CENTERS FOR MEDICARE & MEDICAD SERVICES     OMB NO. 0938-0391       STRUENC OF DEPICENCIES     V21 MUTFILE CONSTRUCTION     A BULDING       NUE OF PROVIDER OR SUPPLIER     345418     V21 MUTFILE CONSTRUCTION       MAKE OF PROVIDER OR SUPPLIER     345418     IN WIG       PELCAN HEALTH AT ASHEVILLE     STREET ADDRESS, CITY, STATE, 2P CODE       VALUE OF PROVIDER OR SUPPLIER     PROVIDER STATUS, 2P CODE       PELCAN HEALTH AT ASHEVILLE     STREET ADDRESS, CITY, STATE, 2P CODE       UNIT OF TRG     SIMMARY STATEMENT OF DEPORTANCES     PROVIDERS AN OF COSECTION (2ACI DEPORTANCES IN A OF COSECTION (2ACI DEPORTANCE		-	ID HUMAN SERVICES			FOR	M APPROVED
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NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS.CITY, STATE, 2P CODE       PELICAN HEALTH AT ASHEVILLE     STREET ADDRESS.CITY, STATE, 2P CODE       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     SWMANANOA, OK 23778       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     SUMMANY STREMENT OF DEPICIENCIES     PADVDERS PLAN OF ORSECTION       (PAD)     On onsite complaint investigation survey was conducted 11/01/22 through 11/03/22. Event IDF 4DX20019257, NC0019570, NC00193322, NC0019257, NC0019570, NC00193322, NC00192055, and NC00194517.2 of 16 complaint investigations were substantiated resulting in deficiencies. Event IDF 4DX011.     F 580       SS=G     CFR(e): 483.10(g)(14)(H)(H)(H)(TS)     S     S       §433.10(g)(14) Notification of Charges. (I) A facility must mediately inform the resident representative(s) whon there is: (A) An accident involving the resident representative(s) whon there is: (A) An accident involving the resident consecond status (this is, a deterioration in he							С
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Precint TAG         IEACH DERICENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION)         PRETX TAG         IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         Continue of the team of the team of team of the team of the team of team of team of team of team of the team of the team of team of the team of team of the team of team of team of team of the team of the team of team of team of team of the team of team of team of team of team of team of the team of team of team of the t	PELICAN				SWANNANOA, NC 28778		
PREFIX Tvo         (EACH CORRECTIVE ATTION SHOULD BE REGULTION OR LSC DENTIFYING INFORMATION)         PREFIX Tvo         (EACH CORRECTIVE ATTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         COMMETTION DEFICIENCY)           F 000         INITIAL COMMENTS         F 000         F 000         On onsile complaint investigation survey was conducted 11/01/22 through 11/03/22. Event ID# 4DX011. The following intakes were investigated: NC00192577, NC00191750, NC00192603, NC00192055, and NC00194571, 20116 complaint investigations were substantiated resulting in deficiencies. Event ID# 4DX011.         F 580         F 580         11/18/22           SS=G         CFR(s): 483.10(g)(14)(0)-(iv)(15)         F 580         F 580         11/18/22           (a) A facility must immediately inform the resident representative(s) when there is: (b) A facility must immediately inform the resident representative(s) when there is: (c) An accident involving the resident which resident then is the potential for requiring physician intervention; (c) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterroation in heath, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significanty (that is, a need to discorting); (d) A decision to treatment), or (d) (d) A decision to treatment), or (d) (d) A decision to theating or the resident from the facility as specified in \$433.15(c)(1(i), (ii) When making notification under paragraph (g) (iii) (iii) The facility must also promptly notify the         (iii) The facility must also promptly notify the	(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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F 000     INITIAL COMMENTS     F 000       On onsite complaint investigation survey was conducted 11/01/22 through 11/03/22. Event 10/f 4DX011. The following intakes were investigated: NC00192677, NC0019170, NC00192603, NC00192619, NC0019270, NC00193332, NC00192619, NC0019270, NC00193332, NC00192619, and NC00194517. 2 of 16 complaint investigations were substantiated resulting in deficiencies. Event 1D/f 4DX011.     F 580       F 580     Notify of Changes (Injury/Decline/Room, etc.)     F 580       SS=G     CFR(s): 483.10(g)(14)(0)-(iv)(15)       § 483.310(g)(14) Notification of Changes. (i) A facility must immediately inform the resident representative(s) when there is: (a) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (b) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in heatth, mental, or psychosocial status in either life-threatening conditions or clinical complications); (c) A need to alter treatment significantly (that is, a a need to discontinger the resident from the facility as specified in \$443.315(c)(1)(i).       (ii) When making notification under paragraph (g) (iii) When making notification under paragraph (g) (iii) (iii) The facility must also promptly notify the	TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		RIATE	DATE
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<ul> <li>§483.10(g)(14) Notification of Changes.</li> <li>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</li> <li>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</li> <li>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</li> <li>(D) A decision to transfer or discharge the resident from the facility must ensure that all pertinent information specified in §483.15(c)(1)(i).</li> <li>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</li> <li>(iii) The facility must also promptly notify the</li> </ul>	F 580	Notify of Changes (In	jury/Decline/Room, etc.)	F 58	30		11/18/22
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**Electronically Signed** 

