the compre resident, the facility m who enters the facility does not develop pre- individual's clinical co they were unavoidabl pressure sores receiv services to promote h prevent new sores fro This REQUIREMENT by: Based on record revi facility failed to clarify	T) #1 was interviewed on She stated the ST that tion on Resident #12 on er with the facility because a different contractor as of ed she had no orders, valuations regarding d not worked with her since e facility. ng (DON) was interviewed M. She stated she was 2 needed assistance and/or neals. She verified that blan indicated she was with meals. She further e expected the NAs to st Resident #12 with all of NT/SVCS TO ESSURE SORES hensive assessment of a nust ensure that a resident v without pressure sores ssure sores unless the ndition demonstrates that e; and a resident having res necessary treatment and uealing, prevent infection and	F 31		

Facility ID: 923265

If continuation sheet Page 81 of 168

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER	-	1 VICTORIA ROAD SHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 314	Continued From page new treatment orders		F 314	physician⊡s orders. Resident #12 is c	n
		ith pressure ulcers (Resident		hospice and the IDT met on 7/30/14 to determine that the current treatment plan remains appropriate. The	nt
	The findings included			wounds were assessed and documented and the Ca	
	05/01/14 with diagnost disease. There were	admitted to the facility on ses of peripheral vascular no standing orders for a a located in the medical		Plan was reviewed and updated. The physician is currently aware of the resident s condition. Th treatment order is correct on the treatment records. The family	e
	05/08/14 coded her w extensive assistance toilet use and hygiene no pressure ulcers bu	-		is aware of the resident □s condition. Any resident with recommended treatments can be affected; therefore, Regional Clinical Nurse reviewed the current treatment records	3
	pressure ulcers asses	sment dated 05/13/14 for ssed her as being at risk for		and compared them to the physician orders between 7/23/14 and 7/24/14 for accuracy of content of treatment orders.	
	due to being a bilater assistance with trans	ulcers due to poor mobility al amputee, requiring fers and bed mobility, being tivities of daily living skills		The Regional Clinical Nurse met with t new treatment nurse on 7-17-14 to educate her on writing a correct treatment order and re-educate her on the process of writing, noting ar	ed
	revealed she was rec cream to her excoriat	014 Treatment Record eiving an in house barrier ed coccyx and peri-area as as noted as healed on		transcribing a physician order including adding it to th 24-hour report. The DON will review new orders for follow-up in the clinical morning meetir process.	ne
	Resident #16 being a pressure ulcer. The of free of skin breakdow pressure reduction de	eloped on 05/21/14 for t risk for developing a goal was for her to remain m. Interventions included evices in the bed and chair, ght shift when sitting up in a		A Qualified Clinical Education Manage was been obtained to provide directed in-service training in all aspects of wou care, including physician s orders, provision of care technique, wound car	Ind

Facility ID: 923265

If continuation sheet Page 82 of 168

	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE SUR	938-039
	CORRECTION	IDENTIFICATION NUMBER:	, í		COMPLETE	
					С	
		345174	B. WING		07/11/2	2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	LITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE CC	(X5) DMPLETION DATE
F 314	Continued From page	e 82	F 314	1		
 chair, and having 2 persons to repositioning to avoid shearing. On 06/26/14 a physician's probest to the physician of the physician of the physician of the physician of the physician orders of the physician orders of time) revealed an order for "Will pressure ulcer buttocks." The signed as received by Nurse Review of the Wound/Skin H revealed one entry dated 06/2 buttocks noted as a stage II in centimeters (cm) by 2.0 cm board a small amount of serous extunations of the physican order server the physican order of the physican order of the physican orders of the physican orders of the physican orders of the physican orders. The physican order of the physican orders of the physican order of the physican order of the physican order of the physican orders. The physican order of the physican order order order or	repositioning to avoid	I shearing.		products and accurate docume all licensed nurses and medica These in-service were conduct 8-01-14 to 8-9-14.	tion aides.	
	ner (NP) revealed Resident entimeter (cm) by 2 cm stage er on her lower back ated the NP requested orders dated 06/26/14 (no ler for "wound care for stage		The DON will audit new orders wound treatments. The Region Nurse will review new orders for wound treatments m months to determine if the orde written correctly. Results will be presented by the DON a	al Clinical onthly x 4 ers are		
	signed as received by Review of the Wound revealed one entry da buttocks noted as a s centimeters (cm) by 2 a small amount of se tissue edema. This r wound nurse, Nurse one word "Hydrocollo	y Nurse #9. I/Skin Healing Record ated 06/26/14 on the right stage II measuring 2.0 2.0 cm by 0.2 cm deep with rous exudate and peripheral note was signed by the #7. Under comments was		reviewed by the Regional Nurs Consultant at the monthly QAP months.		
		014 treatment record there or documented treatments				
	stated the nurse prac wound on Resident # was written for wound	es to identify the new oted on 06/29/14 which stitioner noted a stage II sto's coccyx and an order d care eval and hydrocolloid x to be changed every 3				

If continuation sheet Page 83 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/10/2014 FORM APPROVED IB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 07/11/2014
	ROVIDER OR SUPPLIER	ITATION CENTER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 11 VICTORIA ROAD ASHEVILLE, NC 28801	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	as needed. This treat placed on the Treatm The June 2014 treatm orders written or initia before this entry indic provided until 06/29/1 Interview with the wo 07/01/14 at 1:52 PM Resident #16. Interview with the Nu PM revealed the mea Wound/Skin Healing from the wound care measurements. She measurements only t NP measured. Interview on 07/11/14 Assistant Director of was missing docume records, the treatmen stated Nurse #7 was sheets to ensure treat completed as ordered Interview with the Dir at 3:08 PM revealed 06/26/14 wound care expected that Nurse Nurse #7 the facility's clarified the order wit 06/26/14 when the or revealed she expected be filled out when the there were no initials the treatment was no	thent order was noted as thent Record on 06/29/14. Interfection of the transformation of	F	314			

Facility ID: 923265

If continuation sheet Page 84 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE			
		345174	B. WING				C / 11/2014		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 314	on the treatment reco wound nurse to ensur- should be and know w doing the treatments. Interview with the Nur- 07/11/14 at 4:33 PM r the wound nurse to cl as she would have st #7 was no longer in th reached for comment 2. Resident #12 was 09/23/08 with diagnos failure, altered menta disability, dysphagia (epilepsy, and cerebra The quarterly Minimu 05/13/14 indicated Re impaired in cognition and was totally deper daily living (ADLs). Th with having 1 stage 3 4 pressure ulcer. A care plan was deve 06/04/14 which includ ulcers to reduce in siz reposition frequently, mattress, perineal car incontinence protectio ordered, treatments a physician to see weel assessments. Record reviews of the	e order that was not written and then she expected the re what the wound treatment what the orders were when rse #9 via phone on revealed it would be up to larify the physician's order arted the treatment. Nurse the facility and could not be the facility and could not be the facility and could not be the facility in swallowing), admitted to the facility on ses which include kidney I status with intellect (difficulty in swallowing), al palsy. Im Data Set (MDS) dated esident #12 was severely for daily decision making indent on staff for activities of the MDS coded Resident #12 pressure ulcer and 1 stage Aloped with a revised date of led the goal for the pressure the pressure relieving re as needed, provide on: adult briefs, diet as as ordered, wound care	F	314	4				

	-	ID HUMAN SERVICES				FORM APPROVED OMB NO. 0938-0391		
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED	
		345174	B. WING				C 11/2014	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD SHEVILLE, NC 28801			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 314	Continued From page	e 85	E F	314				
	follows:							
	On 06/26/14 a Physic							
		acrum with normal saline, tic solution) ½ strength to						
	lightly moisten 4x4 ga	auze, and pack inside wound						
	twice dally, and cover	with 4x4 gauze and tape.						
	The MD's order was t 2014 TAR correctly. 1	ranscribed on the June						
	treatment for Resider	nt #12 was initialed by the						
		rse #1 to indicate wound on the following dates:						
	06/26/14, 06/27/14, 0	6/28/14, 06/29/14, and						
		iew of the TAR had no ent being completed twice						
	daily on 06/26/14, 06/ or 06/30/14.	/27/14, 06/28/14, 06/29/14,						
		ed on 07/01/14 at 1:31 PM						
	•	2's pressure sore treatment e sacral wound was clean,						
		tissue surrounding the						
		ducted with Nurse #7 on						
	07/02/14 at 3:12 PM. the June 2014 TAR a	She verified her initials on s having completed						
	Resident #12's sacral	wound treatment once a						
	would complete the re	06/30/14. She stated she esident's first wound						
		afternoons and she would Id daily treatment unless the						
	dressings were soiled	-						
		ducted with Nurse #9 on						
		She verified her hand the June 2014 TAR as to						
		6/26/14. She stated she was						

If continuation sheet Page 86 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391		
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING		C 07/11/2014		
NAME OF P	ROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP CO			
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		I VICTORIA ROAD SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETION DATE DATE		
F 314	to 11 PM on the dates 06/28/14, 06/29/14, a stated she did not per sacrum wound treatm An interview was con consultant Physician' at 1:15 PM. She state #12's wound care wa facility twice daily as she visits the facility of treatments observed ordered for the reside #12, she stated she wo were not being done further stated she wo facility's wound treatm #12's first daily wound and that the evening resident's second dai An interview was con Nursing (DON) on 07 stated if the TARs we to say the treatment of ordered. She further s good monitoring of she the wound nurse to b	eatment and dressing t #12 on her shift from 3 PM s of 06/26/14, 06/27/14, ind 06/30/14. She further rform Resident #12's nents on these days. ducted with the wound s Assistant (PA) on 07/03/14 ed she thought Resident s being preformed in the ordered. She indicated when on Thursdays, the are the ones she has ents. In relation to Resident vas unaware the treatments twice a day as ordered. She uld have expected the nent nurse to do Resident d treatment in the morning nurses would perform the ly wound treatment. ducted with the Director of /03/14 at 2:52 PM. She ere not initialed then she had was not completed as stated there had not been a kin areas and she expected e responsible for wound ure they were correctly ved.	F 314		8/10/14		
SS=J	HAZARDS/SUPERVI The facility must ensu environment remains	SION/DEVICES	1 020				

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 87 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/10/2014 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		0	C 7/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page		F 32	3		
	adequate supervisior prevent accidents.	and assistance devices to				
	by: Based on observatio review, staff and resid failed to transfer 2 of mechanical lift slings operating condition a the slings ripping and (Residents #17 and # manufacturer's recom brand lift with the sam	nd correct size resulting in		Resident #18 continues to be by mechanical lift and is using that is appropriate for the resid needs. The resident's care pla updated as needed and all nur and the support staff that assis which includes, the Maintenand Housekeeping/Laundry Service Physical Therapist and the Floo Technicians were educated.	a new sling lent's in was sing staff st with lifts ce Director, es Director,	
	monitor that air condi hazardous parts exte #5). Immediate Jeopardy	began on 06/15/14 when from a lift when the sling he		Resident #17 continues to be t by mechanical lift and is using that is appropriate for her need resident's care plan was updat	a new sling Is. The	
	was sitting in ripped a Immediate Jeopardy 06/23/14 when Resid when the sling she w fell into a recliner cha removed on 07/11/14	and he fell onto the floor. began for Resident #17 on ent #17 had a fall from a lift as sitting on ripped and she ir. Immediate jeopardy was at 7:00 PM when the facility		needed and all nursing staff an support staff that assist with lift includes, the Maintenance Dire Housekeeping/Laundry Service Physical Therapist and the Floo Technicians were educated.	ts which ector, es Director,	
	provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place are effective. Example three and four are at scope and severity of E.			Resident Room #119 has had a decorative flap removed from t the air conditioning unit by the Maintenance Director on 6/30/7 Resident #5 no longer resides facility.	he base of 14.	
				Residents who require an		

Facility ID: 923265

If continuation sheet Page 88 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING				C /11/2014
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEVILL	E NURSING & REHABIL	ITATION CENTER					
				A	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 88	F	323			
	The findings included			020	incident/accident report and investiga and residents who are assessed to	tion	
	Policy included the pr and sling holes for fra use frayed lift pads." A review of the Owne	•			require a mechanical lift transfer are to to be affected by this issue. Resident have a potential to be affected were identified by the Director of Nursing, t RN Supervisor/ADON and one C.N.A resident requiring the use of mechanic	s that he as cal	
	included the warning accordance with instr slings(s) for wear, tea Bleached, torn, cut, fi				lift and sling for transfers on 6/16/201 Care Plans have been reviewed and updated as needed. All nursing staff educated on any updates. All mecha lift slings were evaluated and per manufacturers recommendations. No replacements were required.	was nical	
	sling sizes provided b supervisor revealed s colored binding with r for each sling: *Green binding indicat maximum weight cap *Blue binding indicate maximum weight cap *Black binding indicate with maximum weigh An attached warning is recommended by t or medical attendant. straps for secure poin device. Do not excee lift. Use only with (br	by the maintenance slings with the following maximum weight limitations ated a large sling with acity of 300 pounds. ed an extra large sling with acity of 450 pounds. ted an extra/extra large sling t capacity of 600 pounds. included "Use the sling that he individual's doctor, nurse Before lifting, check all sling ints of attachment on the lift d weight limitation posted on and name) patient lifts.			Any resident that resides in the facilit be affected by the decorative flap on Air-Conditioning units. Therefore, The Maintenance Director removed all decorative flaps the units on 7/16/14. The Director of Nursing, RN Supervis ADON and Staff Development Coordinator read and reviewed manufacture recommendation for mechanical lift and slings. All licensed nursing staff, certified nursing assistants, therapy, housekeeping ar maintenance staff that assist with transfers and spotting have	the from or/	
	unsafe and could res immediately. Do not (brand name) lifts."	rayed or broken slings are ult in injury. Discard alter slings. Use only on admitted to the facility on			been in serviced and provided instructions based on manufacture recommendations and provided written instruction by Staff Developm coordinator or RN Supervisor/ADON 07/09/2014. The		

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 89 of 168

		ND HUMAN SERVICES			PRINTED: 12/10/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEVILI	E NURSING & REHABI	LITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 323	Continued From page	e 89	F 323	3	
	01/30/14 with diagno	ses which included		education included determining	the
		ss, arthritis, high blood		appropriate Size of sling for the	
	pressure, diabetes, t	hyroid disease and		care and inspection of	
		st recent quarterly Minimum		sling per manufacturer⊡s instru	
	Data Set (MDS) date			batteries/ chargers/ plug in, care	e/
		short or long term memory		inspection of lifts per manufacturer⊡s instructions and	
		tively intact for daily decision Ily dependent on staff for		troubleshooting lifts.	
				All the above employees comple	
		an with a revised date of		return demonstration using a me	echanical
		problem statement that risk for pressure ulcers and		lifts with slings on: 1. Seated transfer	
		part to use a mechanical lift		2. Repositioning up in bed	
	to avoid skin friction			3. Scale operation	
				4. Inspection for holes, tears,	frays or
	-	an with a revised date of		unraveling on sling	
		problem statement that		5. Sling in-service:	
		ed assistance with activities sluded a handwritten note to		6. Safe use of sling with two s members always	ταπ
		transfer with 2 people.		7. Identifying defects in the sli	na (if
		adisiel with 2 people.		defect is found do not use it, giv	
	A review of a nurse's	note dated 06/23/14 at 2:59		the charge nurse)	Ŭ
		ge of status which revealed			
		eing lifted out of a recliner		The Director of Nursing will mor	
		cal lift and the lift pad ripped		daily schedule to ensure that an	-
		r. The notes indicated proximately 6 inches back		had not had the above in service be scheduled to work until in the	
		was no apparent injury noted.		is completed.	
	The notes further ind			An in-service was conducted with	th laundry
		sistant Director of Nursing		and one housekeeper staff that	-
	(ADON) were made	aware immediately.		trained for laundry on 7/10/2014 for inspec	tion of
	A review of a nurse's	note dated 06/24/14 at 7:46		slings to include:	
		entry note for 6:00 AM that		1. Holes, tears, frays or unrav	-
		omplaining of left knee pain		2. Identifying defects in the sli	
		eded (PRN) pain medication.		housekeeping/ laundry employe the defective	
	A review of a nurse's	note dated 06/24/14 at 1:25		sling in the housekeeping / laun	dry

Facility ID: 923265

If continuation sheet Page 90 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/10/2014 DRM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		345174	B. WING				C 07/11/2014
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL			91	1 VICTORIA ROAD		
				A	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From page	90	F	323			
	PM indicated Resider the Director of Nursin	ht #17 was interviewed by g (DON) this afternoon to ent's status related to her		020	supervisor office. Fill out work ord maintenance director to replace sling and dispose of the de		
	stated to the DON that	ites revealed Resident #17 It her left knee hurt and the urse #2 to get a physician's			sling.3. Maintenance director is to recsize sling that was taken out of se		
		-ray. The notes indicated a obtained and would or increased pain and			This in service was completed by PM on 7/10/14 by the Staff Develo coordinator or RN	3: 00	
	A review of a physicia	n's order dated 06/24/14 at ay of left knee due to pain.			Supervisor and Housekeeping/ La supervisor.	lundry	
	5:44 PM indicated left fractures but moderat	y report dated 06/24/14 at t knee x-ray indicated no e osteoarthritis in the left			Any employee that has not attende above named in service after 3:00 7/10/14 will not be allowed to work until in serviced.		
	PM indicated x-ray re	note dated 06/24/14 at 6:44 sults revealed no fracture or			All new employees will be in servic during orientation.		
	and mild osteoarthritis further indicated Resi	up of fluid) of the left knee s was present. The notes dent #17, the DON and otified of x-ray results and			An audit on all slings in the facility completed 7/09/2014 at 8:00 PM to Maintenance Director, Director of Nursing and Housekee Laundry Supervisor. The Audit of to	by the ping/	
	A review of a nurse's	note dated 06/25/14 at 1:35 AM Resident #17 continued			slings included the following: 1. All slings were identified, num		
	to verbalize that her le especially with activity	eft knee was painful or sore and the area was guarded. cated Resident #17's left			 All sings were latitude, full to #42 and size noted The Condition of the slings we inspected for holes, tears, frays ar 	ere	
	knee had no redness, swelling.	-			defects 3. During this audit no sling wer removed due to defects	re	
	06/25/14 indicated the the facility medical dir	n's progress note dated e physician who was also rector documented he was it #17 because of the onset			All new air-conditioning units will b inspected for any sharp edges by Maintenance Director before		

