DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	-		OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345418	B. WING		C 06/29/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEVILL	E HEALTH CARE CENT	ER		984 US HIGHWAY 70 WANNANOA, NC 28778	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS	;	F 000		
		ation (Event ID #VNY311) 5/28/18 through 06/29/18. was identified at:			
	of J.	600 at a scope and severity 684 at a scope and severity			
	Tags F600 and F684 quality of care.	constituted substandard			
		began on 05/29/18 and was 8. An extended survey was			
F 600 SS=J		•	F 600		6/30/18
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	§483.12(a) The facilit	ty must-			
	physical abuse, corpo involuntary seclusion This REQUIREMENT by:	•		Disclaimer:	
		nd Emergency Medical		Submission of this plan of correction do	es
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE	(X6) DATE
Electroni	cally Signed				07/23/2018

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.

		MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	` '	SURVEY
			A. BUILDING	3		
		245442	B. WING		C	
		345418	B. WING		06	/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	E HEALTH CARE CENT	ER		1984 US HIGHWAY 70		
				SWANNANOA, NC 28778		
(X4) ID			ID	PROVIDER'S PLAN OF CORREC		(X5) COMPLETIO
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		DATE
F 600	Continued From pag	e 1	F 60	0		
		e facility neglected to stay		not constitute admission or agree	ment bv	
		minister oxygen, and raise		the provider of the truth or the fac	-	
		for a resident who was		alleged or conclusions set forth in		
	experiencing shortne	ess of breath and assessed		Statement of Deficiencies. The pla		
	with a decreased oxy			correction is submitted solely beca		
	percent. The residen	t was sent to the emergency		required by the provision of federa	al and	
	room for evaluation a	and treatment of pneumonia		state law.		
	(Resident #1).			F600 Free from Abuse and Neg	lect	
				CFR(s): 483.12(a)(1)		
		began on 05/29/18 when		(1) Plan for correcting specific are		
		to raise the head of the bed		concern identified, include the pro	cess	
		en for Resident #1 who was		that led to the concern:		
	experiencing shortne			Upon review of the aforementione		
		aturation of 78%. The		there is evidence that LPN #1 did		
		t to the emergency room for		follow facility procedures when ad	-	
	evaluation and treatr	was removed on 06/29/18		Resident #1 s change of condition including implementation of interv		
	when the facility impl			for low oxygen saturation levels (7		
		ate Jeopardy removal. The		and shortness of breath, which	070)	
	-	f compliance at a lower		subsequently resulted in neglect,	defined	
		evel D (no actual harm with		by CMS as Failure to provide goo		
		e than minimal harm that is		services necessary to avoid physi		
		rdy) to complete employee		harm, mental anguish, or mental i		
		e monitoring systems in		(See 42 CFR Part 488.301.). Inter		
	place are effective.			with LPN #1 states that nurse had		
				instructed CNA #1 to get oxygen		
	The findings included	d:		was completing documentation to		
				Resident #1 to hospital. Per LPN		
		nitted to the facility on		believed that Resident #1 was sitt	-	
	-	ses of heart failure, chronic		edge of bed, and thus could not ra		
	and high blood press	ry disease, respiratory failure,		head of bed. LPN #1 also believe		
	and migh blood press			CNA #1 was applying O2 to reside Interview with LPN #1 revealed th		
	Review of the Eacility	y Standing Orders updated		understood that setting up O2 was		
	08/2011 revealed the			CNA scope of practice, but was tr		
	shortness of breath:			save time in light of Resident #1		
	a. Elevate head of	bead		change of condition. Resident #1		
				saturation rate was 78% which jus		
	b. Check oxygen s	aturation on room air before		supplemental oxygen and monitor		

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		MEDICAID SERVICES			OMB NO. 0938-0			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING					
		345418	B. WING		C			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	06/29/2018			
	KOWDER OR SOLT EIER			1984 US HIGHWAY 70				
ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET			
F 600	Continued From page	2.2	F 00					
1 000	Continued From page		F 60		iowed			
	application of oxygen			baseline O2 saturation rate is ach The plan to correct this identified of				
	c. Apply oxygen to	get oxygen saturation to		includes the completion of a thoro				
	90%.	get engeen oataration to		investigation surrounding the ever				
				5/29/18, completion of a Root Cau				
		tor vital signs (temperature,		Analysis to identify the variables the	nat led			
	heart rate, respiration	, , , , , , , , , , , , , , , , , , , ,		to the process failure, house-wide				
sat e.	saturation after applic	cation of oxygen.		education and in-service training t				
				appropriate staff on areas for oppo				
	e. Noury physician	after above completed.		to include topics of abuse, neglect reporting, resident rights, Physicia				
	Review of the most re	ecent quarterly Minimum		Orders, Standing Orders, Interven				
	Data Set (MDS) date	· ·		respiratory distress, protocol for lo				
	. ,	erely cognitively impaired		Oxygen levels, change of conditio				
	and required limited t	o extensive assistance with		physician notification, resident				
		y living. The MDS was not		assessments, and updating / follow				
	coded for oxygen use	e for Resident #1.		care plans. The facility will also im				
	Deview of the same of	an dated 04/25/49 revealed		monitoring measures and random				
	Resident #1 had alter	an dated 04/25/18 revealed		spread over the course of the nex days to ensure compliance and ef				
		ning related to emphysema		this plan. Lastly, all audit results w	-			
		monia. The goal was for		shared with the facility Quality Ass				
		ain normal breathing pattern		Performance Improvement team a				
	as evidenced by norm	nal respirations, normal skin		Medical Director no less than mon				
	-	piratory rate/pattern through		review. All negative audit results v				
		nis pulse oximetry will remain		immediately brought before the Q				
	-	ough the review date. The		team and Medical Director for imm	nediate			
		d: Monitor for signs and ory distress and report to		review and remedy.(2) The procedure for implementing	ng the			
	MD as needed. Monit	-		acceptable plan of correction for th				
	needed.			specific deficiency cited:				
				On 6/28/18, the Director of Nursin	g			
	Review of the nurse's	s notes dated 05/30/18		immediately suspended LPN #1 p	ending			
		g note was written by Nurse		investigation regarding neglect an				
	#1 at 1:20 AM: Resid	-		to provide quality of care. If invest				
	-	tless, he indicated left flank,		is substantiated, facility will follow				
	-	d where he hurt. Resident		terminating LPN #1 s employmer				
		for short periods while sitting turation would drop, then		reporting event to required agenci licensing boards, as appropriate.	co di lu			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
						С
		345418	B. WING		0	6/29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	P CODE	
				1984 US HIGHWAY 70		
ASHEVILI	_E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 3	F 60	00		
	rise again once he ro		1.00			
		ard over a patient's lungs		On 6/28/18, the Director	of Nursing, Staff	
		unds. The Family Nurse		Development Coordinato	•	
	Practitioner (FNP) ha	-		and Assistant Director of		
	urinalysis with a cultu	ire and sensitivity, and a		a timeline of events surro	ounding the	
	-	t #1's family member, stated		5/29/18 occurrence in or		
		to the emergency room		successfully conduct a R		
		nd treatment, stating she		Analysis of the process fa		
	-	ng a heart attack. The on-		failure was determined at	•	
		ed via telephone at 6:20 PM		timeline by DON and Adr		
		Resident #1 sent to the ER. ng (DON) was notified via		6/28/18. The failed proce		
		cy Management System		that LPN #1 did not follow protocols when he obser	-	
		via telephone for pickup.		78% O2 saturation rate.		
		the facility at 6:45 PM. Vital		saturation rate was obse		
		ssure - 104/67, pulse - 113,		should have placed resid	,	
		perature - 98.1 (orally),		supplemental Oxygen, el		
	-	% on room air. Nurse #1		bed, and remained with r		
	contacted the ER at	11:00 PM and was informed		resident could reach a ba	aseline O2	
	that Resident #1 had	been admitted to the		saturation rate, which LP	N #1 failed to do.	
	hospital for pneumon	ia. The DON was notified via				
	telephone at 11:10 Pl	М.		On 6/28/18, the Director	•	
				conducted 100% chart at		
		ency Medical Services		residents discharged fror		
		ed 05/29/18 revealed they		due to death or hospitaliz		
		cility at 6:27 PM for transport		last 90 days to review for	-	
	-	difficulty breathing to the		monitoring, change of co		
		R). The EMS report revealed cility at 6:41 PM and to		following of standing orde		
		e at 6:44 PM. They departed		residents with no negativ		
		at 7:04 PM and arrived at		noted as a result. Howev		
	the hospital at 7:35 P			findings were added to o		
		arrived at the facility they		Assurance / Performance		
	-	ng flat on his bed with		plan and discussed with	-	
	-	inds. His family member was		Director on 6/29/18.		
	at the bedside and st					
	congestion lately but	was worse today. They sat		On 6/28/18, the facility	s Staff	
		d and he was able to pivot		Development Coordinato		
	with assistance to the			facility s policies and pro		

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		ND HUMAN SERVICES				FOR	ED: 07/30/201
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DAT	<u>O. 0938-039</u> E SURVEY IPLETED
		345418	B. WING			06	C 5/29/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				198	4 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		SW	ANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	e 4	F 6	00			
1 000			FO				
		mity swelling, lung sounds			regarding abuse, neglect, abuse		
		t, and skin was cool and			reporting, and resident rights and beg		
	clammy. Review of the	,0			100% in-servicing of all staff on this to		
	readings on the EMS	69%, 6:59 PM - 73%, 7:00			with post \Box test administered. Starting 6/28/18, no staff is permitted to work		
	-	80%, 7:17 - 92 %, 7:24 -			education is received and post -test	unui	
	•	93%. Oxygen via nasal			completed. Staff education to be		
		at 7:01 PM and a CPAP,			completed by 6/29/18 on abuse, negl	ect	
		irway pressure is a form of			abuse reporting, and resident rights.		
	•	ure ventilator, which applies			staff who have not completed in-pers		
		a continuous basis to keep			over the phone education and post-te		
	•	usly open in people who are			will be mailed a copy of each via USF		
	-	taneously on their own, was			Certified Mail and will not be permitte		
	applied at 7:03 PM.	-			work until this education and post-tes		
					completed. Compliance will be ensure	ed	
	Review of the hospita	al discharge summary dated			and tracked by each employee⊡s		
		esident #1 likely expired due			respective department manager.		
		onia, which may have been a			This training included:		
		nd was significantly affected			(a) Resident Rights \square specific focus of		
	by his congestive hea	art failure.			¿483.12 that The resident has the rig	pht to	
					be free from abuse, neglect,		
		certificate for Resident #1			misappropriation of resident property,		
	revealed he expired o	on 05/30/18 from			exploitation as defined in this subpart		
	pneumonia.				This includes but is not limited to free		
	An interview conduct	ad an 06/20/10 at 10:10 DM			from corporal punishment, involuntary		
		ed on 06/28/18 at 12:10 PM			seclusion and any physical or chemic	al	
		she observed Resident #1 :00 AM to 3:00 PM shift and			restraint not required to treat the resident□s medical symptoms		
		usual and acting different.			residentias medicai symptoms		
		ted it to the FNP and she			(b) Abuse - As defined by the Centers	s for	
		a chest x-ray. Nurse #2			Medicare and Medicaid Services, Abu		
		ported to Nurse #1 about			is the willful inflection of injury,		
		owsier and acting different			unreasonable confinement, intimidation	on.	
	-	d ordered lab work and a			or punishment with resulting physical	- · - 7	
	chest x-ray earlier that				harm, pain or mental anguish. Abuse	also	
	,	-			includes the deprivation by an individ		
	An interview conduct	ed on 06/28/18 at 1:39 PM			including a caretaker, of goods or ser		
		tioner stated she saw			that are necessary to attain or mainta		
		9/18 at 11:15 AM per his			physical, mental, and psychosocial		