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

11/16/2022

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/17/20 FORM APPROVE <u>OMB NO. 0938-03</u> 9	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		C 11/03/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PELICAN	HEALTH AT ASHEVILLE			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 580	Continued From page	o 1	F 5	80		
1 000			F 50	80		
	when there is-	dent representative, if any,				
		or roommate assignment				
	as specified in §483.					
		ent rights under Federal or				
	State law or regulation	ons as specified in paragraph				
	(e)(10) of this section					
		record and periodically				
	• •	mailing and email) and				
	phone number of the	resident				
	representative(s).					
	§483.10(g)(15)					
	•	osite distinct part. A facility				
	-	istinct part (as defined in e in its admission agreement				
		tion, including the various				
		se the composite distinct				
	-	y the policies that apply to				
		en its different locations				
	under §483.15(c)(9).					
		Γ is not met as evidenced				
	by:					
		iew and interviews with the		1. F580 Notify of Chang		
		ctor (MD) the facility failed to f a newly identified open		Based on the findings, it we the facility failed to notify	-	
		I resulting in a delay in		a newly identified open ar		
	-	that developed signs of		#3 s right heel that worse		
	infections for 1 of 3 re			was admitted on 8/9/22 h		
	notification (Resident			discharged to the commu		
				Resident has a dx of PVD		
	The findings included	l:		DM. Upon admission, sta		
		111 I.I. II. II. II.		the resident had a redden		
		nitted to the facility on		open area to her R heel, k		
	-	ses including dementia,		as not initiated until 8/18/2 was notified.		
	diabetes mellitus, and	b was discharged to the		2. Current facility reside	ents could be at	
	community on 08/29/	-		risk of being affected by th		
				deficient practice. 100% s		

Facility ID: 952947

		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURV COMPLETER	
		345418	B. WING		C 11/03/20	022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH AT ASHEVILLE			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 OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) MPLETIO DATE
F 580	Continued From page	e 2	F 58	30		
	Review of the admitti for Resident #3 revea 08/10/22 Nurse #1 do open area was prese On 08/11/22 Nurse #2 open area was prese Review of Resident # revealed no evidence Medical Doctor (MD) were notified of the o	ng 3-day skin assessments aled on 08/09/22 and ocumented a blanchable nt on the right posterior heel. 2 documented a blanchable nt on right posterior heal.		assessments performed by Direc Nursing and Unit Managers bega 11/3/22 and were completed by Any new concerns were added to wound care log by the Director of and notifications were made to th RPs and other as applicable. Tx obtained by Wound care nurse. audit of the current in-house wood performed by the Director of Nur 11/3/22 with no further concerns	an on 11/4/22. o the f Nursing ne MD, orders 100% unds was sing on	
	Wound Observation T revealed the MD or N of an unstageable pre obscured by dead tiss Resident #3. Treatme and the note indicate on 08/09/22. Review of the Wound revealed on 08/18/22 #3's right heel identifi ulcer measured 2.9 c width and 0 cm in dep to clean the area with	IP were notified on 08/18/22 essure ulcer (a wound sue) on the right heel of ent orders were provided, d the wound was acquired I Care NP progress note an initial exam of Resident ed an unstageable pressure m in length and 3 cm in oth. Treatment orders were normal saline and apply a nd cover with a silicone foam		3. The measures that have been place to ensure the deficient prannot recur, are as follows: All nur educated by the Director of Nurse the Staff Development Coordination for proper notification of family, r Medical Director or Nurse Practition responsible party r/t any change decline, room, etc. The education on 11/4/22 and was completed on 11/15/22. On-going education was to the Orientation documentation 11/15/22 and will be provided by Development Coordinator and the Director of Nursing on F580 (Not Changes) for any newly hired statagency staff.	ctice does ses were ing and tor (SDC) esident, tioner and , injury, n began in as added n on the Staff ie tify of	
	dated 08/25/22 revea pressure ulcer increa length and 3 cm in wi % slough (moist non- Care NP recommend	I Care NP progress note led the size of right heel sed and measured 3.9 cm in dth and 0.3 in depth with 80 viable tissue). The Wound ed antibiotics and noted the eased drainage, odor, pain,		4. The Director of Nursing will newly acquired or changes to cu wounds for proper notification 3x 12 weeks. All new admissions a re-admissions will be audited da Director of Nursing to ensure ski is performed and treatment orde place if appropriate. Director of N	rrent //week for nd ily by the n check rs in	