Facility ID: 923265

If continuation sheet Page 91 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/10/2014 MAPPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	СОМ	E SURVEY PLETED C
		345174	B. WING				//11/2014
NAME OF PR	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0/	////2014
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		-	I VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 91	F	323			
	Resident #17 fell into using a lift and the fall above the level of the revealed Resident #1 floor first and she suc pain and today at the had significant tender knee region and prox foreleg on her left leg no significant swelling she had markedly rec notes indicated Resid Oxycodone by mouth hours on a PRN basis notes also indicated F exceeded 300 pound due to severe pain or diagnosis, assessme Resident #17 had a h degenerative joint dis an orthopedic surgeo knee pain. The notes physician had reques of the left lower leg to	history of severe hease, and had been seen by n because of chronic right s further indicated the ted a complete bone x-rays assess for possible await x-ray evaluation before			 being placed into service. On 7/16/14, the Maintenance Director re-educated on preventing accidents resident s room by the Administrator. The Maintenance Director performs weekly room audits to ensure that all equipment is safe from sharp edges. All mechanical lift policies and audits be reviewed as directed by the QAPI committee to ensure the effectiveness of the program. All new employees will be in serviced mechanical lift policies and audits be reviewed as directed by the QAPI committee to ensure the effectiveness of the program. All mechanical lift policies and audits be reviewed as directed by the QAPI committee to ensure the effectiveness of the program. All mechanical lift policies and audits be reviewed as directed by the QAPI committee to ensure the effectiveness of the program. An audit of all mechanical lifts and slim will be done weekly x 3 months and we submitted to the QAPI committee for review and 	in a will on ion. will	
	2:00 PM indicated x-r leg due to pain and c	an's order dated 06/25/14 at ray full left hip and whole left hange Oxycodone to 5 outh twice a day and 5 mg urs PRN for pain.			recommendations by the maintenance director. After three months, the QAPI Commit will recommend a schedule of continu audits.	tee	
	with no time documer clarification to obtain	an's order dated 06/25/14 nted indicated an order left leg x-rays of the hip, tibia alf bone) and femur (thigh n each.			The Quality Assurance Committee wil oversee the implementation of all asp of the above plan and meet within one week to review the pl	ects	

Facility ID: 923265

If continuation sheet Page 92 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/10/201 RM APPROVE NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	· · ·	TE SURVEY MPLETED C
		345174	B. WING				07/11/2014
NAME OF PF	OVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			I VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 323	Continued From page	92	F	323			
	A review of a nurse's PM indicated Resider physician and continu- pain. The notes furth- orders were received medication and x-rays A review of a radiolog 6:15 PM indicated mo- left hip and no acute f destructive lesions in A review of a nurse's 10:25 AM indicated R recliner from a lift and femur, and tibia/fibula further indicated Resi- complain of left leg pa- scheduled for pain wa A review of a nurse's PM indicated Resider of left knee pain and r obtained from pain mo- A review of a physicia with no time documer Resonance Imaging (status post injury due range of motion and r A review of a physicia with no time documer order for MRI of left kn injury with severely de	note dated 06/25/14 at 2:52 ht #17 was assessed by the red to complain of left knee er indicated physician for scheduled pain s of full leg and hip. y report dated 06/25/14 at oderate osteoarthritis of the fracture, dislocation or the left femur. note dated 06/26/14 at resident #17 had a fall into a l x-ray results of her left hip, were negative. The noted dent #17 continued to ain and medication as given. note dated 06/27/14 at 3:25 ht #17 continued to complain moderate relief was redication. an's order dated 07/07/14 hted indicated a Magnetic MRI) x-ray of left knee to severely decreased			reassess for effectiveness, and modify plan as necessary. The Quality Assurance Committee will address mechanical lift and sling safet each Quality Assurance meeting for one year. The Regional Nurse Consultant will at the Quality Assurance Committee meetings for six months as an advisor to ensure the committee is accessing all relevant data at their disposal, fully addressing all current issues, reassessing the effectiveness of their plans of action, revising their plans of action as needed, and keeping issues on the agenda of the committee until the issu has been fully resolved. Individual committee members will be designated as the responsible party to follow up with action plans, give progress reports and provit target completion date. The Administrator will ensure that, price Quality Assurance meetings, all supervisors and Administrative staff are polled for any issues that need to be discussed at the meeting. The Administrator will review any accident/incident reports in the daily stand-up meeting and request staff to report any new issues that need	e de a or to e	
	and normal x-rays. A review of an x-ray re	eport titled MRI left knee			immediate attention. Remedial actions be determined and current plans assessed for effectivene		

Facility ID: 923265

If continuation sheet Page 93 of 168

	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/10/2014 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _			0	C 07/11/2014
	ROVIDER OR SUPPLIER	LITATION CENTER		91	TREET ADDRESS, CITY, STATE, ZIP CODE I VICTORIA ROAD SHEVILLE, NC 28801	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	 without contrast date indicated the followin Moderate to several (middle) compartment contusions. The medial menisor that provides structure extruded (pushed out tear of the extruded to 3. Findings suggest a medial collateral ligar of the knee. Moderate intramuse vastus medialis (large of the thigh). A review of a physicia 3:15 PM indicated to and joint specialist ar scheduled for Monda During an interview of Resident #17 explain sitting in a recliner in under her that had be when staff transferred recliner chair. She st transfer her back to b and NA #15 went to g Nurse Aide (NA) #3 a her room with the lift located on each corn and raised her up out she was suspended to corner of the sling tow and she fell from the chair and her left foot stated when she star 	d 07/08/14 at 2:30 PM g impression: e osteoarthritis of the medial at associated with cus (a semicircular cartilage ral integrity to the knee) is t) and there is a probable	F3	323	in the daily stand-up meeting. If necessary, the Administrator will also convene a meeting of relevan members of the Quality Assurance Committee after the daily stand-up meeting to address problem needing immediate attention. One indication would be any issue that has capacity to cause harm or has caused harm be addressed immediately and be addressed in the next monthly Qua Assurance Meeting. Any issue requiring immediate in-serv of staff will be supervised by the Administrator to ensure 100% of all relevant staff are re-educa prior to returning to work. Any issue requiring immediate audits equipment will be supervised by the Administrator to ensure 100% of all relevant equipment is incl in the audit and any defective equipm is immediately removed from access by staff. On weekends and holidays, the Administrator will be informed by the manager on duty of any incident/accid report involving resident safety to determine if an immediate plan of acti is required to protect residents.	s the d then ality ricing ated of uded ent	

Facility ID: 923265

If continuation sheet Page 94 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 12/10/2014 ORM APPROVED NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING				07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER	I		3	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	LE NURSING & REHABIL			9	91 VICTORIA ROAD			
ASHEVILI	LE NURSING & REHADIL	ITATION CENTER			ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	her back toward the of the chair instead of fa explained when her le in so much pain and w #3 and NA #15 called room and they got an Resident #17 from the bed. Resident #17 st she was put back into faded light blue color totally ripped off and to of the remaining corn She explained the ph left knee on Tuesday negative. She stated Wednesday 06/25/14 much pain in her left x-rays were negative hip and leg. Residen something was wrong she had not had pain fell from the lift and ha medication routinely to medication each day made her feel bad. During an interview o Nurse #2 she stated of afternoon she was at screaming coming fro She explained she ra Resident #17 was in that her left foot was at chair and the mechar pulled lift back and Re screaming. She expl Resident #17 but she or swelling or bruisin	chair so she would fall into alling on the floor. She eff foot hit the floor she was was crying. She stated NA I for Nurse #2 to come to the other sling and lifted e recliner chair back into rated she saw the sling after o bed and the sling was a and the left front corner had the edges of the sling and all ers were torn and frayed. ysician ordered x-rays of her 06/24/14 and they were the physician saw her on because she was having so knee and since the previous he ordered x-rays of her left t #17 stated she felt g with her left knee because in her left knee before she ad not had to take pain out now had to take pain on a regular basis and it n 07/08/14 at 9:34 AM with on 06/23/14 during the the nurse's desk and heard om Resident #17's room. n into the room and her recliner chair screaming stuck between her recliner nical lift. She stated she esident #17 stopped	F	323	3			

Facility ID: 923265

If continuation sheet Page 95 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/10/20 FORM APPROVE MB NO. 0938-03	ED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING				07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	••••••	
	E NURSING & REHABIL	ITATION CENTER		9	1 VICTORIA ROAD			
ASHEVILI	LE NURSING & REHABIL	Ination Center		A	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	N
F 323	and she dropped app down in the recliner of Resident #17 was sift sling still hooked to the verified the left front of ripped off the sling. So Administrator becauss problem and NA # 3 a Resident #17 back to that the Maintenance the room. She stated after Resident #17 was sling was a light blue and thin and looked in dark blue slings that we linen closet. She also was a large sling with of 300 pounds but Res than 300 pounds. She was supposed to hav home on 06/26/14 but hold because of her lars scheduled for a MRI of because of the contine During an interview of NA #3 she stated nume expected to determine for residents by visual they placed it under at was the correct size for explained they were so the sides of the sling resident's body and if of the sling it was not were supposed to pice confirmed she assisted	bed at the left front corner roximately 6 inches back thair. She further stated ting in the recliner with the ne mechanical lift and corner of the sling had totally She stated she ran to get the e she knew it was a serious and NA #15 transferred bed with a different sling Director had brought into a she later looked at the sling as put back in bed and the color and looked stained nuch older than the newer were currently stored in the e stated she realized the sling a maximum weight capacity esident #17 weighed more he explained Resident #17 e been discharged to go t her discharge was put on eft knee pain and she was of her left knee later today nued pain in her left knee. n 07/08/14 at 9:37 AM with se aides (NAs) were e the proper size of lift slings illy looking at the sling when a resident to determine if it for the resident. She supposed to be able to see sticking out from under the f you couldn't see the sides big enough and then they ek a larger size to use. She	F	323				

Facility ID: 923265

If continuation sheet Page 96 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
AND I LAN OI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILD	ING	·		C
		345174	B. WING				U /11/2014
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEVILI	_E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD		
	1				ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 323	and Resident #17 fell also confirmed NA #1 transfer and as they li recliner chair in her ro above the chair when across the left front of back into the chair. S #17 fell she hurt her le have pain and they ca the room. She explain from her and replaced Maintenance Director then they put Resider stated she should hav she used it to lift Resi was the same sling th day to transfer her fro further stated Resider out of bed after her fa did not have a sling th her and she was in be sling arrived for them During an interview of NA #15 she explained assist with transferring recliner chair to bed of resident had requester was leaning to one sid explained she placed side onto the arm of th worn or frayed areas. #17 was raised up with approximately 12 inch were just getting read the bed when she hear realized the noise she at the foot on the left	into the recliner chair. She 5 assisted her with the ifted Resident #17 up from a bom she was suspended up the sling tore completely orner and Resident #17 fell she stated when Resident eff leg and caused her to alled for Nurse #2 to come to ned they got the sling out d it with another one the brought into the room and nt #17 back to bed. She ve inspected the sling before dent #17 and confirmed it ney had used earlier in the m bed to recliner chair. She nt #17 could not be gotten all from the lift because they hat was large enough to lift ed for 8 days before the new to get her out of bed. n 07/08/14 at 2:46 PM with d NA #3 had asked her to g Resident #17 from her on 06/23/14 because the ed to go back to bed and de in her recliner chair. She the loops of the sling on her he lift and she did not notice She explained Resident	F	323			

If continuation sheet Page 97 of 168

	DRRECTION VIDER OR SUPPLIER NURSING & REHABIL SUMMARY STA	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174 ITATION CENTER	. ,			(X3) DATE COMP	SURVEY LETED
(X4) ID PREFIX	NURSING & REHABIL		B. WING _				C
(X4) ID PREFIX	NURSING & REHABIL	ITATION CENTER					_ 11/2014
(X4) ID PREFIX	SUMMARY STA	ITATION CENTER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	
(X4) ID PREFIX	SUMMARY STA	ITATION CENTER		91	1 VICTORIA ROAD		
PREFIX				Α	SHEVILLE, NC 28801		
		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323 C	continued From page	97	F 3	223			
-		ack over her chair so she	1.5	20			
		chair and not on the floor.					
		pushed Resident #17 back					
	•	eft front corner of the sling					
		Resident #17 fell into the					
		ated Resident #17 was					
		and NA #3 went to get					
		ned Nurse #2 came into the					
		17 was complaining of left d Nurse #2 then went and					
		and he came into the room					
		ickly filled with staff. She					
		ent and got another sling					
		Resident #17 while she was					
	eated in the recliner ack to bed.	chair and they lifted her					
	0	n 07/08/14 at 5:16 PM the					
		ON) explained she was not nen the sling ripped and					
		the lift but she saw the					
		owing morning on 06/24/14.					
SI	he stated NA #15 ha	ad told her she heard a					
		esident #17 was suspended					
	•	recliner chair and NA #15					
		r the resident and pushed					
		ecliner chair. She stated					
-		ent #17 because she eft knee was hurting and					
		ho ordered full xrays of her					
		negative. She stated she					
		lesident #17 continued to					
		pain and requested the					
		IRI. She explained she had					
		was available for staff use					
	ince the Maintenance						
		visor had audited slings on ek and all slings that were					
		supposed to have been					

Facility ID: 923265

If continuation sheet Page 98 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL	ITATION CENTER		9	91 VICTORIA ROAD		
ASHEVILL		ITATION CENTER		4	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG F 323	Continued From page discarded. During an interview of Maintenance Director after Resident #17 fel after they got it out fro it as light blue on one other side with a gree further explained one and the sling was fray he was not sure why staff use since it had have been caught wh audits to check for da must have been miss During a follow up inter AM with NA #3 she co the condition of the sl under Resident #17 of describe what it looke Resident #17 fell from During an observation at 10:57 AM the Hous brought a sling to a co it was the sling that ha #17 fell from the lift. If	e 98 n 07/08/14 at 6:03 PM the explained he saw the sling I from the lift on 06/23/14 om under her and described side and darker blue on the en reinforcement band. He whole corner had ripped off yed on the edges. He stated the sling was available for frayed edges and it should en they did the weekly maged or worn slings but it ed somehow. erview on 07/09/14 at 9:45 onfirmed she did not inspect ing when she first placed it on 06/23/14 and could not ed like before it ripped and in the lift into a recliner chair. In and interview on 07/09/14 sekeeping Supervisor onference room and verified ad ripped when Resident He demonstrated and		323	DEFICIENCY)	ATE	
	had the hooks still att. hooked onto the arm the sling had frayed e and on the right side a the remaining hooks o binding. He confirme should have been dis transfer Resident #17	ached that would have been of the lift. He further verified edges along the top left side at the top and bottom near on the green reinforcement d it was an old lift sling and carded before it was used to 7 on 06/23/14. He stated it ough the cracks when the					

Facility ID: 923265

If continuation sheet Page 99 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
	CONNECTION	IDENTIFICATION NOWBER.	A. BUILD	NG _			C
		345174	B. WING				_ 11/2014
NAME OF PI	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEVILL	E NURSING & REHABIL	ITATION CENTER					
					ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page		F	323	3		
	weekly audits of sling	s were done.					
	Director on 07/09/14 a the size of the sling u with a mechanical lift colored reinforcement of the sling. He also reinforcement binding maximum weight cap During an interview o Resident #17's physic Medical Director verif Resident #17 after sh was complaining of se He confirmed Resider in her right knee due he was not aware Re problems with her left pain in her left knee b He confirmed when h Wednesday 06/25/15 severe pain and tender range of motion in he first ordered x-rays of results were negative	erview with the Maintenance at 11:33 AM he confirmed sed to transfer a resident was determined by the t binding around the edges confirmed slings with green as were large slings with a acity of 300 pounds. n 07/09/14 at 12:47 PM cian who was also the facility ied he was asked to see e had a fall from a lift and evere pain in her left knee. In #17 had a history of pain to severe osteoarthritis but sident #17 had any t knee or had complained of before she fell from the lift. e saw Resident #17 on she was complaining of erness and had decreased r left knee. He stated he ther left knee and those and then he ordered x-rays					
	negative. He further still complained of left range of motion he or waiting on the results appropriate treatment During an interview o Assistant Director of I	n 07/11/14 at 1:59 PM the Nursing (ADON)/Day Shift					
	resident transfer was	the size of lift sling for a supposed to be based on and weight. She stated NAs					

Facility ID: 923265

If continuation sheet Page 100 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/10/2014 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345174	B. WING					C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER		9	91 VICTORIA ROAD			
					ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 323	and then select the a on the color coded re- indicated the weight of resident. She stated 06/23/14 when Resid did not go into her roo explained Resident # she asked Resident # She stated Resident # She did not know what transfer Resident #17 required an extra larg because her weight w pounds. During an interview o DON explained during she was told the wroo to transfer Resident # she found out staff ha green reinforcement I was a large sling with of 300 pounds. She o used an x-large sling because her weight w and also confirmed th	nt's height and weight first ppropriate size sling based inforcement band that capacity to transfer the she was working on ent #17 fell from the lift but om until after she fell. She 17 was already in bed and #17 what had happened. #17 told her the sling had being transferred back to fallen back into the recliner eft knee. The ADON stated at size sling staff had used to 7 but thought she would have ge or extra/extra large was greater than 300 n 07/11/14 at 3:06 PM the g her investigation of the fall, ng size sling had been used #17. She further explained ad used a blue sling with a band and that indicated it a maximum weight capacity confirmed staff should have for Resident #17's transfer was greater than 300 pounds he sling that had been used	F	323				
	edges and should not transfer. She stated i worn or frayed slings immediately and not a During another follow 5:23 PM the Maintena	#17 was worn with frayed t have been used for her it was her expectation that should be discarded available for resident use. The provide the the transfer Resident #17 had						
L	7(02-99) Previous Versions Obs							ago 101 of 169

Facility ID: 923265

If continuation sheet Page 101 of 168

		ID HUMAN SERVICES				FORM	MAPPROVED
		MEDICAID SERVICES	(X2) MUI	TIPI	LE CONSTRUCTION	(X3) DATE	0. 0938-0391
-	CORRECTION	IDENTIFICATION NUMBER:					PLETED
							С
		345174	B. WING			07/	11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD		
///////////////////////////////////////					ASHEVILLE, NC 28801		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 323	Continued From page	e 101	F	323	3		
		t binding which indicated a					
		acity of 300 pounds. He					
		t #17's weight exceeded 300					
		g should not have been used					
	been used.	d a larger sling should have					
		admitted to the facility on					
		ses which included left sided					
		rain injury, bilateral leg					
		pressure, and depression.					
		terly Minimum Data Set					
	. ,	4 indicated Resident #18					
		erm memory problems, was					
		aily decision making and					
	was totally dependen	t on staff for transfers.					
	A review of a care pla	an with a revised date of					
		problem statement that					
	Resident #18 was at	risk for pressure ulcers and					
		part to use a mechanical lift					
	to avoid skin friction a	and shearing.					
	A review of a care pla	an with a revised date of					
		problem statement that					
		k for a fall and included a					
	hand written note to u	use a mechanical lift.					
		note dated 06/16/14 at					
		late entry note for 9:30 PM					
		s being lifted out of his chanical lift and the "lift pad					
		eft corner and frayed and					
	ripping apart at top le						
		8 fell approximately "a foot					
		nd landed on the left side of					
	his back and left butto	ock. The notes indicated					
	· ·	ined of left sided back pain					
		the left sided middle back					
	area and pain medica	ation was administered.					

