STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 000	INITIAL COMMENTS The survey team entered the facility on 03/07/19 to conduct an unannounced complaint investigation and onsite follow up and exited on 03/10/19. Additional information was obtained on 03/21/19 and 03/22/19. Therefore, the exit date was changed to 03/22/19. The facility remains out of compliance.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		4/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed

TITLE

(X6) DATE 04/11/2019

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
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

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F 656	Continued From page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update a care plan for pressure ulcers for 1 of 3 sampled residents (Resident #1). On 02/21/19 a wound evaluation by the Nurse Practitioner revealed Resident #1 had a stage 2 pressure ulcer to his thoracic spine and a stage 2 pressure ulcer on his lumbar spine. The care plan was not updated to reflect Resident #1's documented pressure ulcers. The findings included: 1. Resident #1 was admitted to the facility on 03/15/18. Resident #1 had diagnoses which included heart failure, hypertension, diabetes mellitus and non-Alzheimer's dementia. Review of Resident #1's care plan, last updated 01/07/19, revealed a care plan area for pressure ulcer risk. The care plan revealed Resident #1's skin had been documented as intact during the 01/07/19 update. The goal was for Resident #1's skin to remain intact. Interventions included	F 656	F656 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 no longer resides at the facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? Current residents with pressure ulcers were reviewed by the MDS coordinator and the interdisciplinary team on 3/09/2019 and the care plans were reviewed and revised. On 3/09/2019 the MDS coordinator and interdisciplinary team were re-educated on reviewing and revising care plans with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 656

Continued From page 2

completion of a Braden scale, weekly skin inspections, and providing skin care after incontinence episodes.

Review of Resident #1's wound Nurse Practitioner (NP) assessment dated 02/21/19 revealed the following: Resident #1 had a new documented pressure injury located on his thoracic spine. The area was documented as a stage 2 pressure injury, pressure ulcer measuring 1.5 cm (centimeters) length x 1.5 cm width x 0.1 cm depth with an area of 2.25 volume of 0.225. Resident #1 had another new documented pressure injury located on his lumbar spine. The area was documented as a stage 2 pressure injury pressure ulcer measuring 5 cm length x 1.5 cm width x 0.1 cm depth with an area of 7.5 sq. cm and a volume of 0.75 cm.

Review of Resident #1's Physician order dated 02/22/19 written by the NP revealed the following treatment orders for Resident #1, a new order dated 02/22/19 to apply a hydrocolloid dressing daily to Resident #1's upper and lower spine.

Review of Resident #1's wound Nurse Practitioner assessment dated 02/28/19 revealed the following: Wound #1 Right Buttock was an abrasion and had received an outcome of bridged with Wound #2 on Resident #1's left buttock. Wound encounter measurements were 12.3 cm length x 13.4 cm width x 0 depth, with an area of 164.82 sq. cm and a volume of 0 cubic cm. The documentation revealed Resident #1 had no signs of an infection. Wound #2 left buttock was an unstageable pressure injury obscured full thickness skin and tissue loss pressure ulcer and had received a status of not healed. Wound #2 measured 12.3 cm length x 13.4 cm width x 0 cm

F 656

changes in pressure ulcers by the regional nurse consultant.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

On 3/09/19 a certified wound care nurse completed a visual skin assessment of residents currently in the facility having wounds. Care plans were reviewed and revised with any changes noted.

On 3/9/19 the regional nurse educated the current minimum data set coordinator on the requirements for developing a care plan and a process of reviewing new orders daily Monday thru Friday to identify those residents that have pressure ulcers and to ensure that the current care plan is reflective of the resident’s status.

The minimum data set nurse will review the weekly wound care nurse practitioner notes and compare to current plan of care and interventions.

A designated registered nurse will round with wound care nurse practitioner weekly and provide any changes in wound care for residents to the minimum data set nurse.

4. How will the facility monitor its performance to make sure that solutions are sustained?

The Director of Nursing or designated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 656	Continued From page 3	F 656		

depth with an area of 164.82 sq. cm. The pressure ulcer located on Resident #1's thoracic spine was documented as a stage 2 pressure injury measuring 2.1 cm length x 2. 1cm width with an area of 4.41 cm. The wound located on Resident #1's lumbar spine was documented as a stage 2 pressure ulcer measuring 9 cm length x 1.0 cm width x 0 cm depth with an area of 9.9 sq. cm. A new deep tissue injury to Resident #1's right lateral lower leg was documented. Measurements included 2.5 cm length x 2.1 cm width with an area of 5.25 sq. cm. The assessment revealed the wounds were improving.