Facility ID: 952947

If continuation sheet Page 3 of 22

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/17/2022 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345418	B. WING				C 03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH AT ASHEVILLE			19	984 US HIGHWAY 70		
I LLIOAN				S	WANNANOA, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Wound Care Nurse re Resident #3's wound it as an unstageable p (scab like dead skin e color). She cleaned th a dressing and notifie saw Resident #3 right The Wound Care Nur treatments in place for the admitting skin ass 08/09/22, 08/10/22, a During an interview o #1 confirmed he docu assessments for Resi 08/10/22. Nurse #1 re report Resident #3 ha heel to the MD or NP Wound Care Nurse re	n 11/01/22 at 2:43 PM the evealed she first saw on 08/17/22 and described pressure ulcer with eschar either black, brown, or tan in ne wound and covered it with ed the Wound Care NP who t heel wound on 08/18/22. rese confirmed there were no or an open area identified on sessments done on nd 08/11/22. n 11/01/22 at 4:22 PM Nurse umented the skin ident #3 on 08/09/22 and evealed he didn't verbally ad an open area on the right	F	580	<ul> <li>Wound Nurse will monitor The Director Nursing or Wound Care nurse will audin-house skin assessments on 3 residers per unit 5 x a week for 4 weeks: 3 residents per unit 3 x a week for four weeks, and 3 residents per unit 1 x a week for four weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected will not provide recur by reviewing information collected during audits an reporting to Quality Assurance</li> <li>Performance Improvement Committee Data will be brought by Administrator review in Quality Assurance Performance Improvement meetings and changes be made to the plan as necessary to maintain compliance with notification changes.</li> <li>5. Date of Completion is 11/18/22.</li> </ul>	e and d e. to nce will	
	area on Resident #3's An interview was con AM with the MD. The assessments done or 08/11/22 identified an he would expect the r or the NP to obtain the revealed a delay in the #3 at risk for developing on the right heel was During an interview of #2 confirmed she door assessment on 08/11 didn't report an open	s right heel. ducted on 11/02/22 at 11:22 MD revealed the skin n 08/09/22, 08/10/22, and open area on the right heel nurse to notify the physician, eatment orders. The MD eatment would put Resident ing an infection if the area left untreated. n 11/02/22 at 1:56 PM Nurse					

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY PLETED
		345418	B. WING			C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH AT ASHEVILLE			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580 F 607 SS=D	prior to hers and the p been notified with treat An interview was com- PM with the Director of revealed she expecte Wound Care Nurse, h ensure concerns relat missed and the area of The DON revealed af admitting skin assess evidence to support th heel was reported or prior to 08/18/22. During an interview of Administrator reveale Nurse finds something resident's skin assess either the on-call or in treatment orders can Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The facility implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95,	bhysician should've already atment orders in place. ducted on 11/03/22 at 3:08 of Nursing (DON). The DON d Nurses to notify the her, and the MD or NP to ted to the skin weren't was evaluated right away. ter her review of the ments she couldn't find any he open area to the right a treatment was in place n 11/03/22 at 3:31 PM the d the process in place if the g abnormal during a sment, they need to call form NP or MD so be put in place. buse/Neglect Policies -(5)(ii)(iii) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures	F 58			11/18/22

Facility ID: 952947

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 11/17/2022 1 APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345418	B. WING _				03/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH AT ASHEVILLE			19	984 US HIGHWAY 70		
				S	WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page		F 6	607			
	QAPI program require	ed under §483.75.					
	facilities in accordance Act. The policies and	e reporting of crimes -funded long-term care ce with section 1150B of the d procedures must include the following elements.					
		ting a conspicuous notice of lefined at section 1150B(d)					
	retaliation, as defined (2) of the Act.	bhibiting and preventing at section 1150B(d)(1) and is not met as evidenced					
	Based on record rev facility failed to follow procedure by not imm	iew and staff interviews, the their abuse policy and nediately reporting an			Facility failed to implement abuse poli and procedures in the area of reporting when an allegation of resident-to-resident	g ent	
	Administrator for 1 of reviewed for abuse (F	•			abuse was not immediately reported to the Administrator. The Administrator confirmed she did not submit the initial	I	
	Findings included:				report to the State Agency regarding the allegation of alleged abuse until she w informed of the event the following day	as	
	Exploitation implement "it is the policy of this protections for the he each resident by develow written policies and p prevent abuse, negle misappropriation of re violations will be report	alth, welfare and rights of eloping and implementing rocedures that prohibit and ct, exploitation and esident property. All alleged orted to the Administrator			The 24-Hour Initial Report and 5- Day Working Report for stated incident was submitted to the State Agency on 8.30 and 9.5.22 respectively. 2. Current facility residents are at risk being affected by the deficient practice Regional Director of Operations (RDO) conducted an audit of all grievances fr 8/1/22 to 11/3/22 identify any areas of	.22 of e. ) om	
	later than 2 hours after	rames: Immediately, but not er the allegation is made." nitted to the facility on			reportable concerns. All staff were questioned to identify any abuse allegations that may have not been reported. No further areas of concern		