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TATEMENT (OF DEFICIENCIES	X MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COM	IPLETED
		345418	B. WING		0	C 5/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	J/23/2010
				1984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CEN	ITER		SWANNANOA, NC 28778		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETIC DATE
F 600	Continued From pa	ge 5	F 60	00		
	family member and	Nurse #2's request due to		well-being. Instance of abuse of	fall	
	-	are and having an increase in		residents, irrespective of any m		
		d he was not congested or		physical condition, cause physic		
	-	breath (SOB) or difficulty		pain or mental anguish. It includ		
	-	e assessed him. She stated he		abuse, sexual abuse, physical a		
		ain at the site of his broken rib		mental abuse including abuse f		
		chest x-ray per the family's ed Nurse #1 called her that		or enabled through the use of te Willful, as used in this definition	•.	
		5 PM and reported Resident		means the individual must have		
		ad a low oxygen saturation		deliberately, not that the individ		
		rder to send him to the ER for		have intended to inflict injury or		
	-	ted she was not informed			- I carrier	
		en saturation was 78% and		(c) Procedure If an employee	suspects	
		ed staff to raise the head of the		or witnesses abuse, they are to		
		ygen per standing orders to		immediately protect the residen		
	bring his oxygen lev	/el back up.		abuse. Staff must intervene to a	assure the	
				safety of the resident and other	residents.	
		cted on 06/28/18 at 11:17 AM		The alleged perpetrator must be		
		A) #1. NA #1 stated he was at		from the facility, and cannot be		
		the East Hall the evening of		unattended, to avoid any furthe		
		EMS arrived and told Nurse		with residents. The staff member		
		for Resident #1 and asked		immediately report the incident		
		s and if anyone was in the		suspicions to their supervisor, E		
		eard the nurse say no and		Nursing, or Administrator. Appro	opriate	
		tion of Resident #1's room. NA d to take the EMS workers to		agencies will be notified by the	of any	
		. He stated when they walked		Administrator within two hours of suspected abuse, neglect, mist	•	
		nt #1 was lying flat in bed and		or exploitation .	cament	
		rying to breathe, he sounded				
		I short of breath. NA #1 stated		On 6/28/18, the facility□s Staff		
		have any oxygen on and there		Development Coordinator gathe	ered the	
		oncentrator or oxygen tank in		facility s policies and procedur		
		ther stated he was not		regarding Physician Orders, Sta		
	assigned to Reside	nt #1 that evening and had not		Orders, Interventions for respira		
	seen him before tak	king EMS personnel to his		distress, protocol for low Oxyge	n levels,	
	room around 6:45 F	PM.		change of condition, physician		
				resident assessments, and upd	-	
		onducted on 06/28/18 at 12:05		following care plan. SDC, MDS		
	PM with EMS Work	er #1. She stated when they		ADON began 100% in-service e	education	1

Facility ID: 952947

PRINTED: 07/30/2018 FORM APPROVED

			0.00			D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION G	· /	E SURVEY PLETED
			A. BUILDIN	<u> </u>		С
		345418	B. WING		06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	, 00	
				1984 US HIGHWAY 70		
ASHEVILI	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
		_				
F 600	Continued From page		F 60			
		the nurse was at the desk		of all clinical staff (LPN, RN, CNA		
		were there for Resident #1		contract therapy) on this topic wit		
		ess call and he pointed down		test administered. Starting on 6/2		
		someone was with him and		clinical staff is permitted to work u		
		him she needed report and		education is received and post -te	est	
		the desk and do paperwork. d her he would take them to		completed. Staff education to be	Thusisian	
				completed by 6/29/18 regarding F	•	
		she reported when they #1's room he was lying flat		Orders, Standing Orders, Interver respiratory distress, protocol for l		
		n on, and she could hear		Oxygen levels, change of condition		
		EMS Worker #1 stated		physician notification, resident	511,	
		resent in Resident #1's room		assessments, and updating / follo	owina	
		d she didn't see an oxygen		care plan. All staff who have not	, mig	
	-	in the room. She further		completed in-person / over the ph	none	
		family member was in the		education and post-tests will be r		
	room with him and sh	ie was crying, when she		copy of each via USPS Certified		
		ld her she thought he was		will not be permitted to work until		
	having a heart attack	and he was going to die.		education and post-test is comple Compliance will be ensured and		
	An interview conducted	ed on 06/28/18 at 12:15 PM		by each employee □s respective		
		orked with Resident #1 on		department manager.		
		PM shift on 05/29/18,		This training included:		
		e middle of his medication		(a) MD Orders / Standing Orders		
	•	1's family member asked		Educated on process including		
		ent #1 because he was		explanation that there are hard co	•	
		hing and pain in his chest		orders for all residents in the nard		
		se #1 stated he went to		book. When a nurse needs to imp		
		ind assessed him while NA		a Standing order, facility requires place that order in the computer (
		signs. Nurse #1 stated a saturation was 78% at that		and complete an E-Interact change		
		I the resident pointed to his		condition form along with that ord		
		when he asked him where		to also document communication		
		amily was insistent that he		MD communication book. The ex		
		urse #1 stated he went to the		is that MD orders will be followed		
		ne on-call provider for order's		times.		
		paperwork and thought he				
		gen on Resident #1 per		(b) Interventions for respiratory d	istress /	
	facility standing order			low O2 levels □ facility processe		
		when the vital signs were		include:		

Facility ID: 952947

	OF DEFICIENCIES	MEDICAID SERVICES		IPLE CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG		MPLETED
			A. BUILDII			С
		345418	B. WING			6/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0/23/2010
				1984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 7		500		
1 000			FC	500		
		hink about raising the head stated he called the FNP,		Staff member is to be pres	ent if resident	
		nd started the paperwork for		is noted to be in distress a		
		id not go back and assess		O2 saturation,		
		ying to get the paperwork				
		ot go with the EMS to his		Nurse will request that ano	ther staff	
	room when they arriv	ved because he wasn't		member go and retrieve O	2 concentrator	
	finished with the pape	erwork.		or tank with tubing.		
	An interview conduct	ed with the Director of		Staff will follow protocol for	administering	
	Nursing revealed Nur	rse #1 called her on 05/29/18		Oxygen, and how to observe	/e oxygen	
		was sending Resident #1 to		saturation by using Pulse 0	Dx per protocol.	
		's request. She stated she				
		sident #1's oxygen saturation		Nurses will delegate to oth	-	
		all nurses were trained on		with resident once resident	is stadle.	
	standing orders and standing orders on ev	there was a copy of the		After resident is stable the	nurse is to call	
	u	and her expectation was for		MD for orders.		
		he facility standing orders and				
		ead of bed and apply oxygen		Nurse will place all orders i	nto the	
		turation back to 90%. She		computer including orders		
	further stated Nurse	#1 should have followed the		from Standing orders (ex: o	oxygen	
		rs and administered oxygen		placement and settings. Re		
		of the bed for Resident #1.		Order/care plan guide for it in orders).	ems to include	
		ed on 06/28/18 3:16 PM with		Numoo will then start as 1	ating the	
		member revealed she was day on 05/29/18 because he		Nurse will then start compl required paper work to trar		
	asked her to stay with			received. Paperwork to tran		
		pain and the FNP saw him		Change of Condition, and t		
		lab work and a chest x-ray				
	to be done. The famil			If in an emergent situation	arises and the	
		naving difficulty breathing		nurse does not feel that the		
	that evening and she			stable, nurse will instruct a		
		wn machine and showed it to		member to call 911 and he	lp gather the	
		it with the facility machine.		required paperwork.		
		oxygen saturation reading		Change of Ore different MD		
		0 PM and she reported it to		Change of Condition / MD		
	indise #1. Resident #	#1's family member stated		Resident Assessment Wi	ur any change	

Facility ID: 952947

If continuation sheet Page 8 of 47

		MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDING			C	
		345418	B. WING		06/29/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E HEALTH CARE CENT	ER	1984 US HIGHWAY 70 SWANNANOA, NC 28778				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	COMPLETIO	
F 600	Continued From page	e 8	F 60	D			
	Nurse #1 did not asse	ess Resident #1 but he did		of condition, vital signs need to be	9		
	come to the door of h	is room and ask her if she		obtained appropriately, and freque			
		e ER. She further stated		vital signs should be taken at time			
		e Resident #1 oxygen due		incident. If any abnormal VS, vital			
		eath and difficulty breathing		to be obtained at a minimum of ev			
		ntil the EMS arrived around ovided oxygen for him.		hours until VS stable per baseline	-		
				Oxygen - the resident should not	he left		
	An interview conduct	ed on 06/28/18 3:07 PM NA		alone until O2 is at an acceptable			
	#2 revealed Resident	#1's family member called		acceptable baseline), continue to			
		/29/18 around 6:00 PM and		monitor.			
	showed her the oxyge	en saturation reading she					
		e machine and it was 75%.		Blood pressure- if you have an ab			
		ecked Resident #1's oxygen		blood pressure for the resident, yo			
		cility machine and got a		notify the MD immediately and ob	tain		
		mmediately informed Nurse #1 assessed Resident #1		orders, continue to monitor.			
		into the room for him to put		Pulse- if you have an abnormal	oulse for		
		stated she didn't see Nurse		the resident, you are to notify the			
		Resident #1 and she didn't		immediately and obtain orders, co			
	return to the room aft	er she took the oxygen to		to monitor.			
		stated Resident #1 was					
		e was having difficulty		Respirations- encourage resident			
	breathing.			lip breath. In through their nose of			
	An interview conduct	ed on 06/29/18 at 9:00 AM		through their mouth. Slow, deep steady.	anu		
		cian revealed it was his		Sicauy.			
		dent who was short of		Temperature- Administer medicat	ions per		
		sygen saturation of 78% to		standing orders, notify MD, and co			
		and the head of the bed		to monitor.			
		nding orders. He further					
		vider should be called		Updating / Following of Care Plan			
	immediately.			the expectation of the facility that			
	On 06/28/18 at 4:45	PM the Administrator and the		staff will follow and / or update ea resident specific plan of care.	CII		
		Immediate Jeopardy.					
		iodiate ocoparay.		On 6/28/18, the Staff Developmer	nt		
	On 06/29/18 at 2:44 I	PM the facility provided an		Coordinator, Director of Nursing,			
		Illegation of Immediate		Nurse, and ADON began 100% ir			

Facility ID: 952947

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED			
					с			
		345418	B. WING		06/29/2018			
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE				
				1984 US HIGHWAY 70				
ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET			
F 600	Continued From page	- 0	F 60					
1 000			F OU					
	Jeopardy removal that			education with nursing staff that the on-call nurse is to be notified immediately in the one of the				
	(1) Plan for correcting	g specific area of concern		with any and all resident changes	-			
		process that led to the		condition.				
		on 05/29/2018 that LPN #1		On 6/28/18, the Administrator / R	/P			
	failed to ensure the d	elivery of quality care and to		reported the 5/29/18 event to the I				
		from experiencing neglect.		Department of Health and Human				
		wn that lead to the concern		Services via Fax. The Administrate	-			
	was as follows:			proceed with required subsequent				
		n) LPN #1 documented		reporting protocol (5-day report, e	tc) as			
	agitation and verbal a			required.				
	insomnia. Zyprexa IN	seen by Nurse Practitioner		On 6/28/18, the Administrator / R	/D			
		agitation, insomnia, and flank		began neglect investigation by have				
		fever, dyspnea, cough.		DON, ADON, SDC, MDS and Rec	-			
		, urinalysis, CMP, and left rib		Nurse complete 100% interviews				
		practitioner. Respiratory		interviewable residents (BIMS>8)				
		practitioner shows poor		ensure they are free from abuse a	ind			
	compliance and dimin	nished without wheezes,		neglect. No negative findings were				
		v orders for ibuprofen as		during these interviews. On 6/28/1				
	requested for pain.			DON, ADON, SDC, MDS and Reg				
		n) LPN #1 documented		Nurse also completed 100% obse	rvation			
		assessment related to		and skin assessments of				
		oxygen saturation of 78% on ed to send to emergency		non-interviewable residents (BIMS ensure there are no signs or symp				
	room.	to send to emergency		fear, neglect, or abuse. No negativ				
		n) LPN #1 completed		findings were noted during these				
		n was not documented as an		observations and skin assessmen	ts.			
	intervention at this tin	ne. Per the transfer form to		(3) The monitoring procedure to e	nsure			
	-	3%, Res: 28, Pulse: 113,		that the plan of correction is effect				
		al conducted; rated as 4 of		that specific deficiency cited rema				
	10. Known d/x of CO			corrected and / or in compliance w	vith			
	Statements nom	EMS surrounding this event		regulatory requirements:	A hour			
		member was present in		Starting on 6/29/18, each unit s 2				
		1 and head of bed not arrived and that oxygen		report and available push reports reviewed daily (M-F) in clinical me				
	was not being admini			validate identified at-risk residents	-			
	-	LPN #1 documented nurses		are within normal limits, care plan				

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY
			A. BUILDING	3		
		0.15.140	D WING		С	
		345418	B. WING		06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILI	-E HEALTH CARE CEN	TER		1984 US HIGHWAY 70		
				SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 600	Continued From pag	je 10	F 60	0		
		ge of condition and orders to		followed, code statuses honore	d, and	
		ending physician notified and		appropriate O2 protocol is being		
	-	oom. Resident left facility at		as appropriate.		
		n facility was notified that				
		ed to the hospital related to		On 6/29/18, the Regional Nurse		
		for correcting specific area of		Consultant developed a monitor	•	
		nclude the process that led to		sheet to check and validate at-r residents as identified by the 24	-	
	the concern:	on 05/29/2018 that LPN #1		report or available push report.		
		delivery of quality care and to		sheet includes assessment of a		
		from experiencing neglect.		vitals, honoring of code status a		
		own that lead to the concern		plans, and oxygen protocol beir		
	was as follows:			as indicated. Starting 6/29/18, th	-	
	" 5.28.18 (11:37p	m) LPN #1 documented		sheet will be populated and revi	ewed daily	
	-	aggression as well as		(M-F) in morning clinical meetin	-	
	insomnia. Zyprexa II			review and track at-risk resident		
		seen by Nurse Practitioner		previous 24 hours (72 hours if v	veekend).	
		agitation, insomnia, and flank		Charting on C/20/40 the DON A	DON	
		d fever, dyspnea, cough. /, urinalysis, CMP, and left rib		Starting on 6/29/18, the DON, A SDC, MDS, Regional Nurse, or	DON,	
		practitioner. Respiratory		designated nurse manager will	conduct	
		e practitioner shows poor		(3) random audits of patient cha		
		inished without wheezes,		review vitals, code status chang		
		w orders for ibuprofen as		incident reports, orders, change		
	requested for pain.	-		condition and required notification	ons	
		m) LPN #1 documented		therein, as well as care plans 5	•	
		assessment related to		for 4 weeks, then 3x weekly for		
		oxygen saturation of 78% on		then weekly for 4 weeks to mon		
		ed to send to emergency		delivery of quality care and to e		
	room.	m) I DN #1 completed		resident is free from neglect. Ar issues from audits will be discus	•	
	J.29.10 (0.35p	m) LPN #1 completed on was not documented as an		the IDT and QA committee and		
		me. Per the transfer form to		immediately.		
		'8%, Res: 28, Pulse: 113,				
	-	val conducted; rated as 4 of		Starting on 6/30/18, the DON, A	DON,	
	10. Known d/x of CC			SDC, MDS, Regional Nurse, Ma		
	" Statements fron	n EMS surrounding this event		Duty, or designated nurse will c		
		ff member was present in		random abuse post-tests with (3		
	room with Resident		1	each shift daily x 2 weeks, then		1