On 03/07/19 at 5:10 PM an interview was conducted with MDS Nurse #1. The interview revealed she was responsible for initiating and updating the care plans. MDS Nurse #1 stated Resident #1's care plan was not updated to include the documented stage 2 pressure ulcer to his thoracic spine and unstageable pressure ulcers located on his buttock. The interview revealed the last documented care plan update occurred on 01/07/19 in which Resident #1's skin was documented as being intact. She stated the care plan should have been updated following the wound evaluation on 02/21/19 from the wound NP however, she was on vacation and was out of the building. The interview further revealed the MDS Nurse wasn't aware of Resident #1's pressure ulcers prior to 03/07/19. She stated Resident #1's wounds were not discussed during the interdisciplinary team (IDT) meeting held on Thursdays. MDS Nurse #1 indicated she would normally be notified of any new wounds during the IDT meeting.

On 03/07/19 at 5:19 PM an interview was

nurse will audit the care plans of residents with wounds to ensure care plans are in place and updated 3x/week for 4 weeks, then randomly 1x/week for 2 months.

The Director of Nursing will report results of the audits to the monthly Quality Assurance Performance Improvement (QAPI) meeting x 3 months or until time determined by the QAPI members for sustained compliance.

Date of Compliance: 4/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 656	Continued From page 4 conducted with the Director of Nursing (DON). The interview revealed Resident #1 was not brought up during the IDT meetings which were held weekly to discuss wounds. She stated the MDS Nurse was in charge of updating the residents care plans. The DON stated Resident #1's care plan should have been updated to reflect the pressure ulcers located on his thoracic spine and buttock.	F 656		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, wound care Nurse Practitioner interview, Physician interview and Medical Director interview, the facility failed to implement treatment orders to prevent pressure ulcers from deteriorating for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #1). The findings included:	F 686	F686 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 no longer resides at the facility.	4/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 686 Continued From page 5

Resident #1 was admitted to the facility on 03/15/18. Resident #1 had diagnoses which included heart failure, hypertension, diabetes mellitus and non-Alzheimer's dementia.

Review of Resident #1's care plan, last updated 01/07/19, revealed a care plan area for pressure ulcer risk. The care plan revealed Resident #1's skin had been documented as intact during the 01/07/19 update. The goal was for Resident #1's skin to remain intact. Interventions included completion of a Braden scale, weekly skin inspections, and providing skin care after incontinence episodes.

Review of Resident #1's most recent quarterly Minimum Data Set (MDS) dated 01/22/19 revealed Resident #1 was severely cognitively impaired. The MDS indicated Resident #1 required extensive, two-person assistance for bed mobility. Resident #1 was non-ambulatory and had no documented skin conditions.

Review of Resident #1's nursing skin assessment dated 01/31/19 revealed the following: Right buttock, pressure ulcer. Measurements included 5.0 cm length x 1.0 cm width x 0.1 depth. Documentation revealed there had been no change in size of the pressure ulcer to Resident #1's right buttock. Left buttock, pressure ulcer. Measurements included 0.5 cm length x 0.5 cm width x 0.1 cm depth. Resident #1 was identified as having a new pressure ulcer on this date located on his rectum, measurements included 2.0 cm length x 2.0 cm width x 0.1 cm depth.

Review of Resident #1's wound Nurse Practitioner assessment dated 01/31/19 revealed the following: Right buttock abrasion

F 686

2. How the facility will identify other residents having the potential to be affected by the same deficient practice?
Resident□s in the facility with wounds were reviewed to ascertain appropriate treatment orders on 3/09/19.

The facility nurses completed skin assessments on the facility residents in the building on 3/09/2019.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

New physician orders will be reviewed during AM clinical meeting with the IDT members on-going 5 days/week, the nurse supervisor or delegated nurse will review on the weekends.

During the AM clinical meeting 5x/weekly, nursing administration will review the assigned skin checks to ascertain appropriate notification and treatment modalities were implemented if required.

