

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345198</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>04/16/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>Aston Park Health Care Center</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  <b>380 Brevard Road , Asheville, North Carolina, 28806</b>
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E0000	Initial Comments  An unannounced recertification and complaint investigation survey was conducted on 04/13/26 through 04/16/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #22E181-H1.	E0000		05/04/2026
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted from 04/13/26 through 04/16/26. Event ID# 22E181-H1. The following intakes were investigated: 2636637, 2653573, 2662028 and 2691345.  7 of the 7 complaint allegations did not result in deficiency.	F0000		05/04/2026
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary  CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements.  The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	Corrective Action for Affected Residents:  On 4/13/26, the Food Services Manager or designee immediately cleaned the sticky substance identified on the walk-in cooler #2 floor, including the 3 dark spots in the back right corner under the tea decanter cart and the pooled liquid substance in the left front corner. On 4/13/26, the Food Services Manager or designee cleaned all wire racks, the floor of the other walk-in cooler, and all other floors throughout the kitchen to ensure no similar conditions existed.  Identifying other Residents having the Potential to be Affected:  On 4/13/26, the Food Services Manager or designee conducted a comprehensive inspection of the kitchen's walk-in cooler #1, dry storage areas, and the main kitchen floor to identify potential spillage or soiled areas that could impact food safety. On 4/30/2026, the Director of Dining Services or designee will review the kitchen cleaning logs and walk-in cooler conditions for the previous 30 days to identify any patterns or trends requiring corrective action.  Measures put into place or Systemic Changes:  On 4/13/26, the Food Services Manager or designee	05/07/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0812 SS = D	<p>Continued from page 1</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record reviews, and staff interviews, the facility failed to maintain a clean floor in of 1 of 2 walk-in coolers (walk-in cooler #2).</p> <p>The findings included:</p> <p>On 4/13/26 at 9:50 AM, an observation of the kitchen's walk-in cooler #2 was made with the Food Services Manager. The back right corner of the cooler had 3 dark spots that were sticky to the touch on the floor under a cart where tea decanters were stored. The spots were 4 to 5 inches each, sticky to the touch in the centers with dried non-sticky brown circles around the edges. Further observation of walk-in cooler #2 revealed an area in the left front corner covering an 8 x 12-inch area of the floor where a dark, thick liquid substance that was sticky to the touch had pooled to ¼ inch depth in the corner and was partially dried at the edges. Streaks of this substance stretched 5 feet from the pooled area through the doorway with scattered spots of the sticky material visible on the kitchen floor area 6 inches in front of the cooler door.</p> <p>During an interview with the Food Services Manager on 4/13/26 at 10:10 AM he stated the spots in the back of the cooler were likely from tea having dripped from the decanter spouts. The Food Services Manager explained he thought the pooled area and streaks in the front of the cooler were likely juice, and the streaks may have been from the wheels of a cart and might have been there about an hour.</p> <p>Review of the Dietary Aide Weekly Cleaning Schedule indicated the coolers were swept and mopped on Thursdays in the evening.</p> <p>In an interview with the Food Services Manager on 4/15/26 at 11:39 AM he stated kitchen floor cleaning between breakfast and lunch involved the floors being spot swept and mopped in all areas, and at night when closing all floors got swept and mopped with floor cleaner/degreaser. The Food Services Manager revealed there was not a sign off sheet for but this but the Assistant Food Services Manager did rounds early in the mornings to ensure the kitchen was clean before starting for the day. The Food Services Manager stated he would have expected that staff would have cleaned spills in the walk-in cooler when observed by staff.