STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345174	A. BUILDING ______ B. WING ______	C 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE NURSING & REHABILITATION CENTER	91 VICTORIA ROAD ASHEVILLE, NC 28801

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to honor a resident's choice regarding transferring out of bed to a geri chair for 1 of 3 residents reviewed for choices. (Resident #61). The findings included: Resident # 61 was readmitted to the facility 08/27/12 with diagnoses which included end stage renal disease requiring dialysis treatments. A quarterly Minimum Data Set (MDS) dated 07/23/14 indicated Resident #61's cognition was intact. The MDS specified the resident understood others and was able to verbalize his needs. The MDS further indicated the resident was unable to ambulate and was totally dependent on staff assistance for transfers. An interview with Nurse Aide (NA) #1 on 09/10/14 at 9:07 AM revealed she and a helper would be getting Resident #61 up in his geri chair around 10:30 AM. She stated he left the facility for dialysis at 11:00 AM. An observation on 09/10/14 at 10:00 AM revealed	F 242	The facility will promote and honor resident choices in the participation of activities, schedules and health care consistent with his or her interest. Resident #61 was surveyed by the Social Worker to determine their choices in participation in several aspects of their care including their preferred time to get up in the morning. The information was given to the care plan team and care plan was updated at that time. The facility developed and implemented the Resident Champion program where residents are surveyed on a weekly basis on several aspects of their interest and desire to have an active say in their choices. The Administrator reviews each of those weekly and reports results of the interviews to the facility staff during the morning stand up meeting. Staff was educated on the Resident	10/8/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/30/2014

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.

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F 242	Continued From page 1 NA #1 and NA #2 had prepared Resident #61 for a transfer from bed to a geri chair. NA #1 was observed standing on the resident's left of his bed and NA #2 was observed on the opposite side of the bed. A mechanical lift was observed in the resident's room. The resident was observed lying in bed with a sling utilized for the transfer under his torso. An interview with Resident #61 during the observation and before the transfer revealed he did not like getting up this early. He stated the chair hurt him and he would be in this chair throughout his dialysis procedure which took 4 to 4.5 hours. NA #1 and NA #2 were present and heard the resident's statements. NA #2 stated they had to transfer Resident #61 now because they had other residents that needed to get up also. At 10:17 AM on 09/10/14 Nurse #1 was interviewed. She stated when Resident #61 voiced his displeasure of getting up so early the nurse aides should have waited. Nurse #1 added she was unaware the geri chair was uncomfortable for him and that he stayed in this chair throughout his dialysis treatment. An interview was conducted with the Director of Nursing (DON) on 09/12/14 at 10:16 AM. The DON stated she expected staff to honor the resident's wishes to not get up so early before going to dialysis.	F 242	Champion program by the Administrator the week of September 29, 2014. Care Plans and Care Cards are updated by the Interdisciplinary Team which includes MDS, Therapy, Nursing, Dietary, Social Services according to their individual preferences on an as need basis depending on the change in resident preferences but no less than every 90 days . The resident champion program is a long term program for the facility to capture resident choices consistently and routinely. The Administrator will report any resident choices changes to the QAPI committee on monthly basis.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		10/8/14

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F 253	Continued From page 2 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure and maintain wall unit air conditioners in 5 of 12 resident rooms. The findings included: On 09/07/14 at 10:30 AM during the initial tour the following facility environmental observations were made: A. Room 118- the front cover on the wall unit air conditioner was not secure to unit and hanging off on right side of the unit. Plastic vent on air conditioner cover was also broken. B. Room 208- the front cover on the wall unit air conditioner was not secure to unit, and plastic vent on front cover was broken. C. Room 214- the front cover on the wall unit air conditioner was not secure to unit. D. Room 226- 1- 1.5 inch gap around wall unit air conditioner in which there was no insulation. Light could be seen from outside the facility as well as air entering and exiting around unit. E. Room 229- wall unit air conditioner had silver duct tape around outer edge of unit to secure cover to unit. On 09/08/14 at 10:36 PM during a second round of observations the following facility environmental issues were identified: F. Room 118- the front cover on the wall unit air conditioner was not secure to unit and hanging off on right side of the unit. Plastic vent on air conditioner cover was also broken. G. Room 208- the front cover on the wall unit air	F 253	"This plan of correction is the facility's credible allegation of compliance" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility is providing housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. No resident was named in this citation. The Maintenance Director completed the work on the items listed below by September 15, 2014. Room #118 front cover of the wall a/c unit is secure and plastic vent is in place. Room#208 front cover of the wall a/c unit is secure and plastic vent is in place. Room #214 front cover of the wall unit is secure. Room #226 front cover of the wall a/c unit has insulation around it and the gap has been sealed.	

