STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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) COMPLETION DATE
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to collect a physician ordered urine specimen in a timely manner to diagnose a urinary tract infection (UTI) for 1 of 5 residents with physician ordered labs (Resident #1). The findings are: Resident #1 was admitted to the facility on 09/27/11 with diagnoses of hypertension, Multiple Sclerosis, anxiety disorder, depression and end stage chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) dated 03/20/14 revealed Resident #1 was identified as having the ability to make herself understood and to understand others. She was independent for bed mobility, transfers, dressing, personal hygiene and toileting. Review of Resident #1's care plan dated 03/25/14 revealed she had a history of urinary tract infection (UTI) with a goal to be free of UTI by	F 315	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/02/2014

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next review of 06/2014. The interventions included lab tests as ordered by the physician, medications per physician order's, observe and report signs of urine retention, bladder distention, decreased output, urine color and consistency.

Review of physician order dated 03/04/14 revealed urine specimen for culture and sensitivity was to be collected for possible UTI.

Review of nurse's note's revealed:
· 03/10/14 a late entry was entered for 03/04/14 that a specimen collection container was placed in Resident #1's bathroom for a clean catch urine specimen but the resident was unable to void and this was reported off to the next shift.
· 03/11/14 a late entry was entered for 03/08/14 reporting a urine specimen was collected at 3:30 PM and sent to the laboratory for Resident #1. The laboratory called the facility to inform them the urine sample wasn't labeled properly and they would need another sample. A second urine sample was collected at 11:00 PM and sent to the laboratory on 03/09/14.
· 03/09/14 at 5:08 AM - Resident #1 had a temperature of 101.2. The on call doctor and responsible party were notified. A physician order was received for rocephin injection (an antibiotic) and a chest x-ray for Resident #1.
· 03/09/14 at 2:41 PM - Chest x-ray showed bronchopneumonia and the physician was notified and gave an order to continue rocephin injections for 10 days.
· 03/10/14 5:25 PM - Resident #1 was seeing bugs and was increasingly agitated. The physician on call was notified and gave an order for Resident #1 to be sent to the hospital for evaluation and treatment.

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Review of the laboratory results of the urine analysis dated 03/09/14 revealed Resident #1 had a UTI. The culture and sensitivity dated 03/11/14 indicated Resident #1 was growing Klebsiella pneumoniae (Gram-negative bacteria that causes infection) in her urine.

Review of the hospital discharge summary dated 03/13/14 revealed Resident #1 was treated for sepsis (a potentially life-threatening complication of an infection) secondary to pyelonephritis (a kidney infection) and delirium that resolved after treatment for sepsis and pyelonephritis.

An interview on 04/09/14 at 11:58 AM with Resident #1 revealed staff informed her they needed a urine sample and she left the urine sample in a specimen collection container on 03/04/14 in her commode for staff that evening. Resident #1 stated staff informed her there wasn't enough urine to send to the lab and they needed another sample but didn't bring her another collection container for her commode. Resident #1 stated she requested a container for a urine sample several times but staff never brought it to her room.

An interview with Nurse #1 on 04/09/14 at 3:06 PM revealed she took the order for the urinalysis and culture and sensitivity (UA/C&S) on 03/04/14 for Resident #1. Nurse #1 stated she took a specimen collection container to Resident #1 and told her she needed a urine sample. Nurse #1 reported Resident #1 ' s urine sample was not enough to send to the lab and she informed her they would need another sample. Nurse #1 stated the resident was unable to provide another urine sample on her shift so she reported to the 11:00 PM to 7:00 AM shift nurse that the urine needed

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to be collected. Nurse #1 stated she was off the next day and when she returned to work on 03/06/14 she assumed the urine sample had been collected and sent to the lab. She stated when she came to work on 03/08/14 the lab slip for the UA/C&S was hanging on the desk and had not been collected. Nurse #1 stated she collected a sample from Resident #1 and sent it to the lab. She reported the lab called the facility and informed them the specimen wasn't labeled properly and they would need another sample. Nurse #1 stated a second sample was collected at 11:00 PM on 03/08/14 and sent to the lab on 03/09/14. Nurse #1 stated it was unacceptable to take 5 days to collect a urine sample.

An interview with Dr. Holl on 04/09/14 at 4:00 PM revealed it was unacceptable for the facility to wait 5 days to collect a urine specimen. He stated if the UA/C&S had been done when it was ordered they could have treated Resident #1 in the facility and possibly have prevented the sepsis and hospital stay.

An interview with the Administrator on 04/10/14 at 3:50 PM revealed that on 03/04/14 an order was written for Resident #1 to have a UA/C&S. She stated the order was not completed until 03/09/14 which was brought to her attention by Resident #1's son upon her readmission to the facility on 03/13/14. The Administrator stated that since 03/14/14 the facility had implemented corrective actions to ensure physician laboratory orders were carried out in a timely manner for all residents. The Administrator specified these corrective actions included the implementation of the following measures which allowed the facility to be past non compliance:

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· An audit of 100% of resident charts were checked for new laboratory orders from 03/01/14 to present was completed by the Director of Nursing (DON) to ensure that all laboratory orders had been completed as ordered and sent to the laboratory for testing and results were received and communicated to the physician.

· Nurses were in-serviced on collecting routine laboratory specimens within 24 hours of MD order, upon not being able to collect the laboratory specimen the MD would be notified for further orders or interventions.

· New chart orders will be audited 7 days a week by the Unit Manager or designee for laboratory orders, daily for four weeks then every two weeks for two months and then monthly for one month. All audits will be reviewed and reported to Quality Assurance Committee monthly and quarterly thereafter for continued compliance/revisions to the plan if needed.

Observations, review of facility documentation and interviews with staff and residents during the 04/09/14 through 04/10/14 survey revealed that the facility had implemented these corrective actions beginning on 03/14/14 to ensure all laboratory orders were carried out in an efficient and timely manner. Interviews with alert and oriented residents revealed they had no concerns about laboratory orders being carried out in a timely manner. Interviews with nurses revealed they were in-serviced on collecting laboratory orders within 24 hours and if they were not collected within 24 hours to notify the MD for new orders. Review of facility documentation and interviews with the DON and Administrator on 04/10/14 revealed the facility implemented

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F 315	Continued From page 5 monitoring measures to ensure continued compliance beginning on 03/14/14. These measures included 100% of resident charts were audited for laboratory orders being completed and communicated to the MD. In-service was provided for all nurses on how complete laboratory orders within 24 hours and to notify the MD if not completed. Unit Managers monitored all new chart orders and gave copies of monitoring tool to the DON. All laboratory orders were discussed at the daily morning meeting and will be discussed in the Quality Assurance meetings.	F 315		