

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011337 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/17/2015 |
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| NAME OF PROVIDER OR SUPPLIER WESTSIDE ASSISTED LIVING - B | STREET ADDRESS, CITY, STATE, ZIP CODE 121 RICHLAND STREET ASHEVILLE, NC 28806 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| C 000 | Initial Comments The Adult Care Licensure Section and Buncombe County DSS conducted an annual survey on site on June 17, 2015. | C 000 | | |
| C 202 | <p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 residents (#1) residing in the facility were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 9/29/14 revealed a diagnosis of schizophrenia.</p> <p>Review of Resident #3's Resident Register revealed an admission date of 12/1/14 and had previously resided in another family care home.</p> <p>Review of Resident #1's record revealed no documentation of any TB skin test.</p> | C 202 | | |

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| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| C 202 | Continued From page 1 Interview with the Assistant Administrator on 06/17/15 revealed: -When the Assistant Administrator came into the facility to work last November, 2014, many of the records had been removed from the facility. -She would get the TB skin testing done for Resident #1. -Resident #1 was currently in a local psychiatric unit. | C 202 | | |