Facility ID: 923265

If continuation sheet Page 102 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD		
ASHEVILL	LE NORSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	9 102	F	323	3		
	A review of a nurse's AM indicated a late e the responsible party Physician, and the Ac the incident. During an interview o Resident #18 explain sitting in a his wheeld his room with a lift slin used earlier that day from his bed to the wi informed staff to trans and Nurse Aid (NA) # explained NA #4 and hallway with the lift ar located on each corne and raised him up ou stated as he was sus top part of the sling ri bottom left corner ripp	note dated 06/16/14 at 1:15 ntry note for 11:00 PM that for Resident #18, the ministrator were notified of n 07/02/14 at 5:13 PM ed on 06/15/14 he was hair in the hallway outside ng under him that had been when staff transferred him heelchair. He stated he sfer him to bed for the night 4 went to find a lift. He NA #10 came back to the nd connected the hooks er of the sling to the lift arms t of his wheelchair. He pended by the lift, the entire pped and immediately the bed apart and he fell from					
	#4 called for Nurse #4 and lifted Resident #7 hallway into his bed. I the sling after he was was a faded blue cold corners were ripped a frayed and torn. He fu immediately in his ba medication scheduled During an interview o NA #4 she stated the expected to inspect th or frays and if the slin supposed to use that	ng his back. He stated NA 5 and they got another sling 18 from the floor in the Resident #18 stated he saw put into bed and the sling or and both top and bottom and the other corners were urther explained he had pain ck and Nurse #5 gave him d for back pain after the fall. n 07/08/14 at 2:55 PM with nurse aides (NAs) were he slings for any rips, tears, gs had any they were not sling. They were to give the urse and get another sling to					

Facility ID: 923265

If continuation sheet Page 103 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMF	
		345174	B. WING					0 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI	P CODE		
	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD			
					ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI		(X5) COMPLETION DATE
F 323	with the transfer of Re ripped on 06/15/14 ar floor in the hallway. S assisted with the tran Resident #18 up from suspended up above turned him away from sling ripped complete and then simultaneou anything the left botto completely across lea sling hooked to the lift to the floor. During an interview o NA #10 he stated NA with transferring Resi wheelchair to his bed resident had requeste explained the sling wa he placed the loops of the arm of the lift and or frayed areas. He e raised up with the me wheelchair and he had from the wheelchair s Resident #18 into his corner of the sling tor immediately the botto tore and the loop part hooked to the lift arm Resident #18 was ass another sling and they the floor and put him	She confirmed she assisted esident #18 when the sling of Resident #18 fell to the the also confirmed NA #10 sfer and as they lifted this wheelchair he was the floor and they had just the wheelchair when the ly across the left top corner isly before they could do on corner of the sling ripped aving the loop part of the t arm when Resident #18 fell n 07/08/14 at 4:22 PM with #4 had asked him to assist dent #18 from his on 06/15/14 because the ed to go to bed. He as under Resident #18 and f the sling on his side onto he did not notice the worn xplained Resident #18 was chanical lift above his d turned Resident #18 away o NA #4 could push room. He stated the top left e completely across and m left corner of the sling t of the sling was remained . He further stated after sessed by Nurse #5 he got y lifted Resident #18 out of	F	323	3			
		he sling ripped and Resident				If continuati		

Facility ID: 923265

If continuation sheet Page 104 of 168

	-	ND HUMAN SERVICES	- 1			F	NTED: 12/10/2014 ORM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				DATE SURVEY COMPLETED
		345174	B. WING				07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
ASHEVILL	E NURSING & REHABIL	ITATION CENTER					
				'	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 104	F	323			
		nd there was a discussion		020			
		e next morning. She stated					
		's to inspect the slings					
		r tears and frayed areas. any of the slings were frayed					
		the NA's not to use those					
	and give the worn slir	ng to the Maintenance					
	Director, Housekeepi						
		explained she had no idea a a since the					
	Maintenance Director						
		around and collected all the					
		nem and all slings that were					
	discarded.	supposed to have been					
		on 07/08/14 at 6:03 PM the					
	on 06/16/14 after Res	r explained he saw the sling sident #18 fell from the lift on ed it as light blue on one					
		other side. He further					
		as ripped at the seam area					
		had completely ripped off at r. He stated he was not sure					
		ailable for staff use since it					
		d it should have been caught					
	•	ekly audits to check for					
	damaged or worn slir missed somehow.	ngs but it must have been					
		on 07/08/14 at 6:22 PM with					
		on 06/15/14 during the					
	•	s at the nurse's desk and she					
	#18's room. She expl	way outside of Resident ained she assessed					
		and redness to his left middle					
		was complaining of pain. She					
		gave Resident #18 his pain d for chronic back pain after					

Facility ID: 923265

If continuation sheet Page 105 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 1 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMP	SURVEY LETED
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL				91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHADIL	HAHON CENTER			ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	of the sling had comp top corner of the sling to the loop area. She sling and in the center frayed, with a white sy the back, was a light if to her to have been "of time." During an observation at 10:57 AM the Hous brought a sling to a co it was the sling that ha #18 fell from the lift. H verified a corner of the completely at the top left corner had frayed He confirmed it was a have been discarded transfer Resident #18 th before lifting him from She further indicated edges around the mai of the sling but there wa around the loops that stated she did not rem sling to anyone that s 06/15/14 to lift Residen During a follow up inte 07/11/14 at 3:06 PM s had been used to tran- with frayed edges and	Applained the lower left corner letely ripped apart and the had completely frayed up indicated she inspected the r back part of the sling was bot "bleached out" area on oblue in color, and appeared compromised for some and interview on 07/09/14 bekeeping Supervisor onference room and verified ad ripped when Resident le demonstrated and e sling had ripped left corner and the bottom edges and ripped edges. In old lift sling and should before it was used to on 06/15/14. In 07/09/14 at 11:42 AM with she placed the lift sling ne morning of 06/15/14 his bed to his wheelchair. she noticed the frayed terial on the outside edges were no frayed edges hook to the lift arms. She nember reporting the frayed he used the morning of	F	323	3		

Facility ID: 923265

If continuation sheet Page 106 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .			LETED
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	E NURSING & REHABIL	ITATION CENTER		9	91 VICTORIA ROAD		
ASHEVILL					ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	that worn and frayed	slings should be discarded	F	323	3		
	immediately and not a	available for resident use					
	The facility's Administ Nursing were notified 07/09/14 at 1:42 PM f The facility provided a compliance on 07/11/ following interventions facility to remove the Credible Allegation of On 06/15/2014 at 9:30 being assisted by two to transfer from the ch transfer the sling rippo the floor. After the nur he was lifted onto the mechanical lift and sli	arator and Director of of Immediate Jeopardy on for Resident #17 and #18. a credible allegation of 14 at 7:00 PM. The s were put into place by the Immediate Jeopardy. ⁶ Compliance: 0 PM Resident #18 was on A's with a mechanical lift hair to the bed. During the ed and the resident fell onto rse assessed the resident, bed using another ng that was inspected and					
	from service by the ch the medication room. to the maintenance di disposal. The Resident transferred by mecha defects. Staff involve	ipped sling was removed harge nurse and locked in The ripped sling was given irector the next morning for nt #18 continues to be nical lift and sling with no d was educated by the					
	maintenance director recommendation. On 06/23/2014 at 2:50 lifted from the recliner mechanical lift and tw resident up the sling r back into the chair. At	ngs were inspected by the following the manufactures 9 PM Resident #17 was to the bed via a to NA's. Upon lifting the ripped and the resident fell					
	bed using another slir	ng that was inspected and been sling was given to					

Facility ID: 923265

If continuation sheet Page 107 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/20 FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP COI	
	E NURSING & REHABIL	ITATION CENTER	91 V	ICTORIA ROAD	
			ASH	IEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE
F 323	Continued From page	- 107	F 323		
1 020		istrator; the ripped sling was	F 323		
		home administrator office.			
	-	e on one in service by			
		and the nursing home			
	-	inspection. The next day			
		by the RN Supervisor/			
	-	by department. The NA that			
		sfer was in serviced in the parding inspecting slings			
	provided on 06/23/20				
		at have a potential to be			
		ed by Director of Nursing,			
		DON and one NA as resident			
		nechanical lift and sling for			
	transfers on 06/16/14				
		ng, RN Supervisor/ ADON nt Coordinator read and			
		e recommendation for			
		ings. All licensed nursing			
	staff, certified nursing	•			
	housekeeping and m	aintenance staff that assist			
	-	otting have been in serviced			
	-	ions based on manufacture			
	recommendations an by Staff Development	d provided written instruction			
	Supervisor/ADON on				
		appropriate Size of sling for			
	the resident				
	* Care and inspec	tion of sling per			
	manufacturer's instru				
	* Lift batteries/ cha				
		of lifts per manufacturer's			
	instructions * Troubleshooting	lifts			
	-	ees completed a return			
		a mechanical lifts with slings			
	on:				
	* Seated transfer				
	* Floor transfer				

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 108 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 12/10/2014 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA	TE SURVEY MPLETED
		345174	B. WING			07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		
ASHEVILL	E NURSING & REHABIL	LITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page	e 108	F 32	3		
	 Repositioning up Scale operation 	in bed				
		les, tears, frays or unraveling				
	Sling in-service:	with two staff members				
	, , ,	ts in the sling (if defect is				
	found do not use it, g nurse)	ive sling to the charge				
	* The nurse is to r	emove the defective sling				
	-	ce in the locked medication				
		e to pick up for disposal. ill out a work order for				
		ce the defective sling.				
		e director is to reorder the				
	-	was taken out of service				
	This in service was s 07/9/2014 and will be 07/10/2014.	e completed by 3:00 PM on				
		as not attended the above				
		er 3:00 PM on 07/10/14 will				
	completed by Staff D	k until the in service is evelopment Coordinator,				
		sor/ADON or 3 to 11 RN employees will be in serviced				
	•	2014 a list of employees that				
	did not receive the at	oove in-service will be given sing. The Director of Nursing				
		schedule to ensure that had the above in service will				
	-	work until in the in service is				
	An in service will be o	conducted with laundry and				
	laundry on 07/10/201	ff that is crossed trained for 4 for inspection of slings to				
	include: * Holes, tears, fray	ys or unraveling				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMF	PLETED
		345174	B. WING				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 017	1
					91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
IAG		,			DEFICIENCY)		
F 323	Continued From page	e 109	F	323	3		
	* Identifying defect	ts in the slings, the					
		y employee will lock the					
	•	housekeeping / laundry					
	supervisor office. Fill						
	of the defective sling.	to replace sling and dispose					
		ector is to reorder the size					
	sling that was taken o						
		completed by 3:00 PM on					
	-	Development coordinator or					
		ousekeeping/ Laundry					
	supervisor.						
		as not attended the above or 3:00 PM on 07/10/14 will					
		k until in serviced. All new					
		serviced during orientation.					
		in the facility was completed					
		M by the Maintenance					
		lursing and Housekeeping/					
	•	The Audit of the slings					
	included the following	entified, numbered #1 to #42					
	and size noted						
	* The Condition of	the slings were inspected					
	for holes, tears, frays	÷ .					
	-	no sling were removed due					
	to defects						
	Immediate Jeonarduu	was removed on 07/11/14 at					
		ews with nurses, nurse					
		aff revealed awareness of					
		lift slings to make sure they					
	•	n and how to correctly					
	-	he resident. They verified					
	-	service training and they					
		lor coded binding on the lifts					
		orrect sling to use according ht. They stated if they found					
		ayed or torn they were					

If continuation sheet Page 110 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 12/10/2014 FORM APPROVED B NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED C
		345174	B. WING		_	07/11/2014
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD		
				ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETION DATE
F 323	 expected to give it to that he could dispose further revealed they slings that were frayer medication rooms an maintenance to dispose had attended in-servi expected to look for h slings and were experience housekeeping/laundr out a work order for r the sling and reorder Interviews with maint awareness of staff to medication rooms or supervisors office and disposal and replaced lift slings in the facility number marked on it marker and each sling. There was no c tears, trays or defect sheets. 3. Review of the Ow Maintenance Manual the instruction: One p only be used with (br (number A) lifts. The facility provided to 06/16/14 of 31 reside a mechanical lift in or On 07/08/14 at 4:21 f Supervisor and the sing 	the Maintenance Director so of it. Interviews with nurses were expected to place d or worn in the locked d fill out a work order for ose and replace the sling. ekeeping staff revealed they ce training and were holes, tears and fraying of lift cted to lock them in the y supervisors office and fill naintenance to dispose of a new replacement. enance staff revealed lock torn or frayed slings in in the laundry/housekeeping d complete a work order for ment of the sling. A review of y revealed each sling had a with a black permanent g was listed by their er on the audit sheets. There ion on the audit sheets with and the condition of each locumentation of holes, ve slings on the audit her's Operator and , revised 10/2008, included biece fabric easy fit sling can and name A) lifts and the survey team a list dated nts who required the use of der to transfer.	F 32	23		

Facility ID: 923265

If continuation sheet Page 111 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/10/2014 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345174	B. WING				07/11/2014
	ROVIDER OR SUPPLIER	LITATION CENTER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 11 VICTORIA ROAD ASHEVILLE, NC 28801	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	were 2 (brand name maximum weight limit (brand name C) lifts weight limit of 600 po Supervisor stated that go with the specific lift On 07/08/14 at 6:34 H Supervisor stated he piece fabric easy fit s manual as noted abo C) was the same man slings just a generic wa AM with a customer s the manufacturer of tt The customer service the slings were to be recommended lifts (b documentation of a ri staff knew how to use documentation would and a statement that together. The custom confirmed that the lift the manufacturer's re the slings currently us Follow up interview w Supervisor on 07/09/ he had a standing or stated that the facility same brand of slings that when a new med received bids and the decision for all purchas	B) lifts which had a t of 450 pounds and 2 which had a maximum bunds. The Maintenance at the specific slings had to ft. PM, the Maintenance only purchased the one ling from the owner's ove. He stated the lift (brand nufacturer of the easy fit version. As held on 07/09/14 at 9:31 service representative from he slings used in the facility. The representative stated that used only with the orand A) unless there was sk assessment that showed the slings and the lifts. The I have to include the risks they are safe to use ner service representative s (brands B and C) were not commended lifts to use with sed by the facility.	F	323			

Facility ID: 923265

If continuation sheet Page 112 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 / APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				LETED
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			11 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	slings and the lifts hin documentation that he different brand lifts, he ago and he had no do Residents were transi- using the facility total together against the r recommendation as for AM being transferred (Brand C) and an east the hall into his chair Resident #14 was obseen PM lifted via the faciliti lift (brand C with scale weight. The resident weight. The resident weight lift and hooked to ano C without scale) while While raised in the mo- into the hallway where holding the wheelchait then lowered into her nurse aides, 2 therap supervisor assisted di- sling which did not mo- recommendation for ue On 07/01/14 at 9:59 A observed being transf #3 from a shower chais sling and a mechanica On 07/11/14 at 6:50 A leaving Resident #23 mechanical lift (Brand	nself. When asked if he had e tested the slings with the e stated that was 7 years boumentation. ferred via easy fit slings lifts (Brands B and C) nanufacturer's ollows: served on 06/30/14 at 11:01 using a mechanical lift cy fit sling from his bed out to by 2 NAs. served on 06/30/14 at 2:32 ty sling and total mechanical e) in order to obtain her was then unhooked from the other mechanical lift (brand e in the same facility sling. echanical lift, staff rolled her e a staff member was ir secure. Resident #14 was wheelchair. A total of 5 y staff and the maintenance uring this transfer using a eet the manufacturer's use with the coordinating lift. AM, Resident #12 was ferred by NA #13 and Nurse air into bed using an easy fit al lift (Brand C).	F	323			

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 113 of 168

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/10/2014 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING				/11/2014	
	ROVIDER OR SUPPLIER	ITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 91 VICTORIA ROAD ASHEVILLE, NC 28801					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 323	 7:10 AM NA #18 statu used the facility lift ar the transfer. Resident #30 was ob 07/08/14 at 10:02 AM mechanical lift (Brand lifted him from a show bed in his room. Resident #32 was ob AM being transferred Nurse #4 using a tota and easy fit sling. Th her bed into a gericha The Director of Nursi operators manual for 07/11/14 at 3:06 PM stated that based on recommendation the used with the mechan 4. Resident #5 had b 01/17/14 with diagnorist fracture aftercare, an admission Minimum I dated 01/22/14 reveat cognitively intact, ablibe understood. Recon had resided in room facility. Review of resident in revealed Resident #5 6:30 AM due to trippi unit sticking out of the in room 119. Resident 	ed during interview she had nd the easy fit sling during served being transferred on 4 using an easy fit sling and d C). NA #7 and Nurse #3 wer table in the hall into his served on 07/08/14 at 10:11 by NAs #6 and #5 and al mechanical lift (Brand B) he resident was moved from air. ng reviewed the owner's the easy fit slings on with the surveyor. She the manufacturer's easy fit slings should not be nical lifts (Brands B and C). Deen admitted to the facility sis including hypertension, d depression. The Data Set (MDS) assessment	F	323	3			

