PRINTED: 03/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	345438	B. WING _		C 02/17/2017		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE	Ε		STREET ADDRESS, CITY, STATE, ZIP CODI 100 RICEVILLE ROAD ASHEVILLE, NC 28805	•		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	ision of Health Service	F 0	00			
Certification Section of investigation at the far deficient practice. Streview revealed immediate considered. In identified deficient practices	ate Agency administrative ediate jeopardy should have order to fully investigate the actice, the complaint					
combined into one su 02/07/17 and an exit #4Z8O11.	recertification surveys were urvey with a start date of date of 02/17/17. Event ID					
Resident #189 was a morning medications made the error did no responsible party or t Resident #189 was s admitted to the hospi	began on 01/25/17 when dministered Resident #181's in error and the nurse who of inform the physician, the che Director of Nursing. ubsequently sent to and tal after developing nausea					
and pulse. Immediate 02/17/17 at 2:15 PM and implemented an allegation of compliar of compliance at a low (isolated with no actumore than minimal harmonic solutions).	nce. The facility remains out wer scope and severity of D ial harm with a potential for arm that is not immediate					
and monitoring systemare effective related to medication errors and	nservices were completed ms are put into place and to timely notification of d changes in condition.					
	began on 01/25/17 when dministered Resident #181's	PE .	TITLE		(X6) DATE	

Electronically Signed 03/14/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(.	(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017		
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			100 F	EET ADDRESS, CITY, STATE, ZIP CODE RICEVILLE ROAD IEVILLE, NC 28805		02/1//2017	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR' DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 000	made the error did responsible party of nurse failed to obtain monitor the resider related to further miles was subsequente the hospital when hospital was a compliance. The facompliance at a low (isolated with no accompliance	not inform the physician, the or the Director of Nursing. The oin vital signs, assess or out's condition or seek advice edical intervention. Resident ently sent to and admitted to be developed nausea and on in his blood pressure and ecopardy was removed on facility provided and coeptable credible allegation of cility remains out of over scope and severity of Detual harm with a potential for harm that is not immediate a inservices were completed tems were put into place and ed to timely notification of assessment following a change in condition and esident.	F	000				
	2:15 PM when the implemented an accompliance. The fa	ly was removed on 02/17/17 at facility provided and ceptable credible allegation of cility remains out of						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	343430	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2017
	RELS OF SUMMIT RIDGE	<u>:</u>		1	00 RICEVILLE ROAD ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=J	more than minimal ha jeopardy) to ensure ir monitoring systems a effective related to as a medication error an identification of probled 4. 483.45 (F333) at Jammediate Jeopardy Resident #189 was a morning medications subsequently sent to when he developed in drop in his blood presidently provided and incredible allegation of remains out of complications out of complications of the immediate jeopardy) completed and monitory and are effective significant medication. On 03/10/17 an amer provided to the facility and Medicaid Service Survey Agency determined to a service of tags.	al harm with a potential for arm that is not immediate aservices are completed and re put into place and are sessing a resident following d monitoring so that timely ems can be identified. began on 01/25/17 when diministered Resident #181's in error. Resident #189 was and admitted to the hospital ausea and vomiting and a sure and pulse. Immediate ed on 02/17/17 when the implemented an acceptable compliance. The facility ance at a lower scope and with no actual harm with a niminimal harm that is not to ensure inservices are pring systems are put into the related to avoidance of a errors. Inded 2567 report was are contacted to a contacted and the State mined the scope and the State mined		157			3/21/17
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345438		B. WING		C 02/17/2017	
	ROVIDER OR SUPPLIER	<u> </u>		1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805	1 021	1772011
(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 157	consult with the resid consistent with his or representative(s) who (A) An accident involves accident involves and intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-the clinical complications (C) A need to alter trea need to discontinue treatment due to advecommence a new form (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proviphysician. (iii) The facility must a resident and the resident there is-	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or n); eatment significantly (that is, a n existing form of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment	F	157			

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>l</u>	02/11/2017	
THELAH	DEL C OF CLIMMIT DIDO	-		100 RICEVILLE ROAD			
THE LAUF	RELS OF SUMMIT RIDGE			ASHEVILLE, NC 28805			
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F 157	Continued From page	e 4	F 1	57			
	State law or regulatio (e)(10) of this section	ns as specified in paragraph					
	update the address (rephone number of the This REQUIREMENT by: Based on record revision failed to notify the phyand the Responsible and a change in concomiting and a drop in resulting in 1 of 3 san admitted to the hospital Immediate Jeopardy Resident #189 was a morning medications made the error did not responsible party or to Resident #189 was a admitted to the hospitand vomiting and a diand pulse. Immediate 02/17/17 at 2:15 PM and implemented an allegation of compliance at a low (isolated with no actumore than minimal hajeopardy) to ensure ir and monitoring systems.	began on 01/25/17 when dministered Resident #181's in error and the nurse who of inform the physician, the he Director of Nursing. Subsequently sent to and tal after developing nausea rop in his blood pressure a Jeopardy was removed on when the facility provided acceptable credible nice. The facility remains out wer scope and severity of D all harm with a potential for arm that is not immediate in-services were completed ms are put into place and of timely notification of dichanges in condition.		Preparation and/or execution of correction does not constitur admission or agreement by the the truth of the facts alleged or conclusions set forth in the state deficiencies. The plan of corresprepared and/or executed sole it is required by the provisions and State law. The facility will ensure that the physician, and the resident srepresentative are immediately when there is a significant charesident sphysical condition amedication error occurs. Nurse administered incorrect rate to resident # 189 between 8 are The affected resident was tran of the facility on 1/25/17 at 2:00 the medication error was discondinistration. The family meresident was notified of the errod DON on 1/25/17. The physician notified by the Unit Manager of 2 pm. The resident was admit hospital and has not returned the facility. The facility investigation was in	te e provider r tement of ection is ely becaus of Federa e resident, legal y informed and/or medication m-830 am asferred or 0 pm where overed by mber of the for by the ean was n 1/25/17 eted to the to the	r of f see al d e ns n. ut en ne	

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				CIVID INC	7. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345438	B. WING _			02/	17/2017
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IIIL LAGI	CEED OF COMMITT REDO	_		AS	SHEVILLE, NC 28805		
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F 157	Continued From pag	e 5	F 1	57			
		idmitted to the facility on			1/25/17 by the DON.		
		sion diagnoses included a			DON was notified at approximately 1:3	0	
		embolism, a history of deep			pm that a family member was requesting		
	vein thrombosis, pard				that guest be sent to the hospital. At the		
	bradycardia, difficulty			time DON questioned assigned nurse			
	long term anticoagula			reason for need of transfer. Nurse			
	atrophy.				notified DON that she had administered	b	
					the incorrect medication to the guest		
		imum Data Set, a 5 day			during morning medication pass. DON		
	dated 01/27/17, note			questioned nurse regarding her			
	he was understood a			notification to the physician and family			
	_	were not assessed, he had guired extensive assistance			member to which she responded No, I should have. Nurse interviewed by DO	NI	
	· ·	nsfers, dressing, toileting,			on 1/25/17. Nurse was immediately ta		
	_	noted to have taken 6 days			off of assignment and terminated base		
		days of diuretic and received			on failure to notify Physician, family	-	
	Occupational and Ph				member and DON. The facility		
	•	,			investigation was concluded the same	day	
	Review of physician	orders included the following			on 1/25/17 and POC was initiated.	-	
	morning medications	ordered for Resident #189:					
		00 Milligrams (mg) at 8 AM -			The incident was reported to the NC		
	an antiarrhythmic ago				Board of Nursing according to the		
		xtended release 120 mg at 8			disciplinary tree. Their investigation wa		
	-	stolic less than 110 mmHg			assigned to a complaint officer with the	!	
	·) and diastolic less than 60			North Carolina Board of Nursing. This		
	mmHg - for hyperten *Lasix 20 mg at 8 AM				report was made by DON on 2/7/17.		
		grams per day at 8 AM - for			All residents have the potential to be		
	constipation;	grains per day at 0 AWI - 101			affected. On the date of occurrence all		
		icrograms (mcg) at 6 AM -			alert and oriented residents were		
	for thyroid; and				interviewed to determine if any had		
	_	mg/3 ml solution four times			received incorrect medications. No oth	er	
		ordered 01/25/17 - for			issues were identified. On the date of		
	breathing.				occurrence all residents who were not		
					alert and oriented were observed for		
		nt report dated 01/25/17 at			changes in condition through direct		
		189 received a medication			observation and review of medical reco		
		sea and vomiting and			by DON. The audit results were report	ed	
	hypotension. It was	determined that Resident			to the Medical Director. All residents		

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		345438	B. WING				○ /17/2017
NAME OF P	ROVIDER OR SUPPLIER	1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	
		_		10	00 RICEVILLE ROAD		
THE LAUF	THE LAURELS OF SUMMIT RIDGE			Α	SHEVILLE, NC 28805		
(X4) ID PREFIX			ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	√TE	DATE
F 157	Continued From page	e 6	F	157			
	#189 received his roo	ommate's 8 AM medications			observed in the audit had no issues		
	in error.				identified and Medical Director notified		
					the Director of Nursing (DON) on 1/25/		
		#189's roommate's (Resident			The physician and the Responsible Pa	rty	
	· ·	d the roommate's first and			were notified immediately by Nursing		
		re the same as Resident			Administration upon notification of the	4	
	#189's initials. Review of the picture in the computerized medical record system revealed the				medication issue. The resident was se		
	two residents were of different races and had an				for hospital evaluation and treatment, a was discharged from the hospital	iriu	
	age difference of 31 years.				successfully.		
	age difference of of	years.			All licensed nurses were in-serviced by	,	
	Resident #181 was a	admitted to the facility on			the facility Pharmacist on 2/15/17 on the		
		ses including injury of C4			following: 1. Responsibility of reporting		
	cervical spine. Resid				med errors to the physician at the time		
		Resident #189 included:			knowledge of an occurrence of		
	*Amlodipine Besylate	e 10mg at 8 AM for			medication error in order to determine		
	hypertension;				what monitoring and assessment need	s to	
	*Coreg 25mg for hyp				be initiated. 2. Definition of medication	i	
		at 8 AM for depression;			errors. 3. The 6 rights of medication page	ass	
	_	M for urinary retention;			which include right individual, right		
		al spray at 8 AM for sinus			medication, right dose, right time, right		
	congestion:				route and right documentation. 4. The		
		ml subcutaneous at 8 AM for			notification of family/responsible party.	All	
	anticoagulation thera *Multivitamin/mineral				licensed nurses were in-serviced on 2/15/17 by the DON and Regional QA		
	*Senna S 2 tabs at 8	•			Manager.		
		our times a day, first at 8 AM			iviariager.		
	for urinary discomfort				At Clinical Meetings conducted each		
	*Vitamin D3 1000 un	•			weekday, the following will be reviewed	d bv	
					Administrative Nurse Team: a. Physic	-	
	The only nursing note	e in the medical record which			Orders to identify changes, b. Incident		
	related to the medication error was written				Reports, c. Nurse 24 hour reports, d.		
	Director of Nursing o	n 01/25/17 at 2:00 PM. The			Chart reviews.		
		ent had nausea and vomiting					
		ood pressure was 80/60,			Chart audits will be conducted by Nurs		
		e 61, temperature 97.3			Administration Team at 10% weekly for	· 4	
		and oxygen saturation was			weeks then Monthly thereafter.		
		was contacted and an order			Results of all audits will be reviewed by		
	was given to send his	m to the emergency room for			the Director of Mursing Any variance	5	1

C 02/17/2017
(X5) COMPLETIO DATE

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	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	<u> </u>	02/11/2011	
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F 157	The hospital discharg stated Resident #189 observation status se and hypotension from His bradycardia and hespite IV hydration a medications. Plans we following day, however the resident becoming and confused, the resident becoming and confused, the resident protocol. Review of the Employ revealed Nurse #3, we error related to Resid 01/25/17 for "making magnitude which may and welfare." Additionerror occurred at apper AM and the nurse fail Nursing (DON), Phys became aware of the PM. The Responsible Part phone on 02/07/17 at she arrived at the fact to visit Resident #189 throwing up, with a gridrooling. She stated happened and was to administered wrong in the DON came to the	in the hospital until nursing facility on 01/30/17. e summary dated 01/30/17 was initially admitted for condary to his bradycardia the medication misuse. The medication continued and holding additional were for discharge the er on 01/27/17 secondary to gwas somewhat agitated sident was started on the wee Disciplinary Record ho made the medication ent #189 was terminated on errors of sufficient geopardize resident safety nal notes indicated the med roximately 8:30 AM to 9:00 ed to notify the Director of ician or family. The DON error at approximately 1:30 ty (RP) was interviewed via 10:27 AM. She related that fility on 01/25/17 at 1:00 PM is She observed the resident rey colored face and she asked the nurse what old the nurse had medication. The RP stated room quickly confirming the error stated she insisted he	F 15	57			

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	345438	B. WING			02/17/2017		
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at 9:09 AM. Nurse # normal busy day. Shinterruptions from the per usual. She stated Resident #189 a coustated the roommate before. She stated a Resident #189 the wrealized it "immediate that she had spoken times that morning renew order for a nebuseveral other resider inform the physician stated she intended the medication error resident. She stated Resident #189 he wallunch he started vom informed the DON are ror when Resident stated that by the timfamily of the medicate with Resident #189 a Resident #189 a Resident #189's phy 02/15/17 at 11:36 AM was in the building the informed of any medial already left the facilities Nurse #2 notified him not Nurse #3. He state informed and would monitor vital signs madjust dosages of up On 02/15/17 at 12:13	ewed via phone on 02/15/17 3 stated on 01/25/17 it was a ne stated there were multiple erapy during medication pass d she had worked with ple of times before. She had been admitted the day as soon as she gave rong medications, she ely, immediately." She stated to the physician several elating to Resident #189's dizer treatment and related to nts but never thought to of the medication error. She to call the physician about but got busy with another the next time she saw as with therapy and then after niting. She stated that she nd physician about the med #189 got ill. Nurse #3 further ne she went to inform the ion error the family had left	F	157				

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F 157	resident sent to the hat the unit immediately was going on. It was the DON she had give roommate's morning stated she had not an physician or the respectation error. Do employment that day Upon follow up interved 2/16/17 at 1:36 PM expectation that a nuerror would have reprimmediately and the making an initial assecontact the physician The DON stated that notified and the nurs resident's status and responsible party she The facility provided allegation of compliant as follows: Credible Allegation of F157 The facility will ensurand resident's legal in the surand resident's legal in	consible party wanted the cospital. The DON went to and asked Nurse #3 what is then that Nurse #3 informed ren Resident #189, his medications. Nurse #3 then obtified the DON, the consible party of the DN terminated Nurse #3's rew with the DON on the she revealed was her after taking vital signs and ressment the nurse would be for additional guidance. The once the physician was regathered information of the subsequent orders, the bould be notified. The porate nurse and the facility were informed of on 02/15/17 at 2:38 PM. The porate nurse and the facility were informed of on 02/15/17 at 2:38 PM. The porate nurse and the facility were informed of on 02/15/17 at 1:20 PM. The porate of Compliance are that the resident, physician are the properties.	F1	57			

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F 157	or medication error or Nurse administered in resident #189 between to notify the physician. The affected resident facility on 1/25/17 at 2 medication error was administration. The fawas notified of the error the physician was not not 1/25/17 at 2 pm. It the hospital and has the hospital and has the DON. Facility Investigation DON notified at apprefamily member was resident.	nt's physical condition and / ccurs. ncorrect medications to en 8am-830am. Nurse failed in and family member. was transferred out of the 2:00 pm when the	F	157			
	assigned nurse reason Nurse notified DON to the incorrect medicate morning medication processed from the incorrect medicate morning medication processed from the incorrect medication processed from the incorrect motified processed from the incorrect motified from the incorrect medication processed from the incorrect motified from the incore	on for need of transfer. that she had administered ion to the guest during bass. DON questioned notification to physician and ich she responded, "No, I interviewed by DON on immediately taken off of inated based on failure to ally member and DON. The was concluded same day					

