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 08/18/2016

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ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# BDMU11.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, family and staff interviews, the facility failed to provide oral care and nail care for 2 of 4 dependent residents (Resident #131 & Resident #124) reviewed for providing Activities of Daily Living (ADL) assistance. Findings included: 1. Resident #131 was admitted to the facility on 03/01/16 with diagnoses including dysphagia (difficulty swallowing), aphasia (difficulty speaking), hemiplegia (paralysis on one side of the body), and personal history of traumatic brain injury. The significant change Minimum Data Set (MDS) dated for 06/07/16 indicated Resident #131 had short and long term memory problems with significant cognitive impairment. The MDS also indicated Resident #131 required extensive assistance with hygiene and eating. The MDS further indicated Resident #131 had a feeding tube for nutrition. Review of the Care Area Assessment (CAA) indicated Resident #131 had a "decreased ability to understand others or to perform tasks following demonstration" and also	F 312	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 of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F312 How the corrective action will be accomplished for those residents affected: On the last day of the survey, when the facility found out about the issues, Resident #131 was provided mouth/denture care. Resident #124 was provided toe nail care.	9/6/16

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

Electronically Signed | 09/01/2016

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F 312	Continued From page 1 had loss of voluntary arm movement, functional limitation in upper extremity range of motion (ROM), impaired hand dexterity and cognitive deficits. Review of the care plan for 03/23/16 indicated the presence of an ADL care plan, but it did not address oral care for Resident #131. Review of the care guide (instructions for NA's to follow for care of resident) for 08/17/16 indicated no instructions for oral care for Resident #131. During an interview with a family member (FM) of Resident #131 on 08/16/16 at 8:37 AM, FM stated "they haven't taken his teeth out in weeks to brush them." FM also stated she would take his dentures out herself and brush them but she wasn't able to because of a medical condition. During an observation of Resident #131 on 08/16/16 at 1:06 PM, Resident #131 was observed to have a thick yellow substance across his upper denture plate and across his lower denture plate at the gum line. During a 2nd interview with the FM on 08/17/16 at 8:21 AM, FM stated "his teeth weren't taken out last night to be soaked" and the Nurse Aide (NA) had not taken them out that morning to brush them. A 2nd observation of Resident #131 at this time indicated he continued to have a thick yellow substance across his upper and lower denture plates at the gum line. A 3rd observation of Resident #131 on 08/17/16 at 10:19 AM revealed Resident #131 continued to have a thick yellow substance across his upper denture plate and across his lower denture plate at the gum line. A 4th observation of Resident #131 on 08/17/16 at 12:57 PM revealed Resident #131 continued to have a thick yellow substance across his upper denture plate and across his lower denture plate at the gum line. FM was also present and	F 312	How the corrective action will be accomplished for those residents with the potential to be affected by the same practice: The DON and/or SDC educated Nurses and Certified Nursing Assistants on denture care to residents with tube feeding. Residents in-house were examined by DON / Unit Manager/Nurse Supervisor to ensure no other residents with tube feed needed attention to denture care. The DON and/or SDC educated Nurses and Certified Nursing Assistants on toe nail trimming. Residents in-house were examined by DON/Unit Manager/Nurse Supervisor to ensure no other residents needed attention to their toe nails. Measure in place to ensure practices will not occur: SDC/designee to educate new hires on performing denture care twice a day and as needed to residents with tube feed. The Certified Nursing Assistants will perform denture care twice a day on patients that receive tube feed. Currently CNA□s are documenting denture care on tube feed residents on an audit tool indicating the task has been completed and licensed nurses are verifying completion and signing the audit tool for accountability. Unit Manager/designee will verify task has been completed weekly for period of 4 weeks and then monthly for 3 months. Audits will be turned into DON to ensure completion. The Unit Manager will audit weekly times four weeks then monthly thereafter times three weeks. SDC/designee to educate new hires on performing toe nail care twice a week as needed on bath/shower days. The	

