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 01/16/2014

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 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		2/7/14

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

Electronically Signed | 02/10/2014

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 01/16/2014

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 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement contact isolation precautions after receiving a report identifying Methicillin Resistant Staphylococcus Aureus in the urine of 1 of 3 residents reviewed for infection control. The findings included: A review of an undated facility document entitled "Placing Isolation Orders for Housekeeping Staff" revealed in part, nurses receiving instructions to place a resident on Isolation Precautions (Droplet or Contact) should electronically communicate rooms placed in isolation precautions in order to ensure proper cleaning and disinfection of rooms in accordance with Infection Control Policies. Resident #9 was admitted to the facility 11/08/13 with diagnoses which included history of urinary tract infection, urinary retention, and recent lumbar spine surgery. An admission Minimum Data Set (MDS) dated 11/15/13 indicated the resident's cognition was intact and the resident required extensive to total dependence on staff for care. The MDS coded the resident with an indwelling urinary catheter. A Care Area Assessment specified Resident #9 had an indwelling urinary catheter for urinary retention and was at risk for urinary tract infections. A review of Resident #9's medical record revealed the resident was sent to the hospital on 12/09/13. An analysis and culture of the resident's urine was done at that time. On 12/12/13, a report containing information regarding the urine culture results was faxed to	F 441	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation o compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. (XS) COMPLETE DATE How the corrective action will be accomplished 1/16/2014 for the resident(s) affected. Patient immediately placed on Isolation Precautions. 2/12/2014 How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nurses re-educated on	

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 01/16/2014

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 441	Continued From page 2 the facility at 1:44 PM. The urine contained greater than 100,000 culture forming units of Methicillin Resistant Staphylococcus Aurens (MRSA). The report was noted called to the physician on 12/13/13 at 11:02 AM with orders received to initiate antibiotic treatment. An observation of Resident #9's room was conducted on 01/15/14 at 10:10 AM. The room was a private room with a private bathroom. No isolation precaution signs were observed on the room door and no personal protective equipment with the exception of gloves was available for staff. An interview with Nursing Assistant (NA) #1 on 01/16/14 at 1:07 PM revealed Resident #9's urinary collection bag was emptied each 8 hour shift. NA #1 stated he emptied the urinary collection bag into a pitcher kept in a bag in the resident's bathroom and flushed the urine down the resident's bathroom toilet. He stated he always wore gloves when doing this procedure. NA #1 added if he knew the resident's urine was infected, he would also wear a gown to prevent splattering his clothing with infected urine. An interview was conducted with the Staff Development Coordinator (SDC) on 01/16/14 at 2:22 PM. The SDC stated she also monitored infection control in the facility. She stated facility infection control procedures dictated the nurse taking the report should have implemented contact precautions which would have also alerted housekeeping. The SDC stated the nurse should have made nursing assistants aware contact isolation precautions were required. The SDC added a contact isolation precaution sign should have been posted on the resident's room	F 441	policy and procedures on Infection Control in relation to placing patients on isolation. Measures in place to ensure practices will not 2/28/2014 occur. A copy of cultures will be placed in Unit Managers and DON's box each time one is obtained. These results will be given to the SDC and she will ensure that any positive results needing isolation is completed. If isolation is not completed then the SDC will notify Unit Manager or DON who will then address with the staff nurse who failed to initiate the needed precaution and administer disciplinary action. How the facility plans to monitor and ensure correction is achieved and sustained. ongoing SOC/Infection Control Nurse/designee to do weekly observations x4, bi-weekly x2, and monthly x4 with documentation of results of Culture and Sensitivities and Isolation Placement. This documented information will be shared with the QNQI committee and revisions to practice made if needed to ensure compliance.	

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 01/16/2014

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 441	Continued From page 3	F 441		

door and protective equipment should have been made available to staff. The SDC continued covered trash bins to collect used protective equipment should have been set up in the resident's bathroom. The SDC added the nurse should have reported the finding to her as the infection control nurse.

An interview with the Director of Nursing on 01/16/14 at 2:44 PM revealed she expected nurses to report infections as they were noted in laboratory reports and initiate isolation precautions.

An interview with the Housekeeping Supervisor (HS) on 01/16/14 at 3:53 PM revealed housekeepers used a different procedure to clean resident rooms where a potentially contagious infection was present. He stated usually mop water was changed every 3 rooms. When an isolation precaution sign indicating a known infection was present, the housekeeper changed the mop water after mopping that room. The HS stated the housekeeper always used disposable disinfecting wipes in rooms with known contagious infections.