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F 157	reported to the NC Botheir disciplinary trees assigned to a complate Carolina Board of Nut DON on 02/07/17. The licensed nurse in immediately. The incomplete NC Board of Nursing assigned to NCBON All residents have the On the date of occurrous residents were intervited received incorrect issues were identified all residents who were observed for changes observation and revied DON. The audit resumption of the date of occurrous were identified all residents who were observed for changes observation and revied DON. The audit resumption of the date of occurrous were identified all residents who were observed for changes observation and revied DON. The audit resumption of the date of	courrence. The incident was pard of Nursing according to a Their investigation was int officer with the North resing. Report made by the avolved was terminated eident was reported to the and the investigation was Complaint Officer. The potential to be affected and oriented ewed to determine if any at medications. No other and alert and oriented were an alert and oriented were and oriented were an alert and oriented were and oriented were and oriented were an alert and oriented were and orient	F 1	57				
		as notified but not timely. All s were held-other issues						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345438	B. WING _			02/	17/2017
	ROVIDER OR SUPPLIER RELS OF SUMMIT RIDGE	:		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 157	manner. Guest was of appeared ok- then was called when he had is a lin servicing. All licensed nurses were pharmacist on 2/15/1 Responsibility of report physician at the time occurrence of medical determine what monit needs to be initiated. errors. 3. The 6 right include right individual dose, right time, right documentation. 4. The family/responsible parall licensed nurses we by DON and Regional prohibition of cell pholoadministration.	ere in-serviced by the facility 7 on the following. 1. writing med errors to the of knowledge of an ition error in order to toring and assessment 2. Definition of medication its of medication pass which al, right medication, right route and right the notification of rty. ere in-serviced on 2/15/17	F	1157			
F 224	2:15 PM when intervious they had been in-servitake to ensure the DC responsible party wer errors immediately ar condition.	ews with nurses confirmed viced and knew the steps to DN, physician and enotified of medication and subsequent changes in	F	224			3/21/17
SS=J	MISTREATMENT/NE §483.12 The resident	GLECT/MISAPPROPRIATN has the right to be free from oppropriation of resident	F 2				VIZ 11 1 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 02/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	02/1//2017
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 224	subpart. This include freedom from corpor seclusion and any photor required to treat and the seclusion and any photor required to treat and the seclusion and any photor required to treat and the seclusion and any photor required to treat and the seclusion of resider resident property, (b)(1) Prohibit and prexploitation of resider resident property, (b)(2) Establish policitation investigate any such and the seclusion investigate any such and the seclusion investigate any such and the seclusion interview and facility failed to obtain following a medication reviewed for medical resident's physician, responsible party of resident receiving the was not made until 1 developed nausea and gave the wrong med any assessment of the seclusion and the seclusion in the seclusion and the	ation as defined in this s but is not limited to al punishment, involuntary hysical or chemical restraint the resident's symptoms. must develop and licies and procedures that: event abuse, neglect, and ints and misappropriation of	F 25	The facility will ensure that the resic provided with services necessary to physical harm by reporting a signific medication error at the time of occur or when knowledge of a significant medication error has occurred by not the physician for direction of interve and monitoring as appropriate. The affected resident was transferred of the facility on 1/25/17 at 2:00 pm the medication error was discovered administration. The family member resident was notified of the error by DON on 1/25/17. The physician was notified by the Unit Manager on 1/25/2 pm. The resident was admitted to hospital and has not returned to the facility.	avoid cant rrence otifying ntions ed out when d by of the the s 5/17 at o the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			l ,	С	
		345438	B. WING			1) 17/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	1772017	
				10	00 RICEVILLE ROAD			
THE LAUF	RELS OF SUMMIT RIDGE	i			SHEVILLE, NC 28805			
(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 TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 224	Continued From page	e 15	F	224				
	· -	he Director of Nursing. The						
	nurse failed to obtain	•			The facility investigation was initiated o	n		
		condition or seek advice			1/25/17 by the DON.			
	related to further med	lical intervention. Resident			DON notified at approximately 1:30 pm	1		
	#189 was subsequen	tly sent to and admitted to			that a family member was requesting tl	nat		
		developed nausea and			guest by sent to the hospital. At that til	me		
		n his blood pressure and			DON questioned assigned nurse reaso	'n		
		pardy was removed on			for need of transfer. Nurse notified DC			
	02/17/17 when the fa	* ·			that she had administered the incorrec			
		ptable credible allegation of			medication to the guest during morning	•		
	compliance. The facil				medication pass. DON questioned nur			
		r scope and severity of D al harm with a potential for			regarding her notification to the physici and family member to which she	an		
		arm that is not immediate			responded No, I should have. Nurse			
		nservices were completed			interviewed by DON on 1/25/17. Nurse	ے		
		ns were put into place and			was immediately taken off of assignme			
		to timely notification of			and terminated based on failure to noti			
	medication errors, as	<u> </u>			Physician, family member and DON. T	-		
		nange in condition and			facility investigation was concluded the			
	monitoring of the resi	dent.			same day on 1/25/17 and POC was			
					initiated.			
	The findings included	:			The incident was reported to the NC			
					Board of Nursing according to the			
		dmitted to the facility on			disciplinary tree. Their investigation wa			
		sion diagnoses included a			assigned to a complaint officer with the			
	vein thrombosis, parc	embolism, a history of deep			North Carolina Board of Nursing. This report was made by DON on 2/7/17.			
	· ·	walking, atrial fibrillation,						
		int use, muscle wasting and			All residents have the potential to be			
	atrophy.	int doc, mascie wasting and			affected. On the date of occurrence all			
	a opy.				alert and oriented residents were			
	The most recent Mini	mum Data Set, a 5 day			interviewed to determine if any had			
		d he had adequate hearing,			received incorrect medications. No oth	ier		
	he was understood a				issues were identified. On the date of			
	_	vere not assessed, he had			occurrence all residents who were not			
		quired extensive assistance			alert and oriented were observed for			
		nsfers, dressing, toileting,			changes in condition through direct			
		noted to have taken 6 days			observation and review of medical reco			
	of anticoagulants, 7 d	avs of diuretic and received			by DON. The audit results were report	ed		

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		345438	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	0.000		STREET ADDRESS, CITY, STATE, ZIP CODE	U.	2/17/2017
				100 RICEVILLE ROAD		
THE LAUF	RELS OF SUMMIT RIDGE			ASHEVILLE, NC 28805		
(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 SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	Continued From page		F 22			
	morning medications *Amiodarone HCL 20 an antiarrhythmic age *Diltiazem 24 hour Ex AM to be held for sys (milliliters of Mercury) mmHg - for hypertens *Lasix 20 mg at 8 AM *Miralax powder 17 g constipation; *Levothyroxine 25 mg	orders included the following ordered for Resident #189: 0 Milligrams (mg) at 8 AM - ent; stended release 120 mg at 8 tolic less than 110 mmHg and diastolic less than 60 sion and angina; I - a diuretic; rams per day at 8 AM - for eg at 6 AM - for thyroid; and 6/3 ml solution four times a		to the Medical Director. All residents with conditions being given indicated that they were a any medications being given indication of policies and well cared for and not neglect as exidence change in condition. On 2/15/17 all residents having potential to be affected were againterviewed. Alert and oriented did not indicate that they were a any medications being given income and well cared for and not negle residents with cognitive issues were noted that would be medication issues.	notified by no 1/25/17. We no ed by no the ain residents laware of correctly ected. All were No	
	1:30 PM, Resident #1 error resulting in naus hypotension. It was of #189 received his room in error. Review of Resident #189 revealed, the roommalast name initials were well as the management of the residents were of age difference of 31 years. Resident #181 was a 01/24/17 with diagnost cervical spine. Resident #20 provides the resident was a 01/24/17 with diagnost cervical spine.	determined that Resident ommate's 8 AM medications 2189's roommate's record ate Resident #181's first and the the same as Resident who of the picture in the all record system revealed the frifferent races and had an avears. I dmitted to the facility on the ses including injury of C4 the sent #181's morning Resident #189 included:		All licensed nurses were reeduce the Director of Nursing on negle specific emphasis involving mederrors and appropriate response 2/17/17 or prior to their next sch shift. All licensed nurses were in by the facility Pharmacist on 2/1 the following: Responsibility of reporting medethe physician at the time of known an occurrence of medication errors to determine what monitoring are assessment needs to be initiate Definition of medication errors. rights of medication pass which right individual, right medication dose, right time, right route and documentation. 4. The notificating family/responsible party.	ect, with dication es on eeduled n-serviced 5/17 on errors to wledge of or in order ad d. 2. 3. The 6 include , right right ion of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING_			1	C 17/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 02/	1772017
				100 R	ICEVILLE ROAD		
THE LAUF	RELS OF SUMMIT RIDGE	i		ASHE	EVILLE, NC 28805		
(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 224	Continued From page	e 17	F 2	224			
Γ 224	*Coreg 25mg for hyper *Escitalopram 20 mg *Flomax 0.4mg at 8Al *Flonase 0.05 % nasa congestion: *Lovenox 40 mg/0.4 ranticoagulation theral *Multivitamin/mineral *Senna S 2 tabs at 8 *Urecholine 50mg For for urinary discomfort *Vitamin D3 1000 uni The Occupational The 1:21 PM stated Residus suffer from vomiting thatter cleaning up from skills and nursing was The only nursing note related to the medical Director of Nursing or note stated the reside and hypotension. Bloom respirations 20, pulsed degrees Fahrenheit and 95%. The physician was given to send him evaluation and treatment to be at bedside. Review of the undate revealed Resident #1 medications. His vita temperature 97.3 Fahrminute, respiration rail	ertension; at 8 AM for depression; M for urinary retention; al spray at 8 AM for sinus ml subcutaneous at 8 AM for op; at 8 AM; AM for constipation; ur times a day, first at 8 AM .; and t at 8 AM. erapy note of 01/25/17 at lent #189 was noted to his date. Treatment ended a activities of daily living a notified. e in the medical record which tion error was written by the no1/25/17 at 2:00 PM. The ent had nausea and vomiting and pressure was 80/60, 61, temperature 97.3 and oxygen saturation was was contacted and an order in to the emergency room for itent. The family was noted d hospital transfer sheet 89 received the wrong		th A m el re R m al da w in al R sa th A A tiil ta re Q	the following will be reviewed by dministrative Nurse Team in order to conitor any change of condition or metrors: a. Physician Orders, b. Incider eports, c. Nurse 24 hour reports, d. Cheview. In addition, compliance will be conitored thru daily management round guest satisfaction interviews of 10° aily 5 x a week for 4 weeks and randoreekly thereafter. There will be namediate follow up for any concerns ddressed. Results of all audits and customer atisfaction interviews will be reviewed be Director of Nursing OR Administration variances will be addressed at the me identified and appropriate action also if needed. All findings will be exported by the Director of Nursing to the Committee monthly. Additional ducation and training provided for any lentified issues.	nt nart e dds % om	
	Emergency Medical S	Services (EMS) responded					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345438	B. WING			C 2/17/2017	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		271772017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 224	01/25/17. Review of that staff reported Re and his blood pressure noted he was awake mucus membranes a right after taking that 0.5 mg atropine was and heart rate increa at 2:07 PM to 103/65 PM. Review of the hospit 01/25/17 revealed he with a 1 day history as hypotension and I was accidentally give resident's medication Citalopram, Lovenox and Urecholine. The some mild nausea at blood pressure was in the 40s. He was gand once in the eme pressure was noted dosed with another of He was started on in blood pressures imprange with a heart ra Resident #189 staye discharge to another. The hospital discharge revealed Resident #1 medication misadmir bradycardia and hyp indicated that his bracontinued despite trees.	the EMS report revealed esident #189 was vomiting are was 75 systolic. EMS, slow to respond, had pale and stated he just didn't feel handful of pills this morning. given and his blood pressure used from 77/49 and 42 pulse with a pulse of 59 at 2:13 all history and physical dated as presented to the hospital of generalized malaise as well bradycardia. Resident #189 and doses of another including Coreg, as Flomax, Flonase, Senokot are resident was noted to have and nonbloody vomiting, his as 15/58 and his heart rate was given 0.5 mg atropine in route regency department, the blood to drop to 70/50 and was alose of 0.5mg of atropine. It are the travenous hydration and his roved to the 100-110 systolic the currently around 57-59. In the hospital until nursing facility on 01/30/17. The summary dated 01/30/17 are summary dated on the summary department. The summary department and hypotension	F 22	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	1	02/17/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 224	agitated and confus the delirium protocl. Review of the Empl revealed Nurse #3, error related to Res 01/25/17 for "makin magnitude which mand welfare." Addit error occurred at ap AM and the nurse fi. Nursing (DON), Phybecame aware of the PM. Nurse #3 was internat 9:09 AM. Nurse normal busy day. Sinterruptions from the per usual. It was he days off and she was the night before. Since Resident #189 a constated the roommat before. She stated Resident #189 the realized it "immedia"	d due to him being somewhat hed and the hospital started on oyee Disciplinary Record who made the medication ident #189 was terminated on g errors of sufficient ay jeopardize resident safety ional notes indicated the med oproximately 8:30 AM to 9:00 hailed to notify the Director of original or family. The DON he error at approximately 1:30 hie erro	F 23	,			
	medication error bu resident. She furth to the physican sev relating to Resident nebulizer treatment residents but never physician of the me time she saw Resid and then after lunch	the physician about the t got busy with another er stated that she had spoken eral times that morning #189's new order for a and related to several other thought to inform the d error. She stated the next ent #189 he was with therapy in he started vomiting. She staff took his blood pressure					