The DON or designated nurse will review the wounds weekly with the contracted wound NP to ensure the documentation includes, the stage, location, measurements, treatment, progression and any new order changes to ascertain progression towards healing or necessary changes that are necessary to facilitate healing.

The licensed staff will be re-educated by the RN Staff Development on pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 686

Continued From page 6

measurements included 5 cm length x 1 cm width x 0.1 cm depth with an area of 5 sq. cm and a volume (a wound's volume is calculated based on the wounds length, width and depth to determine the amount of space the wound encompasses) of 0.5 cubic cm. There is no change noted in the wound progression. Left buttock abrasion measurements included 0.5 cm length x 0.5 cm width x 0.1 cm depth with an area of 0.25 sq. cm and a volume of 0.025 cubic cm. Anal irritation was noted measuring 2 cm length x 2 cm width x 0.1 cm depth with an area of 4 sq. cm and a volume of 0.4 cubic cm.

Review of Resident #1's February 2019 physician orders revealed the following treatment orders: "skin prep to coccyx daily and evening for redness" and "right and left buttocks apply skin prep hydrocolloid dressing every 3 days and as needed.

Review of Resident #1's February 2019 Treatment Administration Record (TAR) from 2/01/19 to 02/07/19 revealed staff did not initial the TAR as completing the skin prep treatment to the coccyx daily and during the evening (twice a day) on 02/06/19.

Review of Resident #1's wound Nurse Practitioner assessment dated 02/07/19 revealed the following: Right buttock abrasion measurements included 2 cm length x 2.5 cm width x 0.1 cm depth with an area of 5 sq. cm and a volume of 0.5 cubic cm. There is no change noted in the wound progression. Left buttock abrasion measurements included 3 cm length x 1 cm width x 0.1 cm depth with an area of 3 sq. cm and a volume of 0.3 cubic cm. There was no change noted in the wound progression. Anal

F 686

wounds and documentation on the Treatment Records by 4/17/2019. Any licensed nurse not completing the education by 4/17/2019 will not be scheduled until they complete the education.

Any new nursing staff will be educated during their orientation on-boarding process.

4. How will the facility monitor its performance to make sure that solutions are sustained?

The Director of Nursing or designated nurse will perform random wound treatment observations 5x/week times 4 weeks, then weekly times 8 weeks or until time designated by the QAPI members for on-going sustained compliance.

Results of the audits will be presented by the Director of Nursing at the monthly QAPI meeting for review by the committee members x3 months or until time designated by the QAPI members for sustained compliance.

POC Date 4/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 686	Continued From page 7	F 686		

irritation was noted measuring 2 cm length x 2 cm width x 0.1 cm depth with an area of 4 sq. cm. and a volume of 0.4 cubic cm.

Review of Resident #1's February 2019 TAR from 2/07/19 to 02/14/19 revealed staff did not initial the TAR as completing the skin prep treatment to the coccyx daily and evening (twice a day) on the following dates: 02/09/19, 02/10/19, 02/11/19 and 02/13/19.

Further review of Resident #1's February 2019 TAR from 02/07/19 to 02/14/19 staff did not initial the TAR as completing the resident's right and left buttock with skin prep, and application of a hydrocolloid dressing every 3 days on the following dates: 02/08/19 and 02/11/19.

On 3/8/19 at 10:20AM an interview was conducted with Nurse #4. Nurse #4 stated he was the wound nurse from 11/06/18 until early February 2019. The interview revealed Nurse #4's position was terminated due to the facility decision to not have a wound nurse. He stated Resident #1 had two decubitus ulcers located on his buttocks one on the left side and one on the right. Nurse #4 stated the areas were stage 2 due to the skin being broken. The interview revealed Nurse #4 had rounded with the NP while she was in the building and the NP had sent him a copy of her progress notes. Nurse #4 stated he had never noticed what she was calling the abrasion located on the Resident #1's buttocks. Stated in his opinion as a wound care nurse an abrasion was a scrape, or area that could be healed quickly.

Review of Resident #1's wound Nurse Practitioner assessment dated 02/14/19 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 686	Continued From page 8	F 686		

the following: Wound #1 Right buttock abrasion measurements included 2 cm length x 2.5 cm width x 0.1 cm depth with an area of 5 sq. cm and a volume of 0.5 cubic cm. Wound #2 Left buttock abrasion measurements included 2 cm length x 2.5 cm width x 0.1 cm depth with an area of 4 sq. cm and volume of 0.4 cubic cm.

