STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 01/22/2015

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

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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, record review, and staff and consulting physician interviews, the facility failed to follow physician orders for treatment of a pressure ulcer to the upper back for 1 of 3 residents reviewed for wound care. (Resident #1). Findings included: Resident #1 was admitted to the facility 11/26/14 with diagnoses which included a stage III pressure ulcer. An admission Minimum Data Set (MDS) dated 12/03/14 indicated the resident's cognition was intact. The MDS specified Resident #1 was admitted to the facility with a stage III pressure ulcer. A care plan dated 11/26/14 identified Resident #1 with pressure ulcers including a stage III to the thoracic spine (upper back) upon admission. The care plan goal specified the pressure ulcers would show signs of healing and remain free from infection through the next 90 day review. Interventions included administer treatments as	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. F314 Resident # 1 physician orders were checked and verified that treatments matched physician order How corrective action will be accomplished for those residents with the	2/28/15

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

Electronically Signed | 02/13/2015

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F 314	Continued From page 1 ordered by the physician and monitor for effectiveness. a) A review of Resident #1's medical record revealed a physician's order dated 01/10/15. The order specified a foam dressing impregnated with silver nitrate was to be placed on the wound on the resident's upper back every evening shift on Monday and Friday. Continued medical record review revealed Nurse #1 initialed the dressing change for the mid back wound on the treatment administration record for 01/16/15. An interview was conducted via phone with Resident #1's consulting Wound Physician on 01/22/14 at 8:33 AM. The Wound Physician stated he examined Resident #1 in his office on Monday, 01/19/15. When he removed the dressing from the resident's upper back, he found an alginate product (used to maintain a moist environment for wounds and aided in debridement of the wound bed) instead of the silver nitrate product (used to prevent or manage infection in wounds) that he ordered. He added the alginate product was not covered which was required to make this type dressing effective. The Wound Physician stated not only was the alginate product used incorrectly it was not the silver nitrate product he ordered. An interview was conducted via phone with Nurse #1 on 01/22/15 at 9:43 AM. She stated she did change Resident #1's upper back dressing on Friday, 01/16/15. Nurse #1 was unaware she did not follow the physician's orders for the silver nitrate dressing. She stated she must have picked up the wrong product from the treatment	F 314	potential to be affected by the same practice. F314 The DON, Unit Manager or designee will audit all charts of residents with pressure ulcers to ensure accurate treatment per physician orders. Audits initiated on 1/21/15. Completion date 2/13/15. The will educate all nurses on order transcription and treatments. Completion date is 2/13/15. Measures in place to ensure practices will not occur. F314 The (a) DON, Unit Manager, or designee will audit all pressure ulcer patients orders daily Monday through Friday for 4 weeks then bi-weekly for x2, then monthly x3 months. (b) DON, Unit Manager or RN Designee will observe dressing changes on pressure ulcer dressing changes to ensure correct treatment is being applied. This will occur weekly for a period of 2 months, bi-weekly for a period of 1 month and monthly for 9 months. The DON will review during Interdepartmental Risk Meeting weekly to discuss finding and changes in process if needed to ensure orders are followed. How the facility plans to monitor and ensure correction is achieved and sustained. F.314 The Unit Manager or DON or designee will present audits to QA&A monthly time 6 months then quarterly times 2. This time frame can be extended at the discretion of the Administrator based on findings of audits.	

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F 314	Continued From page 2 cart. An interview was conducted with the Director of Nursing on 01/22/15 at 10:46 AM. She stated she expected physicians' ordered were followed at all times. b) Further medical record review revealed a physician's telephone order dated 01/19/15. The order included instructions to apply Gentamicin (an antibiotic) ointment to the upper back wound twice daily. A review of the treatment administration record (TAR) revealed there was no order written for the Gentamicin treatment and the silver nitrate order had not been discontinued. Continued medical record review revealed the medication administration Record (MAR) contained the Gentamicin order. The physician's telephone order indicated Nurse #3 transcribed the order. An observation was conducted of Nurse #2 performing a dressing change to the upper back wound on 01/21/15 at 1:43 PM. Nurse #2 removed a dressing that did not contain a foam pad. She cleaned the wound and applied a foam pad product that contained silver nitrate. An interview was conducted via phone with Nurse #2 on 01/22/15 at 9:57 AM. Nurse #2 confirmed she did apply the silver nitrate dressing to Resident #1's upper back wound on 01/21/15. She stated before she did a dressing change for any resident, she reviewed the physician's order as stated on the TAR. Nurse #2 added she did not see an order for Gentamicin on Resident #1's TAR on 01/21/15.	F 314		

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F 314	Continued From page 3 An interview was conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) on 01/22/15 at 10:46 AM. The DON stated the Gentamicin order was written on the MAR. The RNC explained the nurse that transcribed the Gentamicin order did not let the computer system know to put the Gentamicin on the TAR. He added typically a nurse did not look at the MAR and TAR before doing a dressing change to a wound. The DON and RNC stated the Gentamicin order for the upper back wound should have been on the TAR. The DON stated she expected all physicians' orders were followed at all times. An interview was conducted via phone with Nurse #3 on 01/22/15 at 12:15 PM. Nurse #3 stated he transcribed the Gentamicin order on 01/19/15. He explained the computer defaulted medication orders to the MAR which alerted the pharmacy to send the Gentamicin to the facility. Nurse #3 stated he should have checked for the computer and placed this physician's order on the TAR.	F 314		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		2/28/15

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F 520	Continued From page 4 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and physician interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2014. This was for one recited deficiency which was originally cited in May of 2014 on a recertification survey and on the current complaint investigation. The deficiency was in the area of pressure sores. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. F 314: Pressure Sores: Based on observations, record review, and staff and physician interviews, the facility failed to follow physician's orders for treatment of a pressure ulcer to the upper back for 1 of 3 residents	F 520	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. F520 Resident # 1 physician orders were checked and verified that treatments matched physician order. How corrective action will be	

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F 520	Continued From page 5 reviewed for wound care. (Resident #1). During a recertification survey of May 23, 2014 the facility was cited for F 314 for failing to measure and evaluate a pressure ulcer weekly. On the current complaint investigation survey the facility was again recited for failing to follow physician orders for treating a pressure ulcer. During an interview on 01/22/15 at 10:46 AM the Administrator stated the Quality Assessment and Assurance Committee met monthly. She added the facility had not been aware of any issues involving wound care orders not being followed.	F 520	accomplished for those residents with the potential to be affected by the same practice. F520 The staff development coordinator DON or designee will audit all charts of residents with pressure ulcers to ensure accurate treatment per physician orders. Audits initiated on 1/21/15. Completion date 2/13/15. The DON, Unit Manager or designee will educate all nurses on order transcription and treatments. Completion date is 2/13/15. Measures in place to ensure practices will not occur. F.520 (a) DON, Unit Manager, or designee will audit all pressure ulcer patients□ orders daily Monday through Friday for 4 weeks then bi-weekly for x2, then monthly x3 months. (b) DON, Unit Manager or RN Designee will observe dressing changes on pressure ulcer dressing changes to ensure correct treatment is being applied. This will occur weekly for a period of 2 months, bi-weekly for a period of 1 month and monthly for 9 months. The DON will review during Interdepartmental Risk Meeting weekly to discuss finding and changes in process if needed to ensure orders are followed. How the facility plans to monitor and ensure correction is achieved and sustained. F.520 The Unit Manager or DON or designee will present audits to QA&A monthly time 12 months. This time frame can be extended at the discretion of the Administrator based on findings of audits.	