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345438	B. WING		C 02/17/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	02/11/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 224	stated that she info about the med error On 02/15/17 at 10: conducted with the who worked with Rough The OT stated he wresident and found in vomit. He stated cleaned up and he was described by the verbal than his usual understand him. O "a good bit" and he assistance to transfulfferent. Resident #189's ph 02/15/17 at 11:36 A was in the building informed of any me already left the facil was a different nurshim of the medication.	but she was not sure. She rmed the DON and physician r when Resident #189 got ill. 14 AM an interview was occupational Therapist (OT) esident #189 on 01/25/17. If yent in to work with the him in the bathroom covered he and the nurse aide got him womited again. Resident #189 ne OT as awake but much less	F 22				
	Adjust dosages of under Nurse Aide (NA) #1 at 8:26 AM. NA #1 with Resident #189 #189 was not able to this usual. He was commode which she stated that she Resident #189 vom took his blood press	medication error and possibly approximate medications. was interviewed on 02/15/17 stated she routinely worked and on 01/25/17 Resident to stand and do for himself per unable to get himself off the e said was different for him. Informed Nurse #3 of iting and believed the nurse sure. NA #1 stated she did not A few minutes after she and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345438	B. WING			C)2/17/2017		
	ROVIDER OR SUPPLIER	I ≣		STREET ADDRESS, CITY, STATE, ZIP COL 100 RICEVILLE ROAD ASHEVILLE, NC 28805		211112011		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 224	#189's responsible pashe thought he had to #189 throughout the was informed and Resident #189's responsible was informed and Resident #189's responsible was informed and Resident #189's responsible was going on work that was going on work that Nurse #3 in given Resident #189, medications. Nurse #3 notified the DON, the party of the medication Nurse #3's employmed On 02/15/17 at 3:19 if 01/25/17 nurse aides she could help get Resident #189 at a looking a nebulizer treatment print out the Medication that hospital. It was a informed Nurse #2 are administered the wrostated she never enter Resident #189 as she paperwork. Nurse #2 inform him of the medication cart for On 02/16/17 at 8:38 and owned the pharmacy	arty came in mentioned that arty came in mentioned that aken a turn for the worse. NA ticed a change in Resident morning. By PM the DON stated that bund 1:00 to 1:30 PM that consible party wanted the ospital. The DON stated she the unit and asked Nurse #3 ith Resident #189 and it was formed the DON she had his roommates morning #3 then stated she had not a physician or the responsible on error. DON terminated ent that day. PM Nurse #2 stated that on approached her to ask if esident #189 ready to ital. She went to the hall and ing for equipment to give him it. Nurse #2 proceeded to on Administration Record for after that that Nurse #3 and the DON that she ing medications. Nurse #2 ered the room to assess a was only helping with the then called the physician to dication error and the to the hospital and took over	F 22	24				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017	
NAME OF D	DOVIDED OD CUIDDUED	343430	D: Wilte		TREET ADDRESS CITY STATE ZID CODE	02/	17/2017
	ROVIDER OR SUPPLIER RELS OF SUMMIT RIDGE	:		1	TREET ADDRESS, CITY, STATE, ZIP CODE OO RICEVILLE ROAD ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 224	Resident #189 received the medications he we that some of the medicatually received the similar to his own. He Urecholine may have the addition of coregistabsolutely affected. The facility DON, corpadministrator of a sist Immediate Jeopardy. The facility provided a allegation of compliant as follows: Credible Allegation of The facility will ensure provided with services physical harm by reported the provided with services physical harm by reported the provided with services physical harm by reported the physic	ed and compared them to as ordered. He revealed ications Resident #189 morning of 01/25/17 were further stated the made him nauseous and and lasix would have his blood pressure. Dorate nurse and er facility were informed of on 02/15/17 at 2:38 PM. An acceptable credible nice on 02/16/17 at 2:32 PM Compliance That each resident is a necessary to avoid orting a significant e time of occurrence or significant medication error lying the physician for ons and monitoring as Incorrect medications to an 8am-830am. Nurse failed and family member. The symmotion the resident upon cation error and failed to between the time of error	F	224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING			l	C 17/2017
	ROVIDER OR SUPPLIER	<u> </u>		10	REET ADDRESS, CITY, STATE, ZIP CODE RICEVILLE ROAD SHEVILLE, NC 28805	, <u> </u>	1172011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	on 1/25/17 at 2:00pm was discovered by ac Nursing notified the fa 130-145pm. Unit Mar order to transfer resid The resident was adr not returned to the fa	ransferred out of the facility when the medication error dministration. Director of amily member at approx. hager notified physician and dent to hospital received. hitted to the hospital and has	F	2224			
	Facility Investigation The Director of Nursing (DON) was notified at approximately 1:30pm that a family member was requesting that the resident be sent to the hospital. At that time the DON questioned the assigned nurse regarding the reason for the need to transfer the resident to the hospital. The nurse notified the DON that she had administered the incorrect medication to the resident during morning medication pass. The DON questioned the nurse regarding her notification of physician and family member to which she responded, "No, I should have." Nurse interviewed by DON on 01/25/17. Nurse was immediately taken off of assignment and terminated based on failure to notify Physician, family member and DON. The facility investigation was concluded the same day 01/25/17 and POC (Plan of Correction) was initiated. The licensed nurse involved was terminated immediately due to not reporting the medication error at the time of occurrence. The incident was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C	
		345438	B. WING			02/17/2017
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 224	assigned to a comp Carolina Board of N DON on 02/07/17. All residents who re potential to be affect occurrence (1/25/17 residents were inter determine if any had medications. No oth the date of occurrent	e. Their investigation was laint officer with the North ursing. Report made by the ceive medications have the ted. On the date of all alert and oriented viewed by the DON to	F 22	24		
	and review of medic results were reporte other residents obseneglect as evidence On 2/15/17 all resid affected were again residents did not incany medications bei residents with cogni	a through direct observation ral records. These audit d to the Medical Director. All reved gave no indication of d by no change of condition. The reviewed is a potential to be reviewed. Alert and oriented licate that they were aware of ng given incorrectly. All tive issues were reassessed No issues were noted that				
	would be related to Root Cause Analysi The nurse failed to pon resident #189 us gather baseline data occurred. The nurse failed to perror that would have direct staff on monit	medication issues.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CO 100 RICEVILLE ROAD ASHEVILLE, NC 28805	DE	02/11/2011
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F 224	of guest's medication with another guest or distracting me from manner. Guest was appeared ok- then wordled when he had in the servicing. All licensed nurses worden the Six Rights of and the prohibition of medication administration administration through the servicing. All licensed nurses we facility's Pharmacist 1. Responsibility of rephysician at the time occurrence of medicatermine what more needs to be initiated errors which is "Any medication use proceedication pass which are the service of the service o	ras notified but not timely. All his were held-other issues courred just afterward reporting this error in timely observed at lunch and ras assessed and MD was issues." I were in-serviced by the DON Medication Administration for cell phone use during ration between February 5th evere in serviced by the on 2/15/17 on the following: reporting med errors to the enditoring and assessment ation error in order to itoring and assessment ation error that occurs in the ress." 2. Definition of medication remover that occurs in the ress." 3. The 6 rights of ch included documentation. If family/responsible party. 2. A Nurse in-serviced all 2/15/17 on the prohibition of genedication administration. Will be re-educated by the DON) on neglect, with volving medication errors and reson 02/17/17 or prior to	F 2	224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		02/1//2017
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 224	Continued From page	e 26	F 2	24		
	will include. 1. Resperiors to the physicial knowledge of an occi in order to determine assessment needs to medication errors whim the medication use of medication pass wright medication, right and right documentation family/responsibility passive.	what monitoring and be initiated. 2. Definition of ich is "Any error that occurs process." 3. The 6 right which include right individual, t dose, right time, right route tion. 4. The notification of party. 5. Neglect, with volving medication errors and				
F 253 SS=D	2:15 PM when intervithey had been inservitake to ensure the coadministered to the rimedication errors imministered. The nurses physician and follow assessing and monitored condition. Nurse interinserviced on docum what constituted neg failure to intervene an intervention. 483.10(i)(2) HOUSERSERVICES (i)(2) Housekeeping as	knew to then inform the any further instructions for	F 2	53		3/21/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017	
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP CO 100 RICEVILLE ROAD ASHEVILLE, NC 28805	ODE	02/1//2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 253	by: Based on observation facility failed to keep resident rooms, room resident halls and fail clean and free of state commodes in 5 of 21 205, 206, 208 and 20 The findings included 1. Observations of rook AM, 02/14/17 at 1:20 02/16/17 at 8:34 AM revealed the bathrook brown/black gummy addition the area arowas stained and rust An interview conduct with the Housekeepin her expectation for the trash, dust the sutoilet all way down to mop the room and bafurther stated that she bathroom floor was scommode was stained be cleaned. 2. Observations of rook AM, 02/14/17 at 1:25 02/16/17 at 8:44 AM revealed the bathroom	ons and staff interviews the the walls clean in 2 of 21 as 206 and 208 on 1 of 2 led to keep bathroom floors ins around the base of the resident rooms, rooms 201, 29 on 1 of 2 resident halls. It is 206 and 208 on 1 of 2 led to keep bathroom 201, 29 on 1 of 2 resident halls. It is 206 and 208 on 1 of 2 led to keep bathrooms 201, 29 on 1 of 2 resident halls. It is 207 at 8:48 AM and 02/17/17 at 8:48 AM and 02/17/17 at 8:48 AM areas on the floor. In und the base of the toilet by and the base of the toilet by and seep and athroom every day. She is was in agreement that the atticky and the base of the ed and rusty and needed to 205 on 02/13/17 at 10:15 and 205 on 02/13/17 at 8:58 AM and 02/17/17 at 8:58 AM and 12/17/17 at 8:58 AM and 12/17/17 at 8:58 AM and 16/17/17 at 8:58 AM and 16/17/17/17 at 8:58 AM and 16/17/17/17 at 8:58 AM and 16/17/17/17/17/17/17/17/17/17/17/17/17/17/	F 2		provide ance services nitary, orderly d 208 have ms 201, 205, en stripped of orations on the odes. potential to be een inspected by Any dirty soiled ned upon ing services ional on facility \(\text{'s} \) sations on ain a sanitary, terior. ing Services staff in regards g services to y, and		
	brown/black gummy addition the area aro was stained and rust	und the base of the toilet		A QA Environmental monitor lists all areas of room and be utilized to ensure ongoin	oathroom, will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
			7. BOILDING			С	
		345438	B. WING _			02/17/2017	
	ROVIDER OR SUPPLIER	E	•	STREET ADDRESS, CITY, STATE, ZIP COD 100 RICEVILLE ROAD ASHEVILLE, NC 28805	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETION DATE	
F 253	with the Housekeepin her expectation for the trash, dust the su toilet all way down to mop the room and bathroom floor was scommode was stained be cleaned. 3. Observations of roam AM, 02/14/17 at 1:35 02/16/17 at 8:49 AM revealed the bathrood brown/black gummy area around the base and rusty. In addition stained with what approximate a with the Housekeepin her expectation for the trash, dust the sutoilet all way down to the room and bathroos stains off the walls in stated that she was in bathroom floor was scommode was stained behind bed B needed. 4. Observations of roam AM, 02/14/17 at 1:40 02/16/17 at 8:59 AM revealed the bathrood brown/black gummy	area on 02/17/17 at 8:58 AM ang Supervisor revealed it was the housekeepers to empty arfaces of the room, clean the to the floor and sweep and the throom every day. She the was in agreement that the the did and rusty and needed to area on 02/13/17 10:20 area on 02/15/17 at 8:38 AM, and 02/17/17 at 9:04 AM areas on the floor and the the of the toilet was stained area, the wall behind bed B was area on the floor and the the of the toilet was stained area on the floor and the the of the toilet was stained area on the floor and the the of the toilet was stained area on the floor and the the of the toilet was stained area on the floor and the the of the toilet was stained area on the floor and the the of the toilet was stained area on the floor and the the toilet was stained area on the floor and the the toilet was stained area on the floor and the the toilet was stained area on the floor and the the down of the floor, sweep and mop	F 2	with cleanliness by the Direct Housekeeping or Administrate Manager for room rounds. 5 be inspected daily x 5 days for Director of Housekeeping or A using the QA monitoring tool. Housekeeping Director will sy inspect at least 3 rooms week ongoing basis to ensure ongo compliance. Any issues at the be corrected at the time of instanditional training to be provided indicated. Inspection results will be mon QA committee quarterly to encompliance.	or or QA rooms will or 1 week by Administrator Then restematically kly on an oing at time will spection and ded as		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	345438 B. WIN		B. WING			C 02/47/2047	
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805			
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F 253	Continued From page	· 29	F 2	53			
		the wall behind bed A was eared to be brown coffee					
	with the Housekeepin her expectation for the trash, dust the surtoilet all way down to the room and bathrood stains off the walls in stated that she was in bathroom floor was stommode was staine behind bed A needed 5. Observations of rood AM, 02/14/17 at 1:45 02/16/17 at 9:05 AM arevealed the bathroom brown/black gummy addition the area around the trask of the surface of the sur	icky and the base of the d and rusty and the wall to be cleaned. om 209 on 02/13/17 at 10:30 PM, 02/15/17 at 8:50 AM, and 02/17/17 at 9:14 AM in floor to be sticky with dark areas on the floor. In and the base of the toilet					
	with the Housekeepin her expectation for th the trash, dust the sui toilet all way down to mop the room and ba further stated that she bathroom floor was st	ed on 02/17/17 at 9:14 AM g Supervisor revealed it was e housekeepers to empty rfaces of the room, clean the the floor and sweep and throom every day. She e was in agreement that the cicky and the base of the d and rusty and needed to					
F 272 SS=D	483.20(b)(1) COMPR ASSESSMENTS	EHENSIVE	F 2	72		3/21/17	
	(b) Comprehensive A	ssessments					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345438	B. WING _		0	2/17/2017	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272	Continued From page	30	F 2	72			
	must make a comprete resident's needs, stree preferences, using the instrument (RAI) special assessment must include (ii) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behav (vii) Psychological we (viii) Physical fund problems. (ix) Continence. (x) Disease diagnosi (xi) Dental and nutriti (xii) Skin Conditions. (xiii) Activity pursu (xiv) Medications. (xv) Special treatmen (xvi) Discharge ple (xvii) Documentati regarding the addition on the care areas of the Minimum Data (xviii) Documentati assessment. The assinclude direct observation the resident, as well a licensed and	demographic information re. s. derographic information re. s. dior patterns. ell-being. ctioning and structural is and health conditions. onal status. uit. ts and procedures. anning. ion of summary information real assessment performed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 02/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD		2/11/2011
THE ! ALIE	DELO OF CUMMIT DID	n=		100 RICEVILLE ROAD		
THE LAUF	RELS OF SUMMIT RID	3E		ASHEVILLE, NC 28805		
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F 272	Continued From pa	ge 31	F 2	72		
	observation and co	ocess must include direct mmunication with the resident, ication with licensed and				
	shifts.	care staff members on all				
	by:					
Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for psychotropic drug use and nutrition for 2 of 16 sampled residents (Resident			The facility will continue to co Area Assessments for resider triggered by the MDS.			
	#75 and #104).	oumpied redidente (redident		Resident #75 The Care Area of for Psychotropic Drug Use wa		
	The findings include	ed:		to summarize how the psycho medications affected Residen	it #75'⊡s day	
		s admitted to the facility on oses of heart failure, anxiety		to day function and activities. Area Assessment summary w completed to indicate if there	/ill be	
	Review of the signif	icant change Minimum Data		any adverse drug reactions or dose reductions.		
	was cognitively inta	5/16/16 revealed Resident #75 ct and received antianxiety medications daily during the		Resident #104 The Care Area Assessment for Nutrition was to summarize and analyze ho mechanically altered and ther	completed ow the	
	summary for Psych 06/01/16 revealed F of anxiety that requi medication and dep	Area Assessment (CAA) otropic Drug Use dated Resident #75 had a diagnoses ired the use of an antianxiety oression that required the use at medication and was at risk		actually affected Resident #10 implications of using a therape the resident □s nutritional state quality of life, nutritional imbal medication interactions.	04 and the eutic diet on us and	
	for adverse psychol The CAA summary psychotropic medic Resident #75's day The CAA summary	tropic medication side effects. did not analyze how the ations actually affected to day function and activities. also did not indicate if there rse drug reactions or		All Residents have potential to affected. All Residents Care Assessments have been revieupdated as needed. All MDS reviewed and monitored for co	Area ewed and 's were	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING_	B. WING		C 02/17/2017	
	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE ORICEVILLE ROAD SHEVILLE, NC 28805	1 02	717/2017
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	EFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 272	An interview with the 9:57 AM revealed she facility as the MDS Ni stated she received p facility MDS Consulta had not completed Re for psychotropic drug completed Resident # employed by the facil summary should have specific information a of findings. 2. Resident #104 was 11/23/16 with diagnos pulmonary disease an Review of the admiss (MDS) dated 11/30/16 was moderately cogn further revealed Resident #104 was moderately cogn further revealed Resident #104 and the therapeutic diet on the Resident #104 and the therapeutic diet on the Resident #104 and the therapeutic diet on the	MDS Nurse on 02/16/17 at a had been employed by the urse since July 2016. She eriodic training from the nt. The MDS revealed she esident #75's CAA summary use and the person that #75's was no longer ity. She stated the CAA included more resident and a more in-depth analysis admitted to the facility on ses of chronic obstructive and diabetes. Ion Minimum Data Set it is revealed Resident #104 itively impaired. The MDS dent #104 was coded for a fic diet. Irea Assessment (CAA) for 116 revealed Resident #104 chanically altered, added diet. Contributing are diagnoses of chronic y disease and congestive of diuretic use. The CAA lyze how the mechanically ic diet actually affected e implications of using a per resident's nutritional status ritional imbalances and	F2	272	Dietary Manager, Social Services and MDS/Care plan team WAS in-serviced the Director of Clinical Reimbursement on appropriately completing CAAs triggered by the MDS ON 3/14/2017. A QA monitoring tool will be utilized by DON or Regional Clinical Specialist to review CAAs from the Comprehensive assessments weekly x 1 month and the x 2 weeks for 2 months with any identifissues corrected at that time. Thereaft monitoring and review of 10% of assessments will be done by Regional Clinical Specialist on a quarterly basis. Results will be reviewed by the QA committee monthly x 3 monthly and quarterly thereafter for continued compliance with additional education o training provided for any identified issu	by the en ied er,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3	3) DATE SURVEY COMPLETED
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		345438	B. WING			02/17/2017
	ROVIDER OR SUPPLIER	Ē		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		
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F 272	02/17/17 at 2:15 PM Care Area Assessme Resident #104. DM s formal training on how	Dietary Manager (DM) on revealed she completed the nt summary for Nutrition for tated she had not had any w to write a CAA summary	F	272		
F 278 SS=D	and analyze how nutr day. 483.20(g)-(j) ASSESS ACCURACY/COORD	DINATION/CERTIFIED	F	278		3/21/17
	must accurately reflect (h) Coordination A registered nurse metach assessment with participation of health (i) Certification (1) A registered nurse the assessment is cool (2) Each individual whas each assessment must sign that portion of the assessment for Falsific (1) Under Medicare a who willfully and known (i) Certifies a material	e must sign and certify that mpleted. The completes a portion of the n and certify the accuracy of sessment. ation and Medicaid, an individual wingly- I and false statement in a is subject to a civil money				

