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 04/01/2016

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #62H511.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		4/29/16

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

Electronically Signed | 04/25/2016

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to comprehensively assess 1 of 10 sampled residents by not providing description of the problem, contributing factors and risk factors for a stage IV sacral ulcer and indwelling urinary catheter use (Resident #97). The findings included: Resident #97 was admitted to the facility 03/02/16 with diagnoses which included stage IV sacral ulcer and history of urinary tract infections. An admission Minimum Data Set (MDS) dated 03/16/16 indicated the resident's cognition was severely impaired. The MDS specified Resident #97 required extensive staff assistance for care and was admitted with a stage IV sacral ulcer and an indwelling urinary catheter. Review of the admission MDS comprehensive care area assessment (CAA) for pressure ulcers revealed this CAA specified Resident #97 was admitted with a chronic stage IV sacral ulcer. There was no further documentation to describe the extent of the ulcer, contributing factors, or risk factors regarding the pressure ulcer. Continued review of the admission MDS CAA for urinary incontinence/indwelling catheters revealed this CAA triggered due to the resident's need for an indwelling catheter secondary to chronic stage IV sacral ulcer. There was no further documentation to describe the contributing	F 272	An MDS comprehensive care area assessment (CAA) for pressure ulcers and for urinary incontinence/indwelling catheters describing the extent of the ulcer, contributing factors, or risk factors for resident #97 was completed by the MDS Director on March 31, 2016. All residents with comprehensive assessments have the potential to be affected by the alleged deficient practice. An audit of current residents for their last comprehensive assessment with assessment reference date after 10/1/2015 was completed on April 20, 2016 by the facility's MDS Consultant for all CAA's. The interdisciplinary team (MDS, Activity Director, and Social Worker) were inserviced regarding care area assessments process, care area assessment content, and explanation of care area assessments by the MDS consultant on April 20, 2016. All care area assessments identified from audit needing revisions after 10/1/15 will be revised by Monday, April 25, 2016 by the interdisciplinary team. The MDS Consultant will conduct audits	

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F 272	Continued From page 2 factors, and risk factors regarding the indwelling urinary catheter. An interview was conducted with the MDS Coordinator on 03/31/16 at 3:06 PM. After reading the CAA's, the MDS Coordinator stated they did not fulfill the requirements of a CAA and were not acceptable. She stated she wrote the CAA ' s and recalled she was in a hurry and did not complete them. An interview was conducted with the Director of Nursing (DON) on 04/01/16 at 2:18 PM. The DON stated she expected CAA's contained all required information including description of the problem, contributing factors and risk factors.	F 272	of completed comprehensive assessments weekly x 4 weeks, then monthly x 2 months. Any further revisions identified will be addressed with the MDS Director and will be corrected at that time by the interdisciplinary team with further education or counseling as deemed necessary by the MDS consultant. The MDS Director will report results of audit to the Quality Assessment and Performance Improvement Committee (QAPI) monthly x 3 months with revisions as determined by the QAPI committee.	
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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to use soap and water and utilize a clean area on a bath cloth when providing care of an indwelling urinary catheter for 1 of 1 resident reviewed for indwelling	F 315	An order from resident #97's attending physician was received on March 31, 2016, for a Urinalysis and Culture and Sensitivity. Final report of culture and sensitivity was received on April 2, 2016,	4/29/16