Event ID: 4DX011

Facility ID: 952947

If continuation sheet Page 6 of 22

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
						С
		345418	B. WING			1/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	
PELICAN	HEALTH AT ASHEVILLE			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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	Continued From page	e 6	F 60	7		
	04/29/21 with multiple	e diagnoses that included polar disorder, and anxiety.		identified. Completed: 11.1	5.22.	
				3. The measures that hav	•	
		m Data Set (MDS) dated		place to ensure the deficie		
		esident #1 with intact		not recur, are as follows:		
	cognition.			Regional Directors of Oper re-educated the Administra		
	Resident #2 was adm	nitted to the facility on		Development Coordinator		
		e diagnoses that included		Director of Nursing (DON)		
	right femur fracture a	nd bipolar disorder.		Identification of abuse alle		
				timely reporting to state ag		
		um Data Set (MDS) dated		as the facility Abuse, Negle		
		esident #2 with intact		Exploitation policy and Co	mpliance with	
	cognition.			Reporting Allegations of Abuse/Neglect/Exploitation	Policy	
	Review of the initial in	nvestigative report submitted		stressing the importance o	•	
		R noted an allegation type of		reporting any allegations to		
	resident abuse involv			Administrator or Director o		
	Resident #2, a cognit			(DON). Beginning 11.4.22		
		the facility's investigation		Development Coordinator		
		n 08/29/22 between 10:30		re-educated all facility and	• •	
		esident #1 reported she was		the facility Abuse, Neglect		
		Resident #2 touching her ermission. Resident #1 told		Exploitation Policy includin of abuse allegations & rep		
	Resident #2 to leave			requirements. 100% of sta		
		tely reported the incident to		agency, to be educated by		
		noted the facility was made		Newly hired facility and ag		
		on on 08/30/22 at 8:30 AM,		receive Abuse, Neglect an		
	-	submitted to DHSR via fax		Policy and Compliance wit		
		0/22 at 9:25 AM and law		Allegations of Abuse/Negle		
	enforcement was not	ilieu.		Policy education upon hire first shift worked by. The A	•	
	Resident #1 was out	of the facility and unable to		and /or Director of Nursing		
		time of this investigation.		report violations to NC Sta immediately but no later th	te Agency	
	Resident #2 was disc	harged to another nursing		the allegation involves abu		
		nd unable to be interviewed.		of investigation will be sub	mitted within 5	
				working days of the incide	nt.	
	ן טערוחg a telephone in	nterview on 11/02/22 at 9:33				

Facility ID: 952947

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345418	B. WING			C 1/03/2022
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH AT ASHEVILLE			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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 607	AM, Nurse Aide (NA) the evening of 08/29/2 provide Resident #1 a #2 could not recall the she answered Reside into her room, Reside asleep and woke up t breasts. NA #2 recall Resident #1's room a stated she had told hi she immediately repo statement to Nurse # During a telephone in he worked the evenin assigned to provide F #2's care. Nurse #1 rt 11:00 PM, he was info Resident #1 alleged F room while she was a breasts. Nurse #1 sta Resident #1 she told her room and was sitt asleep and woke up t breasts. Nurse #1 sta assessed with no inju Nurse #1 stated Resid occurred, was instruct remainder of the nigh monitor both resident not recall the exact tin Director of Nursing (E message the next mot explained when the ir on 08/29/22, he did n abuse was supposed Administration immed	#2 confirmed she worked 22 and was assigned to and Resident #2's care. NA e exact time but stated when ent #1's call light and went ent #1 stated she had been to Resident #2 touching her led Resident #2 was not in t the time and Resident #1 in to leave. NA #2 stated orted Resident #1's 1. terview, Nurse #1 confirmed g of 08/29/22 and was Resident #1 and Resident recalled around 10:30 PM to ormed by NA #2 that Resident #2 came into her asleep and touched her ated when he spoke to him Resident #2 came into ting on her bed, she fell to Resident #1 was rry or signs of distress. dent #2 denied the incident ted to remain in his room t and staff were instructed to s closely. Nurse #1 could me but stated he notified the DON) of the incident via text orning, 08/30/22. Nurse #1 noident was reported to him ot know an allegation of to be reported to	F 60	<ul> <li>4. The Regional Director of Op (RDO) or Regional Director of Services (RDCS) will audit all allegations of abuse for timely agency reporting 3 x a week for then 1-time weekly for 8 week Administrator or Director of Nu (DON) will complete abuse qu with 5 current staff members to understanding of identifying ar of abuse weekly for 12 weeks. will monitor its corrective actio ensure that the deficient practic corrected and will not provide reviewing information collecter audits and reporting to Quality Performance Improvement Co Data will be brought by Admin review in Quality Assurance Pr Improvement meetings and ch be made to the plan as necessis maintain compliance with Abus and Reporting.</li> <li>5. Date of compliance: 11.18</li> </ul>	Clinical facility state or 4 weeks, s. The ursing estionnaires o verify nd reporting The facility ins to ice is recur by d during Assurance ommittee. istrator to erformance isanges will sary to se Policy	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>O. 0938-039</u> e survey
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3		IPLETED
		345418	B. WING		C 11/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1984 US HIGHWAY 70	ODE	
PELICAN	HEALTH AT ASHEVILL	E		SWANNANOA, NC 28778		
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	from Nurse #1 the m sometime between 7 on her way to the fac the facility, she imm Administrator, place	received a text message	F 60	77		
F 640 SS=B	Administrator confirm morning of 08/30/22 incident that occurre involving Resident # report was submitted investigation was im Administrator was no contact her or the D first reported to him and explained all sta on the facility's abus reporting allegations Administrator added re-educated on the a Encoding/Transmitti CFR(s): 483.20(f)(1) §483.20(f) Automate requirement- §483.20(f)(1) Encod a facility completes a	ing data. Within 7 days after a resident's assessment, a the following information for facility: sement.	F 64	0		11/18/22