Review of Resident #1's February 2019 TAR from 2/15/19 to 02/21/19 revealed staff did not initial the TAR as completing the skin prep treatment to the coccyx daily and evening (twice a day) on the following dates: 02/16/19, 02/17/19 and 02/20/19.

On 03/8/19 at 1:00 PM an interview was conducted with Nurse #5. Nurse #5 stated Resident #1 had a wound located on his coccyx. He stated he had been the nurse for Resident #1's hall on 2/17/19 and had changed Resident #1's dressing. He stated the wound was the size of a half-dollar. Nurse #5 stated he provided wound care on 02/17/19 however forgot to sign it off as completed on the resident's TAR.

Review of Resident #1's wound Nurse Practitioner assessment dated 02/21/19 revealed the following: Wound #1 Right buttock, abrasion measurements included 9.1 cm length x 7.1 cm width x 0.2 cm depth with an area of 64.61 sq. cm and a volume of 12.922 cubic cm. The NP documented wound #1 had resolved. Wound #2 Left buttock was an abrasion and had received an outcome of bridged with Resident #1's right buttock. Wound #2 measurements included 9.1 cm length x 7.1 cm width x 0.2 cm depth with an area of 64.61 cm volume of 12.922 cm. Resident #1 had a new documented pressure injury located on his thoracic spine. The area was documented as a stage 2 pressure injury,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 686	Continued From page 9 pressure ulcer measuring 1.5 cm length x 1.5 cm width x 0.1 cm depth with an area of 2.25 volume of 0.225. Resident #1 had another new documented pressure injury located on his lumbar spine. The area was documented as a stage 2 pressure injury pressure ulcer measuring 5 cm length x 1.5 cm width x 0.1 cm depth with an area of 7.5 sq. cm and a volume of 0.75 cm. Review of Resident #1's Physician order dated 02/22/19 written by the NP revealed the following treatment orders for Resident #1, "hydrocolloid dressing to left buttock every day shift, change every 2 days for new wound area". The review also revealed a new order dated 02/22/19 to apply a hydrocolloid dressing daily to Resident #1's upper and lower spine. Review of Resident #1's February 2019 TAR revealed the 02/22/19 physician's order for the application of the hydrocolloid dressing to Resident #1's upper and lower spine every day was not entered on the TAR. Further review of the February 2019 TAR revealed staff did not initial the TAR as completing the skin prep treatment to the resident's coccyx daily and evening (twice a day) on the following dates: 02/26/19 and 02/27/19. On 03/22/19 at 9:50 AM an interview was conducted with Nurse #3. Nurse #3 stated she had taken care of Resident #1 during the two weeks prior to his hospitalization and had completed Resident #1's dressing changes. The interview revealed treatment orders were initiated onto the TAR by the nurse receiving the physician order. The interview revealed the nurse who received the physician order on 02/22/19 for the application of a hydrocolloid dressing to Resident	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 686	Continued From page 10	F 686		

#1's upper and lower spine no longer worked in the facility and had categorized the order incorrectly. Nurse #3 stated the order did not show up under Resident #1's TAR for the nurses on the hall to see. Nurse #3 stated when she clicked on the physician order it read, "standard order will not appear on the treatment administration record". Nurse #3 stated the nurses on the hall wouldn't have known to change Resident #1's dressing to his upper and lower spine. The interview revealed Nurse #3 had not applied a hydrocolloid dressing to Resident #1's upper and lower spine on 02/24/19 or 02/27/19.

On 03/22/19 at 10:14 AM an interview was conducted with Nurse #2. Nurse #2 stated Resident #1 had treatment orders which included application of a hydrocolloid dressing to his coccyx. The interview revealed Resident #1 had no treatment orders for a dressing application to his upper or lower spine. Nurse #2 stated she did not know Resident #1 had a wound on his spine. She stated she was responsible for his dressing change on 02/26/19 and 02/28/19.