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F 253	Continued From page 3 conditioner was not secure to unit, and plastic vent on front cover was broken. H. Room 214- the front cover on the wall unit air conditioner was not secure to unit. I. Room 226- 1- 1.5 inch gap around wall unit air conditioner in which there was no insulation. Light could be seen from outside the facility as well as air entering and exiting around unit. J. Room 229- wall unit air conditioner had silver duct tape around outer edge of unit to secure cover to unit. On 09/11/14 at 2:25 PM during a follow-up round of facility observations the following facility environmental issues were identified: K. Room 118- the front cover on the wall unit air conditioner was not secure to unit and hanging off on right side of the unit. Plastic vent on air conditioner cover was also broken. L. Room 208- the front cover on the wall unit air conditioner was not secure to unit, and plastic vent on front cover was broken. M. Room 214- the front cover on the wall unit air conditioner was not secure to unit. N. Room 226- 1- 1.5 inch gap around wall unit air conditioner in which there was no insulation. Light could be seen from outside the facility as well as air entering and exiting around unit. O. Room 229- wall unit air conditioner had silver duct tape around outer edge of unit to secure cover to unit. On 09/12/14 at 1:10 PM a tour of the facility was conducted with the Maintenance Director and the facility Administrator. The following facility issues were identified: P. Room 118- the front cover on the wall unit air conditioner was not secure to unit and hanging off on right side of the unit. Plastic vent on air	F 253	Room #229 a/c wall unit has been repaired and the cover is secure on the unit. Staff educated by the DON between 9/18 and 9/25,2014 on the reporting of front covers, gaps, or units needing repairs using the maintenance request form and putting a copy in the Maintenance box and the Administrator's box. Facility units are audited 2 times per week for 12 weeks by the Maintenance Director to ensure covers are secure, no gaps are around the unit and no duct tape or other materials are used to secure a unit that would not be appropriate. The maintenance director will report results of the audit during morning meeting with department managers 2 times per week for 12 weeks. The maintenance director is responsible for reporting results of the audits to the QAPI committee on a monthly basis for a period of 3 months.	

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F 253	Continued From page 4 conditioner cover was also broken. Q. Room 208- the front cover on the wall unit air conditioner was not secure to unit, and plastic vent on front cover was broken. R. Room 214- the front cover on the wall unit air conditioner was not secure to unit. S. Room 226- 1- 1.5 inch gap around wall unit air conditioner in which there was no insulation. Light could be seen from outside the facility as well as air entering and exiting around unit. T. Room 229- wall unit air conditioner had silver duct tape around outer edge of unit to secure cover to unit Issues with the wall unit air conditioners were acknowledged by the Maintenance Director and the Administrator. The Maintenance Director revealed the front cover of the air conditioners were held on by clips and could easily be dislodged or knocked off the units by a resident in a wheelchair or moving a bed, potentially causing a hazard for the residents. When the front cover became dislodged the inside of the air conditioner was exposed. He also acknowledged the lack of insulation could allow insects to enter the facility. The Maintenance Director stated there were work orders on each unit and anytime an issue was identified by staff, they could fill out a work order and send it to the maintenance department. He further revealed he had no work orders concerning the air conditioners. He also stated he performed a monthly audit of all rooms and had checked air conditioners on 08/31/14, but these issues were not identified. On 09/12/14 at 2:55 PM an interview was conducted with the facility Administrator. He stated he expected the Maintenance Director to fix issues with the air conditioner units as they were found. The Administrator acknowledged the	F 253		

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F 253	Continued From page 5 unsecured front covers of the air conditioners could pose a hazard to residents. He revealed if they were knocked loose and came off of the units, it could expose the workings of the air conditioner; as well as pose a fall or injury risk.	F 253		
F 312 SS=E	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, record review, staff and resident interviews, the facility failed to provide assistance with eating and care of fingernails for 3 of 5 sampled residents dependent on staff for activities of daily living (Residents #4, #104, and #101). The findings included: 1. Resident #4 was admitted to the facility on 09/23/08 with diagnoses which included epilepsy and altered mental status with intellect disability. The quarterly Minimum Data Set (MDS) dated 08/11/14 indicated Resident #4 was severely impaired in cognition for daily decision making and was totally dependent on staff for activities of daily living (ADLs). The MDS further revealed Resident #4 had impaired range of motion of her head and neck, left arm, and both legs. The MDS noted rejection of care was not exhibited	F 312	The facility will ensure that residents are able to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Resident #4 is receiving the necessary assistance to ensure the resident maintains good nutrition, grooming, personal and oral hygiene including assistance with meals. Resident #101 nails have been thoroughly cleaned the C.N.A. and included under the nail, filed and any chipped polish has been removed. Resident #104 nails have been thoroughly cleaned by the C.N.A. and included under the nails and filed.	10/8/14

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F 312 Continued From page 6

and she had a poor appetite "every day."

A review of Resident #4's medical record indicated a speech therapy (ST) assessment dated 12/20/13 indicated Resident #4 had weight loss secondary to a decline in her cognition and communication skills. The clinical summary of the speech therapy (ST) evaluation indicated Resident #4 required total assistance with eating consisting of small bites. Further review of a speech therapy assessment dated 07/18/14 indicated Resident #4 was capable to drink her fluids using a straw and required total assistance with eating.

A review of a care plan with a revised date of 09/03/14 indicated a problem statement that Resident #4 required assistance with ADLs and listed approaches in part for a mechanical soft diet, encouragement of small bites, preferred to be fed in her room, and required assistance with eating, and all other ADLs. The care plan noted Resident #4 had a communication deficit, speech was unclear and grabbled, and staff would anticipate her needs.