Event ID: 4DX011

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:			CONSTRUCTION	(X3) DATE	
		345418	B. WING				C 03/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				19	84 US HIGHWAY 70		
PELICAN	HEALTH AT ASHEVILLE			SI	WANNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 640	reentry, discharge, ar (vi) Background (face is no admission asses §483.20(f)(2) Transm after a facility complet a facility must be cap CMS System informa contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, at the CMS System, incl (i)Admission assessmer (ii) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct (vi) Quarterly review. (vii) A subset of items reentry, discharge, ar (viii) Background (fac- initial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by:	ad death. -sheet) information, if there assment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to ats and data dictionaries, dardized edits defined by ittal requirements. Within y completes a resident's must electronically transmit and complete MDS data to uding the following: nent. t. to nof prior full assessment. tion of prior quarterly upon a resident's transfer, ad death. e-sheet) information, for an MDS data on resident that	F	640	<ol> <li>Facility failed to complete and</li> </ol>		

Facility ID: 952947

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			ATE SURVEY DMPLETED
			A. BUILDING			С
		345418	B. WING			11/03/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
PELICAN	HEALTH AT ASHEVILLE			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 OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 640	Continued From page	e 10	F 64	0		
	<ul> <li>F 640 Continued From page 10 facility failed to complete discharge Minimum Data Set (MDS) assessments within 14 days of the discharge date for 3 of 4 sampled residents reviewed for discharge (Residents #2, #10, and #3).</li> <li>Findings included: <ol> <li>Resident #2 was admitted to the facility on 08/25/22.</li> </ol> </li> <li>A Social Worker progress note dated 09/22/22 at 11:30 AM revealed Resident #2 discharged to another nursing facility. Review of Resident #2's medical record revealed the last completed MDS assessment was an admission dated 08/31/22. A discharge MDS assessment dated 09/21/22 noted a status of "in progress."</li> </ul>			<ul> <li>transmit discharge assessmen days of the assessment refere 2 of 4 sampled residents (Res #10 and #2). Resident #3, #10 Resident #2 discharge assess completed and transmitted on 11.1.22 and (#10 and #2) 11.3 respectively by the Minimum D (MDS) nurse.</li> <li>2) Current facility residents a being affected by this alleged practice. Minimum Data Set N completed an audit of Dischar residents within the past 30 da ensure that Discharge Assess was completed and Transmitte Discharged residents on 11.16 other assessments found to be compliance.</li> </ul>	ance date for ident #3, 0 and ments were (#3) .22 Data Set Data Set are at risk for deficient Jurses ged ays to ment (ND) ed for all 5.22 with no	
	MDS Coordinator #1 employment with the MDS Coordinator #1 assessment was star not been completed. happened or how the overlooked but stated completed within 14 c discharge. During an interview o Administrator explain facility did not have a Coordinators and MD The Administrator star Coordinators started	t it should have been days of Resident #2's n 11/03/22 at 3:39 PM, the ed for a period of time the		<ul> <li>3) Education was provided to nurse(s) and the Interdisciplinat completing discharge assessment of days and transmitting within after a facility completes the reassessment, this was completed 11.15.22 by the Regional Clinic Reimbursement Nurse. Newly Interdisciplinary team member nurses, and agency MDS nurse be educated during orientation hire.</li> <li>4) MDS nurse(s) to monitor a discharge Minimum Data Sets for four weeks then monthly for to ensure they are completed assessment.</li> </ul>	ary Team on nents within 14 days esident⊡s ed on cal ⁄ hired rs, MDS ses will also n and upon at least 5 1x weekly or 3 months	

Facility ID: 952947

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		MEDICAID SERVICES		LE CONSTRUCTION		<u>IO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
						С
		345418	B. WING		1	1/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
PELICAN	HEALTH AT ASHEVILLE			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 OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 640	Continued From page	e 11	F 64	.0		
<ul> <li>Resident #2 got overlooked. She added discharge MDS assessments should have been completed within 14 days of discharge.</li> <li>2. Resident #10 was admitted to the facility on 09/02/22.</li> <li>A nurse progress note dated 09/20/22 at 11:14 AM revealed Resident #10 discharged to the community.</li> <li>Review of Resident #10's medical record revealed the last completed MDS assessment</li> </ul>		ssments should have been days of discharge. admitted to the facility on e dated 09/20/22 at 11:14 at #10 discharged to the et0's medical record		<ul> <li>facility completes the residential assessment. Minimum Data S will report findings of the monin Interdisciplinary Team (IDT) du meetings monthly for three (3) and will make changes to the precessary to maintain compliance completing quarterly Minimum assessments.</li> <li>5) Date of Compliance: 11.1</li> </ul>	Set Nurse toring to the uring QAPI months olan as unce with Data Sets	
		ted 09/09/22. A discharge ted 09/20/22 noted a status				
	During an interview on 11/03/22 at 10:12 AM, MDS Coordinator #1 revealed she started her employment with the facility in October 2022. MDS Coordinator #1 confirmed a discharge MDS assessment was started for Resident #10 but had not been completed. She was not sure what had happened or how the assessment was overlooked but stated it should have been completed within 14 days of Resident #10's discharge.					
	Administrator explain facility did not have a Coordinators and MD The Administrator sta Coordinators started the MDS assessment oldest first, and the d Resident #10 got over	S assessments got behind. ted when the two MDS last month, they prioritized ts that needed completed, ischarge assessment for rlooked. She added ssments should have been				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/17/2022 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345418	B. WING _					C 103/2022
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
PELICAN HEALTH AT ASHEVILLE					84 US HIGHWAY 70			
				SV	VANNANOA, NC 2877	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	9 12	F 6	640				
		dmitted to the facility on charged to the community						
		titioner (NP) discharge 5/22 revealed Resident #3 for discharge home.						
		ge Minimum Data Set or Resident #3 revealed the as 11/01/22.						
	MDS Coordinator #1 employment with the MDS Coordinator #1 assessment was com 11/01/22. She stated assessment should ha	n 11/03/22 at 10:12 AM, revealed she started her facility in October 2022. confirmed a discharge MDS pleted for Resident #3 on the discharge MDS ave been completed within #3's discharge from the						
F 641	Administrator explained time the facility did not Coordinators and MD The Administrator star Coordinators started I the MDS assessment oldest first, and the di Resident #3 got over	ssments should have been lays of discharge.	F 6	641				11/18/22
SS=D	CFR(s): 483.20(g)							
	§483.20(g) Accuracy	or Assessments.						

