STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interview and record review, the facility failed to provide pain management strategies including provision of pain medication and positioning for comfort for 1 of 2 residents (resident #43) who verbalized pain during wound dressing change. Findings include: Resident #43 was admitted to Aston Park Health Care on 12/18/2015 following a brief hospitalization. The resident ' s diagnoses included: CHF, pacemaker, long-term use of anticoagulants, a history of thrombus, aortocoronary bypass graft, urinary retention and colostomy. 04/28/2016 4:36:19 PM MDS Reviewed quarterly Minimum Data Set (MDS) for resident dated 03/25/16, 95 year old cognitively intact male (BIMS score of 15) admitted 12/18/2015 following a brief hospitalization. Admitted to facility with Stage II pressure ulcers to sacrum and heels of both feet which developed into Stage III ulcers. Reviewed care plan and addressed wound management for Stage III ulcers on sacrum and heels on both feet. Resident was being followed	F 309	Aston Park Health Care Center□s Response to this statement of Deficiencies and plan of correction Does not denote agreement with the statement of deficiencies not does it constitute an admission that any deficiency is accurate. Further, Aston Park Health care Center understands its right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal and/or other administrative or legal procedures. F 309: Corrective Action: Nurse #3 was counseled regarding the 4/28/15 8:38AM dressing change on resident #43 and was retrained on the facility□s procedure for responding to pain during dressing changes and correct positioning of residents during dressing changes. Nurse #3 stated that he misinterpreted the resident□s response that is sore as the resident referring to the initial pressure of the cleansing of the	5/26/16

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

Electronically Signed | 05/16/2016

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F 309	Continued From page 1 by wound care management and wound care physician stated on 04/26/16 that sacral wound had increased in size and changed orders for sacral wound. Reviewed wound management treatment record from wound physician visit last week, on 04/19/16 the measurements for resident wounds: left heel measured 0.2 x 0.2 x 0.1, Sacrum 3 x1 x 0.1 and Right heel 0.3 x 0.3 x 0.1. Wound care physician was in on Tuesday morning, 04/26/16 and changed orders due to increase in size of sacral wound. New orders for wound care dated 04/26/16: clean buttocks with wound cleanser, apply calcium alginate AG, and cover with MEpilex, change Monday, Wednesday and Friday (MWF) and as needed (prn). For heels clean wounds with wound cleanser, apply silver stat, cover with gauze, and secure with tape daily and prn. 04/28/2016 8:38:28 AM Nurse #3, was observed for wound treatment. Nurse #3 prepared and brought in tray with supplies for dressing. Asked if we wanted to observe both the sacral and heel wound on both feet and we agreed. Nurse #3 left the room to gather additional supplies and returned with supplies to do the dressing changes on the heels as well. Began by positioning resident #43 on his left side to do sacral wound. Gloved and removed old dressing from sacrum and discarded in trash bag attached to dressing tray, changed gloves after removing old dressing and put on clean gloves and cleaned wound. During cleansing, Nurse #3 rubbed gauze wet with house cleanser several times until removal of black slough (dead tissue on top of the pressure ulcer) area on sacrum. The wound bed started bleeding. Resident #43 moved his entire body	F 309	wound, not that he was in pain for the entire dressing. Nurse #3 was familiar with resident#4s wounds as he had administered treatments and had rounded with the wound care specialist each week on his treatment of the wounds. Nurse #3 stated that resident #43 had never voiced pain or requested pain medication, as surveyor indicated, before during treatment, which contributed to his interpretation of the statement that is sore to just mean it was sore to pressure. Medication Nurse entered room right after the treatment for 9AM medication administration and asked the resident if he was in pain or needed pain medication. Resident #43 declined medication. Nurse #3 was reminded that when residents show signs of pain or voices pain in any way, Nurse should stop treatment and offer pain medication prior to proceeding, even if resident has never accepted pain medication during previous treatments. Nurse should always take time to reposition resident depending on the location of the wounds being treated. Plan of Care was updated in collaboration with Hospice on 4/28/16 relating to Pain Management as resident□s disease process was exacerbating rapidly. Corrective Action for Potential Deficient Practice: All nurses will be retrained in wound care policies and procedures, emphasizing recognition of pain during treatment and offering medication, as well as, proper positioning prior to proceeding with the	