_ ` '		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 02/17/2017	
		345438	B. WING				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 100 RICEVILLE ROAD ASHEVILLE, NC 28805		02/11//2017	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	and false statement i subject to a civil mon \$5,000 for each asse (2) Clinical disagreen	ndividual to certify a material in a resident assessment is ey penalty or not more than ssment.	F 2'	78			
	by: Based on record rev facility failed to accur Data Set (MDS) to re Preadmission Screer (PASRR) determinati (Resident #9) identifi resident. Findings included:	is not met as evidenced iew and staff interviews, the ately code the Minimum flect the Level II hing and Resident Review on for 1 of 1 resident ed as a Level II PASRR		The facility will continue to accode the Minimum Data Set to Level II PASRR. MDS for resident #9 has been to accurately reflect the resident All residents with Level 2 PAS identified at the time of survey reviewed by the DON for accurated.	o reflect the n corrected ent □s status. SRR were y and MDS urate coding		
	Data Set (MDS) date resident was not conserved preadmission Screen (PASRR) process to and/or intellectual disscreening and review determination of need appropriate care setting recommendations for individual's plan of care setting and review of the facility residents which was	y's list of Level II PASRR provided on 02/13/17 during nce indicated Resident #9		The MDS/Care Plan nurse Ware-educated by Director of Cli Reimbursement services regard correct coding for a level 2 PA 3/14/2017. All MDS's have been reviewer monitored for completion and CAA's on 3/16/2017. The DON or Administrative Nureview all new admissions with PASRR to ensure proper codi MDS, weekly for 4 weeks and monthly for 2 months. Result reported to monthly Quality As	nical arding the ASRR ON d and accurate urse will th a Level 2 ing on the I then s will be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 02/17/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 278	conducted with the M the Clinical Resource Resident #9's admiss 01/30/17. The MDS O PASRR Level II was and should have bee MDS assessment. Th the (CRS) missed co Level II. The MDS Co have to submit a mod MDS to reflect Resid PASRR Level II. On 02/15/2017 at 8:3 was conducted with t coded Resident #9': assessment and had Level II status prior to missed coding that R as PASRR Level II. T modification to Resid assessment would be and submitted by the An interview was con Nursing (DON) on 02 stated her expectation MDS assessment da been accurately code determined as PASR was her expectation admission MDS asse immediately to indica level II. The DON sta	25 AM an interview was IDS Coordinator who stated a Specialist (CRS) coded sion assessment dated Coordinator verified the not coded for Resident #9 in coded on the admission ne MDS Coordinator stated ding Resident #9 as PASRR coordinator stated she would diffication to the admission ent #9 was determined as admission MDS not received the PASSR coording the assessment and desident #9 was determined in the CRS stated a ent #9's admission MDS coordinator. Inducted with the Director of 2/15/2017 at 8:44 AM who in was that the admission ted 01/30/17 would have end to reflect Resident #9 was R Level II. The DON stated it that a modification of the essment would be submitted atter Resident #9 was PASRR ted the corporate MDS gout with coding MDS e PASRR Level II for	F 27	Committee for 3 months and quarter thereafter for any further recommendations. The DON will be responsible to follow \(\text{up} \) on any recommendation from the committee further education and/or training as indicated.	,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	345438	B. WING _		C 02/17/2017
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	
PREFIX (EACH DEFICIENCY MI	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
stated her expectation w MDS assessment dated been accurately coded to was determined as PASI she would expect that a admission MDS assessr immediately to reflect Re determined as PASRR L MDS Coordinator from th assisting in coding MDS PASRR Level II for Resid 483.21(b)(3)(i) SERVICE PROFESSIONAL STANI (b)(3) Comprehensive C The services provided or as outlined by the compre must- (i) Meet professional sta This REQUIREMENT is by: Based on medical recor	AM an interview was fim Administrator (IA) who was that the admission I 01/30/17 should have to indicate Resident #9 IRR Level II. The IA stated modification of the ment would be submitted esident #9 was Level II. The IA stated the the corporate office was at the facility and the ident #9 was missed. IES PROVIDED MEET IDARDS Care Plans For arranged by the facility, rehensive care plan, andards of quality. In the ident #9 was missed in the facility is not met as evidenced and review and staff illed to follow physician's its ordered for 1 of 8 is ordered for 1 of 8 is ordered for 1 of 8 is ordered Resident #15).	F2		ed. ers o

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	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE ORICEVILLE ROAD SHEVILLE, NC 28805	<u> 1 02/</u>	1//2017
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 281	o9/13/16 with diagnor failure and kidney fail day admission Minim o9/20/16 indicated Re extensive assistance of Daily Living). The Resident #15 was 5'7 took a diuretic. Record review of care o9/26/16 for Resident was identified as an arelated to dehydration #15 to receive an ade One of the approache was to "obtain weight Record review of the September 2016 indicated to dehydration and yeights to be do 3 pound (lb.) weight of B. physician's on continue encouraging day and to call if there or shortness of breatt Review of the Medicate for 09/13/16 through following order listed weight every morning notify provider for we Record review for characteristics.	mitted to the facility on ses which included heart ure among others. The 5 um Data Set (MDS) dated esident #15 required with most ADL's (Activities MDS also indicated "", weighed 87 pounds, and e plans with an onset date of a #15 indicated a problem alteration in fluid volume in. The goal was for Resident equate amount of fluids daily. Es listed to meet this goal as ordered". physician's orders for cated the following: der on 09/14/16 stated for one and to call if there was a gain der on 09/29/16 stated to a fluids and weights every e was a 3 lbs. weight gain	F:	281	expectations in following physician sorders by 3/20/2017. At each clinical meeting the Nurse Administrative Team will review new Physician orders and the medical record to ensure the order was transcribed an implemented correctly with any issues noted corrected at the time of observat Chart audits will be conducted by Nurs Administration Team at 10% weekly for weeks then monthly thereafter to ensurphysician orders are followed. DON will review findings and bring rest to monthly QA Committee meeting for months and quarterly thereafter with additional training or education provide indicated.	d ion. e r 4 re ults 3	

Facility ID: 923279

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 02/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	1 02/1//2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE COMPLETION
F 281	Continued From page 38 no weights included the following: 09/15, 09/18, 09/19, 09/22, 09/23, 09/24, 09/26, 09/27, 10/02,		F 28	1	
	(DON) on 02/16/17 at	ith the Director of Nursing 10:18 AM, the DON stated for physician's orders to be			
	02/16/17 at 11:06 AM responsible to let the or weights are needed stated the NA's looker	ith Nurse Aide (NA) #1 on , NA #1 stated the nurse is NAs know daily if vital signs d on a resident. NA #1 also d at the Nursing Care Card ed to be done daily for each			
	at 11:49 AM, the DON would be the nurse to		F 28	2	3/21/17
		e Care Plans d or arranged by the facility, nprehensive care plan,			
	care. This REQUIREMENT by: Based on record reviinterviews the facility	alified persons in resident's written plan of is not met as evidenced ew, resident, and staff failed to implement care of 15 residents reviewed		The facility will continue to provide da weights and restorative services as indicated by the care plan.	iily

AND DLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	DE	02/11/2011
		_		100 RICEVILLE ROAD		
THE LAURELS OF SUMMIT RIDGE				ASHEVILLE, NC 28805		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	Continued From page	e 39	F 2	82		
	motion (ROM) and Reweighed per resident Findings included: 1. Resident #58 was 12/13/16 and diagnos vascular accident (CV) The annual Minimum assessment dated 01	ervices to improve range of esident #15 was not 's care plans. admitted to the facility on ses included cerebral /A) and hemiplegia.		Resident # 15 no longer resifacility. Resident #58 has had a restprogram initiated on 2/17/17 by therapy. All residents who have intervolugified professional service restorative programs or weigon their care plan have the paffected. All care plans have reviewed and no other issue:	orative as directed ventions for es related to this indicated ootential to be e been	
	assistance of 1 person personal hygiene and person for dressing and A review of a physicial indicated Resident #8 nursing services for an (AROM) 3-4 times personal A review of the Restonal Personal Per	n for bed mobility, and lextensive assistance of 2 and toileting. an 's order dated 01/06/17 as was to receive restorative assisted range of motion		identified. Licensed Nurses, Care Plan Qualified Professionals respirint erventions on the care plant serviced by the DON or Reg Manager regarding expectat providing services according care BY 3/20/2017.	team, onsible for n will be in ional QA ions for	
	nursing 3-4 times a w Documentation on the Resident #58 receive extremities on 01/10/ 01/13/17, 01/17/17, 0 and 01/23/17. The PF as given the rest of Ja nursing services were of February 2017.	58 was to receive restorative reek until April of 2017. 59 daily record indicated d AROM to bilateral lower 17, 01/11/17, 01/12/17, 1/18/17, 01/19/17, 01/20/17, ROM was not documented anuary 2017. No restorative e documented for the month #58 's care plan dated to following problems:		All restorative referrals from be given to DON for review was communicate restorative new restorative aides. Chart audits will be conducted Administration Team at 10% weeks then monthly thereafted that all care plan intervention followed. All findings will be reviewed and presented to the QA commonthly x 3 months and qual	who will then eds to the ed by Nurse weekly for 4 er to ensure as are by the DON amittee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING _				C 17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805			17/2017
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F 282	ROM: The resident had contractures related to and had a contracture left knee stump. The sto develop any further review period of 04/19 address the problem to assess and record observe and record a joints, staff were to enextremities as able, stherapy (PT) for evaluan assistive device as restorative nursing as Restorative, AROM, reperform ROM exercis further decline in ROM weakness related to himpairment, history of hemiparesis and para resident not to incur a restorative nursing se would maintain function review period of 04/19 address problem were to complete each ARO and rhythmically, ARO adduction, and hip ab kicks and knee extension of 02/15/17 at 9:10 A conducted with the Down was responsible program. The DON streceive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative nubilateral lower extrem related to having a best receive restorative numbers of the receive restorative numbers related to having a best related to having	ad a potential for o CVA with left hemiplegia of the left elbow, wrist, and goal was for the resident not recontractures through next 20/17. Interventions to were as follows: Staff were current ROM of extremities, my increased stiffness in accourage exercise to all taff were to refer to physical ration of potential need for a needed, and refer to needed. Resident was unable to es and was at risk for and secondary to muscle history of CVA, functional of CVA with left sided allysis. The goals were for the my loss of ROM, would have rices 3-4 times a week and conal status through next 20/17. Interventions to the as follows: Resident was DM exercise slowly, gently, DM, hip flexion, hip duction, gluteal sets, left sion.	F2	282	thereafter. Any further education or training provided as indicated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
			A. BOILD			С	
		345438	B. WING			02/	17/2017
	ROVIDER OR SUPPLIER RELS OF SUMMIT RIDG	E		1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	had one restorative a restorative services and the care plan on had been busy with a conducted with the Fonly RA in the facility restorative duties. The performed AROM to lower extremities sin schedule because shad the rapist (OT) had putherapy services and longer required. The discussed stopping resident #58 with the therapist. The RA stawith the DON if Resi receive restorative schedule for AROM providing restorative nursing schedule for Resident #	resident was to be of 2017. The DON stated she aide (RA) who provided for Resident #58 and stated nication between herself, the and therapy Resident #58 and restorative nursing /17 as per the care plan. The not realized that the had not been performed as Resident #58 because she other duties. AM an interview was RA who stated she was the vand had time to perform her he RA stated she had not Resident #58 's bilateral ce 01/23/17 as per care plan he thought the occupational laced the resident back on the restorative services were no RA stated she had not restorative services on the DON or the occupational lated she should have clarified dent #58 was still required to revices as per care plan before she decided to stop services for Resident #58. AM an interview was anterim Administrator (IA) who dectation that the DON would gent #58 was receiving ervices for ROM to prevent a	F	282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345438	B. WING _			C 02/17/2017	
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	: :	02111/2011	
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	#58 was care planned AROM and the care followed. The DON is that the RA would has services for Resident care plan schedule. On 02/16/17 at 10:06 conducted with the IA expectation that Resident have been followed a received ROM. 2. Review of the host discharge of Resident #15 "must be hospital records also should be weighed a breakfast. Resident #15 was ac 09/13/16 with diagnot failure and kidney fail day admission Minim 09/20/16 indicated Rextensive assistance of Daily Living). The Resident #15 was 5' took a diuretic. Record review of car 09/26/16 for Resident was identified as an a related to dehydratio #15 to receive an additional records.	ON who stated Resident d to receive ROM and plan for the resident was not tated it was her expectation we provided restorative a #58 as per the restorative a #58 as per the restorative a who stated it was her ident #58's care plan would and the resident would have a weighed daily". The clarified Resident #15 fter urination and before a weighed daily". The clarified Resident #15 fter urination and before a with most ADL's (Activities MDS also indicated with most ADL's (Activities MDS also indicated a problem alteration in fluid volume and the goal was for Resident equate amount of fluids daily, es listed to meet this goal	F 2	282			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING				C 17/2017
NAME OF PR	ROVIDER OR SUPPLIER	0.000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	17/2017
THE LAUR	RELS OF SUMMIT RIDGE	!			00 RICEVILLE ROAD ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page Record review of the September 2016 indic	physician's orders for	F:	282			
	A. physician's ordinary weights to be do 3 pound (lb.) weight of B. physician's ordinary.	der on 09/14/16 stated for one and to call if there was a gain der on 09/29/16 stated to gain fluids and weights every e was a 3 lbs. weight gain					
	for 09/13/16 through following order listed weight every morning notify provider for wei Record review for characteristics weight #15 betwee indicated the daily we not taken 14 out of 29 no weights included the	ation Administration Record 10/11/16 indicated the under vital signs: obtain due to heart failure and ght gain greater than 3 lbs. Farting for the weights of n 09/13/16 and 10/11/16 eight for Resident #15 was 0 days. Dates recorded with the following: 09/15, 09/18, 09/24, 09/26, 09/27, 10/02, 10/10 and 10/11.					
	(DON) on 02/16/17 at	rith the Director of Nursing t 10:18 AM, the DON stated the for the care plan to be					
F 309 SS=J	02/16/17 at 11:06 AM responsible to let the or weights are needed 483.24, 483.25(k)(l) FFOR HIGHEST WELL	PROVIDE CARE/SERVICES	F:	309			3/21/17
	483.24 Quality of life Quality of life is a fund	damental principle that					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	02/1//2017		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 309	residents. Each residents facility must provide the services to attain or in practicable physical, well-being, consistent comprehensive assess 483.25 Quality of care is a furth applies to all treatments facility residents. Base assessment of a resident aresidents received accordance with profestate plan, and the resident to the facility must ensure provided to residents consistent with profest the comprehensive provided to residents who requires services, consistent work of practice, the composer plan, and the respective plan, and the respective plan a	d services provided to facility dent must receive and the he necessary care and naintain the highest mental, and psychosocial t with the resident's asment and plan of care. e indamental principle that not and care provided to ed on the comprehensive dent, the facility must ensure extreatment and care in essional standards of nensive person-centered sidents' choices, including following: t. t. t. t. t. t. t. t. t. t	F 30	The facility will ensure that each receives and provides the necessand services to attain or maintain	ary care		
	a change in condition	for 1 of 1 sampled resident medication error. Resident		highest practicable physical well b administrating physician orders			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NITIFICATION NI IMBED:		MULTIPLE CONSTRUCTION UILDING		
		345438	B. WING _				C / 17/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADI	DRESS, CITY, STATE, ZIP CODE	1 02/	71172017
				100 RICEVI	ILLE ROAD		
THE LAU	RELS OF SUMMIT RIDG	E		ASHEVILL	LE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
	1						
F 309	morning of 01/25/17 experienced nauseal hypotension. There assessment or moninursing staff until he room. Resident #18 vomiting and a drop pulse. Immediate Jeopardy Resident #189 was a morning medications made the error did nobtain directions and resident's vital signs condition. Resident to the emergency rohospital when he de and a drop in his blo Immediate Jeopardy 2:15 PM when the fa	roommate's medications the and subsequently, vomiting, bradycardia nad was no evidence that any toring was completed by was sent to the emergency 9 developed nausea and in his blood pressure and began on 01/25/17 when administered Resident #181's in error and the nurse who to inform the physician to did not monitor the or assess for a change in #189 was subsequently sent om and admitted to the veloped nausea and vomiting od pressure and pulse.	F3	accura when a directing intervention with the second condition of the second c	ately, and by notification of physicany medication error occurs for ion for any monitoring or entions that would be appropriate significance of the error. Resident # 189 was transferred of cility on 1/25/17 at 2:00 pm whereation error was discovered by histration. The family member of ent was notified of the error by the on 1/25/17. The physician was ead by the Unit Manager on 1/25/17. The resident was admitted to the family investigation was initiated at and has not returned to the family investigation was initiated at approximately 1/30 profamily member was requesting by sent to the hospital. At that questioned assigned nurse reasoned.	out of en the of the he on on on that time	
	compliance. The factompliance at a lower (isolated with no actimore than minimal higopardy) to ensure monitoring systems effective related to a a medication error a identification of prob. The findings include Resident #189 was a 01/19/17. His admis paroxysmal tachycal	ility remains out of er scope and severity of D ual harm with a potential for arm that is not immediate inservices are completed and are put into place and are ssessing a resident following and monitoring so that timely lems can be identified.		for need that she medical medical regards and faresport intervitives in and tear Physical facility same initiated.	hed of transfer. Nurse notified Dhe had administered the incorrectation to the guest during morning the transfer of the properties. DON questioned in the physical part of the ph	oON ect ng urse ccian se nent otify The	