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345418	B. WING		C 11/03/2022		
	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 1	1/03/2022
					US HIGHWAY 70		
PELICAN	HEALTH AT ASHEVILLE				NNANOA, NC 28778		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 641	Continued From page	a 13	F6	211			
1 011			F C	941			
	resident's status.	st accurately reflect the					
		Γ is not met as evidenced					
	by: Based on record rev	iew and staff interviews the			1. The facility failed to accurately	255666	
		ately assess and document			and document an existing pressure		
	an existing open area				n an admission assessment. Corr		
		Data Set (MDS) for 1 of 3		a	ction has been accomplished for th	ne	
	residents reviewed for	or pressure ulcers (Resident		a	lleged deficient practice regarding		
	#3).				ccuracy of Assessment for Reside		
					linimum Data Set (MDS) Assessm		
	The findings included	1:			vith Assessment Reference Date (A		
		- 144			8/16/2022 has been modified by th		
		nitted to the facility on			Regional Minimal Data Set coordina		
	diabetes mellitus, and	ses including dementia,			nclude a stage II on 11.15.22. The or Resident # 3 is now current as p		
	disease.				Resident Assessment Interview (RA		
					uidelines for Section/s M0210 / M0		
	Review of the admitti	ng 3-day skin assessments		3			
	for Resident #3 revea			2	. All current facility residents who	o have	
	08/10/22 Nurse #1 do	ocumented a blanchable		p	ressure ulcer wounds have the pol	tential	
		nt on the right posterior heel.			b be affected by this alleged deficie	ent	
		2 documented a blanchable			ractice. All current Residents with		
	open area was prese	nt on right posterior heal.			Pressure Ulcers will be reviewed by		
		in Minimum Data Oat			Ainimal Data Set Nurse(s) for MDS		
		sion Minimum Data Set			ccuracy and all MDS assessments vill be current on 11.16.22.	and	
	. ,	ated 08/16/22 indicated isk but did not have any		N N			
	unhealed pressure ul			3	. Measures put in place to ensur	e the	
		ts included a pressure			lleged deficient practice does not r		
	reducing device for th				nclude:		
	-				he Clinical Management Team incl	luding	
	During an interview of	on 11/02/22 at 12:52 PM the			dministrator, Director of Nursing (		
		evealed when she became			Init Managers, Minimum Data Set		
		the right heel and after			Coordinator, Social Work Director, A	-	
		3's skin assessments she			Director and have been educated of	n	
	determined the press	sure ulcer wound was		a	ccuracy of MDS on 11.16.22.		

Facility ID: 952947

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	MENT OF HEALTH AN <u>S FOR MEDICARE &amp;</u>	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVI OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING		C 11/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	HEALTH AT ASHEVILLE			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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO	
F 641	Continued From page	e 14	F 641	<ol> <li>Minimum Data Set (MDS) of residuation with current and unhealed Pressure Ulcers will be audited weekly for 3 models by Director of Nursing (DON), Administrator or Unit Manager (UM). Findings of the monitoring will be report to the Interdisciplinary Team (IDT) du QAPI meetings monthly for three (3) months and will make changes to the as necessary to maintain compliance completing quarterly Minimum Data S assessments.</li> <li>Date of compliance: 11.18.22</li> </ol>	onths orted ring plan with	
F 686 SS=G			F 686	<ol> <li>F686 Treatment/Svcs to Prevent Pressure Ulcer was cited. Based on the findings, it was alleged that the facility failed to provide necessary care and</li> </ol>	ne	