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F 309	Continued From page 2 towards the side rail and Nurse #3 said "are you okay?" and resident #43 said ' that is sore. " Nurse #3 continued with the wound care, applied the dressing and dated the dressing change. Nurse #3 did not stop wound care and offer resident pain medication but proceeded on to the next area for wound care. Nurse #3 continued and removed the resident ' s socks to take off the old dressings on the heels. He removed the dressings on both heels and placed them in the trash bag attached to the dressing tray, continued with the cleansing of the right heel, applied the gel to the gauze dressing and taped the dressing on the heel. During the right heel wound dressing, the resident attempted to hold his leg up for the nurse as he was cleaning the wound and was unable to sustain his leg up in the air. The nurse moved next to the left heel and cleaned the wound and applied the dressing with gel and taped on to the resident ' s left heel with dated tape. During the heel wound dressing, the resident remained on his side and was not positioned for comfort with pillows to support his legs and keep his feet and heels off the bed. 04/28/2016 9:30:07 AM Interviewed Nurse #3 following resident ' s wound care and asked him to describe the facility ' s procedure for a clean wound dressing. Additionally asked him about pain management prior to wound care and stated that at times the physician will order medication to be given 30 minutes prior to wound care and then sometimes the wound physician will spray the area with a numbing spray prior to performing the wound care. Nurse #3 stated that the resident did not usually require pain medication prior to wound care or have pain during the wound care. 04/28/2016 9:35:36 AM Spoke with Nurse #4, hall	F 309	treatment. Systematic Changes: In addition to retraining of all wound care nurses in wound care policies and procedures including pain management and positioning, Policies will be reviewed during orientation of new nurses and demonstrated on skills checklist, which is done during orientation and annually. Monitor Plan of Facility: The Staff Development Coordinator or designee will complete a compliance audit once a week for 3 months and randomly thereafter for continued compliance in pain management during wound care. Results of the audits will be reviewed and evaluated by the Facility□s Quality Assurance and Performance Improvement Committee for a 3-month period and then randomly thereafter to assure compliance.	

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F 309	Continued From page 3 nurse assigned to resident, who stated resident did not have pain medication this am prior to wound dressings. 04/28/2016 2:48:30 PM Spoke with Assistant Director Of Nursing (ADON) as DON was not available and asked expectation of facility in providing pain medication prior to wound dressings and asked for facility ' s procedure for giving pain medication prior to wound dressings. ADON stated that facility did not have a procedure on giving pain meds prior to dressing changes; however, some residents have that in place for their wound care. Discussed with her observation of resident #43 ' s wound care and resident ' s non-verbal and verbal reactions to wound care being provided and ADON stated that she would discuss with DON and wound care staff as well as all nursing staff. 04/28/2016 3:02:19 PM Went in to resident's room as his caretaker was coming out of his room and she stated "Resident #43 is not having a good day." Caretaker's family member in room trying to assist resident in bed. Asked resident if it always hurt when he had dressing changed and he said "no, just today." Then stated that he was still nauseated and was not feeling well. Had cool cloth on his forehead and ADON accompanied by caregiver came in to resident ' s room and ADON began to assess resident. 04/29/16 4:00:36 PM Reviewed additional documents submitted by Aston Park Health Care. Documents revealed that resident #43 did not complain of pain during previous dressing changes and did not require pain medication.	F 309		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		5/26/16