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		0.441.5.5.5.5		0 (n) n (
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
		A. BUILDING	·		
	345418	B WING		C	
	343410			06/29/2018	
OVIDER OR SUPPLIER					
E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	ΓΙΟΝ (X5)	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	JLD BE COMPLE	
Continued From page	2 11	F 60	0		
		1.00		then (3)	
•					
notified and sister aw	are and in room. Resident		post-tests will be discussed with ID)T and	
left facility at 6:45pm.	At, 11:00pm facility was		QA committee and addressed		
notified that resident v	was admitted to the hospital		immediately.		
	-		-		
			-	-	
	-				
•				,	
	•				
				insure	
· · ·				erviews	
•					
<i>'</i>			Starting 6/29/18, the Inter Disciplin	ary	
			Team and Medical Director will atte	end	
				•	
	, .		-	sing,	
-	-			000	
				or	
	Continued From page elevated at time EMS was not being admini " 5.30.18 (01:22) nurses note related to orders to send to hos notified and sister aw left facility at 6:45pm. notified that resident y related to pneumonia " 6.28.18 (08:00) N Human Services arriv complaint of event on with F600 for neglect. Upon review of the af is evidence that LPN procedures when ado change of condition ir interventions for low of (78%) and shortness subsequently resulted as "Failure to provide necessary to avoid pf anguish, or mental illr 488.301.). Interview v had instructed CNA # was completing docu #1 to hospital. Per LF Resident #1 was sittir could not raise the he believe that CNA #1 v Interview with LPN #1 understood that settir scope of practice, but light of Resident #1's Resident #1's O2 satu Justified supplementa until baseline O2 satu The plan to correct th	345418	A BULLONG 345418 BUWING	345418 Display COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE E HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX PREFIX Continued From page 11 elevated at time EMS arrived and that oxygen was not being administered PREFIX (EACH DEVICE) Tursses note related to change of condition and orders to send to hospital. Attending physician notified that resident was admitted to the hospital related to pneumonia. F 600 E 12 (B12) (

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			()(0)			<u>10. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDING	3		С
		345418	B. WING			6/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		0/29/2010
				1984 US HIGHWAY 70		
ASHEVILI	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETIC
F 600	Continued From page	e 12	F 60	00		
	investigation surround	ding the event on 5/29/18,		Pharmacist.		
		Cause Analysis to identify		(4) The title of the person re	esponsible for	
		to the process failure,		implementing the acceptable	e plan of	
		n and in-service training to		correction:		
		reas for opportunity to		The individual responsible f		
		se, neglect, abuse reporting, cian Orders, Standing		implementing the credible p correction is the Administra		
		for respiratory distress,				
	protocol for low Oxyg					
	condition, physician r					
	assessments, and up	dating / following care plans.				
	The facility will also ir					
		m audits spread over the				
		days to ensure compliance				
		an. Lastly, all audit results e facility Quality Assurance				
		ement team and the Medical				
		monthly for review. All				
		will be immediately brought				
		n and Medical Director for				
	immediate review and	•				
	(2) The procedure fo					
	deficiency cited:	rrection for the specific				
		Director of Nursing				
	immediately suspend	-				
		ig neglect and failure to				
	provide quality of care					
	substantiated, facility					
	-	employment and reporting				
		ncies and licensing boards,				
	as appropriate. On 6/28/18, the Direc	tor of Nursing Staff				
		nator, MDS nurse, and				
		Nursing created a timeline of				
		ne 5/29/18 occurrence in				
		conduct a Root Cause				
		ss failure. Process failure				
	was determined after	reviewing timeline by DON				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	: 07/30/2018 APPROVED . 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
	345418	B. WING			C 06/2	, 29/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
		1	984 US HIGHWAY 70			
ASHEVILLE HEALTH CARE CENTER	x	5	SWANNANOA, NC 28778			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
identified was that LPN O2 protocols when he of 78% O2 saturation rate saturation rate was obs have placed resident of elevated head of bed, a until resident could read saturation rate, which L " On 6/28/18, the Di conducted 100% chart discharged from facility hospitalization) within th for vital sign monitoring following of standing or was self-identified in 1 negative outcomes note these audit findings we Quality Assurance / Pe plan and discussed with 6/29/18. " On 6/28/18, the fac Coordinator gathered th procedures regarding a reporting, and resident in-servicing of all staff of administered. Starting of permitted to work until of post -test completed. S completed by 6/29/18 of reporting, and resident not completed in-perso	/28/18. The failed process I #1 did not follow facility observed resident with a. At the time a low served, LPN #1 should n supplemental Oxygen, and remained with resident ch a baseline O2 .PN #1 failed to do. rector of Nursing audit of other residents r (either due to death or he last 90 days to review g, change of condition, and rders. Area for opportunity of 15 residents with no ed as a result. However, re added to ongoing rformance Improvement h IDT / Medical Director on cility's Staff Development he facility's policies and abuse, neglect, abuse rights and began 100% on this topic with post - test on 6/28/18, no staff is education is received and caff education to be on abuse, neglect, abuse rights. All staff who have in / over the phone ts will be mailed a copy of ad Mail and will not be this education and Compliance will be y each employee's	F 600		(FICIENCY)		

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY	
AND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED	
		345418	B. WING			C / 29/2018	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	06	29/2010	
ASHEVIL	LE HEALTH CARE CENT	ER		984 US HIGHWAY 70 WANNANOA, NC 28778			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLET		
F 600	 Resident Rights that "The resident ha abuse, neglect, misal property, and exploits subpart. This include freedom from corpora seclusion and any ph not required to treat t symptoms Abuse - As defin Medicare and Medica willful inflection of inju confinement, intimida resulting physical har Abuse also includes t individual, including a services that are nec physical, mental, and Instance of abuse of any mental or physica harm, pain or mental abuse, sexual abuse, abuse including abuse through the use of tex this definition of abuse have acted deliberate must have intended t Procedure - If an witnesses abuse, the the resident from abuse assure the safety of t residents. The allege removed from the fac unattended, to avoid residents. The staff m report the incident or 	- specific focus on §483.12 s the right to be free from ppropriation of resident ation as defined in this es but is not limited to al punishment, involuntary pysical or chemical restraint he resident's medical ed by the "Centers for aid Services, Abuse is the ury, unreasonable tion, or punishment with m, pain or mental anguish. the deprivation by an a caretaker, of goods or essary to attain or maintain psychosocial well-being. all residents, irrespective of al condition, cause physical anguish. It includes verbal physical abuse, and mental the facilitated or enabled chnology. Willful, as used in the means the individual must ely, not that the individual o inflict injury or harm." In employee suspects or y are to immediately protect ise. Staff must intervene to he resident and other d perpetrator must be cility, and cannot be left any further contact with nember will immediately suspicions to their of Nursing, or Administrator.	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/30/2018 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345418	B. WING				C 29/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E HEALTH CARE CENT	ER			1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	" On 6/28/18, the f Coordinator gathered procedures regarding Orders, Interventions protocol for low Oxyg condition, physician n assessments, and up SDC, MDS, DON, and in-service education of CNA, contract therapy test administered. Sta staff is permitted to w received and post -test education to be comp Physician Orders, Sta for respiratory distress levels, change of com- resident assessments care plan. All staff wh in-person / over the p post-tests will be mail Certified Mail and will until this education ar Compliance will be er employee's respective This training included 1. MD Orders / Star process including exp copies orders for all re book. When a nurse r Standing order, facility that order in the comp an E-Interact change that order, and to also in the MD communication.	eatment or exploitation. facility's Staff Development the facility's policies and Physician Orders, Standing for respiratory distress, en levels, change of notification, resident dating / following care plan. d ADON began 100% of all clinical staff (LPN, RN, y) on this topic with post - arting on 6/28/18, no clinical nork until education is st completed. Staff bleted by 6/29/18 regarding anding Orders, Interventions s, protocol for low Oxygen dition, physician notification, s, and updating / following to have not completed hone education and led a copy of each via USPS not be permitted to work and post-test is completed. nsured and tracked by each e department manager. : moding Orders - Educated on planation that there are hard esidents in the narcotics	F	600			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345418	B. WING				C 29/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILI	E HEALTH CARE CENT	ER			1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 600	 Interventions for levels - facility proces Staff member is finoted to be in distress saturation, Nurse will request go and retrieve O2 contubing. Staff will follow provide the state of th	respiratory distress / low O2 ases include: to be present if resident is a and have a low O2 at that another staff member oncentrator or tank with rotocol for administering observe oxygen saturation r protocol. tate to other staff to stay with t is stable. to the nurse is to call MD all orders into the computer emented from Standing acement and settings. Refer ide for items to include in tart completing the required r out if order received. t-interact Change of er form. situation arises and the tat the resident is stable, other staff member to call he required paperwork. tion / MD Notification / t- With any change of need to be obtained quently, vital signs should cident. If any abnormal VS, ined at a minimum of every	F	600			

Facility ID: 952947

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345418	B. WING				APPROVED 0.0938-0391 SURVEY
NAME OF PI	ROVIDER OR SUPPLIER	1		:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ASHEVILL	E HEALTH CARE CENT	ER			1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 600	 blood pressure for the the MD immediately at to monitor. Pulse- if you har resident, you are to n and obtain orders, co Respirations- embreath. In through the mouth. Slow, deep a Temperature- Ad standing orders, notif monitor. Updating / Follow expectation of the fact follow and / or update plan of care. On 6/28/18, the standing staff that the immediately with any condition. On 6/28/18, the standing. On 6/28/18, the standing staff that the immediately with any condition. 	if you have an abnormal e resident, you are to notify and obtain orders, continue ve an abnormal pulse for the otify the MD immediately ntinue to monitor. courage resident to purse lip ir nose out through their nd steady. minister medications per y MD, and continue to ving of Care Plan - It is the ility that nursing staff will e each resident's specific Staff Development of Nursing, MDS Nurse, and n-service education with on-call nurse is to be notified and all resident changes in Administrator / RVP reported he NC Department of Health via Fax. The Administrator uired subsequent reporting t, etc.) as required.	F	003			
	" On 6/28/18, the A neglect investigation SDC, MDS and Regio interviews with intervi to ensure they are fre No negative findings	Administrator / RVP began by having DON, ADON, onal Nurse complete 100% ewable residents (BIMS>8) be from abuse and neglect. were noted during these 8, the DON, ADON, SDC,					

Facility ID: 952947

If continuation sheet Page 18 of 47

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345418	B. WING		C 06/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
	E HEALTH CARE CENT	ED		1984 US HIGHWAY 70	
ASHEVILL				SWANNANOA, NC 28778	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 600	MDS and Regional N observation and skin non-interviewable res there are no signs or or abuse. No negative these observations an (3) The monitoring pr plan of correction is e deficiency cited rema compliance with regu " Starting on 6/29/ report and available " reviewed daily (M-F) identified at-risk resid limits, care plans are honored, and appropria " On 6/29/18, the f developed a monitorii validate at-risk reside 24-hour report or ava flow sheet includes as vitals, honoring of coo and oxygen protocol I Starting 6/29/18, this and reviewed daily (M meeting to review and the previous 24 hours	urse also completed 100% assessments of sidents (BIMS<8) to ensure symptoms of fear, neglect, e findings were noted during nd skin assessments. ocedure to ensure that the effective and that specific ins corrected and / or in latory requirements: 18, each unit's 24-hour push reports" will be in clinical meeting to validate ents' vitals are within normal followed, code statuses riate O2 protocol is being	F 6	500	
	manager will conduct charts to review vitals incident reports, orde required notifications plans 5x weekly for 4 weeks, then weekly for delivery of quality car free from neglect. An	e, or designated nurse (3) random audits of patient s, code status changes, rs, change of condition and therein, as well as care weeks, then 3x weekly for 4 or 4 weeks to monitor e and to ensure resident is y noted issues from audits the IDT and QA committee			