Event ID: 4DX011

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039 ATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	DMPLETED		
						С		
		345418	B. WING		11/03/2022			
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE				
				1984 US HIGHWAY 70				
PELICAN	HEALTH AT ASHEVILLE			SWANNANOA, NC 28778				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIO REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH DEFICIENCY		/E ACTION SHOULD BE D TO THE APPROPRIATE	(X5) COMPLETION DATE				
F 686	Continued From page	o 15	F 68	6				
1 000	1.0		F 00	Resident #3 on 8.9.22	) The initial			
		the weekly skin assessment I for an existing wound on		treatment orders were				
		veloped signs of infection for		8.18.22 by the wound				
		wed for pressure ulcers		2. Current facility re				
	(Resident #3).			being affected by the				
				practice. 100% skin as	-			
	The findings included	1:		performed by Director				
				Managers on 11/3/22				
		nitted to the facility on		by 11/4/22. No new sk				
	-	ses including dementia,		identified at that time.				
	diabetes mellitus, and			audit of the current in-				
	community on 08/29/	was discharged to the		performed by the Dire 11.3.22, all wound and	÷			
		22.		with their supplementa				
	Review of the admitti	ng 3-day skin assessments		were present with no				
	for Resident #3 revea			noted.				
	08/10/22 Nurse #1 do	ocumented a blanchable						
	open area was prese	nt on the right posterior heel.		3. All nurses were e	ducated by the			
	On 08/11/22 Nurse #	2 documented a blanchable		Director of Nursing, U	nit Managers,			
	open area was prese	nt on right posterior heal.		and/or Staff Developm				
				proper identification a				
		g records revealed on		to ensure proper heali				
		#1 initialed the shower audit		began on 11/4/22 and				
		ent #1 received a bed bath skin was intact and good.		11/17/22. Newly hired staff will receive education				
		skin was intaot and good.		identification and care				
	Review of Resident #	43's weekly skin assessment		facilitate proper healin				
		Nurse #3 documented the		prior to first shift work	÷ ·			
	skin was intact.			Development Coordin Nursing.				
	Review of the admiss	sion Minimum Data Set						
		2 assessed the cognition of						
		moderately impaired and						
		ssistance was needed with			at have been put into			
		s, and toilet use. The MDS		place to ensure the de				
		3 was at risk but did not have		not recur, are as follow				
		re ulcers or other skin		Managers or the Wou				
		nents included a pressure		all shower sheets 5 x				
	reducing device for th	he bed and chair.		3 x a week for 4 week	s. then 1 a week for			

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STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI		OMB NO. 0938-039 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	COMPLETED	
					С		
		345418	B. WING		1	1/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PELICAN	HEALTH AT ASHEVILLE			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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	Continued From page	e 16	F 68	6			
	Resident #3 was notifia a plan of care for the was to apply an antis povidone-iodine and of dressing and schedul times a week and as dislodged for a deep (non-blanchable, dark from prolonged press Review of the docum Wound Observation T Care Nurse revealed Doctor (MD) or altern current treatment in p heel with normal salir amount of a debriding tissue) to the wound I foam dressing. The tr be changed daily and and heel boots were a pressure. The docum the first observation of present on admission measured 2.9 centim cm in width and 0 cm amount of bloody dra Review of the Wound (NP) progress note re- initial exam of Reside an unstageable press obscured by dead tiss	Care Nurse documented fied of treatment orders and right heel. The treatment eptic solution of cover with a silicone foam ed to be changed three needed when soiled or tissue injury (ly pigmented skin resulting ure). ent titled; "Weekly Pressure Tool" signed by the Wound on 08/18/22 the Medical ate was notified, and the blace was to clean the right he and apply a nickel thick g ointment (removes dead bed and cover with a silicone eatments were scheduled to a s needed. An air mattress recommended to offload entation indicated this was of a pressure ulcer that was on 08/09/22 and currently eter (cm) in length and 3.2 in depth with a moderate inage.		<ul> <li>four weeks, to determine if any areas are identified. The Direct Nursing or Wound Care nurse win-house skin assessments on a per unit 5 x a week for 4 weeks residents per unit 3 x a week for weeks, and 3 residents per unit week for four weeks. All new a and re-admissions will be audit week for 12 weeks by the Direct Nursing or Unit Managers to en checks are performed and treat orders are in place, if appropria Director of Nursing will audit at current wounds per the wound weekly for 12 weeks to ensure are being taken to anticipate pr wound healing.</li> <li>5. Date of Completion is 11/1</li> </ul>	tor of will audit 3 residents : 3 r four : 1 x a dmissions ed 5x a dtor of sure skin trent te. The least 2 report all steps oper		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/17/2022 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345418	B. WING		_	C 11/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PELICAN	HEALTH AT ASHEVILLE			1984 US HIGHWAY 70 SWANNANOA, NC 287	78		
							0.(7)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 17	F 68	6			
	and cover with a silico and as needed.	one foam dressing every day					
	identified Resident #3 pressure ulcer develo physical mobility, diag diabetes mellitus. Inter	pment related to limited posis of dementia, and rventions included skin ocol or Medical Doctor					
	dated 08/25/22 revea pressure ulcer increas 3 cm in width and 0.3 (moist non-viable tiss recommended antibio	Care NP progress note led the size of right heel sed to 3.9 cm in length and in depth with 80 % slough ue). The Wound Care NP tics and noted the reason ainage, odor, pain, and					
	revealed Resident #3 heel wound. The note NP reported increase signs of possible infec Resident #3 had no in the worsening wound	gress note dated 08/25/22 was evaluated for a right revealed the Wound Care d redness and slough with ction. The note revealed ncreased pain associated to and remained afebrile (no re and pain management					
	08/26/22 a culture wa revealed the lab recei on 08/31/22 the speci no culture was obtain						
		ducted on 11/01/22 at 2:43 are Nurse. The Wound					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED	
		345418	B. WING			C 11/03/2022		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PELICAN	PELICAN HEALTH AT ASHEVILLE				984 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	wound on 08/17/22 at unstageable pressure dead skin either black She cleaned the area the Wound Care NP. assessed Resident #2 provided treatment or Wound Care Nurse or orders were in place of identified on the admi 08/09/22, 08/10/22, at During an interview of #1 confirmed he docu assessments for Resi 08/10/22. Nurse #1 re report Resident #3 ha heel and stated he do skin assessments. Nu Care Nurse reviewed assessments therefor area on Resident #3's A second interview wa 12:52 PM with the Wo Wound Care Nurse re weekly skin assessme concern was commun would and physically Wound Care Nurse re aware of the area on reviewing Resident #3' determined the wound admission. During an interview of #2 confirmed she doc	she first saw Resident #3's ind described it as an e ulcer with eschar (scab like 6, brown, or tan in color). and covered it and notified The Wound Care NP 3's pressure ulcer and ders on 08/18/22. The onfirmed no treatment when the wound was first tting skin assessments on nd 08/11/22. In 11/01/22 at 4:22 PM Nurse imented the skin ident #3 dated 08/09/22 and evealed he didn't verbally ad an open area on the right ocumented the results on the urse #1 stated the Wound the weekly skin re he didn't report the open is right heel. as conducted on 11/02/22 at bund Care Nurse. The evealed she did not review ents for residents unless a hicated to her then she looked at the area. The evealed when she became the right heel and after 3's skin assessments she d was present upon	F	686				
	During an interview of #2 confirmed she doc							