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				(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 02/17/2017
NAME OF P	ROVIDER OR SUPPLIER	0.0.00	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	02/11/2017
				100 RICEVILLE ROAD	
THE LAUF	RELS OF SUMMIT RIDGE			ASHEVILLE, NC 28805	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE COMPLETION
F 309	Continued From page	e 46	F 30	9	
	embolism, difficulty w	alking, atrial fibrillation, long e, muscle wasting and		disciplinary tree. Their investigation assigned to a complaint officer with North Carolina Board of Nursing. report was made by DON on 2/7/1	h the This
	dated 01/27/17, noted he was understood at cognition and mood who behaviors, and recognition and hygiene. He was of anticoagulants, 7 doccupational and Physician of the morning medications and the m	vere not assessed, he had puired extensive assistance asfers, dressing, toileting, noted to have taken 6 days ays of diuretic and received visical therapies. orders included the following ordered for Resident #189: 0 Milligrams (mg) at 8 AM - ent; and diastolic less than 60 sion and angina; - a diuretic; rams per day at 8 AM - for		All residents have the potential to affected. On the date of occurrence alert and oriented residents were interviewed to determine if any has received incorrect medications. No issues were identified. On the date occurrence all residents who were alert and oriented were observed changes in condition through direct observation and review of medicate by DON. The audit results were not to the Medical Director. All reside observed in the audit had no issue identified and Medical Director not the Director of Nursing (DON) on the Director of Nursing (DON) on the past 30 days to identify any deareas of assessments for follow up monitoring. Education and docum was completed as needed. All licensed nurses were in-service the facility Pharmacist on 2/15/17 following: 1. Responsibility of reports and Physician or 2/15/17 following: 1. Responsibility of reports.	be se all d d d d d d d d d d d d d d d d d d
	at 1:30 PM, Resident error resulting in naus hypotension. It was of #189 received his roo in error.	#189 received a medication		med errors to the physician at the knowledge of an occurrence of medication error in order to determ what monitoring and assessment be initiated. 2. Definition of medic errors. 3. The 6 rights of medicati which include right individual, right medication, right dose, right time,	time of nine needs to ation on pass t

Facility ID: 923279

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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/11/2011
THE ! ALIE	NEL O OF OUR MAIT DID OF	_		100 RICEVILLE ROAD	
THE LAUF	RELS OF SUMMIT RIDGE	<u> </u>		ASHEVILLE, NC 28805	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
F 309	Continued From page	e 47	F 309		
	and last name initials	were the same as Resident		route and right documentation. 4. Th	
		w of the picture in the		notification of family/responsible party	<i>/</i> .
		al record system revealed the		The licensed nurse involved was	
		f different races and had an		terminated immediately due to not	
	age difference of 31 y	years.		reporting the medication error at the t	
	Decident #404	dunition to the famility on		of occurrence. The incident was repo	опеа
		dmitted to the facility on ses including injury of C4		to the NC Board of Nursing. The orientation process for new licentation	and
	cervical spine. Resid			nurses will include: 1. Responsibility of	
		Resident #189 included:		reporting med errors to the physician	
	*Amlodipine Besylate			the time of the knowledge of an	
	hypertension;			occurrence of a medication error in or	rder
	*Coreg 25mg for hype	ertension;		to determine what monitoring and	
		at 8 AM for depression;		assessment needs to be initiated. 2.	
	*Flomax 0.4mg at 8A	M for urinary retention;		Definition of medication error. 3. The	6
		al spray at 8 AM for sinus		rights of medication pass, which inclu	
	congestion:			documentation. 4. The notification of	of
	*Lovenox 40 mg/0.4 i anticoagulation thera	ml subcutaneous at 8 AM for py;		family/responsible party.	
	*Multivitamin/mineral			Education on acute change of conditi	on,
	*Senna S 2 tabs at 8			post incident follow-up, notification	
		our times a day, first at 8 AM		process and documentation requirem	
	for urinary discomfort *Vitamin D3 1000 uni			regarding assessment, notification ar	
	Vitallilli D3 1000 ulli	it at 6 Aivi.		follow-up monitoring will be complete with licensed nurses by 3/20/2017 by	
	The only nursing note	e in the medical record for		DON or QA Regional Manager.	uic
		1) on 01/25/17 was written by		The Nurse Administrative Team will re	eview
		ng on 01/25/17 at 2:00 PM.		new Physician orders, incident report	
		esident had nausea and		and 24 hour reports. The Medical Re	
		nsion. Blood pressure was		will be reviewed to ensure that appro	
	80/60, respirations 20), pulse 61, temperature		assessments and monitoring occurre	d
	_	heit and oxygen saturation		and appropriate documentation made) .
		cian was contacted and an			
	_	end him to the emergency		Nursing Administration will conduct	
		and treatment. The family		random audits of 10% of Residents fo	or 4
		edside. There were no other		weeks to ensure compliance. Any	
		essment of Resident #189's		variances will be addressed immedia	тегу.
		n his medical record except		Results of all audits will be forwarded	to
	for the hospital transf	しょうにんし.	1	The suits of all audits will be follwarded	ιυ I

Facility ID: 923279

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP C 100 RICEVILLE ROAD ASHEVILLE, NC 28805	ODE	02/11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	1:21 PM stated Residependence for lower bathing, dressing and suffering from vomiting ended after cleaning living skills and nursion on 02/15/17 at 10:14 conducted with the ownoworked with Resmed error. OT stated after lunch and found covered in vomit. He aide got him cleaned OT described Reside less verbal than his understand him. OT bit." OT also stated assistance to transfed different. OT stated hand went on to his new Review of the undate revealed Resident # medications. His vita temperature 97.3 Faminute, respiration rasis 85/58 and 80/60 and Emergency Medical 01/25/17 and was not PM. Review of the Ereported Resident #1 blood pressure was was awake, slow to membranes and stated the sufficient of the proposed resident #1 blood pressure was was awake, slow to membranes and stated the sufficient was awake, slow to membranes and stated the sufficient was awake, slow to membranes and stated the sufficient was awake, slow to membranes and stated the sufficient was awake, slow to membranes and stated the sufficient was awake, slow to membranes and stated the sufficient was awake.	dent #189 required total or body and upper body d transfers. He was noted ng this date. Treatment up from activities of daily ng was notified. AM an interview was occupational Therapist (OT) sident #189 the day of the label he went in to work with him d him in the bathroom estated he and the nurse up and he vomited again. The stated he vomited again and OT could not stated he vomited "a good the required maximum or which was definitely the reported this to the nurse	F3	the Director of Nursing. Al be reported by the Director the QA Committee monthly and quarterly thereafter. A education and training providentified issues.	of Nursing to for 3 months dditional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345438	B. WING		02	C / 17/2017
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	02	11112011
		_		100 RICEVILLE ROAD		
THE LAUF	THE LAURELS OF SUMMIT RIDGE			ASHEVILLE, NC 28805		
(X4) ID	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		COMPLETION DATE
F 309	Continued From pag		F 30	9		
		used to treat a slow heart				
		his blood pressure and heart				
		77/49 and 42 pulse at 2:07 pulse of 59 at 2:13 PM.				
	FINI to 103/03 WILLIA	puise of 39 at 2.13 Fivi.				
		al history and physical dated				
		e presented with a 1 day				
	history of generalized					
		dycardia. Resident #189 was				
		ses of another resident's				
		Coreg, Citalopram, Lovenox, nokot and Urecholine. The				
		have some mild nausea				
		ring, his blood pressure was				
	-	ate was in the 40s. He was				
		e in route and once in the				
		ent, the blood pressure was				
		0 and was dosed with				
		ng of atropine. He was				
	started on intravenou	is hydration and his blood				
	pressures improved t	to the 100-110 systolic range				
	with a heart rate curr					
	Resident #189 staye					
	discharge to another	nursing facility on 01/30/17.				
	The hospital discharg	ge summary dated 01/30/17				
	stated Resident #189	was initially admitted to				
		econdary to his bradycardia				
	and hypotension fron	n the medication misuse.				
		te IV hydration holding				
		ns. Plans were for discharge				
	the following day, ho					
		the night before, the resident				
		ted and confused. As such,				
	tne resident was star	ted on the delirium protocol.				
	Review of the Emplo	yee Disciplinary Record				
	· ·	who made the medication				
		dent #189, was terminated on				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING				C 17/2017
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ISHEVILLE, NC 28805	<u> </u>	1172011
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	and welfare." Addition medication error occu. AM to 9:00 AM and the Director of Nursing (EThe DON became awapproximately 1:30 Pform that she held Remedications on 01/25 from reporting this errobserved him at lunch Once he had a changassessed and the physical Nurse Aide (NA) #1 wat 8:26 AM. NA #1 st with Resident #189 a #189 was not able to his usual. He was uncommode which she She stated that she in Resident #189 vomiti took his blood pressu take his vital signs. AOT transferred him in #189's responsible pathat she thought he hworse. NA #1 stated that she thought he had no that she thought had not tha	errors of sufficient / jeopardize resident safety nal notes indicated the urred at approximately 8:30 ne nurse failed to notify the DON), Physician or family. //are of the error at M. Nurse #3 noted on this esident #189's morning //17 and she was distracted for. The note stated she n and he appeared okay. // je in condition, he was // sician was called. // as interviewed on 02/15/17 // ated she routinely worked nd on 01/25/17 Resident // stand and do for himself per // sable to get himself off the // said was different for him. // informed Nurse #3 of // ng and believed the nurse // re. NA #1 stated she did not // few minutes after she and // to the chair, Resident // arty came in and mentioned // add taken a turn for the // she had noticed a change in	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG_		(С
		345438	B. WING			1	17/2017
	THE LAURELS OF SUMMIT RIDGE			1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	day before. Both rewith the same letter gave Resident #189 realized the error "in She stated that she several times that m #189's new order for related to several of thought to inform the error. She stated she residents and didn't #3 stated she though pressure after the mosure. She stated th #189 he was with the fine until he ate lunched She stated that she physician about the Resident #189 got il he was nauseated a and as a nurse she womiting as being resince it occurred after she felt he needed he could not administer tubing for it. Resident #189's phy 02/15/17 at 11:36 Al had been notified of likely would have has signs more closely a medication orders. On 02/15/17 at 12:1 she was informed and same she was informed and same she with the signs more closely a medication orders.	sidents' last name started She stated as soon as she the wrong medications, she mediately, immediately." had spoken to the physician orning relating to Resident r a nebulizer treatment and her residents but never e physician of the medication he got busy with other recall writing a note. Nurse ht "they" took his blood edication error but was not he next time she saw Resident erapy. She stated he was h then he started vomiting. informed the DON and medication error when h. Nurse #3 further stated that nd vomited about 12:30 PM would not have assessed the lated to medication errors er the resident ate. She stated his nebulizer treatment but it as she could not locate which is a she could not locate which is a she could not locate which is a she could not locate as ician was interviewed on h. The physician stated if he he medication error he most d the nurse monitor vital and possibly adjust upcoming	F	309			
		ponsible party wanted the hospital. The DON went to					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	` '	COMPLETED	
		345438	B. WING			C 2/17/2017	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		02/1//2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	and it was then that and Nurse #2 that N #189 his roommate! Nurse #3 then state DON, the physician medication error. T did not go to the res Resident #189 and the hospital transpor Nurse #3's employn On 02/15/17 at 3:19 01/25/17 nurse aide she could help get It transport to the hoshall and found Nurs give him a nebulizer proceeded to print of Administration Recording after that, that Nurse the DON that she amedications. Nurse the room to assess only helping with the called the physician medication error and the hospital and too Nurse #3. On 02/16/17 at 8:38 interviewed. He reverselect the medications he that some of the medications he that some of the medication error and the hospital and too Nurse #3.	Nurse #3 what was going on Nurse #3 informed the DON Jurse #3 had given Resident is morning medications. It is morning medications is morning medications. It is morning medication is morning medication in the DON stated she (the DON) is ident's room to assess told Nurse #2 to assist with int. The DON terminated ment that day. If it is now to assess told Nurse #2 to assist with int. The DON terminated ment that day. If it is now to assess told Nurse #2 stated that on as approached her to ask if Resident #189 ready to pital. Nurse #2 went to the er #3 looking for equipment to interest the Medication for the hospital. It was the was the was also as a paperwork. Nurse #2 and diministered the wrong #2 stated she never entered Resident #189 as she was the paperwork. Nurse #2 then it to inform him of the did the impending transport to its over the medication cart for the impending transport to its over the medications ived and compared them to was ordered. He revealed edications Resident #189 is morning of 01/25/17 were	F 30				