Facility ID: 952947

If continuation sheet Page 19 of 47

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/30/2018 APPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION			LETED
		345418	B. WING				06/2	
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	LE HEALTH CARE CENT	ER			1984 US HIGHWAY 70 SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 600	and addressed immere "Starting on 6/30/ MDS, Regional Nurse designated nurse will post-tests with (3) staf then (3) staff each shi with score of 100% to informed of facility ab protocols. Any noted be discussed with IDT addressed immediate "Starting on 6/30/ MDS, Regional Nurse designated nurse mai random resident inter BIMS > 8 and (3) rand assessments / observ BIMS < 8 daily x 2 we weeks, then weekly x residents are free fror noted issues from inter will be discussed with addressed immediate "Starting 6/29/18, and Medical Director review the efficacy of weekly x 4 weeks, the then monthly thereaft compliance with the re The IDT includes the Nursing, Assistant Dir Worker, Activities Dire Manager, Admissions Development Coordir	diately. 18, the DON, ADON, SDC, a, Manager on Duty, or conduct random abuse off each shift daily x 2 weeks, ift 2x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks off each shift daily x 2 weeks, ift 1x per week x 4 weeks of ensure on Duty, or nager with conduct (3) views with residents with dom resident skin vations for residents with deks, then 3x per week x 4 if 4 weeks to ensure m abuse and neglect. Any erviews / skin assessments of IDT and QA committee and ely. the Inter Disciplinary Team will attend QAPI meeting to the aforementioned plan en bi-weekly x 1 month, and er to ensure continued equirements of participation. Administrator, Director of rector of Nursing, Social ector, Business Office is Coordinator, Staff hator, Housekeeping e Director, MDS Nurse,	F	600				

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If continuation sheet Page 20 of 47

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROV	/ED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED	
		345418	B. WING			C 06/29/2018 (X5) COMPLETION	
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL)E		
ASHEVILL	E HEALTH CARE CENT	ER		1984 US HIGHWAY 70 SWANNANOA, NC 28778			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETIC	ON
F 600	Continued From page	20	F 60	00			
		eptable plan of correction: sponsible for implementing					
	when the facility demu trained on the topics of rights, Physician Orde Interventions for resp low Oxygen levels, ch	was removed on 6/29/18 onstrated that staff had been of abuse, neglect, resident ers, Standing Orders, iratory distress, protocol for nange of condition, physician assessments, and updating /					
	Human Services arriv complaint of event on with F600 for neglect. Upon review of the af is evidence that LPN procedures when add change of condition in interventions for low of (78%) and shortness subsequently resulted as "Failure to provide necessary to avoid ph anguish, or mental illr 488.301.). Interview v had instructed CNA # was completing docu #1 to hospital. Per LF Resident #1 was sittin could not raise the her	orementioned event, there #1 did not follow facility Iressing Resident #1's including implementation of oxygen saturation levels of breath, which d in neglect, defined by CMS goods and services hysical harm, mental ness." (See 42 CFR Part with LPN #1 states that nurse to "get oxygen" while he mentation to send Resident PN #1, he believed that ing on edge of bed, and thus and of bed. LPN #1 also was applying O2 to resident.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/30/2018 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345418	B. WING		0	C 6/29/2018
NAME OF PI	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP COD	E	
ASHEVILL	E HEALTH CARE CENT	ER		84 US HIGHWAY 70		
			I	WANNANOA, NC 28778		
(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)	I SHOULD BE	(X5) COMPLETION DATE
F 600	scope of practice, but light of Resident #1's Resident #1's O2 satu justified supplementa until baseline O2 satu The plan to correct the includes the completi investigation surround completion of a Root the variables that led house-wide education appropriate staff on a include topics of abus resident rights, Physi Orders, Interventions protocol for low Oxyg condition, physician r assessments, and up The facility will also in measures and randon course of the next 90 and efficacy of this pl will be shared with the Performance Improve Director no less than negative audit results before the QAPI team immediate review and (2) The procedure for	ng up O2 was out of CNA t was trying to save time in change of condition. uration rate was 78% which I oxygen and monitoring uration rate is achieved is identified concern on of a thorough ding the event on 5/29/18, Cause Analysis to identify to the process failure, n and in-service training to treas for opportunity to se, neglect, abuse reporting, cian Orders, Standing for respiratory distress, en levels, change of notification, resident dating / following care plans. mplement monitoring m audits spread over the days to ensure compliance an. Lastly, all audit results e facility Quality Assurance ement team and the Medical monthly for review. All will be immediately brought n and Medical Director for d remedy.	F 600			
	immediately suspend investigation regardin provide quality of card substantiated, facility terminating LPN #1's	ng neglect and failure to e. If investigation is				

Facility ID: 952947

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345418	B. WING			C 06/29/2018		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVILI	E HEALTH CARE CENT	ER			1984 US HIGHWAY 70 SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 600	as appropriate. On 6/28/18, the Direct Development Coordin Assistant Director of I events surrounding th order to successfully Analysis of the proces was determined after and Administrator on identified was that LP O2 protocols when he 78% O2 saturation ra saturation rate was of have placed resident elevated head of bed until resident could re saturation rate, which " On 6/28/18, the I conducted 100% chai discharged from facili hospitalization) within for vital sign monitorin following of standing w Quality Assurance / F plan and discussed w 6/29/18. " On 6/28/18, the f Coordinator gathered procedures regarding reporting, and resider in-servicing of all staff administered. Starting permitted to work unti post -test completed. completed by 6/29/18	tor of Nursing, Staff hator, MDS nurse, and Nursing created a timeline of he 5/29/18 occurrence in conduct a Root Cause as failure. Process failure reviewing timeline by DON 6/28/18. The failed process N #1 did not follow facility e observed resident with te. At the time a low oserved, LPN #1 should on supplemental Oxygen, and remained with resident ach a baseline O2 LPN #1 failed to do. Director of Nursing t audit of other residents ty (either due to death or the last 90 days to review ng, change of condition, and orders. Area for opportunity 1 of 15 residents with no oted as a result. However, were added to ongoing terformance Improvement ith IDT / Medical Director on acility's Staff Development the facility's policies and abuse, neglect, abuse nt rights and began 100% f on this topic with post - test g on 6/28/18, no staff is I education is received and	F	600				

Facility ID: 952947

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						10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		` '	TE SURVEY MPLETED
			A. BUILDING			С
		345418	B. WING		0	6/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		0/20/2010
				1984 US HIGHWAY 70		
ASHEVILI	_E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROFIDEFICIENCY)		N SHOULD BE	(X5) COMPLETIO DATE	
F 600	Continued From pag	0.23	Гео	0		
1 000			F 60	0		
not completed in-per education and post-t each via USPS Certi permitted to work um	•					
	til this education and					
		d. Compliance will be				
	ensured and tracked	-				
	respective department					
This training includ 4. Resident Right	This training included	-				
	4. Resident Rights	- specific focus on §483.12				
		s the right to be free from				
		ppropriation of resident				
		ation as defined in this				
		es but is not limited to				
		al punishment, involuntary				
		hysical or chemical restraint				
	symptoms	he resident's medical				
		ed by the "Centers for				
		aid Services, Abuse is the				
	willful inflection of inju					
		ation, or punishment with				
		rm, pain or mental anguish.				
		the deprivation by an				
	individual, including a	a caretaker, of goods or				
	services that are nec	essary to attain or maintain				
		l psychosocial well-being.				
		all residents, irrespective of				
		al condition, cause physical				
		anguish. It includes verbal				
		, physical abuse, and mental				
		se facilitated or enabled chnology. Willful, as used in				
		se, means the individual must				
		ely, not that the individual				
		to inflict injury or harm."				
		n employee suspects or				
		ey are to immediately protect				
		use. Staff must intervene to				

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 07/30/20 DRM APPROVE NO. 0938-039
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION		ATE SURVEY OMPLETED
		345418	B. WING			C 06/29/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				198	4 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		sw	ANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOUL		OULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 24	F	500			
		d perpetrator must be sility, and cannot be left					
		any further contact with					
		nember will immediately					
	report the incident or						
	-	of Nursing, or Administrator.					
	•	s will be notified by the					
		wo hours of any suspected					
		eatment or exploitation.					
	" On 6/28/18 the	facility's Staff Development					
		I the facility's policies and					
	÷	Physician Orders, Standing					
		for respiratory distress,					
	protocol for low Oxyg						
	condition, physician r	-					
	assessments, and up	dating / following care plan.					
	SDC, MDS, DON, an	d ADON began 100%					
	in-service education	of all clinical staff (LPN, RN,					
	CNA, contract therap	y) on this topic with post -					
	test administered. Sta	arting on 6/28/18, no clinical					
	staff is permitted to w	ork until education is					
	received and post -te	•					
		bleted by 6/29/18 regarding					
	-	anding Orders, Interventions					
		s, protocol for low Oxygen					
		dition, physician notification,					
		s, and updating / following					
	-	to have not completed					
	in-person / over the p						
	-	led a copy of each via USPS I not be permitted to work					
		nd post-test is completed.					
		nsured and tracked by each					
	-	e department manager.					
	This training included	· •					
		nding Orders - Educated on					
		planation that there are hard					
		esidents in the narcotics					
	copies orders for all I						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345418	B. WING			CORRECTION (X5) ON SHOULD BE COMPLETION HE APPROPRIATE DATE	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		-	
ASHEVILI	E HEALTH CARE CENT	ER			984 US HIGHWAY 70 WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 600	book. When a nurse r Standing order, facilit that order in the comp an E-Interact change that order, and to also in the MD communica is that MD orders will 6. Interventions for levels - facility proces " Staff member is t noted to be in distress saturation, " Nurse will reques go and retrieve O2 co tubing. " Staff will follow p Oxygen, and how to co by using Pulse Ox pe " Nurses will deleg resident once residen " After resident is s for orders. " Nurse will place a including orders imple orders (ex: oxygen plat to Order/care plan gu orders). " Nurse will then s paper work to transfe Paperwork includes E Condition, and transfe " If in an emergent nurse does not feel th nurse will instruct and 911 and help gather t	heeds to implement a y requires nurse to place outer (EMR), and complete of condition form along with o document communication ation book. The expectation be followed at all times. respiratory distress / low O2 sees include: to be present if resident is a and have a low O2 at that another staff member oncentrator or tank with rotocol for administering observe oxygen saturation r protocol. tate to other staff to stay with it is stable. stable the nurse is to call MD all orders into the computer emented from Standing acement and settings. Refer ide for items to include in tart completing the required r out if order received. E-interact Change of er form. situation arises and the hat the resident is stable, other staff member to call he required paperwork.	F	600			

Facility ID: 952947

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			(X3) DATE COMP	SURVEY PLETED
		345418	B. WING		C 06/29/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	ROVIDER OR SUPPLIER	FR					
//0/12/12					SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 600	condition, vital signs r appropriately, and fre be taken at time of ind vitals need to be obta 4 hours until VS stabl " Oxygen - the res until O2 is at an accept baseline), continue to " Blood pressure in blood pressure for the the MD immediately at to monitor. " Pulse- if you ha resident, you are to mand obtain orders, con " Respirations- end breath. In through the mouth. Slow, deep at " Temperature- Ad standing orders, notify monitor. 8. Updating / Follow expectation of the fact follow and / or update plan of care. " On 6/28/18, the S Coordinator, Director ADON began 100% in nursing staff that the of immediately with any condition. " On 6/28/18, the A the 5/29/18 event to ta and Human Services	need to be obtained quently, vital signs should cident. If any abnormal VS, ined at a minimum of every e per baseline. ident should not be left alone ptable level (at acceptable monitor. if you have an abnormal e resident, you are to notify and obtain orders, continue ve an abnormal pulse for the otify the MD immediately ntinue to monitor. courage resident to purse lip ir nose out through their	F	600			

Facility ID: 952947

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/30/2018 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345418	B. WING			_		C 29/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ASHEVILI	E HEALTH CARE CENT	ĒR			984 US HIGHWAY 70 SWANNANOA, NC 2877	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	neglect investigation I SDC, MDS and Regic interviews with intervi to ensure they are fre No negative findings interviews. On 6/28/1 MDS and Regional Ni observation and skin non-interviewable res there are no signs or or abuse. No negative these observations ar (3) The monitoring pro- plan of correction is e deficiency cited rema- compliance with regul "Starting on 6/29/ report and available " reviewed daily (M-F) identified at-risk resid limits, care plans are honored, and appropria "On 6/29/18, the F developed a monitorin validate at-risk reside 24-hour report or avai flow sheet includes as vitals, honoring of coo and oxygen protocol B Starting 6/29/18, this and reviewed daily (M meeting to review and the previous 24 hours "Starting on 6/29/ MDS, Regional Nurse	Administrator / RVP began by having DON, ADON, onal Nurse complete 100% ewable residents (BIMS>8) e from abuse and neglect. were noted during these 8, the DON, ADON, SDC, urse also completed 100% assessments of idents (BIMS<8) to ensure symptoms of fear, neglect, e findings were noted during nd skin assessments. Decedure to ensure that the ffective and that specific ins corrected and / or in atory requirements: 18, each unit's 24-hour push reports" will be n clinical meeting to validate ents' vitals are within normal followed, code statuses iate O2 protocol is being	F	600				