		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 LETED	
		345418	B. WING			C 11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
PELICAN HEALTH AT ASHEVILLE				1	1984 US HIGHWAY 70			
FELICAN				5	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 686	she would've reported Care Nurse but since on 08/09/22 and there assessments prior to treatment orders were revealed she checked identified an open are if not in place would in Nurse. When informe place until 08/18/22 N was missed. An interview was con- 11/02/22 at 9:52 AM. documented the weel Resident #3 indicating 08/15/22. Nurse #3 st skin was intact since identified an open are #3 stated she would in or Wound Care Nurse area on the heel or sk An interview was con- AM with the Medical I revealed Resident #3 development of press predisposing diagnos vascular disease. The treatment would put F developing an infectio right heel was identified untreated. An interview was con- PM with Nurse Aide (0 she documented the so 08/12/22 indicating R	d her findings to the Wound Resident #3 was admitted a were 2 previous hers she assumed a in place. Nurse #2 d treatment orders when she a on a Resident's skin and notify the Wound Care d no treatments were in lurse #2 stated something ducted with Nurse #3 on Nurse #3 confirmed she sty skin assessment for g the skin was intact on tated she was unsure if the the previous assessments a on the right heel. Nurse eport to the Unit Supervisor a if a resident had an open sin. ducted on 11/02/22 at 11:22 Doctor (MD). The MD was at risk for the ure ulcers due to es including peripheral a MD revealed a delay in	F	686				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345418	B. WING _			C 11/03/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
PELICAN	LICAN HEALTH AT ASHEVILLE				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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 686	skin was good on 08/ no open areas or noth hadn't previously obse would report to the nu open area on the skin A second interview wa 8:04 AM with Nurse # providing a treatment #3. Nurse #1 stated h necessary paperwork During an interview of Wound Care NP reve 08/18/22 Resident #3 pressure ulcer on her denied pain to area at indicate infection. On the pressure ulcer pre- redness, slough, and #3 having pain to the she noted those were Wound Care NP reve long the wound was p on the right heel was skin assessments and uncovered or without would increase the ris becoming infected. An interview was com- PM with the Director of revealed she expecte Wound Care Nurse, h ensure concerns relat and the area was eva- revealed after her rev	12/22 meaning there were hing new on the skin she erved. NA #1 stated she irse when she identified an a. as conducted on 11/03/22 at 1. Nurse #1 didn't recall to the right heel of Resident e could only recall doing the for the skin assessment. In 11/03/22 at 10:40 AM the aled her first assessment on had an unstageable right heel. Resident #3 nd there was no odor to her next visit on 08/25/22 esented with increased had an odor. With Resident area and the other changes e signs of an infection. The aled she couldn't say how oresent but if an open area identified on the admission d the area was left treatments in place that sk of a pressure ulcer ducted on 11/03/22 at 3:08 of Nursing (DON). The DON d Nurses to notify the her, and the MD or NP to ted to skin weren't missed luated right away. The DON iew of the admitting skin aldn't find any evidence to	F	586				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/17/2022 A APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345418	B. WING				C 03/2022
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PELICAN	PELICAN HEALTH AT ASHEVILLE				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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 686	Continued From page reported or a treatme 08/18/22. During an interview o Administrator reveale Nurse finds somethin resident's skin assess	e 21 nt was in place prior to n 11/03/22 at 3:31 PM the d the process in place if the g abnormal during a sment, they need to call sician or inform NP or MD so		686		ATE	DATE

Facility ID: 952947

If continuation sheet Page 22 of 22