The Assistant Director of Nursing (ADON) was observed on 09/07/14 at 12:51 PM to set Resident #4 up in her bed, set up her lunch tray, and leave the room. Resident #4 was observed to drink her carton of milk using a straw with no spillage.

Nursing Assistant (NA) #1 was observed on 09/07/14 at 1:01 PM to go into Resident #4's room and ask her "are you going to eat?" and with no response from the resident NA #1 removed the lunch tray from the resident's room with no attempts to feed her. The food on

F 312

Facility nursing staff was re-educated on the shower sheets, cleaning of nails on top and underneath, removal of any chipped nail polish. The re-education was conducted by the DON from September 18, 2015 to September 25, 2014.

The shower sheets have a statement added to them regarding the checking of nails on shower days. The charge nurse reviews them on assigned shower days and communicates on any concerns to the DON via the shower sheet.

The Resident Champion program requires that the person assigned to the resident check nails during each interview to identify any dirt/debris under the nail, unfiled edges and chipped polish.

The Administrator reviews the Resident Champion observations on a weekly basis and reports the findings to department managers during the morning stand up meeting.

The Dining Room Manager audit requires that resident nails are checked at each meal in the main dining room. The results of the audit are indicated on the Dining Room Manager audit tool.

The Administrator reviews the Dining Room audit for each meal and formally reports findings of the audit to the department managers at morning meeting.

The Administrator will formally report

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F 312	Continued From page 7 Resident #4's lunch tray was observed to be un-touched. The ADON was observed on 09/0814 at 5:23 PM to set up Resident #4's supper meal tray, placed a straw in the glass of tea, and leave the room. Resident #4 was observed to drink her glass of tea with no attempts to feed herself. At 5:42 PM, NA #6 was observed to ask Resident #4 "are you not going to eat?" and with no response from the resident, NA #6 removed the meal tray from Resident #4's room. NA #6 was interviewed on 09/08/14 at 5:45 PM, she stated Resident #4 would attempt to feed herself occasionally and that she would always drink her milk. She further stated she was unaware Resident #4 needed assistance with eating. NA #1 was observed on 09/11/14 at 8:12 AM to set Resident #4 up in her bed, set up her breakfast tray, and leave the room. Further observations revealed Resident #4 did not attempt to feed herself, drank 100% of her milk with no spillage, and consumed 0% of her breakfast meal. Continued observations revealed NA #6 go into Resident #4's room at 8:47 AM and stated to the resident "you didn't eat anything today!" and no response from the resident NA #6, with no attempts to feed the resident, removed Resident #4's breakfast tray from her room. NA #1 was interviewed on 09/11/14 at 8:47 AM, she stated she would set up Resident #4's meal tray and deliver the other meal trays to the resident rooms. She indicated Resident #4 would always drink her milk but rarely would she eat her food. She further stated she was unaware	F 312	monthly to the QAPI committee results of the audits for 3 months.	

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F 312	Continued From page 8 Resident #4 needed assistance with eating. The Speech Therapist (ST) was interviewed on 09/12/14 at 8:25 AM, she indicated she had completed Resident #4's assessment on 07/18/14 and Resident #4 required assistance with eating but that assessment was completed by a ST that was no longer employed with the facility. The ADON was interviewed on 09/12/14 at 3:31 PM. She stated she expected the NAs to assist Resident #4 with eating and with all of her ADLs. The ADON stated "she will feed herself some of the time but usually she will only drink her milk." The Director of Nursing (DON) was interviewed on 09/12/14 at 5:05 PM. She stated she would have expected the NAs to assist Resident #4 with all of her meals. 2. Resident # 104 was admitted to the facility on 06/10/13 with diagnoses which included dementia, debility, and generalized muscle weakness. The most recent annual Minimum Data Set (MDS) dated 06/13/14 revealed the resident was severely impaired for making decisions of daily living and required one person assistance with all activities of daily living (ADL) including assistance for personal hygiene and total assistance with bathing. The current care plan last reviewed 06/24/14 revealed Resident #104 required assistance with ADL due to diagnosis of dementia and debility. The ADL care plan goal was for the Resident to experience cleanliness and comfort each day. The ADL care plan included approaches to assist	F 312		

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F 312	Continued From page 9 Resident #104 daily with grooming, provide showers as scheduled on shower days, and assist resident with AM/PM care and record completion at least every morning and evening. A review of the facility shower schedule indicated Resident #104 was scheduled for showers on Wednesday and Saturday on the 2nd shift between 3 PM to 11 PM. A review of Resident #104's Nursing Assistant (NA) care information sheet specified she was dependent on staff for showers and grooming. A review of documentation for bath and hygiene daily report revealed Resident #104 received her shower on Saturday 09/06/14 at 8:42 PM and Wednesday 09/10/14 at 4:00 PM. During an observation on 09/07/14 at 4:45 PM Resident #104 was resting in bed. Resident #104's finger nails were observed to have uneven edges, and a brown substance under all the nails of both hands. During an observation on 09/08/14 at 8:45 AM Resident #104 was sitting in her wheel chair in her room. Resident #104's finger nails were observed to remain unchanged with uneven edges, and a brown substance under all the nails of both hands. During an observation on 09/08/14 at 2:57 PM Resident #104 was resting in bed. Resident #104's finger nails were observed to remain unchanged with uneven edges, and a brown substance under all the nails of both hands. During an observation on 09/10/14 at 12:15 PM	F 312		