Facility ID: 952947

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	TED: 07/30/201 DRM APPROVE NO. 0938-039	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	(X3) D	OATE SURVEY OMPLETED	
		345418	B. WING			C 06/29/2018		
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
ASHEVIL	LE HEALTH CARE CENT	ER			I US HIGHWAY 70 ANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO		SHOULD BE	(X5) COMPLETIOI DATE	
F 600	charts to review vitals incident reports, order required notifications plans 5x weekly for 4 weeks, then weekly for delivery of quality can free from neglect. An will be discussed with and addressed immer "Starting on 6/30/ MDS, Regional Nurse designated nurse will post-tests with (3) staf then (3) staff each sh then (3) staff each sh with score of 100% to informed of facility at protocols. Any noted be discussed with ID addressed immediate "Starting on 6/30/ MDS, Regional Nurse designated nurse ma random resident inter BIMS > 8 and (3) ran assessments / obser BIMS < 8 daily x 2 we weeks, then weekly > residents are free fro noted issues from int will be discussed with addressed immediate "Starting 6/29/18, and Medical Director review the efficacy of weekly x 4 weeks, th then monthly thereaft compliance with the p	s, code status changes, ers, change of condition and therein, as well as care a weeks, then 3x weekly for 4 for 4 weeks to monitor re and to ensure resident is y noted issues from audits in the IDT and QA committee ediately. (18, the DON, ADON, SDC, e, Manager on Duty, or I conduct random abuse aff each shift daily x 2 weeks, nift 2x per week x 4 weeks, nift 1x per week x 4 weeks o ensure staff are well buse / neglect policies and issues from post-tests will T and QA committee and ely. (18, the DON, ADON, SDC, e, Manager on Duty, or unager with conduct (3) rviews with residents with dom resident skin vations for residents with eeks, then 3x per week x 4 (4 weeks to ensure m abuse and neglect. Any erviews / skin assessments in IDT and QA committee and	F	500				

Facility ID: 952947

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345418	B. WING				C / 29/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEVILL	E HEALTH CARE CENTI	ER			184 US HIGHWAY 70 WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Nursing, Assistant Dir Worker, Activities Dire Manager, Admissions Development Coordin Director, Maintenance Dietary Director, Med Pharmacist.	ector of Nursing, Social ector, Business Office Coordinator, Staff hator, Housekeeping Director, MDS Nurse, ical Director, and	F	600			
F 684 SS=J	" The individual rest the credible plan of co Administrator. Immediate Jeopardy v 3:35 PM when the fac and demonstrated the topics of abuse, negle Physician Orders, Sta for respiratory distress levels, change of con- resident assessments care plan. Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fun applies to all treatment facility residents. Base assessment of a reside that residents receive accordance with profe	eptable plan of correction: sponsible for implementing prrection is the was removed on 6/29/18 at cility staff were interviewed ey had been trained on the ect, resident rights, anding Orders, Interventions s, protocol for low Oxygen dition, physician notification, a, and updating / following are ndamental principle that at and care provided to ed on the comprehensive lent, the facility must ensure treatment and care in essional standards of iensive person-centered	F	584			6/30/18

Facility ID: 952947

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						0.0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DOILDING		с	
		345418	B. WING			29/2018
NAME OF P	ROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	LE HEALTH CARE CENT	FR		1984 US HIGHWAY 70		
		LN		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY 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) COMPLETIO DATE
F 684	Continued From page	e 30	F 68	84		
		riew, staff, family, Physician,	1.00	Disclaimer:		
		nd Emergency Medical		Submission of this plan of corre	ction does	
		e facility failed to provide		not constitute admission or agre		
		nursing care for a resident		the provider of the truth or the fa	-	
	-	g shortness of breath and		alleged or conclusions set forth		
	-	reased oxygen saturation of		Statement of Deficiencies. The		
	78 percent. The resid			correction is submitted solely be	ecause it is	
	emergency room for	evaluation and treatment of		required by the provision of fede	eral and	
	pneumonia (Residen	t #1).		state law.		
		began on 05/29/18 when		F684 □ Quality of Care □ CFR(s): 483.25	
		o raise the head of the bed				
		en for Resident #1 who was		(1) Plan for correcting specific a		
	experiencing shortne			concern identified, include the p	orocess	
		aturation of 78%. The		that led to the concern: It was observed that on 05/29/2	019 that	
	evaluation and treatm	t to the emergency room for		LPN #1 failed to ensure the deli		
		was removed on 06/29/18		quality care or to ensure the hig	-	
	when the facility impl			practicable physical, mental, an		
		ate Jeopardy removal. The		psychosocial well-being.	-	
		f compliance at a lower		The process breakdown that lea	ad to the	
	-	evel D (no actual harm with		concern was as follows:		
		e than minimal harm that is		Upon review of the aforementio	ned event,	
	not immediate jeopar	rdy) to complete employee		there is evidence that LPN #1 d	id not	
	education and ensure	e monitoring systems in		follow facility procedures when		
	place are effective.			Resident #1 s change of condi		
				including implementation of inte		
	The findings included	1:		for low oxygen saturation levels	(78%)	
	Decident #1 was!-	nitted to the facility an		and shortness of breath, which	to doliver	
		nitted to the facility on		subsequently resulted in failure		
		ses of heart failure, chronic y disease, respiratory failure,		an acceptable level of quality ca ensure the highest practicable p		
	and high blood press			mental, and psychosocial well-t	-	
				resident. Interview with LPN #1	-	
	Review of the Facility	/ Standing Orders updated		nurse had instructed CNA #1 to		
	08/2011 revealed the			oxygen while he was completing	-	
	shortness of breath:	3		documentation to send Resider	-	
				hospital. Per LPN #1, he believ		
	a. Elevate head of	hood		Resident #1 was sitting on edge		

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
			A. BUILDING	G		С
		345418	B. WING			6/29/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		0/29/2010
				1984 US HIGHWAY 70		
ASHEVIL	LE HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 31	F 68	34		
			1.00	and thus could not raise	the head of bed.	
	b. Check oxygen sa	aturation on room air before		LPN #1 also believe that		
	application of oxygen			applying O2 to resident.	Interview with	
				LPN #1 revealed that he		
		get oxygen saturation to		setting up O2 was out of		
	90%.			practice, but was trying to		
	d Obtain and moni	itor vital signs (temperature,		light of Resident #1□s ch condition. Resident #1□		
		ns) and check oxygen		rate was 78% which justi		
	saturation after applic			supplemental oxygen an		
				baseline O2 saturation ra	-	
	e. Notify physician	after above completed.		The plan to correct this id		
				includes the completion of		
	Data Set (MDS) date	ecent quarterly Minimum		investigation surrounding 5/29/18, completion of a	-	
		erely cognitively impaired		Analysis to identify the va		
		to extensive assistance with		to the process failure, ho		
		y living. The MDS was not		education and in-service		
	coded for oxygen use	e for Resident #1.		appropriate staff on area		
				to include topics of Phys		
		an dated 04/25/18 revealed		Standing Orders, Interve		
	Resident #1 had alter			respiratory distress, prote		
		hing related to emphysema monia. The goal was for		Oxygen levels, change o physician notification, res		
		ain normal breathing pattern		assessments, and updat		
		nal respirations, normal skin		care plans. The facility w		
		spiratory rate/pattern through		monitoring measures and		
		nis pulse oximetry will remain		spread over the course of		
	-	ough the review date. The		days to ensure complian	-	
		d: Monitor for signs and		this plan. Lastly, all audit		
	MD as needed. Moni	ory distress and report to		shared with the facility Q Performance Improveme	2	
	needed.			Medical Director no less		
				review. All negative audit	•	
	Review of the nurse's	s notes dated 05/30/18		immediately brought befo		
		g note was written by Nurse		team and Medical Directed		
	#1 at 1:20 AM: Resid	-		review and remedy. The		
		tless, he indicated left flank,		event was that that LPN		
	side, pain when aske	d where he hurt. Resident		judgement call and reque	ested another	

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If continuation sheet Page 32 of 47

		MEDICAID SERVICES				0.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING		C	
		345418	B. WING			_ 29/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		29/2018
				1984 US HIGHWAY 70		
ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
F 684	Continued From page	e 32	F 68	4		
		for short periods while sitting		staff member (who was not a	licensed	
		turation would drop, then		nurse) to retrieve and set up of		
	rise again once he ro	-		resident and it was ultimately		
		ard over a patient's lungs		administered. LPN #1 failed to		
		unds. The Family Nurse		they, the licensed nurse assig		
	Practitioner (FNP) ha	-		patient, administered oxygen		
	. ,	ire and sensitivity, and a		monitored resident until O2 sa		
		#1's family member, stated		baseline was achieved which	is facility	
	,	to the emergency room		protocol.	,	
		nd treatment, stating she				
		g a heart attack. The on-		(2) The procedure for implem	enting the	
	-	ed via telephone at 6:20 PM		acceptable plan of correction	-	
	and agreed to have F	Resident #1 sent to the ER.		specific deficiency cited:		
	The Director of Nursi	ng (DON) was notified via		On 6/28/18, the Director of Nu	ursing	
	telephone. Emergence	cy Management System		immediately suspended LPN	#1 pending	
	(EMS) was contacted	l via telephone for pickup.		investigation regarding failure	to provide	
	Resident #1 departed	the facility at 6:45 PM. Vital		quality of care. If investigation	is	
	signs were blood pres	ssure - 104/67, pulse - 113,		substantiated, facility will follo	w policy of	
	respirations - 28, tem	perature - 98.1 (orally),		terminating LPN #1□s employ	/ment and	
	oxygen saturation 78	% on room air. Nurse #1		reporting event to required ag	encies and	
	contacted the ER at 2	11:00 PM and was informed		licensing boards, as appropria	ate.	
	that Resident #1 had					
		ia. The DON was notified via		On 6/28/18, the Director of Nu	•	
	telephone at 11:10 Pl	М.		Development Coordinator, MI		
				and Assistant Director of Nurs	-	
		ency Medical Services		a timeline of events surroundi		
		ed 05/29/18 revealed they		5/29/18 occurrence in order to		
		cility at 6:27 PM for transport		successfully conduct a Root C		
		difficulty breathing to the		Analysis of the process failure		
		R). The EMS report revealed		failure was determined after r	-	
		cility at 6:41 PM and to		timeline by DON and Adminis		
		e at 6:44 PM. They departed		6/28/18. The failed process id		
	-	at 7:04 PM and arrived at		that LPN #1 did not follow fac	-	
	the hospital at 7:35 P	-		protocols when he observed r		
		arrived at the facility they		78% O2 saturation rate. At the		
		ng flat on his bed with		saturation rate was observed,		
	adventitious lung sou at the bedside and st	nds. His family member was		should have placed resident of supplemental Oxygen, elevate		

