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 03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ASHEVILLE	91 VICTORIA RD 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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #VE6X11.	F 000	**This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.**	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156	1. Resident # 3 and their responsible party were notified on 3/9/11 by the business office manager of their non-coverage of benefits along with the reason for non-coverage and appeal notice. Resident #31 was notified of their non-coverage of benefits along with the reason and appeal notice on 10/20/10. 2. An audit of all current Medicare recipients will be completed by 3/30/11 by the Administrator to identify residents that require notification of ending Medicare benefits. The administrator will ensure that these residents and/or their responsible party will be notified orally and in writing of their Medicare non-coverage and appeal notices. 3. The Interdisciplinary Team (IDT) which consists of the Administrator, Director of Nursing, Unit Coordinators, Minimum Data Set Coordinators, Admissions Coordinator, Business Office Manager, Social Worker, Activities Director, and Therapy Manager were re-educated regarding notification of rights, rules, services and charges by the Administrator on 3/25/11. The Business Office Manager and the Minimum Data Set Coordinator will be responsible for identification and tracking of resident benefit notifications, along with the IDT, and Nursing Home Administrator.	4/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ✓ | TITLE ✓ ADMINISTRATOR ✓ | (X6) DATE 4-7-11

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.

Original Signature Date: 3-28-11

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BY: _____

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical	F 156	4. Audits of the Medicare Non-Coverage and Appeal Notices will be reviewed bi-weekly in the morning interdisciplinary meeting for four weeks and then bi-monthly for two months, and/or 100% compliance. The results will be noted and reviewed in the monthly Quality Assurance. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director	

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F 156	Continued From page 2 or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews the facility failed to provide prior notice of discontinuation of Medicare Benefits and Appeal Rights for two (2) of three (3) sampled residents. (Residents #3 and #31). The findings are: 1. Review of the business office records revealed Medicare services for Resident #3 ended on 12/08/10. No Record was available in the business office files that a Medicare Non-Coverage and Appeal Rights Notice was sent to Resident #3 or their responsible party. Interview with the Business Office Manager on 3/8/11 at 9:00 am confirmed that Resident #3's Medicare Services ended on 12/08/10 and that a	F 156		

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F 156	Continued From page 3 Medicare Non-Coverage and Appeal Notice was sent to Resident #3 or their responsible party. The Business Office Manager stated during this interview "normally we would have sent the Responsible Party for Resident #3 a Notice of Services ending prior to 12/08/10. We just missed sending the notice." 2. Review of business office records for Resident #31 revealed Medicare benefits for this resident ended on 10/15/10. Review of the Business Office Files revealed a Medicare Non-Coverage and Appeal Notice dated as having been sent to Resident #3 on 10/20/10. Interview with the Business Office Manager on 3/08/11 at 9:00 am confirmed Resident # 31 had been sent a Medicare Non-Coverage Notice and Right to Appeal Notice on 10/20/10, after Medicare Services had ended on 10/15/10. During this interview on 3/08/11 at 9:00 am the Business Office Manager stated the Minimum Data Set (MDS) Nurse "is responsible for notifying the Social Worker and the business office of the end dates of residents Medicare coverage. We did not receive notice for some residents until after Medicare Services had ended." Interview with the Social Worker on 3/09/11 at 9:30 am revealed the Social Worker and the Business Office Manager shared responsibility for sending Medicare Non-Coverage and Appeal Rights Notices to residents and/or responsible parties prior to the end date of Medicare Services. The MDS Nurse tracks Medicare Services and notifies us when the Services will end. We did not receive a notice until after some residents Medicare services had ended."	F 156		

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F 156	Continued From page 4 Interview on 3/09/11 at 10:15 am with the MDS Nurse confirmed she was responsible for tracking residents Medicare Services and notifying the Business Office Manager and/or the Social Worker when residents Medicare Services would end. The Business Office Manager and Social Worker are responsible for sending residents and responsible parties a Medicare Non-Coverage and Appeal Notice prior to the Medicare Coverage end date. During this interview the MDS Nurse stated she "had not provided some residents Medicare end dates to the Social Worker or Business Office Manager until after Medicare services had ended." During this interview, Resident #31 was identified as being one of the residents whose Medicare end date, "had not been provided to the Business Office Manager or Social Worker until after Medicare Services ended on 10/15/10." Interview with the Administrator on 3/09/10 at 11:00 am confirmed the MDS Nurse was responsible for tracking residents' Medicare Services and notifying the Business Office Manager and the Social Worker when Medicare Services would end. The Administrator stated "the Business Office Manager and Social Worker are responsible for notifying residents and/or their responsible party prior to the end date of Medicare benefits."	F 156		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	1. The attending physician was notified on 03/07/11 of the resident #56 change in condition.	4/4/11