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F 312	Continued From page 10 Resident #104 was observed sitting up in bed eating fried chicken legs with her fingers. Resident #104's finger nails were observed to remain unchanged with uneven edges, and a brown substance under all the nails of both hands. An interview was conducted on 09/10/14 at 4:44 PM with NA # 8. NA #8 stated Resident #104 required extensive assistance with ADL care. NA #1 explained that nail care was normally provided for residents during their showers or as needed. NA #8 further explained she provided Resident #104's shower, washed and braided her hair but did not provide her nail care. NA #8 verified Resident #104's nails needed cleaning. An interview was conducted on 09/10/14 at 5:01 PM with Nurse #5. Nurse #5 observed Resident #104's nails and confirmed her nails were not clean and trimmed. Nurse #5 stated she expected the NA's to provide nail care on the residents shower days or as needed. An interview was conducted on 09/10/14 at 5:06 PM with the Assistant Director of Nursing (ADON). The ADON observed Resident #104's nails and confirmed her nails were not clean and trimmed. The ADON stated she expected the NA's to provide nail care on the residents shower days or as needed. An interview was conducted on 09/11/14 at 4:08 PM with the Director of Nursing (DON). The DON stated it was her expectation that nail care was done with showers and more frequently between showers if they were dirty. The DON stated that the NA's are responsible for nail care.	F 312		

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3. Resident #101 was admitted to the facility on 04/14/14 with diagnoses which included dementia, altered mental status, generalized muscle weakness and peripheral neuropathy (nerve damage that can cause numbness and pain in hands and feet). The most recent quarterly Minimum Data Set (MDS) dated 07/21/14 revealed the resident was severely impaired for making decisions of daily living and required one person assistance with all activities of daily living (ADL) including assistance for personal hygiene and total assistance with bathing.

The current care plan last reviewed 07/10/14 revealed Resident #101 required assistance with ADL due to diagnosis of dementia and debility. The ADL care plan goal was for the Resident to experience cleanliness and comfort each day. The ADL care plan included approaches to assist Resident #101 daily with grooming, provide showers as scheduled on shower days, and assist resident with AM/PM care and record completion at least every morning and evening.

A review of the facility shower schedule indicated Resident #101 was scheduled for showers on Wednesday and Saturday on the 1st shift between 7 AM to 3 PM.

A review of Resident #101's Nursing Assistant (NA) care information sheet specified she was dependent on staff for showers and grooming.

A review of documentation for bath and hygiene daily report revealed Resident #101 received her shower on Saturday 09/06/14 at 1:27 AM and Wednesday 09/10/14 at 12:49 PM.

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F 312	Continued From page 12 During an observation on 09/08/14 at 8:45 AM Resident #101 was sitting up in bed eating breakfast. Resident #101's finger nails were observed with chipped polish, uneven edges and a brown substance under all ten nails During an observation on 09/08/14 at 2:57 PM Resident #101 was in her wheel chair watching TV. Resident #101's finger nails were observed with chipped polish, uneven edges and a brown substance under all ten nails During an observation on 09/09/14 at 4:22 PM Resident #101's finger nails remained with chipped polish, uneven edges and a brown substance under all ten nails. During an observation on 09/10/14 at 9:42 AM Resident #101 was sitting up in bed with a blanket on lap watching TV. Resident #101's finger nails remained with chipped polish, uneven edges and a brown substance under all ten nails. During an observation on 09/10/14 at 12:15 PM Resident #101 was observed sitting up in her wheel chair eating fried chicken legs with her fingers. Resident #101's finger nails were observed to remain unchanged with chipped polish, uneven edges, and a brown substance under all the nails of both hands. An interview was conducted on 09/10/14 at 4:44 PM with NA # 8. NA #8 stated Resident #101 required extensive assistance with ADL care. NA #8 explained that nail care was normally provided for residents during their showers or as needed. NA #8 further explained she provided Resident #101's shower, washed and braided her hair but did not have time to provide her nail care. NA #8	F 312		

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F 312	Continued From page 13 verified Resident #101's nails needed cleaning. An interview was conducted on 09/10/14 at 5:01 PM with Nurse #5. Nurse #5 observed Resident #101's nails and confirmed her nails were not clean and trimmed. Nurse #5 stated she expected the NA's to provide nail care on the residents shower days or as needed. An interview was conducted on 09/10/14 at 5:06 PM with the Assistant Director of Nursing (ADON). The ADON observed Resident #101's nails and confirmed her nails were not clean and trimmed. The ADON stated she expected the NA's to provide nail care on the residents shower days or as needed. An interview was conducted on 09/11/14 at 4:08 PM with the Director of Nursing (DON). The DON stated it was her expectation that nail care was done with showers and more frequently between showers if they were dirty. The DON stated that the NA's are responsible for nail care.	F 312		
F 315 SS=D	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.	F 315		10/8/14