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	345438	B. WING		03	C 2/17/2017	
	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		02/1//2017	
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION DATE	
Continued From page "absolutely" affected. The facility DON, consideration of a sill immediate Jeopard. The facility provided allegation of compliants follows: Credible Allegation The facility will ensurant provides the neattain or maintain the well-being, by admit accurately and by nany medication error monitoring or interval appropriate with the Resident #189 was on 1/25/17 at 2:00p was discovered by a was admitted to the	ge 53 d his blood pressure. proporate nurse and lister facility were informed of y on 02/15/17 at 2:38 PM. d an acceptable credible ance on 02/17/17 at 1:20 PM of Compliance are that each resident receives ecessary care and services to be highest practicable physical nistrating physician orders arotification of physician when for occurs for direction for any entions that would be a significance of the error. transferred out of the facility m when the medication error administration. The resident		DEFICIENCY)			
The Director of Nursapproximately 1:30 requesting that the hospital. At that time assigned nurse region transfer the residuatified the DON that	sing (DON) was notified at pm that a family member was resident be sent to the e the DON questioned the arding the reason for the need ent to the hospital. The nurse at she had administered the					
	ROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY O Continued From pa "absolutely" affecte The facility DON, coadministrator of a s Immediate Jeopard The facility provided allegation of complias follows: Credible Allegation The facility will ensuand provides the neattain or maintain the well-being, by adminaccurately and by many medication erromonitoring or intervappropriate with the Resident #189 was on 1/25/17 at 2:00p was discovered by was admitted to the to the facility. Facility Investigation The Director of Nurapproximately 1:30 requesting that the hospital. At that time assigned nurse regito transfer the residentified the DON the	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 "absolutely" affected his blood pressure. The facility DON, corporate nurse and administrator of a sister facility were informed of Immediate Jeopardy on 02/15/17 at 2:38 PM. The facility provided an acceptable credible allegation of compliance on 02/17/17 at 1:20 PM as follows: Credible Allegation of Compliance The facility will ensure that each resident receives and provides the necessary care and services to attain or maintain the highest practicable physical well-being, by administrating physician orders accurately and by notification of physician when any medication error occurs for direction for any monitoring or interventions that would be appropriate with the significance of the error. Resident #189 was transferred out of the facility on 1/25/17 at 2:00pm when the medication error was discovered by administration. The resident was admitted to the hospital and has not returned	ROVIDER OR SUPPLIER RELS OF SUMMIT RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 "absolutely" affected his blood pressure. 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Facility Investigation The Director of Nursing (DON) was notified at approximately 1:30 pm that a family member was requesting that the resident be sent to the hospital. At that time the DON questioned the assigned nurse regarding the reason for the need to transfer the resident to the hospital. The nurse notified the DON that she had administered the	ROUIDER OR SUPPLIER RELS OF SUMMIT RIDGE SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 "absolutely" affected his blood pressure. The facility DON, corporate nurse and administrator of a sister facility were informed of Immediate Jeopardy on 02/15/17 at 2:38 PM. 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At that time the DON questioned the assigned nurse regarding the reason for the need to transfer the resident to the hospital. The nurse notified the DON that she had administered the	RELS OF SUMMIT RIDGE SUMMARY STATEMENT OF DEPICIPIONS (EACH DEPICIENCY) (EACH DEPICIENCY SUBJECTION OF THE PROPERTIES AS INCIDENCY OF THE APPROPRIATE DEPICIENCY STATE. STATE APPROPRIATE DEPICIENCY STATE DEPICIENCY STATE DEPICIENCY STATE DEPICIENCY STATE DEPICIPIONS (EACH DEPICIENCY STATE DEPICIPIONS OF THE APPROPRIATE DEPICIENCY STATE DEPICIPIONS OF THE APPROPRIATE DEPICIENCY) Continued From page 53 "absolutely" affected his blood pressure. 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The nurse notified the DON that she had administered the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017	
	ROVIDER OR SUPPLIER			S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805	<u> 02/</u>	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	I should have." Nurse 01/25/17. Nurse was assignment and term notify Physician, fami facility investigation w 01/25/17 and POC (Finitiated. The licensed nurse in immediately due to merror at the time of or reported to the NC Botheir disciplinary tree. assigned to a compla Carolina Board of Nu DON on 02/07/17. All residents who recopotential to be affected occurrence (1/25/17) residents were intervidetermine if any had medications. No other the date of occurrence alert and oriented we changes in condition and review of medicar results were reported. On 2/15/17 all resider affected were again residents did not indicany medications bein residents with cognitir	which she responded, "No, interviewed by DON on immediately taken off of inated based on failure to ly member and DON. The vas concluded the same day plan of Correction) was a concluded the same day plan of Correction) was a concluded the same day plan of Correction) was a concluded the same day plan of Correction) was a concluded the same day plan of Correction was a correct. The incident was pard of Nursing according to a correct with the North resing. Report made by the serve medications have the ed. On the date of all alert and oriented ewed by the DON to received incorrect was sure identified. On the all residents who were not reconserved by the DON for through direct observation. I records. These audit to the Medical Director. The shaving the potential to be reviewed. Alert and oriented cate that they were aware of given incorrectly. All we issues were reassessed to issues were noted that	F	309			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345438	B. WING			C 02/17/2017	
	ROVIDER OR SUPPLIER	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		02/1//2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 55	F 30	09			
	on resident #189 us gather baseline data occurred. The nurse failed to a error that allowed pl monitoring or interve	perform an initial assessment sing nursing judgment to a after the medication error notify physician of medication hysician to direct staff on entions that would be a significance of the error.					
	In-Servicing						
	Pharmacist on 2/15. Responsibility of repphysician at the time occurrence of medic determine what morneeds to be initiated errors. 3. The 6 rig	The notification of					
	by DON and Regior	were in-serviced on 2/15/17 nal QA Manager on the none usage during medication					
	Director of Nursing assessment in relationship using nursing judgm	ion to change in condition nent or professional standard /17 or prior to the start of their					
	System Change						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COMF	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		I	C / 17/2017
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	021	111/2017
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	Continued From page	e 56	F 3	09		
	will include. 1. Resp errors to the physicia knowledge of an occu in order to determine assessment needs to medication errors wh in the medication use of medication pass w right medication, righ and right documentat family/responsibility p in relation to change	urrence of a medication error				
F 318 SS=E	2:15 PM when intervithey had been inservitake to ensure the coadministered to the rimedication errors immedication errors immedication. The nurses physician and follow assessing and monitocondition. Inservicing all findings. 483.25(c)(2)(3) INCR DECREASE IN RANGO (c) Mobility. (2) A resident with limin receives appropriate	knew to then inform the any further instructions for pring for a change in also included documenting EASE/PREVENT GE OF MOTION hited range of motion treatment and services to tion and/or to prevent further	F 3	18		3/21/17

PRINTED: 03/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 02/17/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/1//2017
THE ! ALIE		_		100 RICEVILLE ROAD	
THE LAUF	RELS OF SUMMIT RIDGE	1		ASHEVILLE, NC 28805	
(X4) ID	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 318	Continued From page	e 57	F 31	8	
	(3) A resident with lim	nited mobility receives			
		equipment, and assistance			
		e mobility with the maximum			
		ence unless a reduction in			
	mobility is demonstra	•			
	· ·	is not met as evidenced			
	by:	n record review regident		The facility will continue to provide	
		n, record review, resident, ne facility failed to provide		The facility will continue to provide restorative services as ordered by	
	range of motion (RON			physician.	
		(8) reviewed for range of		priyoloidii.	
	motion (ROM).	c) . c c c			
	,			Resident #58 will have restorative RO	M
	The findings included	:		according to orders and care plan	
				interventions.	
		mitted to the facility on			
	12/13/16 and diagnos			All residents who have had an increas	
	vascular accident (C\	/A) and hemiplegia.		need for ADL help/decrease in range	
	A raviou of a Pastora	tive Program Therapy to		motion as identified by the MDS proce have the potential to be affected.	388
		ion form dated 12/20/16		Residents identified will be re-screene	ed by
		erapy (PT) was discontinued		therapy and Restorative services initia	,
	on 12/20/16 and reco	• • • •		and care planned. All restorative refe	
		ower extremities assisted		will be reviewed by DON as ordered a	
	range of motion (ARC	DM) and strength with bed		communicated to the Restorative Aide	
		naintain range of motion			
		maintain bed mobility for		Licensed staff, nursing assistants and	
	rolling. The communic			restorative aides will be in-serviced by	/
	_	program for AROM for		Administrative nurses on providing	
	bilateral lower extrem	iities.		restorative care according to orders a	
	The annual Minimum	Data Set (MDS)		care plan interventions to prevent furti decline in ROM. In-servicing will be	ILCI
		/06/17 indicated Resident		completed by 3/20/2017.	
		ntact and required limited		00/11pictod by 0/20/2011.	
		n for bed mobility, and			
		I extensive assistance of 2		Restorative program audits will be	
	person for dressing a			conducted by Nurse Administration Te	eam
		-		at 10% weekly for 4 weeks then mont	

Facility ID: 923279

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			7. BOILDING			С	
		345438	B. WING			2/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO			
THE LANG	RELS OF SUMMIT RIDGE	=		100 RICEVILLE ROAD			
THE EAGNEES OF SOMMIT NIDGE		=		ASHEVILLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 318	Continued From page	e 58	F 31	8			
	indicated Resident #5 nursing services for A A review of a restorat 01/06/17 indicated Ro	an's order dated 01/06/17 58 was to receive restorative AROM 3-4 times per week. tive progress note dated esident #58 was referred to		thereafter to ensure care pla interventions are followed. All findings will be reviewed and presented to the QA cormonthly x 3 months and qua	by the DON mmittee		
	and strength. Reside and had bilateral low progress note indicat benefit from a restora prevent secondary co	program to maintain ROM nt #58 had a history of CVA er extremity amputation. The ed Resident #58 would ative nursing program to omplications that could ty and chronic disease.		thereafter. Any further educ training provided as indicate	ation or		
	Motion Program Daily indicated Resident #5 nursing 3-4 times a w Documentation on the Resident #58 receive extremities on 01/10/01/13/17, 01/17/17, 01/23/17 and was no January 2017 and no	prative Active Range of y Record (AROMPDR) 58 was to receive restorative week until April of 2017. The daily record indicated and AROM to bilateral lower 17, 01/11/17, 01/12/17, 01/18/17, 01/19/17, 01/20/17, or continued for the rest of the restorative nursing services of the month of February					
	O1/19/17 indicated th ROM: The resident h contractures related t and had a contracture left knee stump. The further contractures to 04/19/17. Intervention	#58's care plan dated e following problems: ad a potential for to CVA with left hemiplegia e of the left elbow, wrist, and goal was not to develop any hrough next review period of the sto address the problem of were to assess and record					
	current ROM of extre	emities, observe and record ss in joints, staff were to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		02/17/2017	
	NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	02/17/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 318	staff were to refer to need for an assistive to restorative nursing Restorative, AROM, perform ROM exercis further decline in RO	to all extremities as able, PT for evaluation of potential device as needed, and refer g as needed. resident was unable to ses and was at risk for M secondary to muscle history of CVA, functional	F 318	3		
	hemiparesis and para was not to incur any restorative nursing se would maintain funct review period of 04/1 address problem wer complete each ARON and rhythmically, AR	alysis. The goal was resident loss of ROM and would have ervices 3-4 times a week and ional status through next 9/17. Interventions to re as follows: resident was to M exercise slowly, gently, OM, hip flexion, hip oduction, gluteal sets, left				
	Nursing Communicatindicated occupation discontinued on 01/2 restorative nursing fourper extremity with motion (PROM) to let	4/17 and recommended or increase contracture of left goal for passive range of ft upper extremity, shoulder, and fingers to prevent further				
	observed in bed in hi nursing services were with the resident. Re- hand and wrist contra On 02/14/17 at 8:29	AM Resident #58 was so room and no restorative e observed being provided sident was noted to have left acture. AM Resident #58 was so room and no restorative				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017		
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CO 100 RICEVILLE ROAD ASHEVILLE, NC 28805	DE	, , ,		
(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 BI HE APPROPRIA		(X5) COMPLETION DATE	
F 318	with the resident. On 02/15/17 at 9:10 A conducted with the D who was responsible program. The DON streceive restorative nubilateral lower extrem related to having a beleft and above the knower extremity and w of 2017. The DON staide (RA) who provid Resident #58 and stamiscommunication be restorative aide (RA), had not been receiving services since 01/23/had not realized that not been performed on the shad been busy we stated she had not spaide and therapy and AROMPDR that indice Resident #58 had not since 01/23/17. The Dottained a physician's nursing as recommentand had not created a program as recommentant provide PROM to Reservices she had not created a program as recommentant had not crea	AM an interview was irector of Nursing (DON) for the restorative nursing tated Resident #58 was to ursing services for AROM for ities 3-4 times a week allow knee amputation on the right was to be reevaluated in April ated she had one restorative ed restorative services for ted due to a attween herself, the and therapy Resident #58 arg restorative nursing 17. The DON stated she the restorative services had an Resident #58 because ith other duties. The DON token with the restorative had not reviewed the ated per documentation that a received restorative nursing DON stated she had not so order for restorative anded from OT on 01/24/17	F3	18				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345438	B. WING			C 02/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		02/1//2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 318	would be placed ba services. The DON other duties and the missed for Residen: On 02/15/17 at 9:32 conducted with the only RA in the facilit restorative duties. T performed AROM to lower extremities sit thought OT had place therapy services an longer required. The discussed stopping Resident #58 with the DON if Resident #58. The RA si with the DON if Resident #58. The linformed by the DO PROM to his left up On 02/15/17 at 9:57 conducted with the (DOR) who stated to restorative nursing precommendation for provided to the DON #58 for PROM of the prevent further contintegrity. The DOR provided to the RA in the provided to the provided to the RA in the provided to the provided to the RA in the provided to the provided to the RA in the provided to the provided to the RA in the provided to the provided to the provided to the provided to the RA in the provided to the provided t	e DON stated Resident #58 ck on restorative nursing stated she became busy with e restorative program was t #58. AM an interview was RA who stated she was the y and had time to perform her the RA stated she had not o Resident #58's bilateral nce 01/23/17 because she ced the resident back on d restorative services were no e RA stated she had not restorative services on ne DON or the occupational stated she should have clarified cident #58 was still required to services for AROM before she widing restorative services for RA stated she had not been N that Resident #58 required per extremity. AM an interview was Director of Rehabilitation the DON was in charge of the	F3	18		
	stated OT had not v Resident #58 had b	rerified with the DON on how een progressing with and was not aware Resident				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345438	B. WING			C		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	•	02/17/2017		
(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 318	#58 had not been red AROM and PROM as 01/23/17. The DOR stated the recommended by the DOR stated a breakd occurred between the On 02/15/17 at 10:35 conducted with the Instated it was her expendicular to prevent a decline instatus. The IA stated restorative nursing set to prevent a decline instatus. The IA stated Resident #58 would restorative nursing set operiors or be placed Resident #58 would restorative nursing set to prevent a decline instatus. The IA stated Resident #58 would restorative nursing set to prevent a decline instatus. The IA stated Resident #58 would restorative nursing set operiors or be placed The IA stated she felt communication occur the DON. On 02/15/17 at 11:02 conducted with Resident received any there of January 2017. Resident performing exert he learned from the timo nursing staff mem exercises with him sin	reciving restorative nursing for a recommended since stated his expectation was ursing program would have and continued as rapy for Resident #58. The own in communication a DON and therapy services. AM an interview was sterim Administrator (IA) who exterim Administrator (IA) who exterior that the DON would restorative nursing program PT/OT for Resident #58. The expectation that the DON Resident #58 was receiving ervices as per the schedule in Resident #58 's ROM it was her expectation that the sume restorative nursing I back on PT/OT services.	F3	18				
	wear a prosthesis on On 02/15/17 at 11:46	services so that he could his left lower leg. AM an interview was hysician who stated if PT/OT						

` '		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017	
	ROVIDER OR SUPPLIER RELS OF SUMMIT RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 318		ative nursing for Resident ion was that Resident #58	F 3 ⁻	18			
F 333 SS=J	prevent a decline in R	OM. NTS FREE OF ERRORS	F 33	33		3/21/17	
	The facility must ensure (f)(2) Residents are from edication errors. This REQUIREMENT by: Based on record revipharmacist interview facility failed to prevenerrors for 1 out of 3 safor medication errors. his roommate's medication errors. his roommate's medication errors. his roommate's medication errors. his roommate which is roommate and the command of the command	ee of any significant is not met as evidenced ew, physician interview, and staff interviews, the nt significant medications ampled residents reviewed Resident #189 was given cations the morning of ed in him being hospitalized. Degan on 01/25/17 when dministered Resident #181's in error. Resident #189 was and admitted to the hospital ausea and vomiting and a		The facility will ensure that residere of any significant medication. The affected resident was transfor the facility on 1/25/17 at 2:00 the medication error was discovadministration. The family memoresident was notified of the error DON on 1/25/17. The physician notified by the Unit Manager on 2 pm. The resident was admitted hospital and has not returned to facility.	ferred out pm when ered by ber of the by the was 1/25/17 at		
	Jeopardy was remove facility provided and in credible allegation of remains out of compli severity of D (isolated potential for more that immediate jeopardy) of completed and monitor	sure and pulse. Immediate ed on 02/17/17 when the implemented an acceptable compliance. The facility ance at a lower scope and with no actual harm with a minimal harm that is not so ensure inservices are pring systems are put into e related to avoidance of		The facility investigation was init 1/25/17 by the DON. DON notified at approximately 1 that a family member was reque guest by sent to the hospital. At DON questioned assigned nurse for need of transfer. Nurse notif that she had administered the in medication to the guest during n	/30 pm esting that t that time e reason fied DON accorrect		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE		2/1//2017	
TO UNE OF TH	TO VIDER ON OUT FEILER			100 RICEVILLE ROAD			
THE LAUF	RELS OF SUMMIT RIDGE	İ		ASHEVILLE, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 333	Continued From page	e 64	F 33	33			
	significant medication	errors.		medication pass. DON question	oned nurse		
	The findings included			regarding her notification to the and family member to which shresponded No, I should have.	e physician ne		
	01/19/17. His admiss history of pulmonary ovein thrombosis, parc bradycardia, difficulty long term anticoagula atrophy. The most recent Mini dated 01/27/17, noted he was understood at cognition and mood on behaviors, and recombistory of pulmonary of p	walking, atrial fibrillation, int use, muscle wasting and mum Data Set, a 5 day d he had adequate hearing,		responded No, I should have. interviewed by DON on 1/25/1 was immediately taken off of a and terminated based on failur Physician, family member and facility investigation was conclusame day on 1/25/17 and POC initiated. The incident was reported to the Board of Nursing according to disciplinary tree. Their investigassigned to a complaint officer North Carolina Board of Nursing report was made by DON on 2	7. Nurse ssignment re to notify DON. The uded the c was ne NC the gation was with the ng. This		
	and hygiene. He was of anticoagulants, 7 d Occupational and Physician of morning medications *Amiodarone HCL 20 an antiarrhythmic age *Diltiazem 24 hour Ex AM to be held for sys (milliliters of Mercury) mmHg - for hypertens *Lasix 20 mg at 8 AM *Miralax powder 17 g constipation; *Levothyroxine 25 mg	noted to have taken 6 days days of diuretic and received dysical therapies. orders included the following ordered for Resident #189: 0 Milligrams (mg) at 8 AM - ent; extended release 120 mg at 8 tolic less than 110 mmHg and diastolic less than 60 sion and angina; 1 - a diuretic; rams per day at 8 AM - for cg at 6 AM - for thyroid; and 13 ml solution four times a		All residents that receive medic have the potential to be affected date of occurrence all alert and residents were interviewed to cany had received incorrect medicate of occurrence all residents not alert and oriented were obschanges in condition through dobservation and review of medicate of occurrence all residents not alert and oriented were obschanges in condition through dobservation and review of medication and review of medication and Medical Director. All residentified and Medical Director the Director of Nursing (DON). The physician and the Responwere notified immediately by Nadministration upon notification medication issue. The residentical provides and the provides	ed. On the d oriented determine if dications. d. On the s who were served for direct dical record re reported sidents ssues notified by on 1/25/17. sible Party dursing n of the t was sent		
	Review of the inciden	t report dated 01/25/17 at		for hospital evaluation and trea was discharged from the hospi			

