PRINTED: 02/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345418	B. WING _			01/08/2021	
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH AT ASHEVILLE			STREET ADDRESS, CITY, STATE, ZIP CO 1984 US HIGHWAY 70 SWANNANOA, NC 28778	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIAT		
E 000	Initial Comments		E 0	000			
	was conducted onsite facility on 12/30/20. A obtained offsite throu exit date was change was found in complia related to E-0024 (b)(for Long Term Care FINITIAL COMMENTS)  An unannounced CC Control Survey was owith exit from the facilitormation was obtain therefore, the exit datherefore, the exit datherefore	oVID-19 Focused Infection conducted onsite 12/30/20 lity on 12/30/20. Additional ned through 01/08/21; see was changed to 01/08/21. Sound in compliance with 42 control regulations and has and Centers for Prevention (CDC) sees to prepare for # T19311.	F 0			2/1/21	
36-L	infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection program.	ntrol blish and maintain an and control program a safe, sanitary and bent and to help prevent the asmission of communicable					
ADODATODY	and control program of a minimum, the follow	(IPCP) that must include, at		TITLE		(X6) DATE	

Electronically Signed 02/03/2021

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED	
	345418	B. WING		01/08/2021	
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH AT ASHEVILLE			1984 US HIGHWAY 70	1 0.700,232	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	OULD BE COMPLETION	
§483.80(a)(1) A systereporting, investigatir and communicable d staff, volunteers, visit providing services un arrangement based us conducted according accepted national states §483.80(a)(2) Writter procedures for the probut are not limited to: (i) A system of surveit possible communicate infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trait to be followed to previously (iv) When and how is cresident; including but (A) The type and durate depending upon the involved, and (B) A requirement that least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected si	em for preventing, identifying, ng, and controlling infections iseases for all residents, tors, and other individuals ader a contractual upon the facility assessment to §483.70(e) and following andards;  In standards, policies, and orgam, which must include, it is illiance designed to identify ble diseases or y can spread to other of the infections should be insmission-based precautions went spread of infections; colation should be used for a ut not limited to: attend to infectious agent or organism at the isolation should be the ible for the resident under the iss under which the facility ees with a communicable	F 880	, , , , , , , , , , , , , , , , , , ,		
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From page  §483.80(a)(1) A syster reporting, investigatir and communicable distaff, volunteers, visit providing services ur arrangement based us conducted according accepted national states accepted national states (i) A system of surveit possible communical infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trait to be followed to preve (iv) When and how is resident; including but (A) The type and dur depending upon the involved, and (B) A requirement that least restrictive possicircumstances.  (v) The circumstance must prohibit employ	A 345418  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	A BUILDING  345418  B. WING  GOVIDER OR SUPPLIER  HEALTH AT ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  \$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  \$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	TOUDER OR SUPPLIER  345418  STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1  \$483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  \$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and to whom possible incidents of communicable disease or infections should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		ATE SURVEY MPLETED	
		345418	B. WING	· · · · · · · · · · · · · · · · · · ·	,	01/08/2021	
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH AT ASHEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE  1984 US HIGHWAY 70  SWANNANOA, NC 28778			1 0110012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	identified under the facorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on record rev facility failed to ensur policies and procedur Disease Control and for screening were in failed to document he screening form or rep supervisor and worke three dates for 1 of 3 for COVID screening, during a COVID-19 p 12/29/20, a total of 72 tested positive for CO Findings included: Review of a facility do Administrator and dat "2) Signs and sympto shortness of breath, thigher, increased nas body aches, abnormal	em for recording incidents acility's IPCP and the en by the facility.  Ile, store, process, and to prevent the spread of view.  Ict an annual review of its in program, as necessary.  Is not met as evidenced itew and staff interviews, the etheir infection control res and the Centers for Prevention (CDC) guidelines applemented when Nurse #1 er symptoms on the early for the symptoms to her early for the staff (Nurse #1) reviewed andemic. From 12/11/20 to 2 residents out of 84 had DVID-19.  Document provided by the teed 05/22/20, noted in part: ems to report to nurse: emperature of 99.0 or sal drainage, sore throat, al tiredness, loss of taste and	F 88	To correct the alleged deficient education with all staff in all dephas been initiated and will be compared by 2.1.21. Education will include of the correct screening process of symptoms of COVID and improtifying appropriate personnel experiencing symptoms and revaccordius Health COVID Policy. To ensure other residents or stable affected by this alleged deficient practice, the Administrator, Directive Nursing or assigned personnel all screening sign in and sign of twice a day for 30 days, then days, then three times a week then as needed; Effective 1/7/2 responsible will check that all staged in, out and completed all questions. If a staff member and to any of the questions during the screening process that they have	partments completed e a review s, a review cortance of when view of // aff will not cient ector of will review tut sheet ailly for 60 for 90 days, t1. Person taff have ll swers yes he ve		