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F 315	Continued From page 3 urinary catheters (Resident #97). The findings included: Resident #97 was admitted to the facility 03/02/16 with diagnoses which included dementia, stage IV sacral ulcer, and indwelling urinary catheter to promote healing of sacral ulcer. An admission Minimum Data Set (MDS) dated 03/09/16 indicated the resident's cognition was severely impaired. The MDS further coded the resident required extensive staff assistance for all activities of daily living, was incontinent of bowel, and had an indwelling urinary catheter and a stage IV pressure ulcer upon admission to the facility. A Care Area Assessment completed with the admission MDS specified Resident #97 required an indwelling urinary catheter secondary to a chronic stage IV sacral ulcer. A care plan dated 03/16/16 identified Resident #97 at risk for urinary tract infections due to history of urinary infections. The care plan goal specified the resident would be free of urinary tract infections through the next 90 day period. Interventions included to provide catheter care per protocol. A review of a laboratory report dated 03/31/16 revealed Resident #97 was diagnosed with a urinary tract infection. Nurse Aide (NA) #1 was observed providing urinary catheter care on 03/31/16 at 2:04 PM. NA #1 was observed using a bath cloth that appeared to be wet. The NA encircled the catheter with the bath cloth and wiped the length of the urinary catheter starting at the insertion site and moving toward the urinary drainage bag. NA #1 was observed following this procedure 3 times without changing the position of the bath cloth. During an interview on 04/01/16 at 6:50 AM, NA #1 stated the bath cloth was wet with water without soap. NA #1 did recall wiping the catheter	F 315	which showed less than 10,000 cfu/ml yeas, which does not meet urinary tract infection definition. No treatment orders were obtained. NA1 was inserviced on the proper procedure of using soap and water and utilizing a clean area on a bath cloth when providing care of indwelling catheter on March 31, 2016 by the Staff Development Coordinator nurse. Audit conducted by Infection Control Coordinator on April 4, 2016 revealed five (5) residents with catheters that have the potential to be affected by the alleged deficient practice. A review of the five (5) residents revealed no signs or symptoms of a urinary tract infection per SPICE (Statewide Program for Infection Control and Epidemiology). All certified Nursing Assistants will be inserviced by the Staff Development Coordinator (SDC) or RN Supervisor on the appropriate steps providing care of an indwelling urinary catheter and complete a skills validation by Wednesday, April 27, 2016. Any C.N.A. not receiving the inservice and completing this skills validation will not work until completed. The SDC, or RN will conduct 5 random checks monthly for 2 months with re-education or counseling of employee as deemed necessary by the SDC, RN Spv, or Director of Nursing (DON). Indwelling Catheter Care procedure will be added to the New Employee Orientation and Annual orientation for C.N.A.'s.	

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F 315	Continued From page 4 3 times starting at the insertion site and moving down the catheter toward the drainage bag connection. NA #1 stated she should not have wiped the catheter 3 times without using a clean area on the bath cloth each time she wiped the catheter. She did not offer a reason for not using soap and water. In an interview on 04/01/16 at 2:18 PM, the Director of Nursing (DON) stated she expected staff to provide catheter care using soap and water and wiping the catheter with a clean area on the cloth with each wipe to lessen the chance of urinary tract infections.	F 315	The DON, SDC, or RN Supervisor will report care of indwelling catheter skills validation checks to the Quality Assurance and Performance Improvement Committee monthly x 3 months with revisions as deemed necessary by the QAPI committee.	
F 362 SS=F	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to serve resident meals on time according to the facility's meal schedule for 2 of 3 meals observed which may potentially affect resident medication administration, activity participation and therapy participation. The findings included: 1. Review of the facility's meal schedule revealed the lunch meal was scheduled to be served to residents in the Main Dining Room at between 12:30 PM to 12:45 PM.	F 362	Facility dietary staff will serve resident meals on time according to the facility's meal schedule. All dietary staff were inserviced by the Dietary Manager from March 31, 2016 to April 1, 2016 regarding meal times, meal preparation, and production sheets. Additional bowls were obtained on March 29, 2016. The tray line service time was revised to begin 15 minutes earlier to ensure trays are delivered as scheduled per tray delivery schedule. Dietary staff to follow production sheets for each meal to	4/29/16