Facility ID: 923279

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C	
NAME OF DE	ROVIDER OR SUPPLIER	343430		STREET ADDRESS, CITY, STATE, ZIP CO	•	02/17/2017	
NAME OF F	NOVIDER OR SUFFLIER				DE		
THE LAUF	RELS OF SUMMIT RIDGE	<u> </u>		100 RICEVILLE ROAD			
				ASHEVILLE, NC 28805			
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 333	Continued From page	e 65	F 33	33			
	1:30 PM, Resident #1	189 received a medication		successfully.			
	error resulting in naus						
	_	determined that Resident		All licensed nurses were in-	serviced by		
	* ·	ommate's 8 AM medications		the facility Pharmacist on 2/	15/17 on the		
	in error.			following: 1. Responsibility of	of reporting		
				med errors to the physician	at the time of		
	Review of Resident #	189's roommate's record		knowledge of an occurrence	of		
	•	ate Resident #181's first and		medication error in order to			
		e the same as Resident		what monitoring and assess			
		w of the picture in the		be initiated. 2. Definition of			
	•	al record system revealed the		errors. 3. The 6 rights of me			
	two residents were of different races and had an			which include right individua	-		
	age difference of 31 y	years.		medication, right dose, right	-		
	Decident #191 was a	dmitted to the facility on		route and right documentation			
		dmitted to the facility on ses including injury of C4		notification of family/respons The orientation process for i	•		
	cervical spine. Resid			nurses will include: 1. Respo			
		Resident #189 included:		reporting med errors to the	-		
	*Amlodipine Besylate			the time of the knowledge of			
	hypertension;	ronig at or an io.		occurrence of a medication			
	*Coreg 25mg for hype	ertension;		to determine what monitorin	g and		
		at 8 AM for depression;		assessment needs to be init	-		
		M for urinary retention;		Definition of medication erro	or. 3. The 6		
	*Flonase 0.05 % nasa	al spray at 8 AM for sinus		rights of medication pass, w	hich includes		
	congestion:			documentation. 4. The not	tification of		
	_	ml subcutaneous at 8 AM for		family/responsible party.			
	anticoagulation thera						
	*Multivitamin/mineral			Nursing Administration will o			
	*Senna S 2 tabs at 8	•		random medication adminis			
		ur times a day, first at 8 AM		observations 5 times/week f			
	for urinary discomfort			ensure compliance with the	-		
	*Vitamin D3 1000 uni	t at 8 AM.		medication pass. QA monito	-		
	The anharmatical to			initiated by the administrativ			
		e in the medical record which		during clinical meetings 5 da	•		
		tion error was written by the		determine if changes of con			
		n 01/25/17 at 2:00 PM. The		been adequately assessed v			
		ent had nausea and vomiting		documentation present. Re audits will be forwarded to the			
		ood pressure was 80/60, e 61, temperature 97.3		Nursing. Any variances wil			
	respirations 20, puise	, o i, temperature 31.3		Nursing. Any variances wil	1 100	I	