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F 312	Continued From page 2 indicated she had not seen a toothbrush, toothpaste or a denture cup for Resident #131. An interview with NA #1 at 08/17/16 at 3:06 PM revealed NA #2 had provided no care for Resident #131, but had been in the room to bring a breakfast tray to Resident #131's roommate. NA #1 further indicated she assumed he was a tube feeder because she never saw him eat. An interview with NA #2 at 08/17/16 at 3:11 PM revealed NA #2 had not assisted with oral care for Resident #131, but had provided toileting and bathing assistance. On 08/17/16 at 4:21 PM, NA #3 was in the room of Resident #131. NA #3 was asked if he had provided oral care for Resident #131 since his shift began and NA #3 verified he had not. NA #3 removed the dentures for Resident #131 which revealed a thick yellow substance in the front of and on the roof of his upper dentures, and a thick yellow substance in the front of his lower dentures at the gum line. Resident #131 was also noted to have foul smelling breath. The Unit Manager (UM) also viewed the dentures and acknowledged his dentures appeared to not have been cleaned in several days. NA #3 searched Resident #131's room for a toothbrush, toothpaste or denture cup but could not find any of these items. During an interview on 08/17/16 at 4:44 PM, the UM stated the NA's were expected to remove and brush dentures at night and place them in a denture cup to soak them, if the resident would let them. The UM also stated the NA's were expected to retrieve dentures from the cup in the morning, rinse them off, and assist in placing them in the resident's mouth if the resident required assistance. The UM also verified there was not a denture cup, toothbrush, or toothpaste in the resident's side table, but she did find one	F 312	Certified Nursing Assistants will perform toe nail trimming and cleaning twice a week as needed on patients that are not diabetic. Diabetic patients will be examined and nail care (clipped and cleaned) provided by the Licensed staff on shower/bath days, all patients that cannot be safely trimmed will be referred to the Podiatrist. Currently CNA□s are documenting toenail care on an audit tool indication the task has been completed and licensed nurses are verifying completion and signing the audit tool for accountability. Unit Manager/designee will verify task has been completed on 8 random residents weekly for period of 4 weeks and then monthly for 3 months. Audits will be turned into the DON to ensure completion. The Unit Manager/designee will audit weekly times four weeks then monthly thereafter times three weeks. How the facility plans to monitor and ensure correction is achieved and sustained: The DON will review audits at weekly RISK meetings times 4 weeks then monthly times 3 months, the results will then be presented to the Quality Assessment and Assurance Committee monthly for a period of 4 months to review for compliance and revision as needed.	

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F 312	Continued From page 3	F 312		

unopened oral swab in the top drawer.
On 08/17/16 at 4:59 PM, the Director of Nursing (DON) stated her expectation was for the NA's to assist in taking out dentures at night and soaking them and also to give oral care to twice a day to resident's requiring assistance.

2. Resident #124 was admitted to the facility on 07/08/16. Her diagnoses included muscle weakness, ankylosing spondylitis, rheumatoid arthritis and chronic pain.

Her admission Minimum Data Set dated 07/15/16 coded her with intact cognition, having no behaviors, and requiring extensive assistance of one for most activities of daily living skills including hygiene and dressing.

The care plan for activities of daily living skills was developed on 07/19/16 which stated Resident #124 had a self care deficit related to her limited range of motion. The care plan did not specifically address hygiene or nail care.

The Care Tracker Guide used by nurse aides for resident specific care guidance noted under "Resident Care" that staff needed to anticipate and meet the resident's needs.

Resident #124 was observed on 08/16/16 at 9:43 AM in bed. She was observed with long toenails on each foot which extended beyond her toes. She stated that she needed them cut and had not had them cut since she was admitted.

On 08/17/16 at 8:38 AM, Resident #124 was observed in bed with long toenails which extended beyond the end of her toe

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F 312	Continued From page 4	F 312		

approximately an eighth of an inch. She stated she received showers on Tuesdays and Fridays evenings and received one yesterday (Tuesday 08/16/16). She further stated that no one offered or said anything about cutting her toenails.

On 08/17/16 at 1:02 PM, Nurse Aide (NA) #4 stated she had dressed Resident #124 this morning which included putting her socks on. NA #4 stated she noticed her toenails were long but did not report this to the nurse. NA #4 stated that a resident would see the podiatrist if the resdient was diabetic or had toenails which were in such bad shape a podiatrist was needed to care for them.

Interview with the hall Nurse #1 on 08/17/16 at 1:04 PM revealed she had not received any report from nurse aides regarding Resident #124's nails needed to be trimmed. She further stated that every Monday a staff member was assigned to provide nail care to residents. At this time, the surveyor and Nurse #1 observed the toenails of Resident #124. It was observed that 9 out of 10 toenails extended beyond the end of her toes. Nurse #1 stated that she needed nail care. Resident #124 stated at this time she needed her toenails trimmed and that they had not been trimmed since her admission into the facility.

On 08/18/16 at 8:37 AM, the Director of Nursing (DON) stated she expected toenails to be checked and trimmed on shower days. She further stated that when she had extra staff, she assigned a nurse aide to check fingernails and toenails.

On 08/18/16 at 11:50 AM Resident #124 stated she asked about the podiatrist cutting her toenails

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F 312	Continued From page 5 on Monday when he was at the facility but was told her toenails had to be "bad" for the podiatrist to see her. She again stated no one had cut her toenails since her admission to the facility but they were cut this date and "feel much better."	F 312		