</p> <p>During an interview on 4/15/26 at 11:55 AM with the</p>	F0812	<p>Continued from page 1</p> <p>in-serviced dietary teammates on identifying spillage or soiled areas and the appropriate measures necessary to clean affected areas immediately upon discovery. On 4/13/26, the Food Services Manager or designee in-serviced dietary teammates on cleaning schedules, proper cleaning techniques, thorough sweeping and mopping, and the use of cleaning and sanitizing agents. On 4/13/26, the Director of Dining Services or designee implemented a new cleaning checklist requiring the stockperson to deep-clean floors (deck scrub, squeegee, and mop) and racks in walk-in coolers every Tuesday and Thursday. On 4/13/26, the Director of Dining Services re-educated the Assistant Food Services Manager to ensure that floors, including cooler floors, are thoroughly cleaned at the end of each shift. On 4/13/2026, the Director of Dining Services or designee will revise the Dietary Aide Weekly Cleaning Schedule to include a daily sign-off requirement for walk-in cooler floor cleaning to ensure accountability and documentation of cleaning tasks. On 4/16/2026, the Director of Dining Services or designee will establish a policy requiring dietary teammates to report and immediately clean any spills in walk-in coolers or kitchen areas to prevent the accumulation of debris and potential food safety hazards.</p> <p>Plan to Monitor Performance:</p> <p>The Director of Dining Services, or designee, will audit the kitchen's cleanliness, including walk-in cooler floors and racks, 5 days per week for 4 weeks, then weekly for 2 months. The audit will include verification that spills are cleaned immediately, floors are swept and mopped daily, and deep cleaning tasks are completed according to the new checklist. The Director of Dining Services, or designee, will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance with the set-forth protocol is achieved.</p> <p>Date of Compliance: 5/4/2026</p>	05/07/2026

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F0812 SS = D	Continued from page 2 Assistant Food Services Manager she stated she usually came in at 5:00 AM and one of the first things she did was make sure the kitchen was clean and that the dietary staff had done their cleaning jobs the night before. The Assistant Food Services Manager explained she had come in the morning of 4/13/26 and pulled carts out of the coolers to check dates and look at the floors and did not notice any spills on the floors. She further explained that none of the other kitchen staff had told her there had been any spills in the cooler. The Assistant Food Services Manager indicated she thought the dark sticky material on the cooler floor may have been grape or prune juice from a larger juice pitcher or something from a dessert bowl that had spilled over.  In an interview on 4/16/26 at 12:26 PM with Administrator she explained the sticky material on the cooler floor was in the morning so maybe it had been something that had spilled during breakfast preparations. The Administrator stated kitchen staff did a great job with cleanliness and sanitation, and this was an anomaly.	F0812		05/07/2026
F0880 SS = D	Infection Prevention & Control  CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control  The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	Corrective Action for Affected Residents:  On 04/13/26, the Staff Development Coordinator (SDC) or designee re-educated Facility Aide #1 and Facility Aide #2 on proper procedures for feeding residents and following infection control guidelines when feeding residents. This training included the following points: Always wash residents' hands prior to feeding or serving them food with either hand sanitizer wipes, hand sanitizer rub, or soap and water. Teammates should wash their hands with soap and water prior to feeding or serving residents' food. Never handle a resident's food with your bare hands. If you need to touch a resident's food, such as finger foods, put on gloves first. If you touch something other than the resident's utensils or dishware while feeding that contaminates your hands, the teammate must perform hand hygiene before feeding the resident another bite. On 4/17/26, the interdisciplinary care plan team reviewed Residents #59 and #27 to develop individualized care plans and interventions to support independence as much as possible, while allowing teammates to assist with feeding and to maintain infection control policies. On 4/15/2026, the interdisciplinary care plan team reviewed Resident #59's care plan to address other ways of presenting food to the resident to encourage the resident to pick up food independently, including serving finger foods in bowls and only feeding this resident individually with her added challenges of positioning and constant motion, instead of feeding another resident along	05/07/2026