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F 362	Continued From page 5 Observations on 03/29/16 at 12:50 PM revealed the resident lunch meal service began in the facility's main dining room with a total of sixteen residents eating in the dining room. Observations on 03/29/16 at 1:07 PM revealed the last resident was served a lunch meal in the dining room which was 22 to 37 minutes later than the scheduled meal time. On 03/31/16 at 9:10 AM Dietary staff #1 was interviewed. Dietary staff #1 stated she assisted in preparing resident lunch meals in the kitchen on 03/29/16. Dietary staff #1 specified resident lunch meals were served later than scheduled on 03/29/16 because dietary staff had to delay serving resident trays during the tray line service in order to prepare additional food and to wash bowls in order to be able to complete the meal service. 2. Review of the facility's meal schedule revealed resident breakfast meals were to be served at the following times: Assisted Dining Room: 7:30 AM to 7:40 AM 100 Hallway (first cart): 7:40 AM to 7:50 AM 200 Hallway (first cart): 7:50 AM to 8:00 AM Main Dining Room: 8:00 AM to 8:15 AM 100 Hallway (second cart): 8:15 AM to 8:25 AM 200 Hallway (second cart): 8:25 AM to 8:35 AM Observations on 03/31/16 at 7:55 AM revealed three dietary staff members were preparing resident breakfast meal trays at the kitchen's tray line for residents eating in the facility's assisted dining room. Observations on 03/31/16 at 8:04 AM revealed	F 362	ensure that all food items are prepared before service time to prevent delays. Staff schedules were adjusted for employees to come in 30 minutes earlier for morning shift. The Dietary Manager/designee will audit meal service times, tray delivery times, and production sheets daily. Any delays or discrepancies will be addressed with employee by the Dietary Service Manager/designee with further education and/or counseling as deemed necessary by the Dietary Service Manager. An audit of any needed dishes will be completed by Dietary Manager weekly. Additional replacement dishes will be ordered as needed. Note Dietary Manager change occurred 3/28/16, immediately before this inspection. District Manager change 4/25/16. The Dietary Manager will report results of audits to the Quality Assessment and Performance Improvement Committee monthly x 3 months with revisions as determined by the committee.	

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F 362	Continued From page 6	F 362		

the dietary staff finished preparing breakfast meal trays for residents eating in the assisted dining room. The breakfast meals for residents in the assisted dining room were observed to be prepared by dietary staff 24 minutes to 34 minutes later than their scheduled time of 7:30 AM to 7:40 AM.

Observations on 03/31/16 at 8:15 AM revealed the dietary staff finished preparing the breakfast meal trays for residents who received meals on the first 100 hallway meal cart. These 100 hallway resident breakfast meals were observed to be prepared by dietary staff 25 minutes to 35 minutes later than their scheduled time of 7:40 AM to 7:50 AM.

Observations on 03/31/16 at 8:25 AM revealed the dietary staff finished preparing the breakfast meal trays for residents who received meals from the first 200 hallway meal cart. These 200 hallway resident breakfast meals were observed to be prepared by dietary staff 25 minutes to 35 minutes later than their scheduled time of 7:50 AM to 8:00 AM.

Observations on 03/31/16 from 8:28 AM to 8:38 AM revealed the dietary staff prepared resident breakfast meals and delivered the meals to the facility's main dining room. The breakfast meals for residents who ate in the main dining room were observed to be prepared by dietary staff 23 minutes to 28 minutes later than their scheduled time of 8:00 AM to 8:15 AM.

Observations on 03/31/16 at 8:43 AM revealed dietary staff had to stop serving resident breakfast meals from the kitchen's tray line because they ran out of pancakes to serve and

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F 362	Continued From page 7	F 362		

had to prepare more pancakes in order to continue the meal service.

Observations on 03/31/16 at 8:46 AM revealed dietary staff had to stop serving resident breakfast meals from the kitchen's tray line because they ran out of clean bowls on the tray line and had to wash bowls in the kitchen's dish machine in order to continue the meal service.

Observations on 03/31/16 at 8:52 AM revealed the dietary staff finished preparing the breakfast meal trays for residents who received meals from the second 100 hallway meal cart. These 100 hallway resident breakfast meals were observed to be prepared by dietary staff 27 minutes to 37 minutes later than their scheduled time of 8:15 AM to 8:25 AM.