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F 315	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to empty urinary catheter collection bag for 1 of 2 sampled residents reviewed for care to maintain urinary catheter (Resident #33). The findings included: Resident # 33 was admitted to the facility on 04/22/07 with diagnoses which included chronic pain, calculus of the kidney, debility, chronic kidney disease, pyelonephritis (inflammation of the kidneys due to bacteria entering the bladder), history of urinary tract infections, and pressure ulcers. The most recent quarterly Minimum Data Set (MDS) dated 08/01/14 revealed Resident #33 was cognitively intact for making decisions of daily living and required extensive assistance with all activities of daily living (ADL) including assistance for care of the urinary catheter. The MDS indicated Resident #33 had a urinary catheter required due to high risk for infections of stage 4 pressure ulcer of the buttocks. A review of the current care plan dated 07/30/14 identified the problem for use of an indwelling urinary catheter. The goal was for Resident #33 to experience no infections from the use of catheters. The approaches included provide catheter care every shift every day which included emptying the collection bag. An interview was conducted on 09/08/14 at 9:05 AM with Resident #33. Resident #33 stated this was one of her complaints that her catheter bag was not emptied as needed. She further explained that a number of times it wasn't	F 315	The facility will ensure that residents that did not enter the facility without an indwelling catheter will not receive a catheter unless the residents clinical condition demonstrates that catheterization is 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. Resident #33 is having their catheter bag emptied 2 times per shift, and PRN and recorded on the flow sheet that is kept on the MAR. Staff was re-educated on the expectations for catheters bags to be emptied as needed by the DON between 9/18/2014 and 9/25/2014. The DON, ADON and Charge nurse will monitor compliance of urinary catheter bag emptying through rounds, AHT charting and review of the MAR flowsheet 5x per week for 12 weeks. The DON will report the results of the audits on a daily basis at the morning clinical meeting and if necessary interventions discussed and implemented as appropriate. The DON will report monthly for 3 months to the QA committee the results of the audit.	

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Continued From page 15
emptied and the urine in the bag filled to budging.

On 09/10/14 at 9:52 AM Resident #33's catheter bag was observed filled to the line indicating 2000 cc's urine in it.

On 09/10/14 at 2:04 PM Resident #33's catheter bag and the tubing were observed completely full of urine.

On 09/10/14 at 2:04 PM an interview was conducted with NA #3. NA #3 explained she had checked the urinary collection bag this morning at the beginning of her shift and it was not full then but emptied some urine out of it. NA #3 further explained that it is the NA's responsibility to provide urinary catheter care each shift and as needed which includes emptying the urinary catheter bags. NA #3 stated she should have checked the collection bag more frequently and emptied it. NA #3 confirmed she had not checked the collection bag since this morning and verified the urinary catheter bag was completely full.

On 09/10/14 at 2:04 PM an interview was conducted with Nurse #5. Nurse #5 stated the NA's are responsible for checking the urinary collection bags throughout the day and emptying the catheter bags every shift and more frequently as needed. Nurse #5 explained that the risk for urinary infections increases when the catheter bag becomes too full and urine backs up in the tubing into the bladder. Nurse #5 verified the urinary catheter bag was completely full.

On 09/10/14 at 2:04 PM an interview was conducted with The Assistant Director of Nursing (ADON). The ADON stated the NA's are

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F 315	Continued From page 16 responsible for checking the urinary collection bags throughout the day and emptying the catheter bags every shift and more frequently as needed. The ADON explained that the risk for urinary infections increases when the catheter bag becomes too full and urine backs up in the tubing to the bladder. The ADON verified the urinary catheter bag was completely full. On 09/11/14 at 4:08 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the NA's empty urinary catheter collection bags every shift and as needed to prevent filling up and backing up into the tubing. The DON explained that the risk for urinary infections increases when the catheter bag becomes too full and urine backs up in the tubing to the bladder. The DON verified the urinary catheter bag was completely full.	F 315		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328		10/8/14

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F 328	Continued From page 17 Based on observations, record review, staff, and physician interviews, the facility failed to follow a physician's order to flush a peripherally inserted central catheter (PICC) line within 30 minutes after the infusion of an antibiotic, and failed to provide podiatry services for 2 of 2 residents reviewed for special needs (Residents #33 and #88). The findings included: 1. Resident #33 was re-admitted to the facility on 07/19/13 with diagnoses which included diabetes mellitus type II, pressure sores, kidney disease, and chronic pain. Review of the quarterly Minimum Data Set (MDS) dated 08/01/14 indicated Resident #33 was cognitively intact and capable of making her needs known. The MDS revealed Resident #33 required extensive assistance with most activities of daily living (ADLs) including bed mobility, dressing, toileting, bathing, and personal hygiene. A review of a care plan dated 08/08/14 indicated Resident #33 was to receive IV (the infusion of liquid substances directly into a vein; intravenous) medications with listed approaches in part to monitor the IV site every shift, administer the medications as ordered, change the IV tubing per protocol, and flush the PICC line per the protocol. A review of Resident #33's medical record indicated she had a PICC line inserted on 08/04/14 for administration of an antibiotic (Vancomycin) due to a wound infection. A review of a physician's order dated 08/05/14 indicated the following:	F 328	The facility is ensuring that residents requiring special services such as injections, parenteral. enteral fluids, colostomy,. ureterostomy, ileostomy, trach, suctioning, respiratory, foot care and prostheses are receiving the proper treatment. Resident #33 PICC line medications are being administered per physician orders. The order for the PICC flushes for resident #33 were clarified by the DON on 9/11/2014. Resident #88 has received podiatry care on September 16, 2014. Nurses providing medications and/or flushes through a PICC line were re-educated from 9/24/2014 to 9/25/2014 on the insertion, care and use of PICC lines. The re-education was conducted by PiccFusion. They are a contracted education service provided through Mobile X. Nursing staff were re-educated from 9/12/2014 to 9/16/2014 by the DON and ADON on the expectations of when providing showers they need to assess the toe and finger nails of each resident. The shower sheets have an area to note that toe and finger nails must be noted on the shower sheet and the charge nurse is to review the shower sheet that day. A directed in-service was provided on 10/2/2014 by The Carolinas Center for Medical Excellence (CCME) which	