Facility ID: 923279

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 02/17/2017	
	ROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE ORICEVILLE ROAD SHEVILLE, NC 28805	<u> 021</u>	17/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	95%. The physician was given to send him evaluation and treatm to be at bedside. Review of the undate revealed Resident #1 medications. His vita temperature 97.3 Falminute, respiration ra 85/58 and 80/60 and Emergency Medical S 01/25/17. Review of that staff reported Re and his blood pressur noted he was awake, mucus membranes ar right after taking that 0.5 mg atropine was g and heart rate increas at 2:07 PM to 103/65 PM. Review of the hospita 01/25/17 revealed he history of generalized hypotension and bracacidentally given dos medication including Flomax, Flonase, Ser resident was noted to and nonbloody vomiti 85/58 and his heart ra given 0.5 mg atropine emergency departmenoted to drop to 70/50	and oxygen saturation was was contacted and an order in to the emergency room for itent. The family was noted and hospital transfer sheet 89 received the wrong I signs were listed as irenheit, pulse 61 beats per te 20, and blood pressure the pulse oximetry 95%. Services (EMS) responded the EMS report revealed sident #189 was vomiting ite was 75 systolic. EMS slow to respond, had pale and stated he just didn't feel shandful of pills this morning. Given and his blood pressure sed from 77/49 and 42 pulse with a pulse of 59 at 2:13 I history and physical dated presented with a 1 day malaise as well as lycardia. Resident #189 was see of another resident's Coreg, Citalopram, Lovenox, nokot and Urecholine. The have some mild nausea ing, his blood pressure was ate was in the 40s. He was at in route and once in the int, the blood pressure was	F	3333	addressed at the time identified. All findings will be reported by the Director Nursing to the QA Committee monthly 3 months with additional education and training provided for any identified issued in the provided for any identified in the provided for any ide	for I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345438		B. WING		C 02/17/2017	
	ROVIDER OR SUPPLIER			S 1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805	<u> 02/</u>	17/2017
(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 333	pressures improved to with a heart rate curre Resident #189 stayed discharge to another. The hospital discharge stated Resident #189 observation status se and hypotension form. This continued despit additional medication the following day, how secondary to no rest was somewhat agitat the resident was stard. Review of the Employ revealed Nurse #3, we error related to Resid 01/25/17 for "making magnitude which may and welfare." Additionerror occurred at app AM and the nurse fail Nursing (DON), Phys became aware of the PM. Nurse #3 was intervie at 9:09 AM. Nurse #3 normal busy day. Shinterruptions from the per usual. It was her days off and she was the night before. She Resident #189 a cour	s hydration and his blood to the 100-110 systolic range ently around 57-59. If in the hospital until nursing facility on 01/30/17. The summary dated 01/30/17 was initially admitted to condary to his bradycardia in the medication misuse. If It is likely a summary dated to condary to his bradycardia in the medication misuse. If It is likely a summary dated on the medication were for discharge wever on 01/27/17 the night before, the resident red and confused. As such, and on the delirium protocol. It is likely a summary of the medication ent #189 was terminated on errors of sufficient and provided the medication ent #189 was terminated on errors of sufficient and indicated the medication ent with the summary of the Director of the ician or family. The DON error at approximately 1:30 exwed via phone on 02/15/17 as stated on 01/25/17 it was a se stated there were multiple rapy during medication pass first day back from several tired from getting little sleep as stated she had worked with one of times before. She had been admitted the day	F	333			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345438	B. WING		02	C 2/17/2017
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		31772017
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	that she had spoken times that morning renew order for a nebul several other resident inform the physician of the next time she saw therapy and then afte. She stated she though pressure after the mesure. She stated that physician about the mesure. On 02/15/17 at 10:14 conducted with the ownower with the ownower with the ownower with the ownower with the stated he and the up and he vomited age #189 as awake but mesure and oT could not stated he vomited "a required maximum as was definitely different Resident #189's physically 11:36 AM was in the building the informed of any medial ready left the facility was a different nurse him of the medication he would have had the	ong medications, she aly, immediately." She stated to the physican several lating to Resident #189's izer treatment and related to its but never thought to of the med error. She stated at Resident #189 he was with relunch he started vomiting. In the staff took his blood deerror but she was not a she informed the DON and ned error when Resident. AM an interview was ecupational Therapist (OT) ident #189 the day of the he went in to work with him bathroom covered in vomit. In nurse aide got him cleaned gain. OT described Resident such less verbal than his of understand him. OT good bit." OT also stated he esistance to transfer which st. Inician was interviewed on at morning but was not cation errors until he had at morning but was not cation errors until he had at morning but was not cation errors until he had are ror. He stated normally enurse monitor vitals signs nedication error and possibly	F 33			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 02/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	02/1//2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 333	at 8:26 AM. NA #1 with Resident #189 #189 was not able this usual. He was commode which she stated that she Resident #189 vom took his blood presetake his vital signs. OT transferred him #189's responsible she thought he had #3 stated she had resident #189 throughout the On 02/15/17 at 12:10 was informed arour Resident #189's reside	was interviewed on 02/15/17 stated she routinely worked and on 01/25/17 Resident to stand and do for himself per unable to get himself off the e said was different for him. Informed Nurse #3 of siting and believed the nurse sure. NA #1 stated she did not A few minutes after she and into the chair, Resident party came in mentioned that taken a turn for the worse. NA noticed a change in Resident	F 33	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345438	B. WING		02/17/2	2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	02/17/	2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE CO	(X5) OMPLETION DATE
F 333	Continued From pag	ge 70	F 33	3		
	Immediate Jeopardy	ster facility were informed of on 02/15/17 at 2:38 PM.				
		an acceptable credible ance on 02/16/17 at 2:32 PM				
	any significant medi The affected resider facility on 1/25/17 at	re that residents are free of cation errors. It was transferred out of the 2:00pm when the medication d by administration. The				
	family member of th error by DON on 01 notified by Unit Man	e resident was notified of the /25/17. The physician was ager on 01/25/17 at 2pm. The ed to the hospital and has not				
	The facility investigated by the DON.	ation was initiated on 01/25/17				
	approximately 1:30 requesting that the r	n sing (DON) was notified at pm that a family member was resident be sent to the the DON questioned the				
	to transfer the reside notified the DON that incorrect medication	arding the reason for the need ent to the hospital. The nurse at she had administered the to the resident during pass. The DON questioned				
	the nurse regarding and family member I should have." Nurs	her notification of physician to which she responded, "No, se interviewed by DON on as immediately taken off of				
	assignment and terr notify Physician, fan	ninated based on failure to nily member and DON. The was concluded the same day				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD 100 RICEVILLE ROAD ASHEVILLE, NC 28805	jE	02.1172011
(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 CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 333	initiated. The licensed nurse ir immediately due to nerror at the time of or reported to the NC Betheir disciplinary tree assigned to a compla Carolina Board of Nu DON on 02/07/17. All residents who recpotential to be affected occurrence (1/25/17) residents were intervidetermine if any had medications. No other the date of occurrence alert and oriented we changes in condition and review of medicaresults were reported on 2/15/17 all reside affected were again residents did not indicated any medications being residents with cognitible by licensed nurses. It would be related to medicate the nurse failing to form Medication Administration, and a use of the nurse's pe	Plan of Correction) was nvolved was terminated of reporting the medication occurrence. The incident was oard of Nursing according to . Their investigation was aint officer with the North resing. Report made by the eive medications have the ed. On the date of all alert and oriented iewed by the DON to received incorrect er issues were identified. On the eall residents who were not re observed by the DON for through direct observation all records. These audit I to the Medical Director. Into having the potential to be reviewed. Alert and oriented cate that they were aware of the given incorrectly. All we issues were reassessed No issues were noted that medication issues. tails of the event, facility error likely occurred due to llow the 6 Rights of ation which include: Right cation, right dose, right time,	F	333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		2/17/2017
(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 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	Continued From page include the room num was assigned. There the resident's names different. In-servicing All licensed nurses (vadminister medication DON on the Six Right Administration and the use during medication February 5th thru the All licensed nurses with facility's Pharmacist of 1. Responsibility of rephysician at the time occurrence of medical determine what monineeds to be initiated. errors which is "Any emedication use proceed medication pass which is the notification of DON and Regional Quicensed Nurses on 2 cell phone use during System Change The orientation proceed.	abers and the unit the nurse were similarities between however the race was who are the only staff who has) were in-serviced by the serviced by the serviced by the home of the serviced and assessment home of the serviced and home of the serviced all home of the serviced home of the serviced home of the serviced home.	F 3	DEFICIENCY)	TROFNAIL	
	errors to the physicia knowledge of an occur in order to determine assessment needs to medication errors. 3. pass which included in picture and name (if the confirmation will be o	urrence of a medication error what monitoring and be initiated. 2. Definition of The 6 right of medication dentifying residents via their he nurse is unsure				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
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		345438	B. WING			02/	17/2017
	ROVIDER OR SUPPLIER	:	·	STREET ADDRE 100 RICEVILLE ASHEVILLE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	((E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B ISS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371 SS=E	2:15 PM when intervithey had been inservitake to ensure the coadministered to the ridosage, at the correct and the documentation 483.60(i)(1)-(3) FOOI STORE/PREPARE/S (i)(1) - Procure food fit considered satisfactor authorities. (i) This may include from local producers, and local laws or regulation of the considered satisfactor authorities from using properties of the considered satisfactor authorities. (ii) This provision does facilities from using properties of the consuming food (iii) This provision does from consuming food (iiii) This provision does from consuming food (ii)(2) - Store, prepare accordance with professervice safety. (i)(3) Have a policy restricted foods brought to restrict to ensure safety.	was removed on 02/17/16 at ews with nurses confirmed ced and knew the steps to rrect medications were ght individual, in the correct time, by the correct route on was accurate. D PROCURE, ERVE - SANITARY rom sources approved or rry by federal, state or local cod items obtained directly subject to applicable State ulations. Is not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. distribute and serve food in essional standards for food regarding use and storage of dents by family and other eand sanitary storage,		333	DEFICIENCY)		3/21/17
	handling, and consun This REQUIREMENT by:	nption. is not met as evidenced					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SUI COMPLET	
		345438	B. WING		C 02/17 /	2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/17/	2017
				100 RICEVILLE ROAD		
THE LAUF	RELS OF SUMMIT RIDGE			ASHEVILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Continued From page	e 74	F 3	71		
	Based on observatio facility failed to ensurundated beverages w	ns and staff interviews the e expired strawberries and rere discarded in 1of 2 tors and failed to discarded		The facility will ensure that food prepared, distributed and served sanitary conditions.		
	The Findings included	d:		The identified food was discarde immediately on observation by st	-	
	room was conducted Nurse #1. An observa refrigerator revealed juice in a clear contain of cranberry juice in a	he 100 hall nourishment on 02/13/17 at 8:55 AM with ation of the nourishment 1 full ½ gallon of orange ner with a lid, 1 full ½ gallon clear container with a lid, 1 juice in a clear container		All current residents have the pobe affected. All items in the facil storages areas and dietary refrigwere inspected with no other issuncted.	ity dietary erators	
	with a lid, and ¾ emp a clear container with available for resident container dated 1/20/ strawberries that were substance on the strahe did not know how the nourishment refrigwas not dated. Nurse	ty ½ gallon of tomato juice in a lid that was undated and use and 1 clear plastic		The Food Service Director was in-serviced by the Registered Die the facility'□s policies on food sto according to sanitary conditions 3/7/2017. All dietary staff will be in-serviced Food Service Director on the fac policies on food storage according sanitary conditions ON 3/7/2017.	orage ON d by the ility'⊡s ng to	
	tomato juice and pour the nourishment room strawberries had a fur were outdated and we refrigerator ready for immediately removed discarded them in a troom. On 02/13/17 at 9:00 A conducted with Nurse juice, cranberry juice, juice should have been	red them down the sink in n. Nurse #1 verified the zzy substance on them and ere in the nourishment resident use. Nurse #1 the strawberries and rash bin in the nourishment		A QA monitoring tool will be utilizensure ongoing compliance in alstorage areas by the Food Servic Director 5 times a week x 4 weel then weekly thereafter. A QA monitoring tool will be utilizensure ongoing compliance by the Administrator weekly for 3 monthe Administrator will report findings committee monthly x 3 months a quarterly thereafter. Additional eor training will be provided for an identified.	ed to ne ss. to the QA nd ducation	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345438	B. WING _			C 02/17/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 100 RICEVILLE ROAD ASHEVILLE, NC 28805	DDE	02/1//2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REF	ON SHOULD BE HE APPROPRIA	DATE
F 371	were expired on 01/2 discarded. Nurse #1 was responsible to c refrigerator for outdated. On 02/13/17 at 11:34 conducted with the Ir (IDM) who stated juic containers and store refrigerator should ha in the nourishment rewould have been out when placed in the restrawberries with a discarded by 0. The IDM stated it was orange juice, cranbe tomato juice would hin the nourishment restrawberries would hin the nourishment gray of the IDM stated her expectation strawberries would hin the Ir stated her expectation strawberries would have been 100 hall nourishment policy. The administrates in the restriction of the IDM states are strawberries would hin the Ir stated her expectation straw	#1 stated the strawberries 20/17 and should have been stated he was not sure who heck the nourishment tes and assure the juice was a terim Dietary Manager be that was placed in doin the nourishment ave been dated when placed efrigerator and the juice dated 3 days from the date efrigerator and the ate of 01/20/17 should have 1/23/17 per facility policy. Is her expectation that the erry juice, apple juice, and ave been dated when placed efrigerator and the ave been discarded when placed efrigerator and the ave been discarded when to the check the nourishment but dated food and 100 PM an interview was anterim Administrator (IA) who can was that the expired ave been discarded from the tarefrigerator and the orange of the check of the nourishment out dated when placed in the tarefrigerator as per facility that or stated the DM or	F3	371		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		345438	B. WING _			C 02/17/2017	
	ROVIDER OR SUPPLIER	! ≣		STREET ADDRESS, CITY, STATE, ZIP CO 100 RICEVILLE ROAD ASHEVILLE, NC 28805	DDE	02/11/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 371	1 -	e 76 d beverages and discard as	F3	371			
	on 02/13/17 at 8:35 A observation of the war an unopened gallon of gallon of whole milk the expiration date of 02/17 resident use. The Context was an unopened gallon of whole milk from the conducted with the distract of the conducted with the lift (IDM) who stated mill on the container and by date than the milk discarded. The IDM stof the full gallon of whole gallon of whole milk was 02/09/17 should have remained in the 02/13/17. The IDM stof the Dietary Managassure foods and liquid walk in refrigerator #2 responsibility of the Dietary of the Dietary than the context of the Dietary than the context of the Dietary Managassure foods and liquid walk in refrigerator #2 daily the refrigerator #2 daily the refrigerator that the context of the Dietary than the context of the Dietary than the context of the Dietary Managassure foods and liquid walk in refrigerator #2 daily the refrigerator #2 daily the refrigerator that the context of the Dietary than the context of the Dietary Managassure foods and liquid walk in refrigerator #2 daily the refrigerator #2 daily the refrigerator that the context of the Dietary Managassure foods and liquid walk in refrigerator #2 daily the refrigerator #2 daily the refrigerator that the context of the Dietary Managassure foods and liquid walk in refrigerator #2 daily the refrigerator #2 daily the refrigerator #3 daily the refrigerator #4 daily the refr	alk in refrigerator #2 revealed of whole milk and a ¾ empty hat had a stamped 09/17 and was available for ook immediately removed the om the walk in refrigerator. AM an interview was ook who stated the expired thave been in walk in oble for resident use. The arry aides checked the walk in chedule of 2-3 times a week and the expired whole milk. AM an interview was atterim Dietary Manager of the date was past the use					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
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		345438	B. WING			02/	17/2017
	ROVIDER OR SUPPLIER	Ē		100 RI	T ADDRESS, CITY, STATE, ZIP CODE CEVILLE ROAD VILLE, NC 28805		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page On 02/14/2017 at 5:0 conducted with the In stated her expectation whole milk and the 3/ in the walk in refrigera discarded per the stat container that indicate IA stated the DM or d check the walk in refr dating of beverages at 483.80(a)(1)(2)(4)(e)(PREVENT SPREAD, (a) Infection prevention The facility must esta and control program (a minimum, the follow (1) A system for preve investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according accepted national stat implementation is Pha- (2) Written standards for the program, whice limited to: (i) A system of surveil	o PM an interview was terim Administrator (IA) who in was that the 1 gallon of 4 empty gallon of whole milk ator # 2 would have been imped expiration date on the ed a date of 02/09/17. The esignee was responsible to igerator for appropriate and discard as appropriate. (f) INFECTION CONTROL, LINENS on and control program. blish an infection prevention (IPCP) that must include, at wing elements: enting, identifying, reporting, introlling infections and ses for all residents, staff, and other individuals der a contractual upon the facility assessment to §483.70(e) and following indards (facility assessment asse 2); , policies, and procedures h must include, but are not	F	371		TE	3/21/17
	possible communicab	ole diseases or infections and to other persons in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345438	B. WING _			C 02/17/2017
	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CO 100 RICEVILLE ROAD ASHEVILLE, NC 28805		2111/2011
(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 BE IE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From page	e 78	F4	41		
		m possible incidents of se or infections should be				
	` '	ent spread of infections;				
	(iv) When and how is resident; including bu	olation should be used for a t not limited to:				
	involved, and (B) A requirement that	ation of the isolation, infectious agent or organism it the isolation should be the ble for the resident under the				
	must prohibit employed disease or infected sl	s under which the facility ees with a communicable kin lesions from direct s or their food, if direct ne disease; and				
	(vi) The hand hygiene by staff involved in di	e procedures to be followed rect resident contact.				
	(4) A system for recounder the facility's IP actions taken by the f					
	(e) Linens. Personne process, and transpo spread of infection.	el must handle, store, rt linens so as to prevent the				
	(f) Annual review. Th annual review of its If program, as necessa					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						(С
		345438	B. WING _			02/	17/2017
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
TUELALIE	RELS OF SUMMIT RIDO	25		100	RICEVILLE ROAD		
THE LAU	RELS OF SUMMIT RIDO	3E		AS	SHEVILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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 441	Continued From page	ge 79	F4	441			
	This REQUIREMEN	T is not met as evidenced					
	by:						
	Based on observat	ions, record review and staff			The facility will continue to provide a sa	afe	
	interviews the facilit	y failed to follow droplet			environment for residents by observing	J	
		ility policy and procedure for 1			droplet precautions.		
		ed for infection control					
	(Resident #31).				Resident # 31 had completed the cours	se .	
	The finalines in alred	- al.			of medication and had been		
	The findings include	ea:			asymptomatic for 2 days. Proper signa and isolation cart were in place.	ige	
	The transmission ha	ased precautions of the facility			and isolation cart were in place.		
		ons from the Infection Control			Nurse Aide #2 was re-educated at the		
		ty and revised on 01/2013			time of survey regarding droplet		
	indicated the followi				precautions.		
		-					
		cility will utilize Droplet			All guests have the potential to be		
	1	cified guests known or			affected when isolation precautions are		
		ected with microorganisms			not observed. No other residents in the		
		lets that can be generated by			facility were under isolation precautions	3 .	
	_	g coughing, sneezing, talking or procedures such as			Stoff (including all departments) will be		
	suctioning or trach				Staff (including all departments) will be in-serviced by SDC or DON or Regiona		
	Suctioning of tracin	Sarc.			QA Manager for observing isolation		
	Procedure: Ma	asks			precautions according to facility policy	bv	
	1. Wear a mas	sk when working within three			3/20/2017.	,	
	feet of the guest (re	sident).					
					A QA monitoring tool will be utilized by	the	
					charge nurses to ensure that staff are		
		idmitted to the facility on			observing precaution signs when enter		
	01/10/17.				rooms of residents with precaution sign		
	During tree delices	to rooms during least as			times a week x 4 weeks. Then 3 times		
	, ,	to rooms during lunch on .M, Nurse Aide (NA) #2 was			weekly x 2 months. Any issue will be corrected at the time of the observation	,	
		on the exterior door from the			and additional education provided when		
		m for Resident #31. The			indicated.		
		sign posted that stated			maiotiou.		
		s". This sign also stated the			Observation results will be reported to	the	
	following:				DON weekly for the next 3 month and	. =	
					concerns will be reported to the Quality	,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345438	B. WING _			C 02/17/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP COD 100 RICEVILLE ROAD ASHEVILLE, NC 28805	•	02/1//2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441	C. Dietary may NA #1 was observed meal tray with no ma and receiving another resident in the room observed exiting the During an interview of NA#2 stated she delify room for Resident #3 having a mask on. In the she was supposed to trying to get the meat forgot to put the mass. During an interview of Nurse #1 (N #1) state positive for influenzate treatment, and had a steps for droplet precon 02/07/17. During an interview of Medical Director (ME) residents with the fluent Resident #31. During an interview of Nursing (It precautions had been #31. The DON state put any resident who droplet precautions. Staff have mandatory infection control. The	d hygiene when entering room not enter going into the room with the sk, coming back to the door or meal tray for the 2nd again with no mask, then room without a mask on. on 02/13/17 at 12:15 PM vered the meal trays into the st and his roommate without IA #2 also stated she knew of wear a mask, but she was I trays delivered quickly and	F 4	Committee monthly meetings Continued compliance will be by the QA Committee for 3 m quarterly thereafter. Additions or training will be provided for identified.	monitored onths and al education	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING				C 17/2017
	ROVIDER OR SUPPLIER	=		1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 514 SS=D	and the sign on the de 483.70(i)(1)(5) RES	droplet precaution protocol		441 514			3/21/17
	standards and practic	h accepted professional ces, the facility must ords on each resident that					
	(i) Complete;						
	(ii) Accurately docume	ented;					
	(iii) Readily accessible	e; and					
	(iv) Systematically org	ganized					
	(5) The medical recor	rd must contain-					
	(i) Sufficient information	on to identify the resident;					
	(ii) A record of the res	sident's assessments;					
	(iii) The comprehensing provided;	ve plan of care and services					
	(iv) The results of any and resident review e determinations condu						
	(v) Physician's, nurse professional's progres	e's, and other licensed ss notes; and					
		logy and other diagnostic equired under §483.50.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		· /	(X3) DATE SURVEY COMPLETED				
		345438	B. WING _			Ι,	C 02/17/2017
	ROVIDER OR SUPPLIER	<u> </u>		100	REET ADDRESS, CITY, STATE, ZIP CODE D RICEVILLE ROAD SHEVILLE, NC 28805	<u>. 1 </u>	5271772017
(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 514	This REQUIREMENT by: Based on record rev facility staff failed to records reviewed with information. Resident not complete and did circumstances occurr being sent to the hose following a medication. The findings included Resident #189 was a 01/19/17. His admiss history of pulmonary vein thrombosis, pare bradycardia, difficulty long term anticoagular atrophy. The most recent Minited dated 01/27/17, noted he was understood a cognition and mood who behaviors, and receivith bed mobility, trained hygiene. He was of anticoagulants, 7 of Occupational and Physician of morning medications *Amiodarone HCL 20 an antiarrhythmic age *Diltiazem 24 hour Examples.	is not met as evidenced few and staff interviews, the naintain 1 of 15 clinical n complete and accurate t #189's clinical record was not accurately reflect the ing which precipitated him pital for nausea and vomiting n error. : dmitted to the facility on sion diagnoses included a embolism, a history of deep oxysmal tachycardia, walking, atrial fibrillation, ant use, muscle wasting and mum Data Set, a 5 day d he had adequate hearing, nd understands, his vere not assessed, he had quired extensive assistance nsfers, dressing, toileting, noted to have taken 6 days lays of diuretic and received dysical therapies. orders included the following ordered for Resident #189: 0 Milligrams (mg) at 8 AM - ent; stended release 120 mg at 8 tolic less than 110 mmHg and diastolic less than 60	F	514	The facility will continue to have compaccurate nursing notes regarding assessments in relation to medication errors. Resident # 189 no longer resided in the facility at the time of survey. Medical records of residents who have been identified as having a change in condition have had their charts review for complete and accurate nursing not with any issues addressed if indicated. Licensed nurses will be in-serviced or documentation expectations regarding change of condition, falls, acute episo by DON or Regional QA Manager by 3/20/2017. At clinical meetings conducted each weekday, the following will be reviewed Nurse Administrative Team: a. Physi order to identify any changes, b. Incid Reports, c. 24 hour report, d. Chart Review. The clinical record will be reviewed to determine that the medical record contains the appropriate documentation regarding assessment observations and satisfactions as appropriate. A QA Chart Audit tool will be utilized by	ne e des l. l. des ed by cian ent	

Facility ID: 923279

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 2/17/2017
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, ZIP COD 100 RICEVILLE ROAD ASHEVILLE, NC 28805		2/1//2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pag		F 514			
	constipation; *Levothyroxine 25 m for thyroid; and *Albuterol sulfate 2.5	A - a diuretic; grams per day at 8 AM - for icrograms (mcg) at 6 AM - mg/3 ml solution four times ordered 01/25/17 - for		Administrative nurses to revieweeks then monthly thereafted. The DON will review findings x 3 months and quarterly therefore the QA committee to ensure compliance. Additional educator monitoring to occur as indicated.	r. every month eafter with ongoing ation, training	
	Review of the incident report dated 01/25/17 at 1:30 PM, Resident #189 received a medication error resulting in nausea and vomiting and hypotension. It was determined that Resident #189 received his roommate's 8 AM medications in error.					
	#181) record reveale last name initials wer #189's initials. Revie computerized medica	#189's roommate's (Resident d, the roommate's first and re the same as Resident ew of the picture in the all record system revealed the f different races and had an years.				
	01/24/17 with diagnotervical spine. Reside medications given to *Amlodipine Besylate hypertension; *Coreg 25mg at 8 AM*Escitalopram 20 mg *Flomax 0.4mg at 8 AM*Flonase 0.05 % nascongestion:	Resident #189 included: e 10mg at 8 AM for If for hypertension; at 8 AM for depression; AM for urinary retention; all spray at 8 AM for sinus If subcutaneous at 8 AM for apy; at 8 AM;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345438	B. WING			C 02/17/2017		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE			
F 514	*Urecholine 50mg Four times a day, first at 8 AM for urinary discomfort.; and *Vitamin D3 1000 unit at 8 AM. The only nursing note in the medical record for the 7 AM to 7 PM shift on 01/25/17 was written by the Director of Nursing on 01/25/17 at 2:00 PM. The note stated the resident had nausea and vomiting and hypotension. Blood pressure was 80/60, respirations 20, pulse 61, temperature 97.3 degrees Fahrenheit and oxygen saturation was 95%. The physician was contacted and an order was given to send him to the emergency room for evaluation and treatment. The family was noted to be at bedside. A telephone interview with Nurse #3 who made the medication error was conducted on 02/15/17 at 9:09 AM. Nurse #3 stated it was a busy day as usual and she realized immediately she had given Resdient #189 his roommate;s medications in error at the morning medication pass. She stated that she should have written notes about the incident but "probably did not." She stated she informed the Director of Nursing (DON) about the medication error, after he began having nausea and vomiting which was after he ate lunch. After informing the DON about the medication error		F 5					
	one hour longer to girand count off medical was then terminated. not notified the physimedication error. Interview with the DC revealed she expected nursing note and inclinate and country and country in the property of th	vomiting, she stayed about ve report, finish paperwork tions to another nurse. She Nurse #3 stated she had cian, DON or family of the DN on 02/16/17 at 1:36 PM ed Nurse #3 to write a ude enough information in explain preceding events, vital						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345438	B. WING _			C 02/17/2017			
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 514	Continued From page signs and notification responsible party.		F 5						