On 03/07/19 at 1:15 PM an interview was conducted with Nurse #2. Nurse #2 stated she had worked on Resident #1's hall on 02/26/19. Nurse #2 stated Resident #1 had a slow decline since she started working in the facility 2 months prior. She stated it was hard to get Resident #1 to take his medicine on 02/26/19, letting the supplement med pass run out the side of his mouth after administration. However, she felt it was his natural decline and did not chart any nursing notes. Nurse #2 stated she oversaw wound treatment for the hall due to no wound nurse. Nurse #2 stated she had completed Resident #1's treatment as ordered however did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 686	Continued From page 11	F 686		

not initial the TAR. She stated the wounds did not look bad in her opinion and were not infected. Stated Resident #1 had never refused care.

On 03/07/19 at 4:25 PM an interview was conducted with NA #2. NA #2 stated she had worked with Resident #1 on the week of 2/23/19 to 2/28/19. She stated she had noticed a decline during that week, stating Resident #1 was not eating, drinking, and had decreased urine output. NA #2 stated while providing incontinence care and turning Resident #1 she saw a dressing on his spine. She stated below the dressing she saw a black area, but no drainage was noted. The interview revealed NA #2 did not report black area she observed on the resident's back to the nurse.

On 03/07/19 at 4:59 PM an interview was conducted with Nurse #6. Nurse #6 stated she was working on 02/27/19 during second shift taking care of Resident #1. She stated Resident #1 had declined quickly that week. The interview revealed Resident #1 had stopped eating and needed assistance with meals. Nurse #6 stated prior to Resident #1's decline he was able to feed himself.

On 03/11/19 at 9:42AM an interview was conducted with Nurse Aide #1. NA #1 stated she had cared for Resident #1 during first shift on 02/27/19 and 02/28/19. She stated while changing and turning Resident #1 she noticed his weight loss, and open skin on bony prominences. NA #1 stated she didn't notice any open areas on Resident #1's buttocks.

Review of Resident #1's wound Nurse Practitioner assessment dated 02/28/19 revealed the following: Wound #1 Right Buttock was an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

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F 686 Continued From page 12 F 686

abrasion and had received an outcome of bridged with Wound #2 on Resident #1's left buttock. Wound encounter measurements were 12.3 cm length x 13.4 cm width x 0 depth, with an area of 164.82 sq. cm and a volume of 0 cubic cm. The documentation revealed Resident #1 had no signs of an infection. Wound #2 left buttock was an unstageable pressure injury obscured full thickness skin and tissue loss pressure ulcer and had received a status of not healed. Wound #2 measured 12.3 cm length x 13.4 cm width x 0 cm depth with an area of 164.82 sq. cm. The pressure ulcer located on Resident #1's thoracic spine was documented as a stage 2 pressure injury measuring 2.1 cm length x 2. 1cm width with an area of 4.41 cm. The wound located on Resident #1's lumbar spine was documented as a stage 2 pressure ulcer measuring 9 cm length x 1.0 cm width x 0 cm depth with an area of 9.9 sq. cm. A new deep tissue injury to Resident #1's right lateral lower leg was documented. Measurements included 2.5 cm length x 2.1 cm width with an area of 5.25 sq. cm. The assessment revealed the wound was improving.

On 3/7/19 at 11:58AM an interview was conducted with the wound Nurse Practitioner (NP). She stated she had been seeing Resident #1 for several weeks due to excoriated areas on his bottom. Stated 3 weeks back Resident #1 had a fall which resulted in a decline of health. The NP stated a couple of weeks ago Resident #1 started having open areas on his back along with areas on his bottom, head, and lower leg. She stated during her evaluation on 02/28/19 she had noticed a huge difference, physically the resident wasn't as good as he was previously. The interview revealed an abrasion could be compared to a skin shear or tear in the skin in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 686	Continued From page 13 which she believed Resident #1 had received due to staff pulling him up in the bed. She stated she had provided staff with education on properly assisting the resident up in bed without shearing his skin when she was in the facility. She stated the resident had never refused dressing changes or care. The interview revealed Resident #1 liked to be up during the day in his wheelchair. The NP stated facility nursing staff notify her after a reddened area is noted on a resident's skin. The NP stated a stage 2 pressure ulcer was classified as an open area of skin breakdown in which Resident #1 did not have, she stated Resident #1's treatment orders were appropriate for his wounds. On 03/08/19 at 4:52 PM a follow up interview was conducted with the facility wound Nurse Practitioner. She stated during her wound assessment on 02/28/19 she documented Resident #1 had a full thickness, skin and tissue loss pressure ulcer located on his left buttock. She stated the description was entered due to a transcription error by the scribe whom inputs her evaluation notes. She stated on 02/28/19 Resident #1's buttock appeared to be a deep tissue injury, encompassing the entire area of the resident's buttocks. She stated it was deep purple in color. The interview revealed the area had not been a pressure ulcer prior to 02/28/19. The NP stated her protocol was to notify nursing staff of any changes by giving them her evaluation notes. On 3/8/19 at 10:00 AM an interview was conducted with Nurse #3. Nurse #3 stated she rounded with the wound Nurse Practitioner if she was in the facility on Thursdays. Stated she had worked in the facility since August 2018 and was Resident #1's first shift nurse on 02/24/19,	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 686	Continued From page 14	F 686		