	body aches, abnorma smell, new cough6 see your supervisor a	•		1	ve aise, symptoms		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRAIND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE COMP	SURVEY			
		345418	B. WING _			01/08/2021	
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH AT ASHEVILLE			19	REET ADDRESS, CITY, STATE, ZIP CODE 084 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	have been in the build Review of the CDC gread in part: "As part healthcare personnel themselves for fever with COVID-19." The remind personnel to see develop symptoms of while at work they shand leave the workplas of their shift for fever COVID-19, actively to document absence of COVID-19."  The facility's COVID-spreadsheet for staff line item for Nurse #1 was collected for COV an outside laboratory. It was documented un column that Nurse #1 symptoms of being "verthe symptom listed. Fresults dated 12/10/2 positive for COVID-19.  The COVID-19 Emploing for 12/06/20 noted Nurse #1's name. Time in was recorded Temperature upon endegrees. Screening question #	uidance updated 11/20/20 of routine practice, ask to regularly monitor and symptoms consistent a guidance included: "to stay home when ill or if they onsistent with COVID-19 ould inform their supervisor ace, screen at the beginning and symptoms of ake their temperature and if symptoms consistent with  19 infection and testing dated 12/07/20 revealed a that noted a lab specimen vID-19 testing and sent to for processing on 12/07/20. Inder the clinical information had "COVID-like" weak" with no onset date of Further review revealed test 0 confirmed Nurse #1 was 0.  Dyee Sign In/Out screening of the following:  I as 6:44 AM. Itry was recorded as 97  1 (Do you have any oat, fever, cough, shortness of symptoms) was	F	380	will not be allowed into the facility or we their scheduled shift. Staff is to immediately notify Administrator and D if any questions have been answered y If there are any blanks in the sign in or sign out log that are observed, the Administrator and/or DON will immediately contact the staff to obtain missing information. If a follow up call must be made, the staff that has failed complete the sign in or sign out log completely must receive the education again listed above.  Effective 1.27.21 the Director of Nursin re-educated all staff on the new screen tool to be used at check-in and check-In addition, the previous education was reiterated along with Accordius □ new check-in tool/log. All new hired staff wibe educated upon hire.  The administrator or DON will begin auditing check-in logs on 1.8.21 on the following schedule: twice a day for 30 days, then daily for 60 days, then three times a week for 90 days, then as needed. Results of audits will be broug to monthly Quality Assurance and Performance Improvement meeting ea month for 3 months. Review and revisions will be made as necessary.  DOC: 2.1.21  RCA:  Administrator and Director of Nursing han Ad Hoc QAPI meeting with the IDT team to determine the root cause analytical meeting the roo	on yes.  to  gining out.  sill  ght  ch	

Facility ID: 952947

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING			01/	08/2021
	ROVIDER OR SUPPLIER HEALTH AT ASHEVILLE		•	19	TREET ADDRESS, CITY, STATE, ZIP CODE 984 US HIGHWAY 70 WANNANOA, NC 28778		
				U	TARRANGA, NO 20110		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	sickness or generally 72 hours) was docum Screening question # or around anyone that of COVID 19 in the latcharge nurse) docum Time out was recorded Screening question # during your shift feel symptoms. If yes, pledocumented as "N" to Temperature upon extended a total of 4 radmission/quarantine. The COVID-19 Empled log for 12/09/20 noted Nurse #1's name. Time in was recorded Temperature upon extended as "N" to No time out was recorded Temperature upon extended as "N" to No time out was recorded to Temperature upon extended to Temper	22 (Have you had any type of not feeling well in the last nented as "N" to indicate 'no'. 33 (have been in any location at has had a confirmed case list 14 days, if yes please see lented as "N" to indicate 'no'. 36 das 8:00 PM. 37 (Did you at any time sick or have any respiratory lease see charge nurse) was of indicate 'no'. 38 (at was recorded as 98.1)  Census report for 12/06/20 (residents resided on the new equit. 39 and 44 were all of indicate 'no'. 37 and 44 were all of indicate 'no'. 38 and 44 were all of indicate 'no'. 38 and 44 were all of indicate 'no'. 39 and 44 were all of indicate 'no'. 30 and 44 were all of indicate 'no'. 31 and 44 were all of indicate 'no'. 32 and 44 were all of indicate 'no'. 32 and 44 were all of indicate 'no'. 34 and 44 were all of indicate 'no'. 35 and 44 were all of indicate 'no'. 36 and 44 were all of indicate 'no'. 37 and 44 were all of indicate 'no'. 38 and 44 were all of indicate 'no	F	8880	of the alleged tag F-880 Infection Com After analysis of all documentation; sta sign in logs; COVID staff line listing; at staff interviews the QA team determine that this was an isolated staff incident not reporting symptoms listed on the sin log as instructed to do through varior in-services and huddles. As such, we conclude that this event was isolated a contained.  Holly Self, LNHA	aff nd ed of ign- us	
	documented as "N" to	#1, #2, #3 and #4 were all oindicate 'no'.					