Facility ID: 923265

If continuation sheet Page 114 of 168

	-	ND HUMAN SERVICES				FORM	MAPPROVED
		MEDICAID SERVICES	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
							С
		345174	B. WING			07/	11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	1						
F 323	Continued From page	a 11 <i>4</i>	E -	323			
1 020	1.0	revealed part of the post		525			
		een a new heater had been					
	put in place and the r	oom had been cleared of					
	any debris.						
	Observation on 06/20	1/14 of 10.41 AM of booting					
	unit in room 119 reve)/14 at 10:41 AM of heating aled a strip of metal					
		ottom, under the unit. The					
		inder the heating unit on the					
		t was not attached to the					
	right end and protrude beyond the unit.	ed out several inches					
	Observation on 06/30	0/14 at 1:39 PM of heating					
		aled a protruding strip of					
		ight of the unit. The strip					
	unit.	al inches beyond the heating					
		0/14 at 4:01 PM of heating					
		aled a metal strip protruding					
		er the unit. The metal flap ding several inches beyond					
	the unit on the right s						
	Interview with mainte	•					
		revealed because he had					
		s door on the bottom of the had not been staying					
	attached and kept po						
		sor said he had begun					
		of them during the past 2					
		ance supervisor stated he					
		ort of any resident being anging off the heating unit.					
		pervisor said if staff noticed					
	-	ing off the unit before he had					
		at room to remove it, they					
	were supposed to cor	mplete and submit a work					

Facility ID: 923265

If continuation sheet Page 115 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF PR	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
	E NURSING & REHABIL			91 VICTORIA ROAD	
				ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	TION (X5) JLD BE COMPLETION OPRIATE DATE	
F 323	Continued From page	e 115	F 32	3	
	order to the administr	ator so he would know to			
	remove the door imm any injuries or accide	ediately in order to prevent nts.			
		vith maintenance supervisor			
		PM revealed he had toured he access doors on the			
	-	on all bedrooms in the			
		vered about 4 more doors			
		the units and needed			
	immediate attention.	I he maintenance ad removed the doors from			
		had been hanging out.			
		1/14 at 3:30 PM of the			
	-	119 revealed the access gunit had been removed and			
	was no longer hangir				
F 369	483.35(g) ASSISTIVE	-	F 36	9	8/10/14
SS=D	EQUIPMENT/UTENS	BILS			
		ride special eating equipment ents who need them.			
	This REQUIREMENT	is not met as evidenced			
	-	ns, record review, and staff		Resident #12 was reassessed by	the
	interviews, the facility	r failed to provide an		Registered Dietician (RD), Speech	
	adaptive drinking cup	•		Therapist, and the MDS Team on	h -
	eating device (Reside	or the need of an assistive ent #12).		7/21/14 for the continued need of t adaptive cup. Resident will not con use the adaptive cup	
	The findings included	:		per the team decision.	
		mitted to the facility on ses which include kidney		Anyone requiring adaptive equipmed be affected. Therefore; the Speech	
	failure, altered menta	See which moldue Mulley		Be ancolou. Therefore, the opeeu	•

Event ID: 0W9Y11

Facility ID: 923265

If continuation sheet Page 116 of 168

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
		345174	B. WING		C 07/11/2014			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI			
F 369	Continued From page	9 116	F 369					
		difficulty in swallowing), I palsy.		Team reviewed current residents adaptive equipment for continued 7/18/14. Food Tray Cards and Resident Care Plans v	need on			
	12/20/13 which indica weight loss secondar	erapy evaluation dated ted Resident #12 had y to a decline in her ability to		audited to ensure need for adapti equipment was addressed.	ve			
	speech therapy evalu was to use a nosey c	The clinical summary of the ation indicated Resident #12 up (an 8 ounce cup with a to use for drinking without		All Dietary Staff and Nursing Staff re-educated on adaptive equipme DON, SDC and RD between 7/17 8/9/14.	ent by the			
		or extending the neck), soft diet, and be supervised when eating.		The residents requiring adaptive equipment will be audited by the I week x 12 weeks. The RN Super the MDS Team will audit equipme	visor and			
	05/13/14 indicated Re impaired with cognitic and was totally deper daily living (ADLs). Th Resident #12 had imp	m Data Set (MDS) dated esident #12 was severely on for daily decision making indent on staff for activities of the MDS further revealed paired range of motion of her rm, and both legs. The MDS e was not exhibited.		5 x week x 4 weeks. The RD will audits to the monthly QAPI meeting x 2 months.				
	revised date of 06/04. statement that specifi assistance with ADLs part for a mechanical precautions which co head of the bed (HOE leave HOB elevated f	 #12's care plan with a /14 revealed a problem ed the resident required and listed approaches in soft diet and swallowing nsisted of the following: a) elevated with meals and or at least 30 minutes after 						
	of adaptive equipmen The care plan noted f communication defici	vision with meals, and use t-nosey cup with all meals. Resident #12 had a t, speech was unclear and buld anticipate her needs.						

If continuation sheet Page 117 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 369	Nursing Assistant (N4 07/01/14 at 8:08 AM f bed, set up her break milk, and leave the ro observed to drink her down her face, neck, Resident #12's meal f and dislikes in food bi- cup noted. NA #13 was observed set up Resident #12's room. Resident #12's room the resider no drinking glasses, of tray. NA #13 was interview PM, she indicated she Resident #12's clother meals because she w She further indicated Resident #12 was to her meals. Nurse #3 was interview PM, she stated she w therapy had worked v her in independently of unaware Resident #1 with all of her meals. indicated Resident #1 nosey cup with all me The Dietary Manager.	A) #13 was observed on to set Resident #12 up in her fast tray, open the carton of oom. Resident #12 was carton of milk with spillage gown, and onto the bed. tray card revealed her likes ut no indication for a nosey d on 07/01/14 at 12:36 PM to a lunch tray and leave the vas observed to drink her with spillage down her face, her bed. Further d milk was the only beverage at's meal tray and there were cups or nosey cup on her ved on 07/01/14 at 12:44 e would have to change as and bed linens after her vould spill her milk and food. she was unaware that have a nosey cup with all of ewed on 07/01/14 at 12:50 vas aware that speech with Resident #12 to assist eat and drink but was 2 was to have a nosey cup She verified the care plan 12 was supposed to have a	F	369	9		

If continuation sheet Page 118 of 168

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345174	B. WING		C 07/11/2014	
AME OF PR	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CO		
			91 VI	CTORIA ROAD		
SHEVILL	E NURSING & REHABIL	ITATION CENTER	ASH	EVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE	
F 369	Continued From page	e 118	F 369			
	completed a dietary u	update for Resident #12 in naware that a nosey cup was				
	07/01/14 at 2:37 PM. completed the evalua 12/20/13 was no long the ST's were under a 04/01/14. She indicat information, and/or ev	d not worked with her since				
F 406 SS=E	on 07/01/14 at 3:09 F unaware Resident #1 verified that Resident she was supposed to meals. She further sta expected the NAs, th staff to ensure Reside adaptive eating equip	e nurses, and/or the dietary ent #12 had the indicated	F 406		8/10/14	
	not limited to, physica pathology, occupation health rehabilitative s and mental retardatio resident's comprehen must provide the required required services from accordance with §483	tative services such as, but al therapy, speech-language nal therapy, and mental ervices for mental illness on, are required in the nsive plan of care, the facility uired services; or obtain the m an outside resource (in 3.75(h) of this part) from a d rehabilitative services.				

Facility ID: 923265

If continuation sheet Page 119 of 168

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345174	B. WING			C 07/11/2014	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	01	//11/2014
ASHEVILL	E NURSING & REHABIL	LITATION CENTER			SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 406	Continued From page	- 110	Í -	100			
F 400	Continued From page		F	406			
	by:	is not met as evidenced					
	Based on observatio interviews, and facilit	ns, resident interviews, staff y documentation, the facility bing therapy services for 1 of			Resident # 14 was provided with a Bariatric Wheelchair on May 22, 2014.		
		when the facility did not			Any resident requiring specialized		
	•	a chair to accommodate			equipment can be affected by this		
	her accessing the the months.	erapy gym for close to 4			practice; Therefore, an audit of	20	
	monuns.				specialized mobility equipment was do by the PT, Occupational Therapy	ne	
	The findings included	ŀ			Assistant and the Speech		
					Therapist on 7/21/14. All equipment		
	Resident #14 was ad	mitted to the facility on			audited was found to be appropriate fo	r	
		re ulcers, diabetes, and			the resident it is assigned		
	-	ulmonary disease. Review			to.		
		a faxed date of 12/03/13					
	-	d skilled nursing care, was			An in-service was done for all facility st		
	nonambulatory, requi	g and dressing, was to			between 7/29/14 to 8-9-14 by the DON and Administrator concerning	N	
		apy daily and had specialized			the approved method of communicatio	n to	
	needs related to weig				report equipment malfunction. Staff wil		
					notify the		
	The physician orders	revealed physical therapy			maintenance department for follow-up		
		mes per week times 4			using a maintenance request form and		
		or gait training, therapeutic			remove or replace any		
	exercises and activiti				defective equipment that is unsafe as		
		ucation, and home visit as			needed. The maintenance director will		
		tion completed on 12/06/13 goal to increase time out of			repair the problem and communicate the fix with the Administrator to be logged at		
		long term goal to complete			completed.	a5	
	gait training with rolling						
		-			The maintenance director will report to	the	
		revealed occupational			administrator weekly x 16 weeks		
		lered 5 to 7 times per week			regarding any unrepaired items. The		
		/13 for therapeutic activity,			maintenance director will take the resu		
		g/self care, therapeutic			to the monthly QAPI meeting x 4 month	ns.	
		ducation, thermal modalities ir management, manual					
		egiver education, and nursing					

If continuation sheet Page 120 of 168

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 // APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING _				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD ISHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 406	education. The evalu included a short term transfers with maximu appropriate device and The admission Minim 12/12/13 coded her w assistance needed for toileting. Walking and during this assessme as receiving PT and C was a discharge plan to the community. PT notes dated 12/17 family brought in a wh appeared too small for pressure areas on late 12/18/13 stated the re- bariatric gerichair that PT notes dated 12/19 gerichair was discuss who reported that ma ordering a wider geric notes dated 01/01/14 communicated with the the status of a wheelo Resident #14. The re- had price quotes but or review of the facility in dated 01/02/14 revea wheelchair in the facil and that she was very work on standing in the On 01/06/14, the physic	ation dated 12/07/13 goal to complete wheelchair im assistance of one with d safety. um Data Set (MDS) dated ith intact cognition, total r bed mobility, dressing, and d transfers did not occur int period. She was coded DT. The MDS noted there for Resident #14 to return /13 revealed Resident #14's neelchair from home which ir her and could cause eral hips. PT notes dated esident was transferred to a was also too small for her. /13 stated that the small ed with the rehab manager inagement was working on whair for the resident. PT revealed that the therapist ie rehab manager regarding thair or gerichair for whab manager reported he ordering a chair was under nanagement. PT notes led there was no wider ity for Resident #14 to use <i>r</i> eager to get out of bed and is parallel bars.	F 4	406			

Facility ID: 923265

If continuation sheet Page 121 of 168

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 406 Continued From page 121 management, manual therapy, gait training, home visit as needed. F 406 F 406 Image: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stated that therapy Image: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		-	ID HUMAN SERVICES				FOR	M APPROVED
Image: I	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COM	E SURVEY PLETED
91 VICTORIA ROAD ASHEVILLE NURSING & REHABILITATION CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 406 Continued From page 121 management, manual therapy, gait training, home visit as needed. F 406 F 406 The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stated that therapy F 406			345174	B. WING				-
ASHEVILLE NURSING & REHABILITATION CENTER ASHEVILLE, NC 28801 (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 CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CASHEVILLE, NC 28801 F 406 Continued From page 121 management, manual therapy, gait training, home visit as needed. F 406 F 406 The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stated that therapy F 406	NAME OF PI	ROVIDER OR SUPPLIER		•				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 406 Continued From page 121 management, manual therapy, gait training, home visit as needed. F 406 F 406 F 406 The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stated that therapy F 406	ASHEVILL	E NURSING & REHABIL	ITATION CENTER					
management, manual therapy, gait training, home visit as needed. The PT discharge summary dated 01/27/14 stated the resident had not achieved her goals "due to lack of appropriate equipment to allow pt (patient) to get oob (out of bed)" and that the facility was in the process of obtaining appropriate seating. The note continued stated that therapy	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
will reassess if indicated for further skill. Discharge instructions was for a home exercise program. On 01/27/14 the OT discharge summary stated Resident #14 was limited to in bed activity and she was unable to access the therapy gym at this time. The note stated the facility was awaiting approval for a bariatric wheelchair and the resident was currently unable to sit at the edge of the bed secondary to the air mattress required for multiple skin ulcers. OT would re-evaluate when the wheelchair arrives. The quarterly MDS dated 05/09/14 revealed Resident #14 was cognitively intact and did not transfer, walk, or did any locomotion during the 7 day assessment period. The mobility device normally used was noted as a wheelchair. Physician orders dated 05/22/14 included OT to evaluate and treat Resident #14. OT physician orders dated 05/22/14 included OT to treat 3 times per week for 30 days for therapeutic exercises, therapeutic activities, neuromuscular re-education, self care/ADLs, wheelchair management and modalities as needed. On 06/30/14 at 10:41 AM, Resident #14 stated	F 406	management, manua visit as needed. The PT discharge sur stated the resident ha "due to lack of approp (patient) to get oob (c facility was in the pro- seating. The note co- will reassess if indica Discharge instruction program. On 01/27/14 the OT of Resident #14 was lim she was unable to ac- time. The note stated approval for a bariatri resident was currently the bed secondary to multiple skin ulcers. The quarterly MDS da Resident #14 was co- transfer, walk, or did day assessment perior normally used was no Physician orders date evaluate and treat Re- orders dated 05/22/14 times per week for 30 exercises, therapeution re-education, self car- management and model of the self of the re-education, self car-	I therapy, gait training, home mmary dated 01/27/14 ad not achieved her goals briate equipment to allow pt but of bed)" and that the cess of obtaining appropriate ntinued stated that therapy ted for further skill. s was for a home exercise discharge summary stated lited to in bed activity and cess the therapy gym at this d the facility was awaiting ic wheelchair and the y unable to sit at the edge of the air mattress required for OT would re-evaluate when s. ated 05/09/14 revealed gnitively intact and did not any locomotion during the 7 bd. The mobility device bred as a wheelchair. ed 05/22/14 included OT to esident #14. OT physician 4 included OT to treat 3 0 days for therapeutic c activities, neuromuscular e/ADLs, wheelchair dalities as needed.	F	406			

Facility ID: 923265

If continuation sheet Page 122 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE	
AND I LAN OI	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDI	NG _			C
		345174	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 406	therapy stopped when She stated she has a another facility that fit generally got up arou bed around 4:15 PM. On 07/01/14 at 3:01 F observed propelling h her feet down the hall Resident #14 was ob- doing arm exercises. On 07/02/14 at 12:03 that initially Resident wheelchair. The reside brought one from hom determined it did not f Resident #14 stated of she started in therapy stated therapy had as wheelchair at home a her wheelchair form h reported that therapy was too small. On 07/03/14 at 9:54 A interviewed and state looking for months to accommodate Reside current wheelchair at her wheelchair at new therapy company the new rehab manage bariatric wheelchair a been at previously, so wheelchair for Reside	h she had no wheelchair. wheelchair now from s her. She stated she nd 2:45 PM and returned to PM Resident #14 was terself in a wheelchair using 1. On 07/01/14 at 3:20 PM served in the therapy gym the social worker stated #14 did not come in with a dent's family or a friend later ne however therapy fit the resident properly. On 07/02/14 at 2:57 PM that when she first arrived. She sked her if she had a nd she had a friend bring nome to the facility. She determined that wheelchair AM, the Administrator was d that the facility had been find a wheelchair to ent #14. He stated the e was using was loaned by urther stated that when the y came in (beginning in April) ger stated there was a larger t another facility he had o the facility obtained that	F	406			

ENTER	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		C 07/11/2014	
IAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	ODE	
SHEVILI	E NURSING & REHABIL	ITATION CENTER		VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO HE APPROPRIATE DATE	
F 406 F 425 SS=D	in the facility on 04/01 manager on 05/12/14 involved in the mornin During the morning m had been a discussion an extra wide wheeld stated he was aware suggested they try to her. The rehab mana extra wide wheelchair #14 began therapy ag An interview was conto 07/10/14 at 10:08 AM they had worked with therapy company chat continued on with the April. OT stated that walk and she could not due no wheelchair av She further stated that therapy and exercises using an air mattress the air mattress was a stated therapy service not having the correct access the therapy gy 483.60(a),(b) PHARM ACCURATE PROCEL The facility must prov drugs and biologicals them under an agreen §483.75(h) of this par	hew therapy company began //14. He became the rehab . At that time he became ing management meetings, ianagement meeting, there in of a resident who needed hair. The rehab manager of one at another facility and borrow that wheelchair for iger stated they obtained the the next day and Resident gain. ducted with OT and PT on . Both OT and PT stated Resident #14 prior to the inge in April 2014 and new therapy company since Resident #14 was unable to ot access the therapy gym ailable to fit her properly. It she was unable to do is at bedside due to her and sitting on the edge of a fall risk. Both OT and PT es ended due to the facility it wheelchair for her to /m. IACEUTICAL SVC - DURES, RPH ide routine and emergency to its residents, or obtain	F 406		8/10/14	

Facility ID: 923265

If continuation sheet Page 124 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 / APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345174	B. WING _				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
				g	1 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	HAHON CENTER		ŀ	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page	124	F4	425			
	(including procedures acquiring, receiving, c administering of all dr the needs of each res The facility must emp	ugs and biologicals) to meet ident. loy or obtain the services of who provides consultation provision of pharmacy					
	by: Based on observation and staff interviews the and receive the Glaud for 1 of 1 sampled res Findings include: Resident # 13 was ad 10/17/13 with diagnos glaucoma. A record review of the quarterly assessment that Resident # 13 ha cognitively intact. A care plan dated 04/ problem for Resident secondary to glaucom Medication as ordered	30/14 revealed an identified # 13 of impaired vision na. An intervention included:			Resident # 13 is currently receiving ey drops per physicians order. Any resident requiring medications can affected by this practice. Therefore, th DON, SDC and RN Supervisor did a Medication Administration Cart to Medication Administration Record for every resider on every unit audit to ensure all physici ordered medications are available on 7/15/14. All physician ordered were available. The DON and SDC re-educated the licensed nursing staff between 7/17/14 8/9/14 regarding the process for obtaining medications when ordered and for using the back-up pharmacy located locally.	be e nt an to	