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F 328	Continued From page 18 a) Vancomycin 1000 milligrams (mg) IV (PICC line) every 12 hours for 6 weeks. b) Flush PICC line using the SASH method (Sterile saline, Antibiotic, Sterile saline, and Heparin (anticoagulant; blood thinner), 5 milliliters (ml) sterile saline before giving antibiotic (ABT), flush with 5 ml sterile saline after ABT has infused and 5 ml of heparin with each antibiotic. On 09/10/14 at 8:14 AM Resident #33 was observed laying in her bed with her gown sleeve pulled up, with the upper portion of her arm and chest exposed, and a clear dressing noted over the insertion site of her PICC line with two ports; one port red in color for use of blood draws as needed for lab work and the other port purple in color to be used for the administration of IV fluids and/or medications. On 09/10/14 at 11:30 AM the Assistant Director of Nursing (ADON) was observed to flush 2.5 ml of heparin through the red colored port of the PICC line and 2.5 ml of heparin through the purple colored port, flush 10 ml of sterile saline through each red and purple port, hang the antibiotic, Vancomycin and connect the ABT tubing to the purple colored port of the PICC line for infusion. On 09/10/14 at 4:43 PM Resident #33 was observed laying in her bed asleep. Her family member was at her bedside and stated "the antibiotic has just finished." On 09/10/14 at 6:14 PM the ADON was observed to disconnect the ABT tubing from the port of the PICC line, flush both ports with 5 ml of sterile saline, and then she flushed both ports with 2.5 ml of heparin.	F 328	addressed the assessment of nail care on shower days and PRN with supporting documentation,reporting appropriately and timely to the charge nurse. The DON,ADON,QA,Education,and Nurse Supervisor will monitor each resident by weekly x 12 weeks to ensure that nail care has been provided. Results of the audit will be reported in the morning clinical meeting with interventions discussed and impletmented. The DON will report to the QAPI committee on a monthly basis for 3 months the results of the audit.	

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A telephone interview was conducted with a pharmacist on 09/12/14 at 1:32 PM. He stated he would have expected the nurse to disconnect the antibiotic tubing from the PICC line immediately or within 30 minutes after the antibiotic had completely infused and flushed the PICC line with sterile saline and then flushed with heparin to maintain the patency of the PICC line.

A telephone interview was conducted with the physician on 09/12/14 at 2:18 PM. He stated he would have expected the nurse to have disconnected the tubing from the PICC line immediately after the antibiotic had completely infused. He further stated he would have expected the PICC line to be flushed immediately after the antibiotic had infused with sterile saline and then flushed with 5 ml of heparin last to maintain the PICC line.

An interview was conducted with the ADON on 09/12/14 at 3:31 PM. She verified she was supposed to flush each port of the PICC line with 5 ml of sterile saline prior to hanging the antibiotic and after the ABT was completely infused she was supposed to flush each port again with 5 ml of sterile saline and then flush with 5ml of heparin through each port to maintain the patency of the PICC line. She stated she was not thinking clearly about what she was supposed to be doing and she had not reviewed the physician's order prior to hanging the ABT. She further stated she had forgotten the ABT was infusing.

An interview was conducted with the Director of Nursing (DON) on 09/12/14 at 5:05 PM. The DON stated her expectation would have been for the ADON to have disconnected the antibiotic tubing from the PICC line port immediately after

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F 328	Continued From page 20 the medication had completely infused to maintain the patency of the PICC line. 2. Resident #88 was admitted to the facility on 10/10/13 with diagnoses that included dementia, heart disease, and diabetes. Review of the quarterly Minimum Data Set (MDS) dated 07/14/14 indicated resident had moderate cognitive impairment. The MDS revealed Resident #88 required extensive assistance with most activities of daily living (ADL's) including personal hygiene, bathing, and toilet use. Review of Resident #88's care plan updated as recently as August of 2014, indicated he required staff assistance for personal hygiene and bathing among other problem areas. Responsibility for this task was assigned to Nursing Assistants (NA's). Review of Resident #88's medical record indicated he needed a podiatry consult and the consult was ordered on 02/12/14. Further review of the medical record revealed the podiatry consult was not completed. On 09/07/14 at 9:03 AM an observation was made of Resident #88. He was bare footed and revealed to have long, thick, yellowed toenails, one-half inch past the end of each toe. Sharp edges from the nails on the third and fourth toes of his right foot were observed to be curled into the end of his toes. On 09/10/14 at 9:20 AM Resident #88 was observed sitting on the side of his bed in a sleep gown. Toenails on both feet were visible and remained long and curled. Resident #88 was asked if the toenails caused him any pain and he stated he did not have much feeling in his feet.	F 328		