Time out was recorded as 8:25 PM.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345418	B. WING		01/08/2021		
NAME OF PROVIDER OR SUPPLIER  PELICAN HEALTH AT ASHEVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE  1984 US HIGHWAY 70  SWANNANOA, NC 28778	1 01/00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 880	Continued From page Temperature upon edegrees. Review of the Daily revealed a total of 7 admission/quaranting. The facility's COVID Line List dated 12/2 COVID-19 was confreview revealed a topositive for COVID-10 During a telephone of the new admission/Quaranting. The facility's COVID-10 was confred to the new admission/Quaranting. The confirmed Nurselectory of the new admission/Quaranting. The facility of t	ge 5 exit was recorded as 97  Census report for 12/10/20 residents resided on the new re unit.  -19 Resident Surveillance 1/20 revealed the first positive resident on 12/11/20. Further resident had tested 19 as of 12/29/20.  Interview on 01/05/21 at 4:27 Ilephone interview on 1, the Administrator verbalized 7 residents that resided on quarantine unit on 12/09/20.  e #1 was assigned to work	F 88	,			
	with some fatigue. I symptoms she had an ir frequently caused stearache, headache, in the morning with a symptoms were relied She added fatigue wworking a lot of hour was instructed to reconsistent with COV not report her symptoms.	ection, headache and earache Nurse #1 explained the at the time were normal for mer ear problem which ymptoms of sinus pressure, and at times, even woke up a "stuffy head" and her eved by taking medication. yas normal for her due to rs. Nurse #1 confirmed she port any signs or symptoms //ID-19 and explained she did toms on 12/06/20 because loped those type of symptoms					

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1 ' '	E SURVEY PLETED
	345418	B. WING			01/	/08/2021
PELICAN HEALTH AT ASHEVILLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1984 US HIGHWAY 70 SWANNANOA, NC 28778		, 5.755,252	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	,	EACH CORRECTIVE ACTION SHOULD	3E	(X5) COMPLETION DATE
due to her inner ear pher symptoms to be overbalized she was to the facility's weekly to 12/11/20 her results on Nurse #1 stated that was "never really syndeveloped a fever or cold, weak and tired. symptoms started on she was feeling better work on 12/09/20 and During a telephone in PM, the Administrato Nurse Supervisors con the evening shift to the next business day that the sample was Sunday 12/06/20 but the lab until Monday sent Nurse #1's test is sometime during the facility did not retrieve computer system unto confirmed Nurse #1 to Symptoms consistent self-diagnose their systaff were instructed their supervisor who make the determination work as scheduled on started their shift. The Indi Nurse #1 had report on 12/06/20 as previous results of the systaff was previous pre	croblem and did not believe COVID related. Nurse #1 ested on 12/06/20 as part of esting and was notified on were positive for COVID-19. after testing positive, she aptomatic" as she never lost her appetite but did stay Nurse #1 confirmed her 12/06/20 and verbalized or when she reported back to d 12/10/20.  Atterview on 01/05/21 at 12:10 or explained sometimes the ollected samples for testing that were sent out to the lab by. She stated it was possible collected from Nurse #1 on would not have been sent to 12/07/20. She added the lab results to the facility night of 12/10/20 and the est the results from the est the staff were instructed on report any signs or with COVID-19 and not remptoms. She explained to report their symptoms to would then assess and on if they could report to go home if they had already the Administrator was not sure ted her symptoms to anyone ously instructed and stated	F	380			
	ROVIDER OR SUPPLIER  HEALTH AT ASHEVILLE  SUMMARY ST (EACH DEFICIENC REGULATORY OR I  Continued From page due to her inner ear pher symptoms to be overbalized she was te the facility's weekly te 12/11/20 her results overbalized she was te the facility's weekly te 12/11/20 her results overbalized she was te the facility's weekly te 12/11/20 her results overbalized she was 'never really syndeveloped a fever or cold, weak and tired. symptoms started on she was feeling bette work on 12/09/20 and  During a telephone in PM, the Administrator Nurse Supervisors co on the evening shift to the next business day that the sample was over Sunday 12/06/20 but the lab until Monday sent Nurse #1's test over sometime during the facility did not retrieve computer system unt confirmed Nurse #1's The Administrator sta multiple occasions to symptoms consistent