Facility ID: 952947

If continuation sheet Page 33 of 47

EXTENDENT OF DEPICENCIES NOD PLAN OF CORRECTION (X) IDENTIFICATION NUMBER: (X) UNUTFIE CONSTRUCTION A BUILDING (X) UNUTFIE CONSTRUCTION BUILDING (X) UNUTFIE SUBJUICONSTRUCTION BUILDING (X) UNUTFIE SUBJUICDING <th></th> <th></th> <th>ID HUMAN SERVICES MEDICAID SERVICES</th> <th></th> <th></th> <th>FOR</th> <th>D: 07/30/2018 M APPROVED O. 0938-0391</th>			ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/30/2018 M APPROVED O. 0938-0391
345418 B. WNG STREET ADDRESS. CITY. STATE. 2IP CODE ASHEVILLE HEALTH CARE CENTER STREET ADDRESS. CITY. STATE. 2IP CODE 1984 US HIGHWAY 70 MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. 2IP CODE 1984 US HIGHWAY 70 MAKE OF PROVIDER CARE CENTER IP OF ORDERS. CITY. STATE. 2IP CODE 1984 US HIGHWAY 70 WANNA OA, NC 23778 IP OF ORDERSCHOLLER CHONG NEEDED BY 2ULL RECORRECTION CALL DENTIFYING INFORMATION IP OF ORDERSCHOLLER CHONG NEEDED BY 2ULL RECORRECTION CARE CONSTRUCTION PROFENDE CONSTRUCTION OR LGC DENTIFYING INFORMATION INFORMATION OR LGC DENTIFYING INFORMATION IP OF ORDERSCHOLLER CHONG NEEDED BY 2ULL RECORRECTION CARE CONSTRUCTION F 684 Continued From page 33 Resident #1 up in bed and he was able to pivot with assistance to the gummey. Physical exam revealed lower streemity swelling, lung sounds full of fluid throughout, and skin was cool and clammy. Review of the CMS report revealed the following: 6:57 PM - 69%, 6:59 PM - 73%, 7:00 pm s9%, 7:07 PM - 80%, 7:17 - 22 %, 7:24 - monitioning, change of condition, and following of standing orders. Area for continuous positive airway pressure is a form of positive airway pressure sensa atomation mid air pressure on a continuous basis to keep the airways continuously open in people who are able to breats be spontaneously on their own, was applied at 7:03 PM. F 684 Condition, and following of standing orders. Standing Orders, Interventions for respiratory distress, protocol for low Coxygen levels, change of condition, physician nothas sequid a spiration and was significantly affected by his co	STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · ·		(X3) DATI COM	E SURVEY PLETED
ASHEVILLE HEALTH CARE CENTER 1984 US HIGHWAY 70 SWANNANOA, NC 20778 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES RESULATORY OR LSC IDENTEYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODERCTIVE ALTORY OR LSC IDENTEYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODERCTIVE ALTORY OR LSC IDENTEYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODERCTIVE ALTORY OR LSC IDENTEYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODERCTIVE ALTORY AND OF CORRECTION (EACH ODERCTIVE ALTORY AND OF CORRECTION) F 684 Continued From page 33 Resident #1 up in bed and he was able to pivot with assistance to the gumey. Physical exam revealed lower extremity swelling. lung sounds full of fluid throughout, and skin was cool and clammy. Review of the CMS report revealed the following: 65.7 PM - 69%, 65.9 PM - 73%, 7:00 pm - 89%, 7:07 PM - 80%, 7:17 - 92 %, 7:24 - 91%, and 7:32 PM - 93%. Oxygen via nasal cannula was applied at 7:03 PM. F 684 F esident signation, and following of standing orders. Area for opportunity was stel identified in 1 of 15 residents with no negative outcomes mild air pressure on a continuous basis to keep the airways continuously opet in people who are applied at 7:03 PM. F 684 F order for provide as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discusses protocol for Iow Oxygen levels, change of condition, physician notification, resident #1 keing provide at 11 killy expliced due to his severe pneumonia. O n 6/28/18, the facility is Staff Develo			345418	B. WING		C 06/29/2018	
ASHEVILLE HEALTH CARE CENTER SWANNANGA, NC 28778 IVA 10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENT WINTS REPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDENTS FLAN OF CORRECTION (EACH CORRECTIVA OT EACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 33 Resident #1 up in bed and he was able to pivot with assistance to the gumey. Physical exam revealed lower extremity swelling. Lung sounds full of fluid throughout, and skin was cool and clammy. Review of the oxygen saturation readings on the EMS report revealed the following: 6:57 PM - 69%, 6:59 PM - 73%, 7:00 pm - 89%, 7:07 PM - 80%, 7:17 - 92 %, 7:24 - gentions grows on a continuous basis to keep the ainvays continuous points to keep the ainvays continuous points to keep the ainvays continuous points on their own, was applied at 7:03 PM. F 684 Review of the hospital discharge summary dated 05/30/18 revealed Resident #1 revealed he expired on 05/30/18 from pneumonia. F 684 Confloxup spoint and three review for the objective for Maxing of the hospital discharge summary dated 05/30/18 revealed Resident #1 revealed he expired on 05/30/18 from pneumonia. F 684 An interview conducted on 06/32/18 at 12:10 PM with Nurse #2 stated she reported to Nurse #1 about Resident with and acting different. She stated she reported to Nurse #1 about Resident #1 being drowsier and acting different and that the FNP had ordered lab work and a On 6/28/18, ht facility:::s proticol for Work until education is received and post -test completed. Staff education to be completed. Staff education to be completed. Staff education to be completed. Staff education to be completed. Staff educatio	NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WANNANAO, NC 28778 PRETEX TAG SUMMARY STATEMENT OF DEFICIENCIES (REQUILATORY OR LSC.DENTIFYING INFORMATION) D PRETEX (REQUILATORY OR LSC.DENTIFYING INFORMATION) D P PRETEX (REQUILATORY OR LSC.DENTIFYING INFORMATION) D P PRETEX (REQUILATORY OR LSC.DENTIFYING INFORMATION) D P PRETEX (REQUILATORY OR LSC.DENTIFYING INFORMATION) P P PRETEX (REQUILATORY OR LSC.DENTIFYING INFORMATION) P P P PRETEX (REQUILATORY OR LSC.DENTIFYING INFORMATION) P P P P P P P P P P P P P P P P P P P					1984 US HIGHWAY 70		
PREFIX TAG CECHO DEFICIENCY MUST BE PRECIBED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CREAR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 33 Resident #1 up in bed and he was able to pivot with assistance to the gurney. Physical exam revealed lower extremity swelling, lung sounds full of fluid throughout, and skin was cool and clammy. Review of the oxygen saturation readings on the EMS report revealed the following: 6:57 PM = 69%, 6:59 PM - 73%, 7:24 - 91%, and 7:32 PM - 93%, Oxygen via nasal cannula was applied at 7:01 PM and a CPAP, continuous positive airway pressure is a form of positive airway pressure ventilator, which applies mill air pressure on a continuous boas to keep the airways continuously open in people who are able to breathe spontaneously on their own, was applied at 7:03 PM. F 684 Review of the hospital discharge summary dated 05/30/18 revealed Resident #1 likely expired due to his severe neumonia, which may have been a result of aspiration and was significantly affected by his congestive heart failure. F 684 An interview conducted on 06/28/18 to 12:10 PM with Nurse #2 stated she reported it to the FNP and she ordered lab work and a chest vray. Nurse #2 further stated she reported it to the FNP and she ordered lab work and a chest vray. Nurse #2 further stated she reported it to the FNP and she ordered lab work and a chest vray. Nurse #2 further stated she reported it to Warse #1 about Resident #1 being drowsier and acting different and that the FNP had ordered lab work and a F 684	ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
Resident #1 up in bed and he was able to pivot with assistance to the gurney. Physical exam revealed lower extremity swelling, lung sounds full of fluid throughout, and skin was cool and clarmy. Review of the oxygen saturation readings on the EMS report revealed the following: 6:57 PM - 69%, 6:59 PM - 73%, 7:00 pm - 89%, 7:07 PM - 80%, 7:17 - 92 %, 7:24 - 91%, and 7:32 PM - 93%. Oxygen via nasal cannula was applied at 7:01 PM and a CPAP, continuous positive airway pressure ventilator, which applies mild air pressure on a continuous basis to keep the airways continuously open in people who are able to breathe spontaneously on their own, was applied at 7:03 PM. On 6/28/18, the Director of Nursing conducted 100% chart audit of other residents discharge of condition, and following of standing orders. Area for opportunity was self identified in 1 of 15 residents with no negative outcomes noted as a result. However, these audit findings were added to ongoing Quality Assurance / Performance Improvement plan and discussed with IDT / Medical Director on 6/28/18, the facility □s Staff Development Coordinator gathered the facility □ splcies and procedures regarding Physician Orders, Standing Orders, Interventions for respiratory distress, protocol for low Oxygen levels, change of condition, physician notification, resident #1 being drowsier and acting different and that the FNP had ordered lab work and a	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
he was drowsier than usual and acting different.test administered. Starting on 6/28/18, no clinical staff is permitted to work until education is received and post -test completed. Staff education to be completed by 6/29/18 regarding Physician Orders, Standing Orders, Interventions for	F 684	Resident #1 up in bec with assistance to the revealed lower extrem full of fluid throughout clammy. Review of th readings on the EMS following: 6:57 PM - 6 pm - 89%, 7:07 PM - 91%, and 7:32 PM - 9 cannula was applied continuous positive a positive airway press mild air pressure on a the airways continuou able to breathe spont applied at 7:03 PM. Review of the hospita 05/30/18 revealed Re to his severe pneumor result of aspiration an by his congestive hea Review of the death of revealed he expired of pneumonia. An interview conductor with Nurse #2 stated	d and he was able to pivot e gurney. Physical exam nity swelling, lung sounds t, and skin was cool and he oxygen saturation report revealed the 59%, 6:59 PM - 73%, 7:00 80%, 7:17 - 92 %, 7:24 - 03%. Oxygen via nasal at 7:01 PM and a CPAP, irway pressure is a form of ure ventilator, which applies a continuous basis to keep usly open in people who are aneously on their own, was al discharge summary dated esident #1 likely expired due onia, which may have been a nd was significantly affected art failure. certificate for Resident #1 on 05/30/18 from ed on 06/28/18 at 12:10 PM she observed Resident #1	F 68	 resident could reach a baseline saturation rate, which LPN #1 f On 6/28/18, the Director of Nur conducted 100% chart audit of residents discharged from facili due to death or hospitalization) last 90 days to review for vital s monitoring, change of condition following of standing orders. Ar opportunity was self identified i residents with no negative outo noted as a result. However, the findings were added to ongoing Assurance / Performance Impre plan and discussed with IDT / N Director on 6/29/18. On 6/28/18, the facility s Staff Development Coordinator gath facility s policies and procedur regarding Physician Orders, St Orders, Interventions for respiradistress, protocol for low Oxyge change of condition, physician resident assessments, and upo following care plan. SDC, MDS ADON began 100% in-service of all clinical staff (LPN, RN, CI 	ailed to do. ailed ther and area for n 1 of 15 comes area dor g Quality ovement Medical ered the res anding atory en levels, notification, dating / b, DON, and education NA,	
chest x-ray earlier that day. respiratory distress, protocol for low An interview conducted on 06/28/18 at 1:39 PM Oxygen levels, change of condition, physician notification, resident		he was drowsier than She stated she report ordered lab work and further stated she rep Resident #1 being dro and that the FNP had chest x-ray earlier that	usual and acting different. ted it to the FNP and she a chest x-ray. Nurse #2 ported to Nurse #1 about owsier and acting different l ordered lab work and a at day.		test administered. Starting on 6 clinical staff is permitted to wor education is received and post completed. Staff education to b completed by 6/29/18 regarding Orders, Standing Orders, Inter- respiratory distress, protocol fo Oxygen levels, change of cond	S/28/18, no k until -test g Physician ventions for r low	

Facility ID: 952947

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					OMB NO. 093	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	
			A. BUILDING		с	
		345418	B. WING		06/29/20	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/20/20	
				1984 US HIGHWAY 70		
ASHEVILI	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMP	(X5) PLETIO DATE
F 684	Continued From page	e 34	F 68	4		
		tioner stated she saw	1.00	assessments, and updating / follo	wina	
		9/18 at 11:15 AM per his		care plan. All staff who have not		
		lurse #2's request due to		completed in-person / over the ph	none	
	-	e and having an increase in		education and post-tests will be n		
	-	he was not congested or		copy of each via USPS Certified I		
		oreath (SOB) or difficulty		will not be permitted to work until		
	-	assessed him. She stated he		education and post-test is comple		
		in at the site of his broken rib nest x-ray per the family's		Compliance will be ensured and t by each employee s respective	lackeu	
		d Nurse #1 called her that		department manager.		
		PM and reported Resident		This training included:		
		a low oxygen saturation		MD Orders / Standing Orders D	Educated	
	•	ler to send him to the ER for		on process including explanation		
		d she was not informed		there are hard copies orders for a		
		n saturation was 78% and		residents in the narcotics book. W		
		I staff to raise the head of the gen per standing orders to		nurse needs to implement a Stan order, facility requires nurse to pla	-	
	bring his oxygen leve			order in the computer (EMR), and		
				complete an E-Interact change of		
	An interview conduct	ed on 06/28/18 at 11:17 AM		condition form along with that ord		
	with Nurse Aide (NA)	#1. NA #1 stated he was at		to also document communication	in the	
		ne East Hall the evening of		MD communication book. The ex		
		MS arrived and told Nurse		is that MD orders will be followed	at all	
		or Resident #1 and asked		times.		
		and if anyone was in the ard the nurse say no and		Interventions for respiratory distre		
		on of Resident #1's room. NA		O2 levels facility processes inc		
	•	to take the EMS workers to				
		He stated when they walked		(a) Staff member is to be present	if	
	in the room Resident	#1 was lying flat in bed and		resident is noted to be in distress	and	
		ring to breathe, he sounded		have a low O2 saturation,		
		short of breath. NA #1 stated				
		ive any oxygen on and there		(b) Nurse will request that anothe		
		ncentrator or oxygen tank in ner stated he was not		member go and retrieve O2 conc or tank with tubing.		
		#1 that evening and had not				
	-	ng EMS personnel to his		(c)Staff will follow protocol for		
	room around 6:45 PM			administering Oxygen, and how to	o	
	1		1	observe oxygen saturation by usi		