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F 281	Continued From page 5 by: Based on medical record review and staff interviews the facility failed to follow physician orders for labwork (Residents #38 and #86) and monitoring blood pressures (Resident #126) for three (3) of ten (10) sampled residents. In addition, licensed staff failed to communicate possible seizure activity of one (1) of three (3) sampled residents with seizures (Resident #56). This affected a total of four (4) of eleven (11) sampled residents. (Residents #38, #56, #86 and #126) The findings are: 1. Resident #56 was admitted to the facility 1/25/11 with diagnoses that included blindness and seizure disorder. An admission Minimum Data Set (MDS) assessment completed 2/2/11 assessed Resident #56 with no impairment of short or long term memory. Review of interdisciplinary progress notes in the resident's medical record revealed the following: 1/29/11 Resident with observed seizure activity. 3/5/11 Resident reported a seizure however it was not witnessed by staff. 3/7/11 Resident transferred to hospital due to unwitnessed head injury and change in cognitive status On 3/9/11 at 2:50 PM Nursing Assistant (NA) #2 reported he was working with Resident #56 on 3/5/11 who he considered to be alert and appropriate. NA #2 stated Resident #56 reported to him that he thought he had a seizure. NA #2 stated the seizure was not witnessed by staff and,	F 281	The attending physician was notified on 3/10/11 by the Unit Coordinator of the last available B12 laboratory result for resident # 86. A laboratory sample was obtained on 3/11/11 for the B12 level and the attending physician was notified of the results on 3/14/11. No new orders were received. No adverse outcomes noted. The attending physician was notified on 3/10/11 by the Unit Coordinator of the blood pressures that were obtained for resident # 126. No new orders were received. No adverse outcomes noted. The attending physician was notified on 3/09/11 by the Unit Coordinator of the date of the most recent HgA1c for resident #38. A laboratory sample was obtained on 3/10/11 for the HgA1c level for resident # 38 and the attending physician was notified of the results on 3/10/11. No new orders were received. No adverse outcomes noted. 2. An audit of all residents in the facility with a diagnosis of seizure disorder was conducted by the Unit Coordinators and the Director of Nursing by reviewing the twenty-four hour report and each of these residents chart notes for the previous 30 days to determine if any residents reported seizure activity. No residents were identified to be affected. A 100% audit of all facility residents with ongoing yearly labs will be completed by the Unit Coordinators by 4/1/11 to determine if all labs previously ordered had been collected and results were available. A 100% audit of all facility residents with orders for daily blood pressures will be completed by the Director of Nursing and the Unit Coordinators by 4/4/11 to ensure that results were obtained.	