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F0880 SS = D	<p>Continued from page 3</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which 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; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record reviews, and staff interviews, the facility failed to follow their infection control policies and procedures for hand hygiene while feeding residents when Facility Aide #1</p>	F0880	<p>Continued from page 3 with them.</p> <p>Identifying other Residents having the Potential to be Affected: On 4/17/2026, the DON or designee and SDC or designee reviewed residents requiring finger foods and discussed those who had to be fed by teammates or had challenging issues during feeding to address other ways of presenting food to the resident to encourage them to pick up food independently, including serving finger foods in bowls and only feeding these residents one at a time, instead of feeding another resident along with them.</p> <p>Measures put in place or Systemic Changes: On 4/14/2026, the SDC or designee initiated mandatory re-education on Aston Park's policy regarding feeding residents with nursing teammates, including those who have also had feeding assistance training. This training included the following points: Always wash residents' hands prior to feeding or serving them food with either hand sanitizer wipes, hand sanitizer rub, or soap and water. Never handle a resident's food with your bare hands. Teammates should wash their hands with soap and water prior to feeding or serving residents' food. If you need to touch a resident's food, such as finger foods, put on gloves first. If you touch something other than the resident's utensils or dishware while feeding that contaminates your hands, the teammate must perform hand hygiene before feeding the resident another bite On 4/14/2026, the facility's policy titled "Teammate Hygiene and Handwashing" was reviewed and revised to clarify that when assisting residents to dine, if teammates must touch ready-to-eat food or a resident's hands during feeding, gloves must be worn or hand hygiene must be performed immediately after contact before continuing to feed the same resident or moving to another resident.</p> <p>Plan to Monitor Performance: Beginning 4/15/2026, the Staff Development Coordinator/Infection Preventionist or designee will observe teammates assisting residents with meals in the dining room to ensure proper hand hygiene and infection control practices are followed. These observations will occur daily for two weeks, then three times per week for two weeks, then weekly for four weeks. The Staff Development Coordinator/Infection Preventionist or designee will use a monitoring tool to document observations, including: teammates performed hand hygiene before serving or feeding residents; teammates did not handle residents' food with bare hands; teammates wore gloves when touching ready-to-eat food or residents' hands during</p>	05/07/2026

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<p>F0880 SS = D</p>	<p>Continued from page 4 handled food with bare hands while feeding Resident #59. In addition, Facility Aide #2 handled food with bare hands while feeding Resident #59 and did not perform hand hygiene in between feeding Resident #59 and Resident #27 after touching Resident #59's food and hands. This deficiency occurred for 2 of 12 staff members observed for infection control practices while feeding residents (Facility Aide #1 and Facility Aide #2).</p> <p>The findings included:</p> <p>Review of the facility's policy titled "Standard Precautions" revised 11/30/22 indicates:</p> <p>Hands are to be washed with soap and water when visibly soiled, after direct or indirect contact with dirt, body fluids, before eating, and after using the restroom.</p> <p>Hand hygiene should also occur after using gloves and between resident contacts.</p> <p>Review of the facility's policy titled "Teammate Hygiene and Handwashing" revised 7/ 9/25 indicated:</p> <p>Teammates should never use bare hand contact with any foods, ready to eat or otherwise. All teammates should wash their hands per hand washing policies and procedures.</p> <p>Teammates do not need to wear gloves when distributing food to residents at the dining tables or when assisting residents to dine, unless touching ready-to-eat food.</p> <p>Handwashing is required to prevent cross contamination when changing tasks or activities that contaminate the hands.</p> <p>a. On 04/13/26 at 12:14 PM, observation was made of Facility Aide #1 assisting Resident #59 with her meal. Facility Aide #1 cut a hamburger on a bun with a knife and fork then picked up a piece of the bun and burger with her hand without using a barrier and placed it in Resident #59's hands. Resident #59 had trouble grasping the piece of bun, so Facility Aide #1 reached with both her uncovered hands and grasped both of Resident #59's hands to reposition the food in the resident's hands. Facility Aide #1 continued to feed Resident #59 using uncovered hands to pick up pieces of hamburger.</p> <p>During an interview on 4/13/26 at 12:21 PM with Facility Aide #1 she explained she was taught not to</p>	<p>F0880</p>	<p>Continued from page 4 feeding; teammates performed hand hygiene between residents when feeding multiple residents. Any non-compliance identified will result in immediate re-education of the teammates and, as appropriate, supervisory intervention. The SDC will report on monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance with the set-forth protocol is achieved.</p> <p>Date of Compliance: 5/4/2026</p>	<p>05/07/2026</p>