02/27/19 and 02/28/19. Nurse #3 stated she had completed Resident #1's treatment on 02/27/19 however had not initialed the TAR. She stated Resident #1 had wounds to his lower back and bottom. Nurse #3 stated she rounded with the wound NP on 02/28/19 and the wound NP removed the dressing on the resident's coccyx and asked Nurse #3 to come look at the wound. Nurse #3 stated the NP said to her the area was an unstageable pressure ulcer located on his coccyx. Nurse #3 stated Resident #1's wounds didn't look extremely different from when she had seen them caring for him as a hall nurse. She stated the resident had a decline in his overall health in the weeks prior. Nurse #3 stated she thought the wounds on Resident #1 were pressure ulcers prior to 2/28/19.

On 03/07/19 at 5:19 PM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #1 was getting up and could propel himself around in his wheelchair. The interview revealed Resident #1 was not brought up during the interdisciplinary team (IDT) meetings held weekly to discuss wounds. The DON stated her expectation was for the nurses to follow physician orders regarding dressing changes, be aware if a residents wound is declining and to notify her or a physician of the decline. The interview revealed nursing staff were not treating Resident #1's wound as a pressure ulcer due to the NP's progress notes. The DON stated it was her expectation of nursing staff to initial the TAR signing completion of a treatment.

On 3/8/19 at 9:43AM an interview was conducted with the Medical Director (MD). The MD stated he was not familiar with Resident #1 however was the Medical Director covering the facility. He said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 686	Continued From page 15	F 686		

an abrasion usually healed within 1 week and created a scabbed area. The MD stated if the wound area was recurrent than it had probably started as an abrasion but transitioned into a worsening pressure ulcer. He stated if the wound had extended into a 2-3-month period and had increased in size getting worse then something was making it worse. The MD stated he would be okay with the incident had the resident been on comfort measures however if he wasn't this incident was an issue. The MD stated since the facility did not have a wound nurse, the nurses rounding with the NP should have caught that the wound was increasing in size.

On 03/08/19 at 12:03 PM an follow up interview was conducted with the facility's Medical Director. He stated eschar and extensive black tissue does not occur over night and would take at least 2 weeks to develop. The interview revealed as a wound progressed, treatment orders should reflect if a wound increased in size. He stated if a wound was not improving another treatment option should have been explored to prevent further tissue breakdown.

On 03/08/19 at 2:00 PM a follow up interview was conducted with the Resident #1's Physician. The Physician stated Resident #1 had a bleeding ulcer in July 2018. He stated he believed Resident #1 had experienced failure to thrive extending from the bleeding ulcer in July 2018. The physician stated any time following that episode was borrowed time for Resident #1. He stated he had seen Resident #1 on 02/01/19 and had based his skin assessment from the NP notes. The physician stated he could not speak for the state of the wounds due to having not seen them. He stated he was just going by what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 686	Continued From page 16 the NP had documented in her notes.	F 686		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		4/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 842	Continued From page 17 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have accurate information in the medical records about a change in condition and treatments were not documented as completed for 1 of 3 sampled residents reviewed for pressure sores (Resident #1). Findings included:	F 842	F842 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 no longer resides at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 842

Continued From page 18

Resident # 1 was admitted to the facility on 03/15/2018.

Review of Resident #1 Treatment Administration Record (TAR): January 2019
-Skin Prep to coccyx related to prevention of skin breakdown every day and evening shift for redness.
Treatment not documented on 1/2/19, 1/4/19 -1/8/19, 1/12/19, 1/14/19, 1/21/19, 1/24/19
-Right and Left buttock skin prep and hydrocolloid dressing every 3 days and PRN. Change every day shift every 3 days.
Days of missed treatment included 1/6/19, 1/12/19, 1/24/19.