Observations on 03/31/16 at 9:03 AM revealed the dietary staff finished preparing the breakfast meal trays for residents who received meals from the second 200 hallway meal cart. These 200 hallway resident breakfast meals were observed to be prepared by dietary staff 28 minutes to 38 minutes later than their scheduled time of 8:25 AM to 8:35 AM.

On 03/31/16 at 9:05 AM Dietary staff #2, who served resident meals from the kitchen's tray line during the breakfast meal of 03/31/16, was interviewed. Dietary staff #2 stated resident breakfast meals were served later than scheduled on 03/31/16 because the kitchen's breakfast tray line was schedule to begin at 7:30 AM, but the dietary staff did not begin serving meals until 7:50 AM. Dietary staff #2 stated resident breakfast meals were also served later than scheduled on 03/31/16 because during the

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F 362	Continued From page 8 tray line service staff had to stop serving meals to prepare more pancakes and had to wash more bowls in order to complete the meal service. 03/31/16 at 9:15 AM the facility's Dietary Manager (DM) was interviewed. The DM confirmed the kitchen's breakfast tray line on 03/31/16 started twenty minutes later than scheduled which resulted in resident breakfast meals being served later than scheduled. The DM stated the tray line started later than scheduled on 03/31/16 because dietary staff were late in performing their job responsibilities to ensure the breakfast tray line began on schedule at 7:30 AM. The DM also stated that during the breakfast tray line service of 03/31/16 staff had to stop serving resident meals from the tray line in order to prepare additional food and to wash bowls were resulted in resident meals being served later than scheduled.	F 362		
F 371 SS=F	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 failed to keep food preparation equipment	F 371	Dietary staff will store, prepare, distribute, and serve food under sanitary conditions.	4/29/16

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F 371	Continued From page 9 clean in the kitchen and failed to keep the microwave ovens clean in 2 of 2 clean utility/nourishment rooms. The findings included: 1. Observations on 03/29/16 from 8:55 AM to 9:25 AM of food preparation equipment in the facility's kitchen revealed the following equipment, which was ready for use, was unclean: a An ice scoop holder was observed attached to the side of the kitchen's ice machine. A plastic ice scoop was observed inside the holder with the scoop portion resting directly on the holder's interior bottom portion. When the ice scoop was removed from the holder a brown tinged slimy substance and accumulated water was observed on the interior bottom of the ice scoop holder. The brownish substance could be easily wiped away with a paper towel. Interview with the Dietary Manager (DM) on 03/29/16 at 9:25 AM revealed the ice scoop holder should be kept clean and dry. The DM was unsure if the ice scoop holder was on the kitchen's cleaning schedule. b. Observations of the kitchen's two convection ovens revealed both ovens were unclean with accumulated dried blackened food spills inside each of their cooking compartments. Interview with the DM on 03/29/16 at 9:25 AM revealed the convection ovens were on the kitchen's weekly cleaning schedule, but should be cleaned more often as needed. c. Observations of the kitchen's stove top	F 371	Ice scoop and holder were cleaned immediately. Maintenance replaced with new ice scoop and holder on April 25, 2016. Convection ovens and stove top noted as having food spills were cleaned by District Manager on April 1, 2016. >Three cooking skillets with blackened debris were taken out of service immediately, then replaced with new skillets on April 25, 2016.< Knife sharpener noted to be in contact with unclean items was discarded by Maintanance. Microwave ovens in two nourishment rooms noted to be with food debris were cleaned by the dietary aid and dietary manager on March 31, 2016 during survey. Dietary staff was inserviced on March 29, 2016 by Dietary Manager on proper serving, proper storing, and preparing food. >Dietary staff educated not to use skillets or cooking utensils with blackened debris for food prep. Instructed Dietary staff to clean and sanitize all cooking utensils to remove blackened debris. Instructed staff to notify Dietary Manager or Administrator of skillets or utensils that have blackened debris that is unable to be removed so utensils can be replaced. These topics will also be included in general orientation for this department. Dietary department sanitation audit will be completed daily x 2 weeks, then weekly x 3 months, then monthly by Dietary Manager or designee. The audit will include sanitation, storage, and sufficient supply, along with sanitation of cookware	

