DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 10/19/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to change the dressings on three pressure ulcers as ordered by the physician for one (1) of three (3) residents (Resident #10). The findings are: Resident #10 was admitted to the facility with diagnoses of cerebrovascular accident, debility, and pressure ulcer. The latest Minimum Data Set (MDS), dated 09/10/11, revealed the resident had severe cognitive impairment and required extensive to total assistance with activities of daily living. The MDS also revealed the resident had one stage 3 and three stage 2 pressure ulcers on his buttocks and coccyx. The MDS further revealed the resident had an indwelling urinary catheter and was frequently incontinent of stool. A review of the plan of care for Resident #10, dated 09/22/11, revealed that prevention and treatment of pressure ulcers was a problem with	F 314	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **How the corrective action will be accomplished for the resident(s) affected.** Resident #10 had the prescribed dressing applied immediately and appropriately documented on the Treatment Record.	10/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/3/11

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 314	Continued From page 1 interventions that included keeping the skin clean and dry and treating the ulcers according to the latest physician orders. A review of the medical record of Resident #10 revealed that the most recent physician order for pressure ulcer dressing changes was dated 09/20/11. The order instructed the nurse to clean the area, to apply a protective skin wipe to the surrounding excoriated areas, and to pack the stage 3 wound with silver alginate. The order also instructed the nurse to cover the stage 2 wounds with a hydrocolloid dressing, and to cover the stage 3 wound with a transparent dressing. The physician ordered that the dressing be changed every three days and as necessary until healed. On 10/19/11 at 3:45 PM, the Wound Care Nurse (WCN) was observed during the third day dressing change for Resident #10. The resident was in his bed at the time. When the WCN removed the resident's incontinence brief, there was no dressing on any of the wounds. The WCN measured the wounds and applied dressings according to the physician orders. The WCN stated at that time that she was concerned that the dressings were missing and she had not been informed. She stated that if the dressings had come off or had been removed by nursing staff because they were compromised by stool, she would expect to be notified so she could redress the wounds. She stated the wounds were smaller than previous measurements and healing well. She stated she saw no change to the wounds that might indicate they had worsened due to a lack of dressing.	F 314	~~How corrective action will be~~ **accomplished for those residents with the potential to be affected by the same practice.** All residents in the facility with pressure ulcers/wounds have the potential to be affected by a missing dressing. 1. In-service training for CNA staff on when to report problem with a dressing a. Soiled b. Loose c. Off 2. In-service training for licensed nursing staff on action/reaction to above a. Immediately replace the dressing according to MD order b. Notify Wound Nurse via Wound Care Communication Notebook to allow follow-up if needed. In-service will be done by 11/10/11. Interdisciplinary Wound Care Rounds done weekly.	11/10/11

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F 314	Continued From page 2 On 10/19/11 at 4:27 PM, Licensed Nurse (LN) #1 was interviewed. She stated she had been told by Nursing Assistant (NA) #1 at 1:00 PM that the resident's dressings were off, but she stated that NA #1 did not give a reason why. LN #1 stated she informed the Unit Manager and the WCN. On 10/19/11 at 4:32 PM, NA #1 was interviewed. She stated she had cared for Resident #10 that day. She stated that the resident had an indwelling urinary catheter, but was incontinent of stool. She stated she checked his incontinence brief at 7:45 AM while he was in a standing position and he was continent, but in that position she could not see if the wound dressings were in place. She stated the resident then went to therapy until 11:00 AM. When she checked the resident's brief at 11:45 AM, he was again standing and continent. At 1:15 PM, NA #1 put the resident to bed and checked his brief again. She stated he had a small amount of stool and she saw no dressings on the wounds. She stated the dressings were also not lying loose in the brief. She reported that the dressings were missing to Nurse #1. On 10/19/11 at 4:51 PM, NA #2 was interviewed. She stated she had cared for Resident #10 on the PM shift the previous evening, 10/18/11. NA #2 stated that when she did incontinence care for the resident around 8:00 PM the previous night, she noticed that the dressings were loose and soiled with stool. She stated she informed LN # 2. On 10/19/11 at 4:55 PM, LN #2 was interviewed. She stated that on the PM shift the previous evening, NA #2 had informed her that the	F 314	**Measures in place to ensure practices will not occur.** Random audits of 10 dressings a month for placement, date, initial, documentation for three months by DON, or designee. Start November, 2011. **How the facility plans to monitor and ensure correction is achieved and sustained.** Audit results to QA committee monthly for 3 months to ensure compliance and revise POC as needed.	

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F 314	Continued From page 3 dressings were loose and soiled with stool. She stated she did not change them at that time. LN #2 stated that around 10:00 PM, NA #2 and another NA informed her that they had found the dressings off the wounds during their last incontinence round. She stated she went to look at the wounds and did not see anything "open or draining." She stated she told the NAs to apply a barrier cream to the wounds for protection and she would change the dressings later. She stated she informed the night shift nurse that the dressings had come off during last rounds. She stated she did not change the dressings before she felt the facility. On 10/19/11 at 5:07 PM, the Unit Manager was interviewed. She stated that Resident #10 had stage 2 and stage 3 pressure ulcers and was incontinent of stool. She stated the loose stool could be detrimental to the wounds and the dressings should be changed if they were compromised by stool or were loose or had come off the wounds. The Unit Manager stated that the physician order read to change the dressings every three days and as needed. She stated if the dressings were soiled or loose, they needed to be changed. She stated she would expect the dressings to be changed the previous evening when the NA reported they were soiled and loose, and when the NAs reported they were off the wounds. She stated she expected the nurse to change the dressings before she left or the night shift nurse to change the dressings. On 10/19/11 at 5:30 PM, the Director of Nursing was interviewed. She stated that with no dressings on the resident's wounds, any loose stool could have worsened the wounds. She	F 314		

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F 314	Continued From page 4 stated she expected the nurse to change the dressings when she learned they were soiled and loose and when she learned they had come off. She stated she also expected the night shift nurse to change the dressings if needed.	F 314		