Facility ID: 952947

If continuation sheet Page 35 of 47

<u>CENTER</u>	<u>S FOR MEDI</u> CARE &	MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345418	B. WING			C 6/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2010
				1984 US HIGHWAY 70		
ASHEVILI	LE HEALTH CARE CENT	ER		SWANNANOA, NC 28778		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	e 35	F 68	34		
	An interview was cor PM with EMS Worke arrived at the facility and she told him they for a respiratory distr the hall, she asked if he said no, she told h he continued to sit at She stated NA #1 tol Resident #1's room, walked into Resident in bed, with no oxyge him trying to breathe there were no staff p when they arrived ar tank or concentrator stated Resident #1's room with him and sl asked her why she to having a heart attack An interview conduct with Nurse #1, who w the 3:00 PM to 11:00 revealed he was in th pass and Resident # him to assess Reside having difficulty brea around 6:00 PM. Nur Resident #1's room a #2 obtained his vital Resident #1's oxygen	nducted on 06/28/18 at 12:05 r #1. She stated when they the nurse was at the desk y were there for Resident #1 ress call and he pointed down isomeone was with him and him she needed report and at the desk and do paperwork. d her he would take them to she reported when they it #1's room he was lying flat en on, and she could hear . EMS Worker #1 stated resent in Resident #1's room ad she didn't see an oxygen in the room. She further family member was in the ne was crying, when she old her she thought he was a and he was going to die. ted on 06/28/18 at 12:15 PM vorked with Resident #1 on 0 PM shift on 05/29/18, he middle of his medication 1's family member asked ent #1 because he was thing and pain in his chest rse #1 stated he went to and assessed him while NA signs. Nurse #1 stated n saturation was 78% at that d the resident pointed to his		 Ox per protocol. (d) Nurses will delegate to other stay with resident once resider (e)After resident is stable their call MD for orders. (f) Nurse will place all orders in computer including orders imp from Standing orders (ex: oxyginate placement and settings. Refer Order/care plan guide for item in orders). (g) Nurse will then start compler required paper work to transfer received. Paperwork includes Change of Condition, and tran (h) If in an emergent situation the nurse does not feel that the stable, nurse will instruct anothe member to call 911 and help grequired paperwork. Change of Condition / MD Note Resident Assessment With a of condition, vital signs need to obtained appropriately, and free vital signs should be taken at the incident. If any abnormal VS, with the obtained at a minimum of hours until VS stable per base 	nt is stable. hurse is to hor the lemented gen to s to include eting the r out if order E-interact sfer form. arises and e resident is her staff ather the ification / iny change b be equently, ime of vitals need f every 4	
	his pain was but his be sent to the ER. No nurse's desk to call t	t when he asked him where family was insistent that he urse #1 stated he went to the he on-call provider for order's paperwork and thought he		Oxygen - the resident should alone until O2 is at an accepta acceptable baseline), continue monitor.	ble level (at	

Facility ID: 952947

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · ·	COMPLETED	
					с		
		345418	B. WING		0	06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				1984 US HIGHWAY 70			
ASHEVILI	E HEALTH CARE CENT	EK		SWANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 684	Continued From page	e 36	F 68	4			
	facility standing order			Blood pressure- if you have	e an abnormal		
		when the vital signs were		blood pressure for the resid			
	-	hink about raising the head		notify the MD immediately			
		stated he called the FNP,		orders, continue to monitor			
		nd started the paperwork for					
		id not go back and assess		Pulse- if you have an abn			
		ying to get the paperwork		the resident, you are to not	•		
		ot go with the EMS to his		immediately and obtain oro to monitor.	lers, continue		
	finished with the pape	ed because he wasn't		to monitor.			
		SIWOIK.		Respirations- encourage re	sident to nurse		
	An interview conduct	ed with the Director of		lip breath. In through their			
		se #1 called her on 05/29/18		through their mouth. Slow			
	-	was sending Resident #1 to		steady.			
	the ER per his family	's request. She stated she					
		sident #1's oxygen saturation		Temperature- Administer n			
		all nurses were trained on		standing orders, notify MD	, and continue		
		here was a copy of the		to monitor.			
	standing orders on ev			Lindoting / Following of Co	ro Dion □ Itio		
		and her expectation was for effective for effective and effective standing orders and		Updating / Following of Ca the expectation of the facili			
		e ad of bed and apply oxygen		staff will follow and / or upo	• •		
		uration back to 90%. She		resident s specific plan of			
		#1 should have followed the			-		
		s and administered oxygen		On 6/28/18, the Staff Deve	lopment		
	and raised the head of	of the bed for Resident #1.		Coordinator, Director of Nu			
				Nurse, and ADON began 1			
		ed on 06/28/18 3:16 PM with		education with nursing stat			
	-	member revealed she was		on-call nurse is to be notified	•		
		lay on 05/29/18 because he		with any and all resident ch condition.	langes in		
	asked her to stay with	pain and the FNP saw him					
		lab work and a chest x-ray		(3) The monitoring proced	ure to ensure		
	to be done. The famil	-		that the plan of correction i			
		naving difficulty breathing		that specific deficiency cite			
	that evening and she			corrected and / or in compl			
	saturation with her ov	vn machine and showed it to		regulatory requirements:			
		t with the facility machine.		Starting on 6/29/18, each u			
	She stated NA #2's o	xygen saturation reading		report and available push i	eports will be		

Facility ID: 952947

If continuation sheet Page 37 of 47

		MEDICAID SERVICES					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	. ,	E SURVEY	
			A. BUILDING			C	
		345418	B. WING				
	ROVIDER OR SUPPLIER	040410		STREET ADDRESS, CITY, STATE, ZIP		6/29/2018	
	ROVIDER OR SOFFLIER			1984 US HIGHWAY 70	CODE		
ASHEVIL	LE HEALTH CARE CENT	ER					
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	SWANNANOA, NC 28778 PROVIDER'S PLAN C		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	COMPLETIO	
F 684	Continued From pag	e 37	F 684	4			
	was 78% around 6:0	0 PM and she reported it to		reviewed daily (M-F) in cl	inical meeting to		
		1's family member stated		validate identified at-risk	residents vitals		
		ess Resident #1 but he did		are within normal limits, c			
		his room and ask her if she		followed, code statuses h			
		he ER. She further stated		appropriate O2 protocol is	s being followed		
		ve Resident #1 oxygen due reath and difficulty breathing		as appropriate.			
		until the EMS arrived around		On 6/29/18, the Regional	Nurse		
		ovided oxygen for him.		Consultant developed a r			
				sheet to check and validate	-		
	An interview conduct	ed on 06/28/18 3:07 PM NA		residents as identified by	the 24-hour		
	#2 revealed Resident #1's family member called			report or available push r			
		5/29/18 around 6:00 PM and		sheet includes assessme			
		en saturation reading she		vitals, honoring of code s			
	-	te machine and it was 75%. ecked Resident #1's oxygen		plans, and oxygen protoc as indicated. Starting 6/2	÷		
		icility machine and got a		sheet will be populated a			
		mmediately informed Nurse		(M-F) in morning clinical i	•		
		e #1 assessed Resident #1		review and track at-risk re			
	and she took oxygen	into the room for him to put		previous 24 hours (72 ho	urs if weekend).		
		stated she didn't see Nurse					
		Resident #1 and she didn't		Starting on 6/29/18, the E			
		ter she took the oxygen to		SDC, MDS, Regional Nu			
		r stated Resident #1 was ne was having difficulty		designated nurse manage(3) random audits of patie			
	breathing.			review vitals, code status			
	brouting.			incident reports, orders, o			
	An interview conduct	ted on 06/29/18 at 9:00 AM		condition and required no			
		ician revealed it was his		therein, as well as care p	-		
	-	ident who was short of		for 4 weeks, then 3x wee			
		xygen saturation of 78% to		then weekly for 4 weeks t			
		and the head of the bed		delivery of quality care. A	-		
		nding orders. He further ovider should be called		from audits will be discus and QA committee and a			
	immediately.			immediately.			
		PM the Administrator and the		Starting 6/29/18, the Inter	· ·		
	DON were notified of	f Immediate Jeopardy.		Team and Medical Direct			
				QAPI meeting to review t	ne enicacy of the		

Facility ID: 952947

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/30/201 FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345418	B. WING		C 06/29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	
ASHEVILLE HEALTH CARE CENTER			1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 684	On 06/29/18 at 2:44 I acceptable credible a Jeopardy removal that (1) Plan for correcting identified, include the concern: It was observed that failed to ensure the d ensure the highest pr and psychosocial we The process breakdo was as follows: " 5.28.18 (11:37pr agitation and verbal a insomnia. Zyprexa IM " 5.29.18 Patient s related to increased a pain. No documented Order for chest x-ray x-ray given by nurse assessment by nurse compliance and dimin rales, or rhonchi. New requested for pain. " 5.29.18 (6:19pr change of condition a shortness of breath, room air. Orders note room. " 5.29.18 (6:35pr transfer form. Oxyget intervention at this tir the hospital - O2: 78 B/P: 104/67. Pain eva 10. Known d/x of CO " Statements from	PM the facility provided an illegation of Immediate at included: g specific area of concern e process that led to the on 05/29/2018 that LPN #1 elivery of quality care or to racticable physical, mental, II-being. wwn that lead to the concern m) LPN #1 documented aggression as well as 1 given. seen by Nurse Practitioner agitation, insomnia, and flank d fever, dyspnea, cough. , urinalysis, CMP, and left rib practitioner. Respiratory e practitioner shows poor hished without wheezes, w orders for ibuprofen as m) LPN #1 documented assessment related to bygen saturation of 78% on ed to send to emergency m) LPN #1 completed h was not documented as an ne. Per the transfer form to 3%, Res: 28, Pulse: 113, al conducted; rated as 4 of	F 6	 aforementioned plan weel then bi-weekly x 1 month, thereafter to ensure contir with the requirements of p IDT includes the Administ Nursing, Assistant Director Social Worker, Activities I Business Office Manager, Coordinator, Staff Develop Coordinator, Housekeepir Maintenance Director, ME Dietary Director, Medical I Pharmacist. (4) The title of the person implementing the accepta correction: The individual responsible implementing the credible correction is the Administr 	then monthly nued compliance participation. The rrator, Director of or of Nursing, Director, , Admissions pment ng Director, DS Nurse, Director, and responsible for able plan of