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F 371	Continued From page 10 revealed it was unclean with accumulated blackened and burned food spills. Interview with the DM on 03/29/16 at 9:25 AM revealed the stove top was on the kitchen's weekly cleaning schedule, but should be cleaned more often as needed. d. Three (3) cooking skillets, which were stored as clean, were unclean with unidentifiable accumulated blackened debris that could be chipped away. During an interview with the DM on 03/29/16 at 9:25 AM she agreed these skillets were not clean and needed to be replaced. e. A manual knife sharpener was observed stored in a plastic wall container with an unclean string which held keys and soiled papers. The knife sharpener was in direct contact with these unclean items. Interview with the DM on 03/30/16 at 3:00 PM revealed the knife sharpener should have been stored in a clean drawer. 2. Observations on 04/01/16 at 9:05 AM of the facility's 200 hallway clean utility/nourishment room revealed it contained a microwave oven. Observations of the interior cooking compartment of the microwave oven revealed it was unclean with accumulated dried food splatters. Nurse #2 was present during this observation and confirmed the microwave oven was for resident use and was unclean. On 04/01/16 at 10:55 AM the facility's Housekeeping Director (HD) was interviewed.	F 371	and equipment, to include stove top, ovens, skillets, ice scoop, and holder. If needed, Dietary manager will order additional supplies of dinnerware. Dietary Manager will address any areas noted to need cleaning with responsible employee as noted on cleaning schedule with re-education and/or counseling as deemed appropriate by Dietary Manager. Housekeeping Director/designee will complete nourishment room audits to include microwave on a daily basis. Any areas identified as needing cleaning will be addressed with employee by the Housekeeping Director to include re-education or counseling. >Cleaning of microwave will be added to housekeeping cleaning schedule by April 29, 2016, and will be cleaned daily by housekeeping staff.< Housekeeping staff to be educated on nourishment room cleaning to include microwave daily by the Housekeeping Director by April 29, 2016. The Dietary Manager and Housekeeping Director will report results of audits to the Quality Assessment and Performance Improvement Committee monthly x 3 months with revisions as determined by the QAPI Committee. (It seems important to note that the facility and the dietary services department received a sanitation grade A, 97.5, on April 14, 2016.)	

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	345174	A. BUILDING _____ B. WING _____	C 04/01/2016

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 371	Continued From page 11	F 371		

The HD stated that it was the housekeeping department's responsibility to clean the microwave ovens located in the facility's two clean utility/nourishment rooms. The HD stated these microwaves were not on the department's daily cleaning list, but staff were instructed to clean them as needed. The HD stated that it was an oversight by housekeeping staff to not clean these microwaves at least daily. The HD was unsure when the microwave oven in the facility's 200 hallway's clean utility/nourishment room was last cleaned by staff.

3. Observations on 04/01/16 at 9:10 AM of the facility's 100 hallway clean utility/nourishment room revealed it contained a microwave oven. Observations of the interior cooking compartment of the microwave oven revealed it was unclean with accumulated dried food splatters. Nurse #2 was present during this observation and confirmed the microwave oven was for resident use and was unclean.

On 04/01/16 at 10:55 AM the facility's Housekeeping Director (HD) was interviewed. The HD stated that it was the housekeeping department's responsibility to clean the microwave ovens located in the facility's two clean utility/nourishment rooms. The HD stated these microwave were not on the department's daily cleaning list, but staff were instructed to clean them as needed. The HD stated that it was an oversight by housekeeping staff to not clean these microwaves at least daily. The HD was unsure when the microwave oven in the facility's 100 hallway's clean utility/nourishment room was last cleaned by staff.