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On 09/11/14 at 9:20 AM Resident #88 was observed sitting in his wheelchair. His family member was also in the room. He was asked to remove the socks from his feet. Resident #88 removed the sock from his right foot. Toenails remain long and curled into tips of toes. He again denied pain, but re-stated he did not have much feeling in his feet.

On 09/11/14 at 2:45 PM an interview was conducted with Nurse #2. She acknowledged by looking at the medical record that a podiatry consult had been ordered for Resident #88, but had not been completed. She stated she was going to contact the MDS nurse.

On 09/11/14 at 2:55 PM an interview was conducted with the MDS nurse. She revealed she did not know why the podiatry consult had not been completed, but she would contact the Social Worker, who scheduled appointments.

On 09/11/14 at 3:00 PM an interview was conducted with NA #3. She stated Resident #88 was compliant with all personal care he required, including personal hygiene. She indicated when she usually saw him in the morning he had his socks on and she had not observed any issues with his feet, even when assisting with his care. NA #3 stated she saw his toenails this morning. She stated he complained of his toes being sore, and she was going to report to the nurse that Resident #88 needed to have his toenails trimmed.

On 09/11/14 at 3:05 PM an interview was conducted with Nurse #2. She stated it was her expectation that the NA's caring for a resident

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F 328	Continued From page 22 reported any issues they observed, including need for nail care. Nurse #2 revealed she had not been informed of any issues with Resident #88's toenails. On 09/11/14 at 3:10 PM an interview was conducted with the MDS nurse. She acknowledged Resident #88 missed the podiatry appointment on 02/12/14 when he was out of the facility at the hospital. She stated the podiatry appointment had not been rescheduled. On 09/11/14 at 3:15 PM an interview was conducted with NA #4. She stated she worked with Resident #88, but had never given him a shower. She stated she had only given him a bed bath and he always kept on his socks. NA #4 indicated she did not recall seeing his feet and was not aware of an issue with his nails. On 09/11/14 at 3:25 PM an interview was conducted with Nurse #2. She indicated that both NA's #3 and #4 gave showers and stated there is a shower sheet the NA's fill out to report any issues, including the need for nail care a resident may have. Nurse #2 stated she had not seen any reports that suggested Resident #88 had an issue with toenails. Review of the shower sheets for the past two months revealed no issue was documented concerning Resident #88's toenails. On 09/11/14 at 4:15 PM an interview was conducted with the Social Worker. She stated she did not know why Resident #88 was not rescheduled to see the podiatrist. She indicated she knew Resident #88 had been out of the facility to the hospital, but acknowledged she did	F 328		

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F 328	Continued From page 23 not know why he had not seen the podiatrist. On 09/12/14 at 8:20 AM an interview was conducted with Nurse #3. He stated he had not had any reports from the NA's that Resident #88 needed nail care. Nurse #3 stated if he had known Resident #88 needed nail care, he would have gotten a podiatrist consult immediately. On 09/12/14 at 3:30 PM an interview was conducted the Director of Nursing (DON). She stated it was her expectation that NA's document any issues with residents' feet on the shower sheets as well as notifying the nurse of any issues they observed. The DON revealed she had reviewed the shower sheets of Resident #88, and there was no documentation he needed nail care. She acknowledged Resident #88 needed to have been rescheduled to see the podiatrist.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility exceeded 5 % medication error rate as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9 %, for 2 of 3 residents observed during medication pass (Residents #33 and #52). The findings included:	F 332	The facility will ensure that medication error rates do not exceed 5%. Resident #33 is receiving their medications as prescribed by the physician. Resident #52 is receiving their medications as prescribed by the	10/8/14

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	345174	A. BUILDING ______ B. WING ______	C 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE NURSING & REHABILITATION CENTER	**91 VICTORIA ROAD ASHEVILLE, NC 28801**