self-diagnose their sy staff were instructed of their supervisor who over make the determinati work as scheduled or started their shift. The if Nurse #1 had repor on 12/06/20 as previous when she spoke with	CORRECTION IDENTIFICATION NUMBER:  345418  ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER  HEALTH AT ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  due to her inner ear problem and did not believe her symptoms to be COVID related. Nurse #1 verbalized she was tested on 12/06/20 as part of the facility's weekly testing and was notified on 12/11/20 her results were positive for COVID-19. Nurse #1 stated that after testing positive, she was "never really symptomatic" as she never developed a fever or lost her appetite but did stay cold, weak and tired. Nurse #1 confirmed her symptoms started on 12/06/20 and verbalized she was feeling better when she reported back to work on 12/09/20 and 12/10/20.  During a telephone interview on 01/05/21 at 12:10 PM, the Administrator explained sometimes the Nurse Supervisors collected samples for testing on the evening shift that were sent out to the lab the next business day. She stated it was possible that the sample was collected from Nurse #1 on Sunday 12/06/20 but would not have been sent to the lab until Monday 12/07/20. She added the lab sent Nurse #1's test results to the facility sometime during the night of 12/10/20 and the facility did not retrieve the results from the computer system until 12/11/20 which had confirmed Nurse #1 was positive for COVID-19. The Administrator stated staff were instructed on multiple occasions to report any signs or symptoms consistent with COVID-19 and not self-diagnose their symptoms. She explained staff were instructed to report their symptoms to their supervisor who would then assess and make the determination if they could report to work as scheduled or go home if they had already started their shift. The Administrator was not sure if Nurse #1 had reported her symptoms to anyone on 12/06/20 as previously instructed and stated when she spoke with Nurse #1 on 12/11/20 to	ROVIDER OR SUPPLIER  #BEALTH AT ASHEVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  due to her inner ear problem and did not believe her symptoms to be COVID related. Nurse #1 verbalized she was tested on 12/06/20 as part of the facility's weekly testing and was notified on 12/11/20 her results were positive for COVID-19. Nurse #1 stated that after testing positive, she was "never really symptomatic" as she never developed a fever or lost her appetite but did stay cold, weak and tired. 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Nurse #1 confirmed her symptoms stated on 12/06/20 and verbalized she was feeling better when she reported back to work on 12/09/20 and 12/10/20.  During a telephone interview on 01/05/21 at 12:10 PM. the Administrator explained sometimes the Nurse Supervisors collected samples for testing on the evening shift that were sent out to the lab the next business day. She stated it was possible that the sample was collected from Nurse #1 on 12/07/20. She added the lab sent Nurse #1's test results to the facility sometime during the right of 12/10/20 and the facility did not retrieve the results from the computer system until 12/11/20 which had confirmed Nurse #1 was possible than the sample was collected from Nurse #1 on 12/01/20 and not self-diagnose their symptoms. She explained staff were instructed to report their symptoms to their supervisor who would then assess and make the determination if they could report to work as scheduled or go home if they had already started their shift. The Administrator was not sure if Nurse #1 had reported her symptoms to anyone on 12/06/20 as previously instructed and stated when she spoke with Nurse #1 on 12/11/20 to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345418	B. WING _			01/08/2021
NAME OF PROVIDER OR SUPPLIER PELICAN HEALTH AT ASHEVILLE			,	STREET ADDRESS, CITY, STATE, ZIP CODE 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	her she just felt "run-o having sinus related s when she had worked During a follow-up tele 01/05/21 at 2:18 PM, staff were instructed to developed any signs of taste or smell, naus diarrhea, fever, etc. a facility. After the rece Administrator stated in could not "self-diagno they were to report ar	down" but never mentioned symptoms or headache d on 12/06/20.  ephone interview on the Administrator clarified o call their supervisor if they or symptoms such as: loss sea and/or vomiting, nd not report to work at the ent outbreak, the t was reiterated to staff they use" their symptoms and	F8	80		