Review of Resident #1 Treatment Administration Record (TAR): February 2019
-Skin Prep to coccyx related to prevention of skin breakdown. Change every day and evening shift for redness.
Treatment not documented on 2/6/19, 2/9/19, 2/10/19, 2/11/19, 2/13/19, 2/16/19, 2/17/19, 2/20/19, 2/26/19, 2/27/19.

Review of Resident #1 vital signs revealed no documented vital signs from 2/23/19 through 2/28/19. The review revealed one documented set of vital signs located in a nursing note dated 3/1/19 including a temperature of 102.4, respirations 22.

A review of the medical record revealed no documentation from 11/22/2018 through 01/23/2019, and then no documentation from 02/12/2019 to 02/23/2019. After 02/23/2019 the next documentation was on 03/01/2019.

F 842

facility.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice?

Resident�s in the facility with wounds were reviewed to ascertain there was no change in condition of wound on 3/09/2019.

The facility nurses completed skin assessments on the facility residents in the building on 3/09/2019.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The Director of nursing/Assistant Director of nursing re-educated the licensed nurses on required and proper documentation for a change of condition, along with required documentation to be completed by the end of their respective shift. Education completed by 4/17/2019. Any licensed nurse not completing the education by 4/17/2019 will not be scheduled until they complete the education.

Any new licensed staff will receive the education during their orientation on-boarding.

The Director of nursing or designated nurse will review resident treatment records and progress notes daily x4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

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F 842	Continued From page 19 A review of the nurse aides (NAs) Activities of Daily Living charting from 02/13/2019 through 02/27/2019 in the Patient Care Chart revealed that no input and outcomes were documented. An interview with NA # 1 on 03/07/2019 at 04:25 PM revealed that Resident # 1 was noted to be declining about a week before he went to the hospital, and that he had not been eating or drinking. She stated she did not report it to the nurse because she figured the nurse already knew. The interview further revealed all intake and output are documented in the resident's electronic chart at the end of each shift. An interview with NA # 2 on 03/07/2019 at 04:59 PM revealed that Resident # 1 had declined quickly that week. He quit eating or drinking and when staff tried to feed him he would not chew or swallow the food, it had to be wiped out. She stated she did report it to the nurse (Nurse # 3) on 02/27/19 when black stuff was coming out of his mouth and she came and cleaned out his mouth. NA #2 explained all residents on the east hall were to have vital signs taken every Wednesday and documented in Patient Care Chart located in the resident's electronic chart. An interview with Nurse # 3 on 03/08/19 at 09:59 AM revealed that Resident # 1 had been declining. On 02/27/2019 he was not eating or drinking, and the NA called her to his room because of black stuff coming from his mouth. She cleaned out his mouth but did not notice any sores in his mouth. She further stated that this was the evening before he was sent out. An interview with Nurse # 5 on 03/08/2019 at 12:40 PM revealed that prior to going to the	F 842	weeks, then weekly x8 weeks to ensure documentation is complete on the treatment record and on any change of condition. 4. How will the facility monitor its performance to make sure that solutions are sustained? Results of the audits will be presented by the Director of Nursing or designee at the monthly QAPI meeting for review by the committee members x3 months or until time designated by the QAPI members for sustained compliance. POC Date 4/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING ______ B. WING ______	C 03/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	**500 BEAVERDAM ROAD ASHEVILLE, NC 28804**

(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 842	Continued From page 20 hospital Resident #1 had refused care by the NAs. He further stated that when Resident # 1 was repositioned he was able to pull the pillow out and go back to his back. Nurse # 5 reported it was hard to put an exact date on Resident # 1 decline, just knew that he declined his eating and drinking. Regarding vital signs if the residents are sick he would get the vital signs himself. Also, there is a schedule at the nursing station for residents that needed a nursing note done weekly including vital signs. He stated he usually got his own vital signs and would document in the electronic chart. An interview with the Interim Director of Nursing on 03/07/2019 at 05:19 PM revealed her expectations were that any change of condition and vital signs should be documented in the resident's electronic chart.	F 842		