Facility ID: 923265

If continuation sheet Page 125 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345174	B. WING _				C 11/2014
NAME OF PI	ROVIDER OR SUPPLIER	I	- T	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 •	
				91	I VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL			A	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	revealed that repeat is written on a medication the pharmacy for that followed: "Reorder m in advance of need to is on hand. The refill otherwise transmitted A record review of a p 06/01/14 revealed La one drop in each eye Glaucoma. A record review of the Record (MAR) for Re June, 2014 revealed 0.005 % was to be in night for glaucoma. F had been signed and 06/28/14 thru 06/30/1 it was circled on the N During an interview w 06/30/14 at 11:35 AM her eye drops for glau administered over the An interview with Nur PM revealed that on a she was the nurse wit those nights for Resid circled the Latanopro and it meant the med because the medicati	tions from the pharmacy medications (refills) were on order form provided by purpose, and ordered as edications three to four days o assure an adequate supply order is called in, faxed, or i to the pharmacy". ohysician's order dated ntoprost Sol 0.005 % Instill every night at bedtime for e Medication Administration sident # 13, for the month of that Latanoprost solution stilled in each eye every urther review revealed that it circled for the dates of 4 and no explanation of why MAR. with Resident # 13 on I Resident # 13 stated that ucoma had not been e weekend. se # 13 on 07/01/14 at 3:35 06/28/2014 and 06/29/2014 no initialed the MAR on dent # 13. She revealed she st eye drops on the MAR, ication was not given ion was not available. se # 14 on 07/01/14 at 3:40 worked on 06/30/14	F	125	7/17/14 to 8/9/14 notifying the physici and DON when a medication is unavailable. The QA Nurse and RN Supervisor will do daily Medication Administration Record audits for issue regarding missing documentation on the medication record. The audits will be of daily x 8 weeks and brought to the monthly QAPI meeting by the DON for review and recommendations	s ne Ione	
EODM CMS 256	An interview with Nur PM revealed that she evening shift, and she	se # 14 on 07/01/14 at 3:40					

Facility ID: 923265

If continuation sheet Page 126 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345174	B. WING		C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO		
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		VICTORIA ROAD HEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONE APPROPRIATEDATE	
F 425 F 425 SS=D	Resident # 13 as not available. She also re- medication from phan not arrived from the p An observation of a m at 11:45 AM revealed Lantoprost for Reside Date filled 06/30/14. An interview with the on 07/03/14 at 8:50 A who was passing med- medication was due, available, was respon- clarifying any orders f pharmacy. She further not receive the medic report it to the pharma- revealed it is her expe- should have been ord responsible for that m pass, and there shoul communication about medication to the pha- was expected to follow medication had not an same day. 483.75(g) EMPLOY O FT/PT/CONSULT PR The facility must emp or consultant basis th to carry out the provision Professional staff mus- registered in accordate	oprost on the MAR for given because it was not wealed that she ordered the macy on 06/30/14 and it had harmacy on her shift. The dication cart on 07/01/14 an unopened bottle of ent # 13. The label read: Director of Nursing (DON) M revealed that the nurse dications at the time the but finds it was not hsible for communicating and for the medication with the er revealed if the nurse does tation right away, she should acy and the DON. She ectation that the medication dered by the nurse hedication during her med ld have been the specific need for the trimacy. She stated the nurse wup with pharmacy if the rrived at the facility that DUALIFIED OFESSIONALS loy on a full-time, part-time ose professionals necessary sions of these requirements. at be licensed, certified, or nce with applicable State	F 425		8/10/14	

Facility ID: 923265

If continuation sheet Page 127 of 168

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/10/2014 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345174	B. WING			C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	LE NURSING & REHABIL	LITATION CENTER			I VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 499	Continued From page laws.	e 127	F	499			
	by: Based on record rev facility failed to preve who was employed b nursing duties withou The findings included A review of a facility t through 04/15/14 indi in at the facility on 03 04/02/14, 04/03/14 0- and 04/09/14. During an interview of Nurse #2 verified she the nurse's stations b 04/09/14. She furthe Nurse #7 did not hav was not told what her be.	time sheet dated 03/15/14 icated Nurse #7 was clocked 8/28/14, 03/31/14, 04/01/14, 4/04/14, 04/07/14, 04/08/14 on 07/07/14 at 11:40 AM e had observed Nurse #7 at between 03/28/14 and er stated she had been told e a nursing license but she r duties were supposed to			No resident was named in the citation Nurse #7 is no longer employed at Asheville Nursing & Rehabilitation. The DON has been in-serviced by the Regional Nurse Consultant on 7/29/14 communicating any issues that affect the nursing staff at Asheville Nursing & Rehabilitation regarding expired/lost or penalty that has been applied to a nurse s license. The Human Resources Director and S Development Coordinator were in-serviced by the DON and RN Supervisor between 7/17/14 and 8/9/14 concerning the communication of issue that could affect the employee s licensure and ability to practice nursing	on taff 4 es	
	Nurse #7 she verified her nursing license w by the North Carolina license was reinstate during that time she w a license to practice of and was told by the for (DON) who no longer office work. She exp not give her any writt could or could not do	on 07/07/14 at 3:18 PM with d she was made aware that vas suspended on 03/28/14 a Board of Nursing and her d on 04/10/14. She stated was aware she did not have nursing in North Carolina ormer Director of Nursing r worked at the facility to do lained the former DON did en guidance as to what she b. Nurse #7 confirmed the ct and she had worked in the			A current license/certifications have be audited by the Human Resources Dire and the Staff Development Coordinato with the North Carolina Board of Nursin and the North Carolina Nurse Aide Registry on 7/28/14 and all other employee license/certifications a current. This audit will be done month by the Human Resources Director and any licensed employee's license/certification that will expire with 30 days will be given notice in writing a	ctor r ng re ly	

Facility ID: 923265

If continuation sheet Page 128 of 168

OF DEFICIENCIES				0	MB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	PLE CONSTRUCTION G	(×	(3) DATE SURVEY COMPLETED C
	345174	B. WING			07/11/2014
ROVIDER OR SUPPLIER	1		STREET ADDRESS, CI	TY, STATE, ZIP CODE	
LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 2	8801	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CO	ORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
Continued From page	e 128	F4	99		
During an interview o Assistant Director of I Supervisor stated she DON who no longer v Nurse #7 did not have 03/28/14 and 04/10/1 assigned to do admin the former DON did n administrative duties shift supervisor confir verbal orders from a p assistant on 03/31/14 nursing license during have been practicing During an interview o DON who had had or couple of weeks state informed her Nurse # license from 03/28/14 reinstated on 04/10/1 supposed to be doing She stated Nurse #7 verbal orders from the	n 07/11/14 at 1:59 PM the Nursing (ADON)/Day shift e was told by the former vorked at the facility that e a nursing license between 4 and was supposed to be istrative duties. She stated tot tell her what the included. The ADON/Day med Nurse #7 had signed obysician and physician's but she did not have a valid g that time and should not as a licensed nurse. n 07/11/14 at 3:06 PM the hy worked at the facility for a ed the former DON had 7 did not have a nursing 4 and was she was only g administrative paperwork. should not have taken e physician and physician		of upcoming re employee has license renewa expires, they w Asheville Nurs Rehabilitation The Human Re complete a mo on all licensed The DON will Regional Clinic and Human Re Corporate Offi violations agai summary of the removal of the DON. The nur period of the li Reinstatement discussed by t determine retu to work status. The Human Re	enewal dates. If the not provided a al by the date their license will not be allowed to work a sing & until their license is current esources Director will onthly review of credentials and certified staff. communicate with the cal Nurse, Administrator esources Department at the ce if a nurse has any inst their license. A he issues leading to the e license will be done by the rse will not work during the cense suspension. t of the nurse will be the above employees to urn esources Director will onthly review of credentials	e e
483.75(I)(1) RES RECORDS-COMPLE LE The facility must mair	TE/ACCURATE/ACCESSIB	F 5	to the QAPI Co and recommendati	ommittee monthly for review	
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page facility between 03/28 During an interview of Assistant Director of I Supervisor stated she DON who no longer w Nurse #7 did not have 03/28/14 and 04/10/1 assigned to do admin the former DON did na administrative duties shift supervisor confir verbal orders from a p assistant on 03/31/14 nursing license during have been practicing During an interview o DON who had had or couple of weeks state informed her Nurse # license from 03/28/14 reinstated on 04/10/1 supposed to be doing She stated Nurse #7 verbal orders from the assistant on 03/31/14 licensed nurse during 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance	LE NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 128 facility between 03/28/14 and 04/09/14. During an interview on 07/11/14 at 1:59 PM the Assistant Director of Nursing (ADON)/Day shift Supervisor stated she was told by the former DON who no longer worked at the facility that Nurse #7 did not have a nursing license between 03/28/14 and 04/10/14 and was supposed to be assigned to do administrative duties. She stated the former DON did not tell her what the administrative duties included. The ADON/Day shift supervisor confirmed Nurse #7 had signed verbal orders from a physician and physician's assistant on 03/31/14 but she did not have a valid nursing license during that time and should not have been practicing as a licensed nurse. During an interview on 07/11/14 at 3:06 PM the DON who had had only worked at the facility for a couple of weeks stated the former DON had informed her Nurse #7 did not have a nursing license from 03/28/14 until her license was reinstated on 04/10/14 and was she was only supposed to be doing administrative paperwork. She stated Nurse #7 should not have taken verbal orders from the physician and physician assistant on 03/31/14 because she was not a licensed nurse during that time. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	LE NURSING & REHABILITATION CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 128 facility between 03/28/14 and 04/09/14. F 4 During an interview on 07/11/14 at 1:59 PM the Assistant Director of Nursing (ADON)/Day shift Supervisor stated she was told by the former DON who no longer worked at the facility that Nurse #7 did not have a nursing license between 03/28/14 and 04/10/14 and was supposed to be assigned to do administrative duties. She stated the former DON did not tell her what the administrative duties included. The ADON/Day shift supervisor confirmed Nurse #7 had signed verbal orders from a physician and physician's assistant on 03/31/14 but she did not have a valid nursing license during that time and should not have been practicing as a licensed nurse. During an interview on 07/11/14 at 3:06 PM the DON who had nad only worked at the facility for a couple of weeks stated the former DON had informed her Nurse #7 did not have a nursing license from 03/28/14 until her license was reinstated on 04/10/14 and was she was only supposed to be doing administrative paperwork. She stated Nurse #7 should not have taken verbal orders from the physician and physician assistant on 03/31/14 because she was not a licensed nurse during that time. F 5 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE F 5	If UCTORIA ROAD ASHEVILLE, NC 22SUMMARY STATEMENT OF DEFICIENCIES (EACH OE DEFICIENCY MIST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)DPROV (EACH CC (CROSS-REContinued From page 128 facility between 03/28/14 and 04/09/14.F 499TFDuring an interview on 07/11/14 at 1:59 PM the Assistant Director of Nursing (ADON)/Day shift Supervisor stated she was told by the former DON who no longer worked at the facility that Nurse #7 did not have a nursing license between 03/28/14 and 04/10/14 and was supposed to be assigned to do administrative duties. She stated the former DON did not tell her what the administrative duties included. The ADON/Day shift supervisor confirmed Nurse #7 had signed verbal orders from a physician and physician's assistant on 03/31/14 but she did not have a valid nursing license during that time and should not have been practicing as a licensed nurse.The DON will Regional Clinit Regional Clinit Re	LE NURSING & REHABILITATION CENTER 91 VICTORIA ROAD ASHEVILLE, NC 28801 Image: Continued From page 128 facility between 03/28/14 and 04/09/14. p. (EACH OGREGATIVE TO THE PREPORTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 499 Continued From page 128 facility between 03/28/14 and 04/09/14. F 499 the Administrator and DON will be notified of upcoming renewal dates. If the employee has not provided a license renewal by the dates. If the employee has not provided a license renewal by the date their license expires, they will not be allowed to work a Asheville Nursing & Rehabilitation until their license is current The Human Resources Director will complete a monthly review of credentials on all licensed and certified staff. During an interview on 07/11/14 at 3:06 PM the DON who no 103/11/14 but she did not have a valid nursing license during that time and should not have been practicing as a licensed nurse. F 409 During an interview on 07/11/14 at 3:06 PM the DON who had had only worked at the facility for a couple of weeks stated the former DON had informed her Nurse #7 did not have a valid nursing license form 03/28/14 until her license was reinstated on 04/10/14 and was she was ont a licensed nurse. No administrative gaperwork. She stated Nurse #7 should not have taken verbal orders from tephysician and physician assistant on 03/31/14 because she was not a licensed nurse during that time. F 514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE F 514

Facility ID: 923265

If continuation sheet Page 129 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	•
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 514	systematically organia The clinical record mu information to identify resident's assessmen services provided; the preadmission screeni and progress notes. This REQUIREMENT by: Based on record revif facility failed to mainta medical records to indor results, treatment addr physician orders for 5 (Resident #14, #16, # The findings included 1. Resident #14 was 12/05/13 with pressur obstructive pulmonary specialized needs related The admission Minim 12/12/13 coded her wa assistance needed for toileting. She was cop pressure ulcers. A care plan was developed	ed; readily accessible; and zed. ust contain sufficient the resident; a record of the its; the plan of care and a results of any ng conducted by the State; is not met as evidenced ews and staff interviews, the ain complete and accurate clude pain assessment scale ministration records and of 28 sampled residents e11, #2, and #8). : admitted to the facility on re ulcers, diabetes, chronic y disease and had ated to weight. um Data Set (MDS) dated vith intact cognition, total r bed mobility, dressing, and ded with having 2 stage 3 loped on 12/18/13 which the pressure ulcers to	F 514	The current treatments records and physician orders were clarified for accuracy by the physician for resident #14, #2, and #8. Care plans were reviewed and updated as neede and staff was educated regarding the current orders. Resident #14, #16, an #11 had a pain assessment complete and are monitored for changes through use of the numeric p scale in the medication records. Any resident could be affected by this practice, therefore, the RCD, DON, S and Unit Manager have audited and cross referenced the physician □s orders and audited the Treatment Records for accuracy on 7/17/14 and 7/18/14. All Licensed Nursing staff have been re-educated on accuracy of treatment	ed d pain DC
	ordered, therapeutic r or less, prevent sheet	entions included diet as mattress, turn every 2 hours t friction by using a pull pad ed, support with pillows,		orders, physicians orders and documentation of treatments by the D between 7-17-14 to 8-9-14. Daily aud the treatment record are being done b	its of

Facility ID: 923265

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/20 FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345174	B. WING		C 07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIF	P CODE
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETIC O THE APPROPRIATE DATE
F 514	treatments as ordered care physician to see effectiveness of the of Review of the medicat orders and treatment (TARs) did not match evidence of missed th *On 12/06/13 a physi stated the left upper th wound cleanser, path Alginate in wound, con change daily. The TA treatment being comp Interview with the Nu PM revealed she did 12/05/13 instead of 1 *On 12/12/13 a physi changed the treatment the wound with normal alginate with foam dat treatment was not init 12/12/13, 12/14/13, 1 12/22/13, 12/28/13, at *On 01/16/14 physicia add bactroban to left change. The facility TARs for the entire m TAR for February 207 Bactroban but it was	d, measure weekly, wound e weekly and observe the current treatment. al record revealed physician administration records and the TARs included reatments as follows: cian's telephone order thigh was to be cleaned with ed dry, place Maxorb over with Optiform AG and AR had no initials for the obted on 12/06/13. rse #7 on 07/07/14 at 2:32 the treatment just signed on 2/06/13. cian's telephone order nt to the left thigh to clean al saline and apply silvadene tily. The TAR revealed the tialed as being provided on 2/15/13, 12/20/13, 12/21/13, and 12/29/13. an telephone orders noted to thigh wound at dressing was unable to produce the nonth of January 2014. The 14 revealed the addition for noted as a "prn" (as needed)	F 51	the RN Supervisor and C week to ensure accuracy and treatment orders. A requiring a numerical sco completed for all resident better assess and docum pain. All resident's have a assessment completed e a numerical pain scale for a numerical score and lic initials. This form was ad resident's medication adr record to better assess a change in pain. All licens were educated by the DC of the numerical pain sca 7/17/14 and 8/9/14. The physician will be not condition related to pain a appropriate. The nurse will place the i 24-hour report for follow- next morning meeting. Residents will be reviewed needs or change of cond pain in the clinical morning meeting for follo recommendations. The N daily by the QA Nurse or RN Supervisor for abs documentation and follow The pain scale audit, treat	v of treatments Pain Scale ore will be ts every shift to nent a change in a pain every shift utilizing orm that requires censed nurses ded to each ministration and document a sed nursing staff DN using a visual ale form between ified of change in as clinically issue on the up during the ed for special lition related to w-up and MARS are audited sence of w-up as needed.
	never initialed as bein with the Nurse #7 on revealed she did the change but it was not	r February revealed it was ng administered. Interview 07/07/14 at 2:32 PM bactroban with the dressing t listed together on the TAR. s of treatment sheets were		audit, medication record taken to the monthly QAF meeting by the DON x 6 further review and recom	PI months for

	-	ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/10/2014 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		345174	B. WING		0	C 7/11/2014
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL	•	
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD		
				ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 514	missing. In addition I revealed the treatment foam was not listed of entry for alginate with The treatment record treatment that was not on 02/15/14, 02/16/1- 02/23/14. Interview of 07/07/14 at 2:32 PM the same as the thigh *Review of the March thigh wound was cleat and maxsorb alginate with a 4 x 4. The TAI bactroban. The TAR initialed as being give 03/05/14. A physicial discontinued the treat instructions to leave to physician assistant's dated 03/06/14 noted resolved. Interview w 2:32 PM revealed sho difference. *The wound PA's not left thigh had sudden closure. Physician of cleanse left upper thi thin layer of bactrobat wound 3 times per we cover with tape. This provided on the March The TAR reflected the times a week to daily being done daily beg end of March 2014.	February 2014's TAR ent for silvadene alginate with in the TAR. There was an in 4 x 4 to the left groin daily. Inoted that the left groin of initialed as administered 4, 02/17/14, 02/18/14 and with the Nurse #7 on revealed the groin area was in area. In 2014 TAR revealed the left aned with wound cleanser is was applied and covered R did not include the revealed no treatment was en on 03/01/14, 03/04/14 or in's telephone order tment on 03/06/14 with	F 51			