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F 332	Continued From page 24 1. Resident #33 was re-admitted to the facility on 07/19/13 with diagnoses which included multiple sclerosis, diabetes mellitus type II, and pressure sores. Review of the quarterly Minimum Data Set (MDS) dated 08/01/14 indicated Resident #33 was cognitively intact and capable of making her needs known. On 09/10/14 at 11:30 AM, the Assistant Director of Nursing (ADON) was observed to administer medications to Resident #33 by intravenous infusion (IV) through the port of a peripherally inserted central catheter (PICC line). Using a needleless syringe, she flushed 2.5 milliliters (ml) of heparin (a blood thinner medication) into the port, just prior to the infusion of an antibiotic. A review of the resident's clinical record revealed a physician order dated 08/05/14 to flush 5 ml of heparin into the PICC line port after the infusion of the antibiotic. A review of the Medication Administration Records (MAR) for Resident #33 dated for the months of August, 2014 and September, 2014 revealed the order had been correctly transcribed to flush heparin 5 ml via IV PICC line after the infusion of the antibiotic. On 09/12/14 at 3:31 PM the ADON was interviewed. She stated she mistakenly flushed/administered the heparin before the antibiotic was started by IV PICC line instead of flushing the IV PICC line after the antibiotic was completely infused. She further stated she was unaware she had infused the wrong amount of heparin into the port of the IV PICC line because she had not reviewed the physician's orders.	F 332	physician. Nursing staff were re-educated on the administering of medications by the DON from 9/18/2014 to 9/25/2014. Med Passes are being conducted on a monthly basis for 3 months by the Pharmacist, Regional QA nurse,ADON,and Evening/Weekend Supervisor to ensure compliance and medication error rate does not exceed 5%. Results of the audits are discussed by the DON at the morning clinical meeting 1 time per month and PRN. The QA nurse will report results of the audits on a monthly basis x 3 months to the QAPI committee.	

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F 332	Continued From page 25 On 09/12/14 at 5:05 PM the Director of Nursing (DON) was interviewed. The DON confirmed that the ADON had not administered the heparin flush to Resident #33 as was prescribed by the physician. 2. Resident #52 was re-admitted to the facility on 05/07/14 with diagnoses which included acute respiratory failure, obstructive chronic bronchitis, and heart disease. Review of the quarterly Minimum Data Set (MDS) dated 07/09/14 indicated Resident #52 was cognitively intact and capable of making his needs known. On 09/11/14 at 4:57 PM Nurse #11 was observed to administer Advair Diskus Inhaler one puff by mouth to Resident #52. A review of the resident's clinical record revealed physician orders dated 05/09/14 for Advair Diskus Inhaler one puff by mouth twice daily, rinse mouth after use. A review of the Medication Administration Records (MAR) for Resident #52 dated for the months of August, 2014 and September, 2014 revealed Advair Diskus Inhaler one puff by mouth twice daily, rinse mouth after use and the order was correctly transcribed according to the physician's order. On 09/11/14 at 5:40 PM Resident #52 was interviewed. He stated some of the nurses always bring him an extra cup of water and remind him to rinse his mouth after he had used the Advair Diskus Inhaler. He further stated there were times when he was not reminded and he had not rinsed his mouth after he used the Advair Diskus Inhaler.	F 332		

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F 332	Continued From page 26 On 09/11/14 at 5:42 PM Nurse #11 was interviewed. He stated he forgot to ask Resident #52 to rinse his mouth after he had administered the Advair Diskus Inhaler. On 09/12/14 at 5:05 PM the Director of Nursing (DON) was interviewed. She stated she expected the nurses to follow the physician's orders and she would have expected Nurse #6 to have had Resident #52 rinse his mouth after he administered the Advair Diskus Inhaler.	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility kitchen staff failed to wash hands and change dirty gloves prior to handling food during 1 of 1 food preparation and service observations. The findings included: Observations were made on 09/11/14 at 12:20 PM of the facility food service line preparing and serving resident meals. Dietary Aide #1 (DA #1)	F 371	Facility dietary staff will store, prepare, distribute and serve food under sanitary conditions. Dietary staff #1 was re-educated on the proper use of gloves and handwashing by food service director on 9/11/2014. Dietary staff has been re-educated by the food service director on 9/11/2014 on	10/8/14

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F 371	Continued From page 27 was observed plating food on the service line and passing the plates to dietary staff to be placed on trays. DA #1 was observed wearing gloves. During the food service process, DA #1 was observed as he walked away from the food service line and to the walk-in cooler. He was observed as he opened the cooler door with gloved hand, walked into cooler, removed two slices of bread, exited cooler and closed door with gloved hand, placed bread in a wax paper wrapper he retrieved from a box, walked back to food service line and handed the wrapped bread to a dietary worker to place on a resident's tray. DA #1 returned to plating food for residents without washing hands or changing gloves. On 09/11/14 at 12:30 PM an interview was conducted with the Dietary Manager (DM). He was informed that DA #1 had left the service line, entered and exited walk-in cooler, and returned to food service line without washing hands and changing gloves. The DM immediately stopped the food service line and instructed DA #1 to wash hands and change gloves. On 09/11/14 at 12:35 PM an interview was conducted with DA #1. He acknowledged he had walked away from the service line and touched unclean areas of the kitchen and returned to service line without washing hands and changing gloves. On 09/11/14 at 12:37 PM an interview was conducted with the DM. He indicated it was his expectation that dietary staff always washed their hands and changed gloves when moving between tasks, and especially when handling food to prevent cross-contamination. He acknowledged he would have expected DA #1 to	F 371	proper serving, storing, and preparing food under sanitary conditions which included the proper use of gloves and handwashing. Dietary Manager will audit kitchen sanitation 3 times per week for a period of 3 months then monthly for 3 months. Results of the audit will be discussed at morning meeting with department managers. Dietary Manager is responsible for reporting results of audits to the QAPI meeting monthly for 3 months.	

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F 371	Continued From page 28 have washed his hands and changed his gloves before he returned to the service line after he stepped away and entered the cooler.	F 371		