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F 441 SS=D	Continued From page 4 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy reviews the facility staff failed to perform hand hygiene and change gloves from one wound dressing site to another wound dressing site for 1 of 3 residents (resident #43). Findings included: The Handwashing/Hand Hygiene policy was reviewed from Infection Control Policy and Procedure Manual © 2001 MED-PASS, Inc. (Revised August 2009) provided by the Director of Nursing (DON) on 04/28/16 1:55:03 PM. According to policy, 4. If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. Before and after direct contact with residents; e. Before handling clean or soiled dressing, gauze pads, etc.; h. After handling used dressings, contaminated equipment, etc. 04/28/2016 4:36:19 PM MDS Reviewed quarterly Minimum Data Set (MDS) for resident dated 03/25/16, 95 year old was cognitively intact. Resident #43 was admitted on 12/18/2015 following a brief hospitalization. Diagnoses included: CHF, pacemaker, long-term use of anticoagulants for history of thrombus, aortocoronary bypass graft, urinary retention and colostomy. Reviewed care plan and addressed wound management for Stage III ulcers on sacrum and heels on both feet. Resident was being followed by wound care management and wound care physician stated on 04/26/16 that sacral wound had increased in size and changed orders for	F 441	Corrective Action: Nurse #3 was counseled by the Director of Nursing and retrained on performing a clean wound technique, including hand hygiene, donning and changing of gloves and disposal of materials on 4/28/16. Corrective Action for Potential Deficient Practice: All nurses will be retrained on performing a clean wound technique, including hand hygiene, donning and changing of gloves and disposal of materials. Systematic Changes: In addition to retraining all nurses in wound care policies and procedures, emphases will be placed on performing a clean wound technique, including hand hygiene, donning and changing of gloves and disposal of materials. Policies and procedures will be reviewed during orientation of new nurses and demonstrated on skills checklist, which is done during orientation and annually. Monitor Plan of Facility: The Staff Development Coordinator or designee will complete a compliance audit once a week for 3 months and randomly thereafter for continued compliance in performing a clean wound technique as well as observing for proper hand hygiene, donning and changing of gloves and disposal of materials. Results of the	

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F 441	Continued From page 6 sacral wound. 04/28/2016 8:38:28 AM Nurse #3 was observed to do wound dressing treatment. Nurse #3 prepared and brought in tray with supplies for dressing. Asked if we wanted to observe both the sacral and heel wound on both feet and we agreed. Nurse #3 left the room to gather additional supplies and returned with supplies to do the dressing changes on the heels as well. Nurse #3 began by positioning resident #43 on his left side to do sacral wound. Gloved and removed old dressing from sacrum and discarded in trash bag attached to dressing tray, changed gloves after removing old dressing and put on clean gloves and cleaned wound. During cleansing and removal of black slough (dead tissue) area on sacrum, resident #43 moved his entire body towards the side rail and said ' that is sore, " nurse said to resident " sorry buddy " when he moved during the dressing change. Nurse #3 continued with the wound care, applied the dressing and dated the dressing change. Nurse #3 did not stop wound care and proceeded on to the next area for wound care. Nurse #3 continued and removed the resident ' s socks to take off the old dressings on the heels. He removed the dressings on both heels and placed them in the trash bag attached to the dressing tray and without performing hand hygiene or changing gloves continued with the cleansing of the right heel, applied the gel to the gauze dressing and taped the dressing on the heel. The nurse moved next to the left heel with the same gloves and without performing hand hygiene and cleaned the wound and applied the dressing with gel and taped on to the resident ' s left heel with dated tape.	F 441	audits will be reviewed and evaluated by the Facility□s Quality Assurance and Performance Improvement Committee for a 3-month period and then randomly thereafter to assure compliance.	

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F 441	Continued From page 7 04/28/2016 9:30:07 AM Interviewed Nurse #3 following resident ' s wound care and asked him to describe the facility ' s procedure for a clean wound dressing. Nurse #3 was able to describe the correct procedure for performing a clean wound technique including hand hygiene, donning and changing gloves and disposal of materials. 04/28/2016 9:52:40 AM Spoke with DON about her expectations regarding clean technique dressing changes and recited correct technique for completing dressing change. Stated that there is a procedure at the main nurse ' s station for doing wound care or dressing change under clean technique and nurses could reference this procedure prior to performing wound care. 04/28/2016 2:48:30 PM Spoke with Assistant Director Of Nursing (ADON) as DON was not available and asked expectation of facility in providing wound dressings under clean technique. Stated that expectation is that gloves are worn to take dressing off and re-glove to put on new dressing. Additionally, re-glove and start over process when moving to a new area for wound treatment.	F 441		