If continuation sheet Page 132 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG _			C
		345174	B. WING			07/	11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	_E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	daily treatments. Inte 07/07/14 at 2:32 PM i explain this and the D present at this time st physician orders to m on the TAR. *The facility was unat beginning of April 201 was provided 04/01/1 Resident #14 was how readmitted to the facil *Review of the dischar 04/09/14, revealed the thigh of apply Silvadir areas. This was initial 04/09/14 during seco *On 04/10/14 physicia to cleanse with norma of silver alginate to fit be done twice per we initialed as completed *On 04/24/14 physicia discontinued the treat apply a sheet of silver cover with 4 x 4 and r as needed. The TAR completed as ordered *The TAR for May 20 to cleanse wound witt alginate, cover with C tape and change even There was no physici record to support this	erview with Nurse #7 on revealed she could not birector of Nursing (DON) ated there should be atch each treatment located ble to provide TARs for the 14 to reveal what treatment 4 through 04/03/14. spitalized from 04/03/14 and lity on 04/09/14. arge summary, dated eatment orders to the left ne twice a day to open led as being completed on nd shift per the TAR. an orders changed the order al saline, apply a small piece wound, cover with 4 x 4 to ek and as needed. This was I as ordered on the TAR. an telephone orders tment and changed it to r alginate to open area and nedfix twice per week and reflected this treatment was	F	514			

Facility ID: 923265

If continuation sheet Page 133 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345174	B. WING _			(07/	C 11/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE			
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 514	administered daily with needed to be change- included no initials for 05/29/14, 05/30/14 ar treatment was provide those days. *The TAR for June 20 apply sheet of silver a with 4 x 4 and medfix needed. Hand writter generated treatment v leg/under folds and "T record had no physici this treatment change treatments were not p indicated with the har most recent physiciar (04/24/14 2 x week). 07/07/14 at 2:32 PM r explain the missing pl TAR. Review of the measur since 05/29/14 reveal been improving. Mea were 3.2 cm x 2.2 cm wound measured 1.5 On 06/30/14 at 10:41 observed in bed on an that she has had the of thigh since being adm stated the wound con Thursday. On 06/30/14 at 2:32 F	th no explanation as to why it d daily. The May 2014 TAR 05/27/14, 05/28/14, nd 05/31/14 indicating no ed to the thigh wound on 14 included the treatment of alginate to open area cover BIW (sic for BID) and as n under this computer were the words for left upper Tue Thur Sat." The medical an's order to correspond to e. Initials reflected the provided as ordered as ndwritten notation or per the a's order in the record Interview with Nurse #7 on revealed she could not hysician order or clarify the rements taken by the PA ed the thigh wound has asurements on 05/29/14 x 0.1 and on 06/27/14 the cm x 1.3 cm x 0.1 cm. AM, Resident #14 was n air mattress. She stated open area on her upper nitted to the facility. She	F 5	514				

Facility ID: 923265

If continuation sheet Page 134 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED		
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING		COMPLETED			
		345174	B. WING			07/11/2014			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801					
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 514	an adhesive dressing Interview with the wor 07/03/14 at 1:15 PM r wound care being pro ordered. She stated f Thursdays, the treatm place were the ones s to Resident #14, she admission. It would h The PA stated the thig caused by a large ski sheet got pushed up in not helped with the he On 07/07/14 at 2:32 F were interviewed. Th that if the TAR's were to say that the treatm Related to the missing physician orders, Nur the medical record we During follow up inter PM, the DON stated to monitoring of skin are stated she expected N for wound orders and correctly transcribed a 2. Resident #16 was a 05/01/14 with diagnos	Al saline and covered it with	F	514					
	patch applied to her r	ight shoulder 12 hours daily,							

Facility ID: 923265

If continuation sheet Page 135 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/10/2014 FORM APPROVED IB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION) DATE SURVEY COMPLETED C
		345174	B. WING				07/11/2014
NAME OF PF	ROVIDER OR SUPPLIER		I	s	STREET ADDRESS, CITY, STATE, ZIP CODE	I	
	E NURSING & REHABIL	ITATION CENTER		9	1 VICTORIA ROAD		
				A	ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	Continued From page	e 135	F	514			
	and every 6 hours as included to assess pa scale included to note	ree times a day routinely needed. Orders also ain every shift and a pain e 0 = no pain, 1-3 = mild e pain, 8 - 10 = worst pain					
	with intact cognition a scheduled and as needed	et dated 05/08/14 coded her and as receiving routinely eded pain medication but time of the assessment.					
	Resident #16 being a comfort. The goal wa decrease in pain leve symptoms of decreas 1 hour following interv included to monitor for provide alternative ma medications per orde	as for her to verbalize a el or show signs and se in pain level 30 minutes to ventions. Interventions or complaints of pain, easures , administer pain rs, and work with resident in optimal level of pain					
	(MAR) for May 2014 initialed that a pain as but only documented and 05/28/14. On se assessment was also completed but only do 05/02/14, 05/07/14, 0 shift initialed and doc all but 6 days in May.	o initialed as being ocumented a scale rating on 5/24/14 and 05/25/14. Third umented via pain scale on Per the MAR pain was and the as needed Norco					
		014 MAR revealed first shift pain assessment being					

Facility ID: 923265

If continuation sheet Page 136 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG_		COMPLETED		
		345174	B. WING			C 07/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	E NURSING & REHABIL	ITATION CENTER						
				A	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Continued From page complete but no scale documented 13 days entry with a pain scale number indicating she Third shift included in assessment was com scale rating 9 days. If needed Norco was ac pain scale indicated 4 The 60 day MDS date receiving routinely scl medication. At the tim stated she had freque level of 4 (from a scal worst). On 06/26/14 the phys needed Norco to 2 tal Interview with Nurse a revealed that when as the resident about the was not able to answe observed signs and s pain. She stated she did the assessment a and could take a pro medication on the bac stated there was not e to put both her initials assessment scale sin	e 136 e. Second shift initials only and only one e rating, 11 days with only a e had no pain and 5 blanks. itials daily that a pain pleted but only noted a During this month the as dministered 9 times when a times she had pain. ed 06/27/14 coded her as heduled and as needed pain ne of this assessment she ent pain and scaled it on a e of 1 - 10 with 10 being dician increased the as blets every six hours. #4 on 07/03/14 at 11:40 AM ssessing pain, she asked air pain, or if the resident er about their pain, she ymptoms of a resident's initialed the MAR that she nd if the resident had pain (as needed) pain d document the	TAG	514		ATE	DATE	
	pharmacies and the s changed, she stated t as to how to documen assessment.	here had been no training						

Facility ID: 923265

If continuation sheet Page 137 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDI	NG _			C	
		345174	B. WING				- 11/2014	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 514	Continued From page	2 137	F	514				
	Nurse #10 stated on 0 she assessed a residu looked for nonverbal s She stated she would the number correlatin stated that forms were however, she could n as to how to complete MAR was reviewed in Nurse #11 stated on 0 she should put the nu scale on the MAR wh assessment on a resi given based on the pa documented on the ba An interview was com Nursing on 07/07/14 a the pain assessments every shift should inco resident or observing for non verbal/cognitiv based on a scale of 1 to write the numerical the MAR. 3. Resident #14 was 12/05/13 with pressur obstructive pulmonary specialized needs rela- The significant chang dated 05/09/14 codec total assistance need dressing, and toileting not occur during this a	27/07/14 at 10:27 AM that ent for pain verbally or signs and symptoms of pain. document the MAR with g with the pain scale. She e reviewed in orientation, ot recall if the expectation e the pain assessment and orientation. 27/07/14 at 10:33 AM that mber based on the pain en she did her pain dent. Any prn medication ain scale would be ack of the MAR. ducted with the Director of at 5:01 PM. She stated that is scheduled to be done clude the nurse asking the signs and symptoms of pain vely impaired residents - 10. She expected nurses result of the assessment on admitted to the facility on re ulcers, diabetes, chronic y disease and had ated to weight. e Minimum Data Set (MDS) I her with intact cognition,						

Facility ID: 923265

If continuation sheet Page 138 of 168

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	
ASHEVILI	E NURSING & REHABII.	LITATION CENTER		VICTORIA ROAD HEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 514	Continued From page	e 138	F 514		
		medication, having frequent ut of 10) which she believed y activity.			
	medication: Tylenol 3 times a day, oxycont until on 05/05/14 it w day at night, then dis ultram 50 mg 2 tabs oxycodone 10 mg ev pain. Orders also in shift and a pain scale pain, 1-3 = mild pain = worst pain possible				
	(MAR) for May 2014 assessment was con three shifts. Only 3 t number indicating the intensity. According	npleted every day on all imes was there a numeric			
	each day each shift i was completed as or a numeric pain scale	or June 2014 revealed initials ndicating a pain assessment dered. Only third shift coded each night, indicating she received the as needed during the month.			
	revealed that when a the resident about the was not able to answ observed signs and s pain. She stated she	#4 on 07/03/14 at 11:40 AM ssessing pain, she asked eir pain, or if the resident ver about their pain, she symptoms of a resident's e initialed the MAR that she and if the resident had pain			

Facility ID: 923265

If continuation sheet Page 139 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345174	B. WING				C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	and could take a pro- medication, she would administration and eff medication on the bac stated there was not of to put both her initials assessment scale sin about a year ago. Wh pharmacies and the si changed, she stated to as to how to documer assessment. Nurse #10 stated on 0 she assessed a reside looked for nonverbal si She stated she would the number correlation stated that forms are however, she could n as to how to complete MAR was reviewed in Nurse #11 stated on 0 she should put the nur scale on the MAR wh assessment on a resi given based on the pa documented on the bac An interview with the 07/07/14 at 5:01 PM. assessments schedul should include the nur observing signs and si verbal/cognitively imp scale of 1 - 10. She effects	(as needed) pain d document the fectiveness of the ck of the MAR. She further enough space on the MAR and a number of the pain ce the pharmacy changed hen the facility changed pacing on the MAR there had been no training at the pain scale 07/07/14 at 10:27 AM that ent for pain verbally or signs and symptoms of pain. document the MAR with g with the pain scale. She reviewed in orientation, ot recall if the expectation e the pain assessment and o orientation. 07/07/14 at 10:33 AM that mber based on the pain en she did her pain dent. Any prn medication ain scale would be	F	514			

If continuation sheet Page 140 of 168

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 / APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING				C 11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 514	 4. Resident #11 was a 08/01/07 with diagnost Alzheimer's disease, I a stroke. The most red Data Set (MDS) indicaterm and long term m severely impaired in comaking. A review of monthly p 2014 and June 2014 is every shift with a pain 1-3 mild pain; 4-7 more possible. The orderst document non-pharm as follows: reposition is breathing = 3 and dist was initiated document A review of a physicial indicated Tylenol 650 under the tongue ever A review of a Medicatt (MAR) dated 05/01/14 the following document assessments: 7:00 AM - 3:00 PM shout no numeric pain store assessments and counter the tong a numeric pain store was no document assessments on the 7 	admitted to the facility on ses which included heart disease, diabetes and ecent quarterly Minimum ated Resident #11 had short emory problems and was cognition for daily decision hysician's orders dated May indicated to assess for pain scale as follows: 0 no pain; derate pain; 8-10 worst pain further indicated to alogical pain interventions ng = 1; massage = 2; deep traction = 4 and if any of 1- 4 ht and initial. n's order dated 06/05/14 milligrams by mouth or ry 6 hours while awake. ion Administration Record 4 through 05/31/14 revealed ntation regarding pain hift documented their initials cale. 3:00 - 11:00 PM shift ic pain scale on 23 days but shift documented their pain scale. entation of pain ':00 AM - 3:00 PM shift on 4 or on the 11:00 PM - 7:00	F	514				

If continuation sheet Page 141 of 168

			0.00		OMB NO. 0938-039				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C				
		345174	B. WING		07/11/2014				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•				
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 514	05/31/14 revealed the regarding non-pharm 7:00 AM - 3:00 PM sh initials but not the nur 05/30/14 where the in but no initials. 3:00 PM - 11:00 PM s interventions but no in 11:00 PM - 7:00 AM s no numeric intervention documentation for no interventions on the 7 05/28/14 and 05/29/1 AM shift on 05/31/14. A review of a MAR da 06/30/14 revealed the regarding pain assess 7:00 AM - 3:00 PM sh initials and no numeri 3:00 PM - 11:00 PM s pain scale but no initi 11:00 PM - 7:00 AM s pain scale and their in documented their initis scale on the remaind There was no docum assessments on the 7 06/27/14 or on 06/30/ also not documented shift on 06/28/14 or o shift on 06/29/14 or o	e following documentation alogical pain interventions: nift only documented their meric intervention except on netervention was documented shift documented the nitials. shift documented initials but ons. There was no n-pharmalogical pain 7:00 AM - 3:00 PM shift on 4 or on the 11:00 PM - 7:00 ated 06/01/14 through e following documentation sments: nift only documented their ic pain scale. shift documented a numeric nitials on 5 days but only ials and no numeric pain er of the days. entation of pain 7:00 AM - 3:00 PM shift on (14. Pain assessments were on the 3:00 PM - 11:00 PM n the 11:00 PM - 7:00 AM n 06/30/14. ated 06/01/14 through e following documentation alogical pain interventions: nift documented their initials netrvention.	F 5	14					

Facility ID: 923265

If continuation sheet Page 142 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING _				C /11/2014	
NAME OF P	ROVIDER OR SUPPLIER	·		STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				91	VICTORIA ROAD			
ASHEVILL	E NURSING & REHABIL	LITATION CENTER		AS	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	7:00 AM shift docume and initials on 5 days remaining days. There was no docum non-pharmalogical pa AM - 3:00 PM shift or - 11:00 PM shift on 06/2 During an interview of Nurse #4 explained w resident's pain, she a pain, or if the residen about their pain, she symptoms of pain. S MAR that she did the not enough space on initials and a number scale since the pharm about a year ago. Sh changed pharmacies changed and there ha how to document the During an interview of Nurse #2 stated she a pain by asking them i used the pain scale to their pain. She confir space on the MAR to the number related to resident's pain. She non-pharmalogical pa way but they needed so they could docume	a but no initials. 11:00 PM - ented numeric interventions but only their initials on the entation for ain interventions on the 7:00 n 06/27/14 or on the 3:00 PM 5/28/14 or on the 11:00 PM - 29/14 or 06/30/14. In 07/03/14 at 11:40 AM when she assessed a usked the resident about their t was not able to answer observed for signs and he stated she initialed the assessment but there was the MAR to put both her of the pain assessment nacy changed the forms he explained when the facility the spacing on the MAR ad been no training as to pain scale assessment. In 07/07/14 at 11:03 AM assessed her residents for f they had pain and she o document the severity of rmed there was not enough document her initials and o the severity of the stated she documented the ain interventions the same bigger spaces on the MAR ent correctly.	F	514				
	During an interview o	-						

If continuation sheet Page 143 of 168

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 // APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345174	B. WING				C 11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG			ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 514	MAR for pain assess pharmalogical pain in they weren't done by was her expectation t were ordered to be do include documentatio severity of the resider pain scale and the nu stated the non-pharm should also have the corresponding to the i initials documented. 5. Resident #2 was re diagnoses which inclu obstruction, colostom diverticular (a sac in t abscess (a localized i displacement of tissue (eruption of the intest the skin) fistulas (a tu area to the surface of generalized muscle w Record reviews of the Record (TAR), Medica (MAR) and physician following inaccurate re On 02/20/14 a physic received to apply Bac daily for 5 days to the Band-Aid for 5 days. transcribed on the TA transcribed on the MA completed for Bactrot big toe instead of 5 day	nents and non- terventions indicated to her nursing staff. She stated it hat pain assessments that one every shift should n by the nurse of the nt's pain according to the rse's initials. She further alogical pain interventions numerical number intervention and the nurse's eadmitted on 06/11/14 with ided diabetes, small bowel y, history of recurrent he walls of the intestine) nflammation or e) and enterocutaneous ine with the outer layer of be like passage from an another), debility, and reakness. e Treatment Administration ation Administration Record (MD) orders revealed the ecords: ian's (MD) order was troban (antibiotic) ointment left big toe and cover with a The order was not R. The order was AR and was documented as oan for 10 days to the left	F	514				

If continuation sheet Page 144 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	
		345174	B. WING				C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 514	the infected left big to for 20-30 minutes twice ointment after soaking treatment was transce discontinued on 04/19 received to discontinue On 04/09/14 an MD of cleanse fistula area we the area, apply ABD (secure with medfix (at tape) tape, change two pouchkins (an ostomy drainage. The treatme completed as ordered 04/14/14 and noted a MD order was received dated on 04/14/14. On 04/11/14 a treatme TAR to apply zinc creater around fistulas as need initialed as completed no MD order for this to On 04/14/14 a treatme TAR to cleanse fistulate water and apply visco cover with ABD and st There was no MD ordor of the dressing change shift. On 04/16/14 an MD of viscopaste (a type of inner thighs bilaterally blistering until healed specified on the MD of	e in clean warm salt water ce daily, apply Bactroban g and cover with gauze. The ribed on the TAR as 2/14 but no MD order was ue the treatment. Ander was received to with warm soapy water, dry a gauze surgical pad) and kind of medical dressing vice daily, and may use y supply) for excess ents were initialed as d daily from 04/09/14 to s changed on 04/14/14. No ed to change this treatment ent was transcribed on the am to excoriated area eded. This treatment was I for 17 days but there was reatment. ent was transcribed on the a area with warm soapy opaste over excoriated area, ecure with tape every shift. ler to change the frequency les from twice daily to every order was received to apply skin protective ointment) to y due to redness and and there was no frequency	F	514	4		