Facility ID: 952947

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CENTERS FOR MEDICARE & MEDI			ID HUMAN SERVICES					PPROVED	
346418 B. WING 06/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1384 US HIGHWAY 70 ASHEVILLE HEALTH CARE CENTER SUMAMAY STATEMENT OF DEPCIENCIES (PREEX) SUMANAS STATEMENT OF DEPCIENCIES (PREEX) DEPCIENCY MUST SWANANAO, N.C. 28773 Commentation (PREEX) Commentation (PREEX) <t< td=""><td>STATEMENT (</td><td>OF DEFICIENCIES</td><th>(X1) PROVIDER/SUPPLIER/CLIA</th><td>. ,</td><td></td><td></td><td>X3) DATE SUF COMPLET</td><td>RVEY</td></t<>	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			X3) DATE SUF COMPLET	RVEY	
194 US HIGHWAY 10 SWANAANOA, NC 28778 195 US HIGHWAY 10 SWANAHOA, NC 28778			345418	B. WING			_		
ASHEVILLE HEALTH CARE CENTER SWANNANOA, NC 28778 (M4 ID PHEERX TXG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WUST ERECORDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) D PMEERX TAG PROVIDERS PLAN OF CORRECTION NOT CROSS-REFERENCE TO THE APPROPRATE 0.000, COMELTION CROSS-REFERENCE TO THE APPROPRIATE 0.000, COMELTION DATE F 684 Continued From page 39 elevated at time EMS arrived and that oxygen was not being administered. F 684 F 684 - 5.30.18 (C122pm) LPN #1 documented nurses note related to change of condition and orders to send to hospital. Attenting physician notified that resident was admitted to the hospital related to pneumonia. F 684 - 6.28.18 (08:00) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/29/18. Exolity was cited with F684 for Quality of Care. Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for low oxygen saturation levels (70%) and shortness of breath, which subsequently resulted in failure to deliver an acceptable level of updity care or to ensure the highest practicable physical, mental, and psychosocial well-being of the resident. Interview with LPN #1 states that nurse had instructed CNA #1 to "get oxygen" while he was completing documentation to send Resident #1 to hospital. Per LPN #1, he believe that CNA #1 was asplying O2 to resident. Interview with LPN #1 revaaled that be understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1 schange of condition. Resident #1 sc C	NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE			
Date Description SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S FLAV OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFINENCES TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 39 elevated at time ENS arrived and that oxygen was not being administered. " 5.30.18 (01:22pm) LPN #1 documented nurses note related to change of condition and orders to send to hospital. Attending physician notified that resident was admitted to the hospital related to pneumonia. " 6.28.18 (08:00) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/29/18. Facility was tited with F684 for Quality of Care. Upon review of the adoresmitoned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for two oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in failure to deliver an acceptable level of quality care to ensome the highest practicable physical, mental, and psychoscial with LPN #1 states that nurse had instruced CNA #1 to 'get oxygen' while he was completing documentation to send Resident #1 to hospital. Per LPN #1, the believed that Resident #1 was sisting n edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying 02 to resident. Interview with LPN #1 states that nurse had instruced CNA #1 to 'get oxygen' while he was completing documentation to send Resident #1 to hospital. Per LPN #1, the believed that Resident #1 was sisting n edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying 02 to resident. Interview with LPN #1 revealed that he understood that setting up 02 was out Of CNA scope of practice, but was trying to save time in light of Resident #1's ch									
Preserve TAG IEACI DEFICIENCY MIGT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG IEACI CONSERTURE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION IDENTIFYING INFORMATION F 684 Continued From page 39 elevated at time EMS arrived and that oxygen was not being administered. F 684 F 684 * 5.30.18 (01:22pm) LPN #1 documented nurses note related to change of condition and orders to send to hospital. Attending physician notified that resident was admitted to the hospital related to pneumonia. F 684 * 6.28.18 (00:0) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/20/18. Facility was cited with F684 for Quality of Care. Upon review of the aforementioned event, there is evidence that LPN #1 did no follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for tow oxygen saturation levels (78%) and shortness of breath, which subsequently resulted in failure to deliver an acceptable level of quality care or to ensure the highest practicable physical, mental, and psychoscial well-being of the resident. Hreview with LPN #1 states that nurse had instructed CNA #1 to 'get oxygen' while he was completing documentation to send Resident #1 to hospital Per LPN #1, he believed that Resident #1 was sitting on edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying O2 to resident. Interview with LPN #1 revealed that he understood that setting up O2 was out of CNA scope of practice, but was trying to save time in light of Resident #1's change of condition. Resident #1's O2 saturation rate was 78% which justified supplementation oxygen and	ASHEVILL	E HEALTH CARE CENT	ER		SWANNANOA, NC 28778				
elevated at time EMS arrived and that oxygen was not being administered. * 5:30:18 (01:22pm) LPN #1 documented nurses note related to change of condition and orders to send to hospital. Attending physician notified and sister aware and in room. Resident left facility at 6:45pm. At, 11:00pm facility was notified that resident was admitted to the hospital related to pneumonia. * 6:28:18 (08:00) NC Department of Health and Human Services arrive to facility to investigate complaint of event on 5/29/18. Facility was cited with F684 for Quality of Care. Upon review of the aforementioned event, there is evidence that LPN #1 did not follow facility procedures when addressing Resident #1's change of condition including implementation of interventions for low oxygen saturation levels (/78%) and shortness of breasth, which subsequently resulted in failure to deliver an acceptable level of quality cares that interview with LPN #1 states that nurse had instructed CNA #1 to "get oxygen" while he was completing documentation to send Resident #1 was sitting on edge of bed, and thus could not raise the head of bed. LPN #1 also believe that CNA #1 was applying 0.2 to resident. Interview with LPN #1 also believe that CNA #1 was applying 0.2 to resident. Interview as triting the addressing up 0.2 was out of CNA scope of practice, but was trying to save time in light of Resident #1's change of condition. Resident #1's 0.2 saturation rate was 78% which justified supplementation rate was 78% which justified supplementation rate was 78% which justified supplementation and was	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIV CROSS-REFERENCE	'E ACTION SHOULD BE D TO THE APPROPRIATI		OMPLETION	
monitoring until baseline O2 saturation rate is achieved The plan to correct this identified concern includes the completion of a thorough	F 684	elevated at time EMS was not being admini " 5.30.18 (01:22) nurses note related to orders to send to hos notified and sister aw left facility at 6:45pm. notified that resident f related to pneumonia " 6.28.18 (08:00) N Human Services arriv complaint of event on with F684 for Quality Upon review of the af is evidence that LPN procedures when add change of condition if interventions for low of (78%) and shortness subsequently resulted acceptable level of qu highest practicable pl psychosocial well-bei with LPN #1 states th #1 to "get oxygen" with documentation to ser Per LPN #1, he believes sitting on edge of bed the head of bed. LPN was applying O2 to re #1 revealed that he u was out of CNA scoper to save time in light of condition. Resident # 78% which justified si monitoring until basel achieved The plan to correct th	a arrived and that oxygen stered. pm) LPN #1 documented o change of condition and pital. Attending physician are and in room. Resident At, 11:00pm facility was was admitted to the hospital NC Department of Health and re to facility to investigate of Care. Forementioned event, there #1 did not follow facility dressing Resident #1's ncluding implementation of oxygen saturation levels of breath, which d in failure to deliver an uality care or to ensure the hysical, mental, and ng of the resident. Interview at nurse had instructed CNA hile he was completing nd Resident #1 to hospital. ved that Resident #1 was I, and thus could not raise #1 also believe that CNA #1 esident. Interview with LPN nderstood that setting up O2 e of practice, but was trying f Resident #1's change of #1's O2 saturation rate was upplemental oxygen and ine O2 saturation rate is	F 6	584				

Facility ID: 952947

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/30/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345418	B. WING		C 06/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE
ASHEVILL	E HEALTH CARE CENT	ER		1984 US HIGHWAY 70 SWANNANOA, NC 28778	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 684	completion of a Root the variables that led house-wide education appropriate staff on a include topics of Phy Orders, Interventions protocol for low Oxyg condition, physician r assessments, and up The facility will also in measures and randon course of the next 90 and efficacy of this pl will be shared with the Performance Improve Director no less than negative audit results before the QAPI team immediate review and this event was that the judgment call and red member (who was no retrieve and set up oo was ultimately not ad ensure that they, the the patient, administer resident until O2 satu achieved which is fac (2) The procedure for acceptable plan of co deficiency cited: " On 6/28/18, the I immediately suspend investigation regardin care. If investigation i follow policy of termin	ding the event on 5/29/18, Cause Analysis to identify to the process failure, n and in-service training to reas for opportunity to visician Orders, Standing for respiratory distress, en levels, change of notification, resident dating / following care plans. mplement monitoring m audits spread over the days to ensure compliance an. Lastly, all audit results e facility Quality Assurance ement team and the Medical monthly for review. All will be immediately brought n and Medical Director for d remedy. The root cause of at LPN #1 made a poor quested another staff of a licensed nurse) to kygen for a resident and it ministered. LPN #1 failed to licensed nurse assigned to ered oxygen and monitored tration baseline was cility protocol. r implementing the prection for the specific Director of Nursing ed LPN #1 pending ng failure to provide quality of s substantiated, facility will nating LPN #1's employment o required agencies and	F 6	584	

Facility ID: 952947

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-039 E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		IPLETED		
						С		
		345418	B. WING		0	6/29/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E			
ASHEVILI	E HEALTH CARE CENT	ER		1984 US HIGHWAY 70				
//0///2///2				SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 684	Continued From page	2 41	F 68	34				
	On 6/28/18, the Direc							
		nator, MDS nurse, and						
	· ·	Nursing created a timeline of						
		ne 5/29/18 occurrence in						
		conduct a Root Cause						
		ss failure. Process failure						
		reviewing timeline by DON						
		6/28/18. The failed process						
		N #1 did not follow facility e observed resident with						
	78% O2 saturation ra							
		bserved, LPN #1 should						
		on supplemental Oxygen,						
		, and remained with resident						
	until resident could re							
	saturation rate, which							
		Director of Nursing rt audit of other residents						
		ity (either due to death or						
		the last 90 days to review						
		ng, change of condition, and						
		orders. Area for opportunity						
		1 of 15 residents with no						
		oted as a result. However,						
	-	vere added to ongoing						
		Performance Improvement vith IDT / Medical Director on						
	6/29/18.							
	" On 6/28/18, the f	facility's Staff Development						
		the facility's policies and						
		Physician Orders, Standing						
		for respiratory distress,						
	protocol for low Oxyg							
	condition, physician r	iotification, resident idating / following care plan.						
		d ADON began 100%						
		of all clinical staff (LPN, RN,						

Facility ID: 952947

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUR COMPLETE C		
		345418	B. WING			06/29/2018		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ASHEVILI	E HEALTH CARE CENT	ER			984 US HIGHWAY 70 WANNANOA, NC 28778			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	BE ATE	(X5) COMPLETION DATE		
F 684	test administered. Sta staff is permitted to w received and post -te- education to be comp Physician Orders, Sta for respiratory distres levels, change of con resident assessments care plan. All staff wh in-person / over the p post-tests will be mail Certified Mail and will until this education ar Compliance will be er employee's respective This training included 1. MD Orders / Star process including exp copies orders for all m book. When a nurse m Standing order, facilit that order in the comp an E-Interact change that order, and to also in the MD communication is that MD orders will 2. Interventions for levels - facility proces " Staff member is for noted to be in distress saturation, " Nurse will request go and retrieve O2 co tubing. " Staff will follow p Oxygen, and how to co by using Pulse Ox pe	arting on 6/28/18, no clinical ork until education is st completed. Staff bleted by 6/29/18 regarding anding Orders, Interventions s, protocol for low Oxygen dition, physician notification, s, and updating / following to have not completed hone education and led a copy of each via USPS not be permitted to work and post-test is completed. Insured and tracked by each the department manager. The ding Orders - Educated on blanation that there are hard tesidents in the narcotics needs to implement a y requires nurse to place buter (EMR), and complete of condition form along with to document communication be followed at all times. The spiratory distress / low O2 sees include: to be present if resident is s and have a low O2 at that another staff member oncentrator or tank with	F	684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING _				C 29/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				19	984 US HIGHWAY 70		
ASHEVILI	E HEALTH CARE CENT	ER					
(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 X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 684	for orders. "Nurse will place a including orders imple orders (ex: oxygen plat to Order/care plan gu orders). "Nurse will then st paper work to transfe Paperwork includes E Condition, and transfe "If in an emergent nurse does not feel th nurse will instruct and 911 and help gather th 3. Change of Condi Resident Assessment condition, vital signs r appropriately, and fre be taken at time of ind vitals need to be obta 4 hours until VS stabl "Oxygen - the resuntil O2 is at an accept baseline), continue to "Blood pressure for the the MD immediately at to monitor. "Pulse- if you ha resident, you are to mand obtain orders, co "Respirations- end	at is stable. stable the nurse is to call MD all orders into the computer emented from Standing acement and settings. Refer ide for items to include in tart completing the required r out if order received. interact Change of er form. : situation arises and the mat the resident is stable, other staff member to call he required paperwork. tion / MD Notification / t- With any change of need to be obtained quently, vital signs should cident. If any abnormal VS, ined at a minimum of every e per baseline. ident should not be left alone ptable level (at acceptable monitor. if you have an abnormal e resident, you are to notify and obtain orders, continue ve an abnormal pulse for the otify the MD immediately ntinue to monitor. courage resident to purse lip ir nose out through their	F	584			

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU				FORM	07/30/2018 APPROVED 0.0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				C	
		345418	B. WING			-		29/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ASHEVILL	E HEALTH CARE CENT	ER		1984 US HIGHWAY 70 SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	 standing orders, notify monitor. 4. Updating / Follow expectation of the fact follow and / or update plan of care. " On 6/28/18, the S Coordinator, Director ADON began 100% in nursing staff that the orimmediately with any condition. (3) The monitoring pr plan of correction is endeficiency cited remain compliance with regult." Starting on 6/29/7 report and available "I reviewed daily (M-F) i identified at-risk reside limits, care plans are finonored, and appropriation. " On 6/29/18, the F developed a monitorir validate at-risk reside 24-hour report or avait flow sheet includes as vitals, honoring of correction is and reviewed daily (M meeting to review and the previous 24 hours 	minister medications per y MD, and continue to wing of Care Plan - It is the sility that nursing staff will e each resident's specific Staff Development of Nursing, MDS Nurse, and n-service education with on-call nurse is to be notified and all resident changes in rocedure to ensure that the ffective and that specific ins corrected and / or in latory requirements: 18, each unit's 24-hour push reports" will be in clinical meeting to validate ents' vitals are within normal followed, code statuses riate O2 protocol is being te. Regional Nurse Consultant ng flow sheet to check and nts as identified by the ilable "push report." This ssessment of abnormal de status and care plans, being followed as indicated. flow sheet will be populated A-F) in morning clinical d track at-risk residents over a (72 hours if weekend).	F	684		EFICIENCY)		
	" Starting on 6/29/	s (72 hours if weekend). 18, the DON, ADON, SDC, e, or designated nurse						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345418	B. WING				/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEVILL	E HEALTH CARE CENT	ER			1984 US HIGHWAY 70 SWANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOL		BE	(X5) COMPLETION DATE
F 684	⁴ Continued From page 45 manager will conduct (3) random audits of patient charts to review vitals, code status changes, incident reports, orders, change of condition and required notifications therein, as well as care plans 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to monitor delivery of quality care. Any noted issues from audits will be discussed with the IDT and QA committee and addressed immediately. " Starting 6/29/18, the Inter Disciplinary Team and Medical Director will attend QAPI meeting to review the efficacy of the aforementioned plan weekly x 4 weeks, then bi-weekly x 1 month, and then monthly thereafter to ensure continued compliance with the requirements of participation. The IDT includes the Administrator, Director of Nursing, Assistant Director, Business Office Manager, Admissions Coordinator, Staff Development Coordinator, Housekeeping Director, Maintenance Director, and Pharmacist.		F	684			
		eptable plan of correction: sponsible for implementing					
	3:35 PM when the fac and demonstrated th topics of Physician O Interventions for resp low Oxygen levels, ch	was removed on 6/29/18 at cility staff were interviewed ey had been trained on the rders, Standing Orders, iratory distress, protocol for hange of condition, physician assessments, and updating /					

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		ID HUMAN SERVICES					APPROVED		
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY		
			A. BUILDI	LDING					
		345418	B. WING		C 06/29/2018				
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010		
	LE HEALTH CARE CENT	ED			984 US HIGHWAY 70				
ASHEVILI	LE HEALTH CARE CENT	ER			SWANNANOA, NC 28778				
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION				
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE		
					DEFICIENCY)				
			1						
	1								

Facility ID: 952947

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