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F0880 SS = D	<p>Continued from page 5</p> <p>touch residents' food with bare hands. Facility Aide #1 stated she should have used gloves when she had to hold Resident #59's food.</p> <p>b. An observation was made on 04/14/26 at 12:39 PM of Facility Aide #2 placing pieces of cut meat patty in Resident #59's hands with her left hand without using a barrier. Twice while putting the food in Resident #59's hands, Facility Aide #2 touched the resident's hands with both her bare hands. Facility Aide #2 then used her left hand to pick up a spoon to feed Resident #27 without sanitizing her hands. After spoon feeding 2 bites to Resident #27 with her left hand, she then picked up a cup with her left hand without sanitizing her hands and gave Resident #59 a drink.</p> <p>In an interview with Facility Aide #2 on 4/14/26 at 12:50 PM she explained she had assisted Resident #59 with eating, and the resident used her fingers to feed herself but sometimes needed help getting the food. Facility Aide #2 stated she had sanitized her own hands prior to assisting the residents with this meal. When asked what she had been taught about handling food with bare hands she stated she knew not to touch food without gloves or to use a barrier like a napkin. Facility Aide #2 further explained she had tried to put the food in Resident #59's hands with the fork first and the resident would not take it, so she just used her hands. Facility Aide #2 revealed she had been trained when feeding two residents to use a different hand for each person or just touch the end of their utensil to not spread germs and to sanitize hands in between if feeding one person at a time. Facility Aide #2 stated she was left-handed and used her left hand to feed Resident #27 after touching Resident #59's food and hands. Facility Aide #2 also stated she realized what she did was not what she had been taught in the Feeding Assistant course and did not know why she did that, just that she had been focused on Resident #27 getting the bites of food.</p> <p>Review of training records for Feeding Assistant training revealed the course included hand hygiene, infection prevention practices while assisting with feeding, and return demonstration of correctly feeding residents. Facility Aide #1 completed Feeding Assistant training on 1/9/26 and Facility Aide #2 completed Feeding Assistant training on 3/19/26.</p> <p>On 4/14/26 at 4:14 PM an interview was conducted with the Staff Development Coordinator (SDC), who taught the Feeding Assistant course to Facility Aides, and was also the Infection Preventionist. The SDC explained the hand hygiene processes taught</p>	F0880		05/07/2026

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F0880 SS = D	<p>Continued from page 6 when staff assisted residents with meals was to wash their hands before they started and sanitize their hands between residents. The SDC then explained what staff were taught when feeding two residents at the same time. She stated they needed to be careful not to break the infection prevention barrier between the two residents by keeping each resident's food and utensils separate. The SDC stated if they had broken that barrier between the two, for example by touching a resident with their hands or used the same hand to touch anything other than the end of the utensil for both residents, that they should have sanitized their hands before continuing to feed. The SDC explained she watched the Facility Aides feed residents during the Feeding Assistant course and checks on them in the dining rooms when they are first starting on their own. The SDC indicated Facility Aide #1 and Facility Aide #2 were doing well overall but had gotten confused and made a mistake.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 4/14/26 at 1:00 PM with Facility Aide #2 present, she explained staff were taught not to handle food with their bare hands because it was an infection risk but to hand food to a resident with a package wrapper, napkin or fork, or to wear gloves. The ADON further explained staff were taught it was alright to feed two residents at a time when using practices to prevent cross contamination. The ADON stated practices to prevent cross contamination could include using one hand for one resident and the other hand for the other resident, or to just touch the end of the resident's utensils. The ADON revealed that if staff touched a resident with their hands or used both hands while feeding one resident, they should perform hand hygiene before continuing to feed the other resident.</p> <p>An interview was completed on 04/16/26 at 12:35 PM with the Director of Nursing (DON), with the Administrator and SDC present. The DON explained Resident #59 had been able to use finger foods but could be a little complicated and they were trialing different ways to make it easier for staff to assist her to feed herself and stay as independent as possible. The DON stated that staff were expected to wash their hands with soap and water before handling food and to perform hand hygiene in between residents. The Administrator stated the facility usually did a good job with hand hygiene.</p>	F0880		05/07/2026