Facility ID: 923265

If continuation sheet Page 145 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 // APPROVED). 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				LETED	
		345174	B. WING				C 11/2014	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 514	and was initialed as c MD clarification order frequency of this treat The May MAR reveal apply viscopaste to in redness and blistering specified of PRN (as "frequency needs clari- initials on the MAR fo- was not transcribed to MD Orders to clarify t PRN or 3 times daily. The May TAR listed at fistula area with warm to excoriation, apply A every shift and PRN. as providing the care MD order for this trea- treatment order dated dressing changes twice The June TAR record the fistula sites with c cream, and apply an every shift and PRN. documented as care p shifts were missing do was received in May o in frequency of the tree MD treatment order d for dressing changes	ompleted 3 times daily. No s were received for the ment. ed the 04/16/14 MD order to ner thighs bilaterally due to g until healed with frequency needed) and a note iffication". There were no r providing this treatment, it o the TAR and there were no he treatment for cleansing the soapy water apply z-guard ABD and secure with tape The TAR was documented every shift, but there was no tment. The last MD 04/09/14 received was for ce daily. ed a treatment for cleansing leanser, apply barrier ABD secured with tape The TAR was not provided as ordered: 15 pocumentation. No MD order for June to clarify the change eatment ordered. The last ated 04/09/14 received was twice daily.	F	514				

If continuation sheet Page 146 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG _			C
		345174	B. WING			07/	11/2014
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			1 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	dressing changes and wound care on the oth changes that were or daily. Nurse #7 furthe wound condition were doctor for order chang MD orders and the TA through June 2014 fo there were discrepand orders onto the TAR, as the MD orders were Interview on 07/11/14 Assistant Director of N was missing documen records, the treatmen stated Nurse #7 was sheets to ensure treat completed as ordered An interview with the on 07/07/14 at 3:18 P the treatment records dressing was complet there were no initials the treatment was no The DON further state that if a telephone or TAR then she expected ensure what the appri- was and know when the completed. The DON and the TAR from Jar 2014 for Resident #2, were discrepancies in TAR. The DON further missing initials which	ed she provided the daily d other nurses provided her shifts for any dressing dered twice or three times er stated any changes in the ereported to the facility ges. Nurse #7 reviewed the AR from February 2014 r Resident #2, confirmed cies in the transcribing of and they were not recorded re received. at 1:59 PM with the Nursing revealed that if there nation in the treatment t was not completed. She auditing the treatment tweet being d. Director of Nursing (DON) M revealed she expected to be filled out when the ted. The DON stated if on the treatment record then t completed as ordered. ed on 07/07/14 at 3:35 PM ler was not written on the ed the wound nurse to opriate wound treatment the treatment was to be reviewed the MD orders nuary 2014 through July The DON verified there order transcription to the r confirmed there were indicated treatment was not	F	514			
	missing initials which						

Facility ID: 923265

If continuation sheet Page 147 of 168

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 APPROVED
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			C
		345174	B. WING				_ 11/2014
NAME OF P	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			01 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 514	F 514 Continued From page 147 as the MD orders were received.		F	514			
	as the MD orders we	re received.					
	01/10/13 with diagnos ulcer, chronic skin ulc	eadmitted to the facility on ses which included pressure cers, diabetes, chronic ession, psychosis, and yeakness.					
	The following records incomplete or inaccur						
	04/05/14 through 05/3 assessments were co indicated a wound to	ompleted weekly and the left hip buttock area. s but were not completed					
	dated 06/17/14 had a buttock ulcer with a s placement. The recor #8 received daily dres	tal discharge instructions surgical repair of the left kin flap and drainage tube d further indicated Resident ssing changes to the surgical uppointment in 2 weeks.					
	Record (TAR), Medic	e Treatment Administration ation Administration Record (MD) orders revealed the ecords:					
	gel to the dressing ch (buttock area). This M	(an antibiotic skin cream) ange of the left ishium ID order for flagyl ointment dressing change order on					
	On 02/06/14 an MD c cleanse the left buttoo	order was received to ck area wound with normal					

Facility ID: 923265

If continuation sheet Page 148 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/10/2014 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C / 11/2014
NAME OF P	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	-
ASHEVILI	E NURSING & REHABIL	ITATION CENTER			91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	enzyme skin debrider (antibiotic ointment) in gauze packing and co secure with medfix (a tape) twice daily. The treatments were trans change. The TAR wa missing initials of carr On 03/28/14 an MD of the wound with Dakin strength then rinse w packing wick of gauze Monday, Wednesday antibiotic powder to th apply gauze dressing order was transcribed On the April 2014 TA order was transcribed changes. On 04/16/1 to continue the dress (M-W-F). The TAR wa 04/16/14 for dressing and PRN (as needed received to change th day and no wound ca completed after 04/26 On the May 2014 TAI transcribed for wound be completed 2 times There was no MD or 04/16/14 for (M-W-F) was received to apply wound, cleanse wour	a covered with santyl (an ment gel) and gentamicin nto the wound daily. Use ½" over with a 4x4 gauze and a kind of medical dressing a TAR indicated the scribed for a daily dressing s initialed twice daily but was e provided for 5 shifts. order was received to irrigate t's (an antiseptic solution) ¼ ith normal saline, place a e into the tract every and Friday (M-W-F). Apply he skin around the wound, and secure with tape. The d to the TAR on 03/28/14. R the 03/28/14 wound care d for (M-W-F) dressing 4 an MD order was received ing changes as ordered on as transcribed starting changes every other day), but there was no order he frequency to every other are was initialed as 5/14. R there was a treatment d care dressing changes to a daily starting on 04/02/14. der to change the frequency ges from (M-W-F) to 2 times	F	514			

Facility ID: 923265

If continuation sheet Page 149 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10 FORM APPR OMB NO. 0938	OVE
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345174	B. WING		07/11/2014	4
NAME OF P	ROVIDER OR SUPPLIER	l	STI	REET ADDRESS, CITY, STATE, ZIP CO		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER		VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPL E APPROPRIATE DAT	ETIO
F 514	Continued From page	e 149	F 514			
	dressing 2 times daily on the May TAR start	/. This order was transcribed ing 05/30/14.				
	On the June 2014 TA were transcribed as p multiple shifts were m documentation up to revealed a surgical re scheduled for 06/17/1 received dated 06/17/2 changes to the surgic with Xenflo (a type of dressing) and gauze July 2014 TAR reveal	anges as previously ordered. R wound care treatments previously ordered, but hissing initialed 06/17/14. The MD orders epair of the wound was				
	PM revealed the wou received from the wou was provided by the f provided the daily dre nurses provided wour for any dressing chan or three times daily. I changes in the wound the wound clinic for o reviewed the MD orde January 2014 through confirmed there were	und care physician and care facility. She stated she essing changes and other and care on the other shifts ages that were ordered twice Nurse #7 further stated any d condition were reported to rder changes. Nurse #7 ers and the TAR from an July 2014 for Resident #8, discrepancies in order TAR, and the orders were				
	Assistant Director of I were missing docume	1/14 at 1:59 PM with the Nursing revealed that if there entation in the treatment It was not completed. She				

Facility ID: 923265

If continuation sheet Page 150 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/1 FORM APPF OMB NO. 0938	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345174	B. WING		C 07/11/201	14
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
ASHEVILI	E NURSING & REHABIL	ITATION CENTER		1 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMP	(X5) PLETION DATE
F 514 F 520 SS=J	sheets to ensure treat completed as ordered An interview with the on 07/07/14 at 3:18 P the treatment records dressing was complet there were no initials the treatment was not The DON further state that if a telephone or the TAR then she exp ensure what the appr was and know when the completed. The DON and the TAR from Jan 2014 for Resident #8. were discrepancies in TAR. The DON further missing initials which provided, and the treat as the MD orders wer 483.75(o)(1) QAA COMMITTEE-MEMBI QUARTERLY/PLANS A facility must mainta assurance committee nursing services; a ph facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to	auditing the treatment tments were being d. Director of Nursing (DON) PM revealed she expected to be filled out when the ted. The DON stated if on the treatment record then t completed as ordered. ed on 07/07/14 at 3:35 PM der that was not written on bected the wound nurse to opriate wound treatment the treatment was to be reviewed the MD orders nuary 2014 through July The DON verified there order transcription to the er confirmed there were indicated treatment was not atments were not recorded the received. ERS/MEET	F 514		8/10/	14

Facility ID: 923265

If continuation sheet Page 151 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER		1 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 520	develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such c requirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observatio manufacturer's recom interviews, the facility implement plans of ac using slings that were ensure staff used the the Quality Assurance facility administration transfer residents via slings without proper the slings for safety a ripped causing him to staff were inserviced and audited for wear sling ripped and she f transfer. Immediate Jeopardy Resident #18 had fall was sitting in ripped a The Quality Assurance immediately identify a comprehensive action	ents appropriate plans of tified quality deficiencies. Aary may not require ords of such committee h disclosure is related to the committee with the section. By the committee to identify eficiencies will not be used as the committee to identify eficiencies will not be used as the section. By the committee to identify eficiencies will not be used as the committee to identify eficiencies will not be used as the section. The committee to identify eficiencies will not be used as the section. The committee to identify eficiencies will not be used as the section. The committee to identify eficiencies will not be used as the section. The continued to develop and the mechanical section of the review process. The continued to have staff the mechanical lifts and training on the inspection of fter Resident #18's sling the fall to the floor. Before all and all slings were identified and tear, Resident #17's feel into a chair during a began on 06/15/14 when from a lift when the sling he and he fell onto the floor. the Committee failed to	F 520		h a air to por. he ped e s red py ed

Facility ID: 923265

If continuation sheet Page 152 of 168

	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/10/2014 MAPPROVED D. 0938-0391
-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			I VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520	when the sling she wa fell into a recliner cha removed on 07/11/14 provided and impleme allegation of compliant of compliance at a low (a pattern of deficience potential for more tha immediate jeopardy) is systems put into place The findings included 1. A review of the face Policy included the pr and sling holes for fra use frayed lift pads." A review of the Owne Maintenance Manual, included the warning accordance with instr slings(s) for wear, tea Bleached, torn, cut, fr unsafe and could rest immediately." A review of the manuf sling sizes provided b supervisor revealed s colored binding with r for each sling: *Green binding indicate maximum weight cap.	ent #17 had a fall from a lift as sitting on ripped and she ir. Immediate jeopardy was at 7:00 PM when the facility ented an acceptable credible ice. The facility remains out ver scope and severity of E y, no actual harm with n minimal harm that is not o ensure monitoring of e are effective. : : : : : : : : : : : : : : : : : : :	F	520	On 6/23/2014 at 2:59 PM Resident #1 was lifted from the recliner to the bed v a mechanical lift and two CNA S. Upon lifting the resident of the sling ripped and the resident fell ba- into the chair. After the resident was assessed by the nurse she was lifted into the bed using anoth sling that was inspected and had no defect. The ripper sling was given to Nursing Home Administrator; the ripped sling was locked in the Nursing home administrator office. The C.NA was give one on one in service by maintenance director and the nursing home administrator on sling inspection The next day the C.NA was in service by the RN Supervisor/ ADON and the therapy department. Th C.NA that was spotting the transfer was in serviced in the general service regarding inspecting slings provided on 6/23/2014. Any other resident that have a potentia be affected were identified by Director Nursing, the RN Supervisor/ ADON and one C.NA as resident requiring the use of mechanic lift and sling for transfers on 6/16/2014. The Director of Nursing, RN Supervisor ADON and Staff Development Coordinator read and reviewed manufacture recommendation for mechanical lift and slings. All licensed nursing staff, certified nursing	via up ack se, her ed ven n. ne in al to r of	
	*Black binding indicat	ed an extra/extra large sling capacity of 600 pounds.			assistants, therapy, housekeeping and maintenance staff that assist with	ł	

Facility ID: 923265

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345174	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	I		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER			VICTORIA ROAD HEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	9 153	F	520			
	An attached warning is recommended by th or medical attendant. straps for secure point device. Do not exceed lift. Use only with (bra Bleached, torn, cut, fr unsafe and could resu- immediately. Do not (brand name) lifts." A review of a nurse's 12:54 AM indicated a that Resident #18 wa wheelchair with a mea- ripped at the bottom I ripping apart at top le indicated Resident #1 or less" to the floor ar his back and left butto Resident #18 compla with redness noted to area and pain medica During an interview o the Director of Nursin was called the night th #18 fell from the lift ar about the incident the she expected the NA' before using them for She further stated if a or torn she expected and give the worn slin Director, Housekeepin Charge Nurse. She e	included "Use the sling that he individual's doctor, nurse Before lifting, check all sling its of attachment on the lift d weight limitation posted on and name) patient lifts. rayed or broken slings are ult in injury. Discard alter slings. Use only on note dated 06/16/14 at late entry note for 9:30 PM s being lifted out of his chanical lift and the "lift pad eft corner and frayed and ft corner." The notes 8 fell approximately "a foot nd landed on the left side of ock. The notes indicated ined of left sided back pain the left sided middle back ation was administered. n 07/08/14 at 5:16 PM with g (DON), she explained she he sling ripped and Resident nd there was a discussion e next morning. She stated is to inspect the slings tears and frayed areas. my of the slings were frayed the NA's not to use those ing to the Maintenance ing Supervisor, or the xplained she had no idea ailable for staff use since the			transfers and spotting have been in serviced and provided instructions based on manufacture recommendations and provided written instruction by Staff Developme coordinator or RN Supervisor/ADON of 07/09/2014 * Determining the appropriate Size sling for the resident * Care and inspection of sling per manufacturer is instructions * Lift batteries/ chargers/ plug in * Care/ inspection of lifts per manufacturer is instructions * Troubleshooting lifts All the above employees completed a return demonstration using a mechanic lifts with slings on: * Seated transfer * Floor transfer * Repositioning up in bed * Scale operation * Inspection for holes, tears, frays of unraveling on sling Sling in-service: * Safe use of sling with two staff members always * Identifying defects in the sling (if defect is found do not use it, give sling the charge nurse) * The nurse is to remove the defect sling from service and place in the lock medication room for maintenance to pickup for disposal * The nurse is to fill out a work orde maintenance to replace the defective sling. * The Maintenance director is to reorder the same size sling that was ta	on: of cal or to ive ked er for	

Facility ID: 923265

If continuation sheet Page 154 of 168

	-	ND HUMAN SERVICES			PRINTED: 12/10/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
ASHEVILL	E NURSING & REHABIL	LITATION CENTER	-	1 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLET
F 520	slings and checked the worn or frayed were st discarded. During an interview of Maintenance Director on 06/16/14 after Rest 06/15/14. He describ side and white on the described the sling wo of the top corner and the bottom left corner why the sling was aver had frayed edges and when they did the we damaged or worn slin missed somehow. During an observation at 10:57 AM the Hous brought a sling to a c it was the sling that h #18 fell from the lift. Her verified a corner of the completely at the top left corner had frayed He confirmed it was a have been discarded transfer Resident #18 During a follow up int 07/11/14 at 3:06 PM had been used to transfer free to the top	around and collected all the nem and all slings that were supposed to have been an 07/08/14 at 6:03 PM the r explained he saw the sling sident #18 fell from the lift on ed it as light blue on one e other side. He further as ripped at the seam area had completely ripped off at r. He stated he was not sure ailable for staff use since it d it should have been caught ekly audits to check for ngs but it must have been an and interview on 07/09/14 sekeeping Supervisor onference room and verified ad ripped when Resident He demonstrated and te sling had ripped left corner and the bottom I edges and ripped edges. an old lift sling and should before it was used to	F 520		d by 3:00 ended the 3:00 PM on rvice is ent RN is will be in t of t of t t of t of
	that worn and frayed	stated it was her expectation slings should be discarded available for resident use		the defective sling. * Maintenance director is to size sling that was taken out o This in service will be complete	f service

Facility ID: 923265

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/20 FORM APPROVE OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345174	B. WING		07/11/2014		
NAME OF PI	ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILL	E NURSING & REHABIL	ITATION CENTER	91 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO		
F 520	Continued From page		F 520				
	the actions taken rela	ew and interviews revealed ated to Resident #18's fall		PM on 7/10/14 by the Staff Developm coordinator or RN			
		service education sign in of Proper use of Lift slings		Supervisor and Housekeeping/ Laund supervisor. Any employee who has not attended to			
	-	fe was signed by 37 staff		in-service will not be allowed to work in they have attended the in-service. All	until		
	agenda included usin	er and 1 laundry staff). The g 2 staff for all mechanical		employees will be in serviced during orientation.			
	communication if lift s	ng defects in lift slings, sling is found defective, sfore use if not safe, writing a		An audit on all slings in the facility was completed 7/09/2014 at 8:00 PM by th Maintenance Director,			
	work order to report a new slings to replace	a bad lift sling and reordering defective ones. On		Director of Nursing and Housekeeping Laundry Supervisor. The Audit of the	g/		
	stated he provided th	the maintenance supervisor e first inservice on 06/16/14 o additional inservices with		slings included the following: * All slings were identified, numbe	rod #		
	staff related to sling u			1 to #42 and size noted * The Condition of the slings were			
	housekeeping superv	maintenance supervisor and visor counted, numbered,		inspected for holes, tears, frays and defects			
	condition. An addition	 A slings were pulled due to nal audit sheet dated nore slings for a total of 30 		 During this audit no sling were removed due to defects The following interventions and system 	mic		
	slings in the facility.	On 07/08/14 at 6:03 PM the sor stated he completed the		changes will ensure effective operatio the Quality			
	same audit every Tue numbered each sling	esday. He also stated he to make auditing easier and		Assurance Committee. All Quality Assurance Committee members will b	e		
		was being observed ance supervisor stated that ping supervisor found more		in-serviced on 07/11/14 or prior to returning to work by the corpo Nurse Consultant and/or the Regional			
	slings that were not c	aught on the first audit, added them to the audit		Director concerning the following procedures. All weekend managers will be in-serviced on 07/11	1		
		note dated 06/23/14 at 2:59 ge of status which revealed		or prior to returning to work by the Administrator regarding reporting incident/accident reports to t	he		
	Resident #17 was be	ing lifted out of a recliner cal lift and the lift pad ripped		Administrator on the weekends.			

Facility ID: 923265

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/10/201 M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		345174	B. WING			/11/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	E NURSING & REHABI		9	91 VICTORIA ROAD		
ASHEVILL	E NORSING & REHABI	ENATION CENTER		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	Continued From page	e 156	F 520			
	at the left front corne	r. The notes indicated				
		proximately 6 inches back		* The Quality Assurance Co		
		was no apparent injury noted.		oversee the implementation of	f all aspects	
		licated the Physician, sistant Director of Nursing		of the above	k to roviou	
	(ADON) were made			plan and meet within one wee the plan, reassess for effective		
		aware infinediately.		modify the		
	A review of an x-ray	report titled MRI left knee		plan as necessary. The Qualit	v Assurance	
	-	d 07/08/14 at 2:30 PM		Committee will address mecha	-	
	indicated the followin			and sling		
		e osteoarthritis of the medial		safety at each Quality Assurar	nce meeting	
	(middle) compartmer	nt associated with		for one year.		
	contusions.	cus (a semicircular cartilage		* The corporate Nurse Con	sultant will	
		ral integrity to the knee) is		attend the Quality Assurance		
	-	t) and there is a probable		meetings for six		
	tear of the extruded b			months as an advisor to ensur	e the	
		a grade 1 sprain of the		committee is accessing all rele	evant data	
	•	ment (MCL) on the inner part		at their disposal,		
	of the knee.	aular awalling within the		fully addressing all current iss		
		scular swelling within the e muscle located on the front		reassessing the effectiveness plans of action, revising	of their	
	of the thigh).			their plans of action as needed	d, and	
	er alle allgil).			keeping issues on the agenda		
	A review of a physicia	an's order dated 07/11/14 at		committee until the		
		refer Resident #17 to a bone		issue has been fully resolved.		
		nd the appointment was		committee members will be de	esignated as	
	scheduled for Monda	ay 07/21/14 at 2:00 PM.		the	with action	
	During an interview o	on 07/08/14 at 5:16 PM the		responsible party to follow up plans, give progress reports a		
		was not called on 06/23/14		target		
		and Resident #17 fell from		completion date.		
	the lift but she saw th	ne incident report the				
		06/24/14. She stated NA		* The Administrator will ens	,	
		heard a ripping sound when		prior to Quality Assurance me	etings, all	
		Ispended in the sling above		supervisors and	for any	
		d NA #15 put her knee up nd pushed her back toward		Administrative staff are polled issues that need to be discuss	-	
	- under me resident ar	IN THIS DECIDEL DACK TOWARD				

Facility ID: 923265

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF F	ROVIDER OR SUPPLIER	•	- I	STREET ADDRESS, CITY, STATE, ZIP CODE	·
ASHEVILLE NURSING & REHABILITATION CENTER				91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 520	why the sling was ava Maintenance Director Supervisor had audite each week and all slin were supposed to har During an interview of Maintenance Director after Resident #17 fer after they got it out fro it as light blue on one other side with a gree further explained one and the sling was fray he was not sure why staff use since it had have been caught wh audits to check for da must have been miss During an observation at 10:57 AM the Hous brought a sling to a c it was the sling that h #17 fell from the lift. verified a corner of th completely off and the had the hooks still att hooked onto the arm the sling had frayed e and on the right side the remaining hooks binding. He confirme should have been dis transfer Resident #17 must have slipped the weekly audits of sling	ailable for staff use since the r and Housekeeping ed slings on Tuesdays of ings that were worn or frayed ve been discarded. In 07/08/14 at 6:03 PM the r explained he saw the sling Il from the lift on 06/23/14 om under her and described e side and darker blue on the en reinforcement band. He whole corner had ripped off yed on the edges. He stated the sling was available for frayed edges and it should then they did the weekly imaged or worn slings but it ed somehow. In and interview on 07/09/14 sekeeping Supervisor onference room and verified ad ripped when Resident He demonstrated and e sling had ripped e piece that had ripped off ached that would have been of the lift. He further verified edges along the top left side at the top and bottom near on the green reinforcement di t was an old lift sling and ccarded before it was used to Y on 06/23/14. He stated it rough the cracks when the	F 52	 * The Administrator will review accident/incident reports in the dat stand-up meeting and request staff to report any new isseneed immediate attention. Remed actions will be determined and current plans ass for effectiveness in the daily stand meeting. If necessary, the Administrator will a convene a meeting of relevant me of the Quality Assurance Committee after the dat stand-up meeting to address probineeding immediate attention. If indicated, i will be scheduled for follow-up immediately and then taken to the Quality Assurance Committee me One indication would be any issue has the capacity to cause harm or has caused harm * Any issue requiring immediate in-serviced prior to returning to work * Any issue requiring immediatient of equipment will be supervised by Administrator to ensure 100% of all relevant staff a in-serviced prior to returning to work 	ally sues that dial essed d-up also embers ally olems issues e monthly eting. e that m. e that m. re ised by are ork. te audits y the ment is ective

Facility ID: 923265

If continuation sheet Page 158 of 168

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/20 ² MAPPROVE D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345174	B. WING				C / 11/2014
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E NURSING & REHABI	LITATION CENTER			1 VICTORIA ROAD		
-				A	SHEVILLE, NC 28801		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From pag	e 158		520			
1 020		g her investigation of the fall,		520	* On the weekends and holidays, t	ho	
		ng size sling had been used			Administrator will be informed by the	lie	
		#17. She further explained			manager on duty of any		
		ad used a blue sling with a			incident/accident report involving resi	dent	
	•	band and that indicated it			safety to determine if an immediate p		
		n a maximum weight capacity			of action is required to protect resider	nts.	
	-	confirmed staff should have for Resident #17's transfer					
		was greater than 300 pounds					
		he sling that had been used					
		#17 was worn with frayed					
	-	t have been used for her					
		it was her expectation that					
	worn or frayed slings immediately and not	available for resident use.					
	, , , , , , , , , , , , , , , , , , ,						
		nd interviews revealed the					
		ten related to Resident #17's n it ripped were as follows:					
		was conducted on 06/23/14					
		slings and transfers using					
		staff (17 nurse aides, 8					
	housekeeper) signed	eping supervisor and 1					
		hese staff had also attended					
		n 07/09/14 at 1:42 PM the					
	Administrator stated	he provided this inservice.					
	b. An audit of the slir	ngs completed on 06/24/14					
	revealed 30 slings w	ere in use at that time and					
		on 06/23/14 was not on the					
		g been inspected. Interview					
	revealed that he and	e supervisor on 07/08/14 the housekeeping					
		le slings every Tuesday and					
		kly audits until 07/16/14 at					
	which point the audit	s will be done monthly.					
	On 07/09/14 at 1:42	PM the Administrator stated					

Facility ID: 923265

If continuation sheet Page 159 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
ASHEVILI	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 520	that after the first slin maintenance supervis staff on checking slin audit of the slings wai it was just an accider not identified in the al 06/23/14 resulting in incident the Administr maintenance supervis inservice. He stated the exactly how many station inservicing on the slin and tear as of this da responsibility of main the staff coordinator as staff were eventually stated the inservicing were comfortable usid did not know who or the been inserviced on withe the slings. On 07/10/14 at 5:56 for the Quality Assurance third Wednesday of en- issues that were to be committee were trend during the morning station meetings were held M all department heads meetings discussed to reports, nursing issue old and new grievand any environmental co- Administrator, the teat taken to the QA commi- frequency and/or sev- stated if the same issues	g ripped on 06/15/14, the sor provided an inservice to gs for wear and tear. An s also completed. He stated at that there was a worn sling udit that was used on another fall. After this rator stated he and the sor completed another hat he was unaware of aff had received any ngs and checking for wear te. He stated it was the tenance supervisor, DON, and himself to make sure all inserviced. He further would continue until staff ng the lifts and slings. He how many staff still had not that to look for when using PM the Administrator stated e (QA) committee met the each month. He stated that e followed by the QA ds and problems identified raff meetings. Morning staff Monday through Friday with . The morning staff hings including all incident es from the 24 hour reports, ess, any resident behaviors, oncerns. Per the am decided on what was	F 52	0	

Facility ID: 923265

If continuation sheet Page 160 of 168

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345174	B. WING		07/11/2014
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CO	
ASHEVILL	E NURSING & REHABII.	LITATION CENTER		VICTORIA ROAD HEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
	that the team decided they started inservici slings and then the o Administrator stated action for the QA add He also stated that th continue for 3 months the maintenance dire monthly on 07/16/14. stated that the results	ed, the Administrator stated d on a mini QA. He stated ng and the auditing of the rdering of new slings. The he had no written plan of tressing the sling incidents. he weekly audits were to s and he couldn't say why ector thought the audits went . The Administrator further s of the inservices and audits			
	the June QA meeting and the July QA wou The facility's Adminis Nursing were notified 07/10/14 at 6:08 PM assurance plan of ac address the falls of R facility provided a cre compliance on 07/11 following intervention				
	assisted by two CNA transfer from the cha transfer the sling ripp the floor. After the nu he was lifted onto the mechanical lift and sl had no defects. The from service by the c the medication room. to the maintenance d	PM Resident #18 was being 's with a mechanical lift to ir to the bed. During the red and the resident fell onto rrse assessed the resident,			

Facility ID: 923265

If continuation sheet Page 161 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/10/2014 RM APPROVED NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345174	B. WING			0	C 7/11/2014	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	LE NURSING & REHABIL			91	1 VICTORIA ROAD			
ASILVILI				A	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 520	transferred by mecha defects. Staff involve charge nurse on sling On 06/16/2014 all slin maintenance director recommendation. On 6/23/2014 at 2:59 from the recliner to th and two CNA'S. Upo sling ripped and the r chair. After the reside nurse, she was lifted sling that was inspect ripped sling was give Administrator; the ripp Nursing home admini given one on one in s director and the nursi sling inspection. The service by the RN Su therapy department. the transfer was in se service regarding insp 6/23/2014. Any other resident tha affected were identifit the RN Supervisor/ A resident requiring the sling for transfers on The Director of Nursi and Staff Developme reviewed manufactur mechanical lift and sl staff, certified nursing housekeeping and m with transfers and sport	anical lift and sling with no ed was educated by the g inspection. Ings were inspected by the following the manufactures PM Resident #17 was lifted the bed via a mechanical lift on lifting the resident up the esident fell back into the ent was assessed by the into the bed using another ted and had no defect. The into the bed using another ted and had no defect. The n to Nursing Home ped sling was locked in the istrator office. The CNA was service by maintenance ing home administrator on next day the CNA was in pervisor/ ADON and the The CNA that was spotting erviced in the general in pecting slings provided on at have a potential to be ied by Director of Nursing, .DON and one CNA as a use of mechanical lift and 6/16/2014. ng, RN Supervisor/ ADON nt Coordinator read and e recommendation for ings. All licensed nursing g assistants, therapy, aintenance staff that assist otting have been in serviced ions based on manufacture	F	520				

Facility ID: 923265

If continuation sheet Page 162 of 168

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMP	LETED
							C
		345174	B. WING			07/11/2014	
NAME OF PI	ROVIDER OR SUPPLIER	-		;	STREET ADDRESS, CITY, STATE, ZIP CODE		
					91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PREFI		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		
			-				
F 520	Continued From page	162		520			
1 520				520			
	RN Supervisor/ADON						
	•	appropriate Size of sling for					
	the resident	tion of sling per manufacturer					
	's instructions	tion of sing per manufacturer					
	· Lift batteries/ cha	argers/ plug in					
		of lifts per manufacturer 's					
	instructions						
	· Troubleshooting	lifts					
		ees completed a return					
		a mechanical lifts with slings					
	on:	-					
	 Seated transfer 						
	 Floor transfer 						
	 Repositioning up 	in bed					
	Scale operation						
	-	les, tears, frays or unraveling					
	on sling						
	Sling in-service:						
		with two staff members					
	always	ts in the sling (if defect is					
		ive sling to the charge					
	nurse)						
	,	emove the defective sling					
		e in the locked medication					
		e to pickup for disposal.					
		ll out a work order for					
	maintenance to repla	ce the defective sling.					
	The Maintenance	e director is to reorder the					
	same size sling that v	vas taken out of service					
	This in service was st						
		completed by 3:00 PM on					
	7/10/2014.						
		as not attended the above					
		er 3:00 PM on 7/10/14 will					
		k until the in service is					
		evelopment Coordinator,					
	Luay Shift KIN Supervis	sor/ADON or 3 to 11 RN					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/10/2014 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		345174	B. WING				
	ROVIDER OR SUPPLIER	545174	5		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	11/2014
	CONDER OR SOLT LIER				91 VICTORIA ROAD		
ASHEVILL	E NURSING & REHABIL	ITATION CENTER			ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
TAG F 520	Continued From page Supervisor. All new e during orientation. At 3:00 PM on 7/10/2 did not receive the ab to the Director of Nurs will monitor the daily s anyone that had not h not be scheduled to w completed. An in service will be c one housekeeper stat laundry on 7/10/2014 include: • Holes, tears, fray • Identifying defect housekeeping/ laundr defective sling in the f supervisor office. Fill maintenance director of the defective sling. • Maintenance director of the adjust the staff D RN Supervisor and H supervisor. Any employee that ha named in service afte not be allowed to wor employees will be in s An audit on all slings 7/09/2014 at 8:00 PM Director, Director of N	e 163 employees will be in serviced 2014 a list of employees that ove in-service will be given sing. The Director of Nursing schedule to ensure that had the above in service will work until in the in service is conducted with laundry and ff that is crossed trained for for inspection of slings to rs or unraveling is in the slings, the ry employee will lock the housekeeping / laundry out work order for to replace sling and dispose ector is to reorder the size out of service completed by 3: 00 PM on Development coordinator or ousekeeping/ Laundry as not attended the above r 3:00 PM on 7/10/14 will k until in serviced. All new serviced during orientation. in the facility was completed by the Maintenance lursing and Housekeeping/ The Audit of the slings		520	DEFICIENCY)	ATE	
	• All slings were in #42 and size noted	dentified, numbered # 1 to the slings were inspected					

Facility ID: 923265

If continuation sheet Page 164 of 168

DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>CENTERS FOR MEDICARE & MEDICAID SERVICES</u>							
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345174	B. WING			C 07/11/2014	
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILLE NURSING & REHABILITATION CENTER					91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE	
F 520	 During this audit to defects The following interver will ensure effective of Assurance Committee Committee members 07/11/14 or prior to recorporate Nurse Consection Concerning the weekend managers with 07/11/14 or prior to recorporate Nurse Consection to repart of the weekends. The Quality Assurous oversee the implement above plan and meet the plan, reassess for the plan as necessary. Committee will address safety at each Quality year. The corporate Nuthe Quality Assurance six months as an advisis accessing all relevation for the effectiveness of the their plans of action a issues on the agenda issue has been fully recommittee members or responsible party to for give progress reports completion date. 	no sling were removed due tions and systemic changes peration of the Quality e. All Quality Assurance will be in-serviced on turning to work by the sultant and/or the Regional he following procedures. All vill be in-serviced on turning to work by the ng reporting orts to the Administrator on rrance Committee will htation of all aspects of the within one week to review reffectiveness, and modify v. The Quality Assurance as mechanical lift and sling v Assurance meeting for one urse Consultant will attend e Committee meetings for isor to ensure the committee ant data at their disposal, rrent issues, reassessing heir plans of action, revising s needed, and keeping of the committee until the esolved. Individual will be designated as the pollow up with action plans,	F	520			

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/10/2014 / APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345174	B. WING				C 11/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILLE NURSING & REHABILITATION CENTER				91 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ACTION SHOULD BE			
F 520	Quality Assurance me Administrative staff ar need to be discussed The Administration accident/incident repor- meeting and request issues that need imm actions will be determ assessed for effective meeting. If necessary convene a meeting of Quality Assurance Co stand-up meeting to a immediate attention. If scheduled for follow-u Quality Assurance Co indication would be an capacity to cause har Any issue requiring staff will be supervise ensure 100% of all re prior to returning to w Any issue requiring to ensure 100% of all included in the audit ar is immediately remove On the weekends informed by the mana- incident/accident report to determine if an imm required to protect resonant Immediate Jeopardy w	eetings, all supervisors and re polled for any issues that at the meeting. r will review any orts in the daily stand-up staff to report any new ediate attention. Remedial ined and current plans eness in the daily stand-up , the Administrator will also relevant members of the mmittee after the daily address problems needing f indicated, issues will be up at the next scheduled ommittee meeting. One ny issue that has the m or has caused harm. Ing immediate in-servicing of d by the Administrator to levant staff are in-serviced ork. Ing immediate audits of vervised by the Administrator relevant equipment is and any defective equipment ed from access by staff. s, the Administrator will be uger on duty of any ort involving resident safety mediate plan of action is	F	520			

If continuation sheet Page 166 of 168

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/10/20 FORM APPROV OMB NO. 0938-03
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345174	B. WING		C 07/11/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
				91 VICTORIA ROAD	
ASHEVILL	E NURSING & REHABIL	LITATION CENTER		ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIC THE APPROPRIATE DATE
	expectations to check were not frayed or to position them under to they had received in- were aware of the co which indicated the co to the resident's weig a lift sling that was fra expected to give it to that he could dispose further revealed they slings that were fraye	aff revealed awareness of k lift slings to make sure they rn and how to correctly the resident. They verified service training and they lor coded binding on the lifts orrect sling to use according th. They stated if they found ayed or torn they were the Maintenance Director so e of it. Interviews with nurses were expected to place ed or worn in the locked			
	maintenance to dispo Interviews with house had attended in-servi expected to look for h slings and were expe housekeeping/laundr out a work order for r the sling and reorder Interviews with maint	noles, tears and fraying of lift ected to lock them in the y supervisors office and fill maintenance to dispose of a new replacement. enance staff revealed			
	medication rooms or supervisors office and disposal and replaced lift slings in the facility number marked on it marker and each slin corresponding number was also documentat the date of the audit a	er on the audit sheets. There tion on the audit sheets with and the condition of each			
	tears, frays or defecti sheets. Interviews w committee revealed t QA committee was to	documentation of holes, ive slings on the audit ith members of the QA hey understood the way the o function, how issues would d their individual roles in			

Facility ID: 923265

If continuation sheet Page 167 of 168

		ID HUMAN SERVICES MEDICAID SERVICES			F	TED: 12/10/2014 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345174	B. WING			C 07/11/2014
NAME OF F	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP C	CODE	
ASHEVIL	LE NURSING & REHABIL	ITATION CENTER		91 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				TION SHOULD BE	(X5) COMPLETION DATE
F 520	10	menting a plan of action,	F	520		

Facility ID: 923265

If continuation sheet Page 168 of 168