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F 281	Continued From page 6 though the resident did not appear to be in any distress, he reported to the nurse on the hall that Resident #56 thought he had a seizure. NA #2 stated the nurse had him take the resident's vital signs; which were taken and provided to the nurse. On 3/9/11 at 11:10 AM Licensed Nurse (LN) #3 stated she was in training with LN #4 on 3/5/11. LN #3 stated that she was on her way to lunch when LN #4 asked her to chart that Resident #56 reported having a seizure that morning. LN #3 stated she wrote the 3/5/11 interdisciplinary progress note (about the resident's report of a seizure) in the resident's medical record and had no further involvement with Resident #56 . On 3/9/11 at 4:15 PM LN #4 stated she was working from 7AM-11PM on 3/5/11 on the hall Resident #56 resided. LN #4 stated she became aware sometime after lunch that Resident #56 reported having a seizure. LN #4 stated she considered Resident #56 to be reliable and she assessed him and saw no signs of seizure activity. LN #4 stated she did not document the resident's report of a seizure on the 24 hour report or report the concern to oncoming staff since she was working a double shift that day; thinking she would monitor the resident through the duration of her shift. On 3/9/11 at 6:40 PM LN #2 stated she worked with Resident #56 from 7AM-3PM on 3/7/11. LN #2 stated the resident was appropriate in the morning hours on 3/7/11 but then staff noticed a change in his behaviors after lunch. LN #2 stated a physician was in the building and he was asked to assess Resident #56. LN #2 stated the physician recommended sending Resident #56 to	F 281	3. An inservice was conducted by the Director of Nursing and Staff Development Coordinator on 3/11/11 through 4/4/11 for licensed nurses regarding physician and family notification of change in resident status. An inservice for all licensed nurses was conducted by the Staff Development Coordinator on 3/11/11 through 4/4/11 ordering, reviewing, and auditing monthly labs and verifying documentation of ordered vital signs. 4. The Director of Nursing and Unit Coordinators will conduct audits of the twenty-four hour report and nursing notes to ensure that physician and family notification of change in resident status has occurred. These audits will be conducted daily (Monday through Friday) for four weeks, then bi-weekly for four weeks and/or 100% compliance. The Unit Coordinators and RN supervisor will conduct audits to ensure all ordered labs have been obtained and results received. These audits will be conducted daily (Monday through Friday) for four weeks, then three times per week for four weeks, then monthly for two months and/or 100% compliance. The Unit Coordinators and RN Supervisor will conduct audits of all residents who have ordered daily blood pressure measurements to ensure that they are obtained and documented. These audits will be conducted daily (Sunday through Saturday) for fourteen days, then three times per week for four weeks, then monthly for two months and/or 100% compliance. The results of these audits will be noted and reviewed in the monthly Quality Assurance. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical	

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F 281	Continued From page 7 the emergency room for an evaluation. LN #2 stated she called EMS for transport and the responsible party (family member of Resident #56) to inform them of the resident being sent to the ER. LN #2 stated the responsible party of Resident #56 asked her if she knew the resident reported having a seizure two days prior. LN #2 stated the family member stated Resident #56 had told them on Saturday in a phone conversation that he thought he had a seizure. LN #2 stated she was not aware of the reported seizure as it was not on the 24 hour report nor had it been reported to her from staff working the prior shift. On 3/911 at 4:35 PM the nursing supervisor over the unit Resident #56 resided stated the reported seizure should have been included on the 24 hour nursing report so that nurses working subsequent shifts would be aware of the concern. 2. Resident #86 was admitted to the facility 10/22/07 with diagnoses that included B12 deficiency. Review of March 2011 physician orders revealed Resident #86 received a monthly injection of 1000 micrograms (mcg) of Vitamin B12. Physician orders included to have a B12 level done every year with August designated as the month to complete the lab work. Review of lab work completed for Resident #86 through 2010 revealed a B12 level was not done. On 3/10/11 at 11:00 AM the nursing supervisor over the unit Resident #86 resided reported that another management staff member (no longer employed by the facility) was responsible for ensuring lab work was done. The nursing supervisor reported the former employee should have noted the need for the B12 level on the	F 281	Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

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F 281	Continued From page 8 August 2010 Medication Administration Record (MAR) for Resident #86 which would have been a trigger for nurses to initiate a lab requisition. The nursing supervisor reviewed the resident's medical record and confirmed the B12 level was not done in 2010 as ordered by the resident's physician. On 3/10/11 at 4:30 PM the Director of Nursing (DON) reviewed the facility practice for obtaining labs which included: when the monthly physician cumulative orders were reviewed the nurse doing the review was responsible for putting a "FYI" (for your information) on the individual resident's MAR to alert the nurse the lab is due. The DON stated third shift nurses were then responsible for checking each residents MAR and, at some point in the month, fill out a lab requisition slip. The DON could offer no explanation why the B12 had not been done for Resident #86. 3. Resident #126 was admitted to the facility 2/2/11 with physician orders that included to check blood pressure every day. This order had been recorded on the Medication Administration Record (MAR) for February 2011 and March 2011 however, there were no blood pressures recorded on the MAR. Review of the medical record of Resident #126 revealed the only documented blood pressures since admission were done 2/3/11, 2/8/11, 2/15/11, 2/22/11, 3/1/11 and 3/8/11. On 3/10/11 at 10:10 AM the nursing supervisor over the unit Resident #126 resided stated although it was not clear why daily blood pressures were ordered, if blood pressures were ordered every day they should be done. No explanation could be provided why the blood	F 281		

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F 281	Continued From page 9 pressures were not done as ordered by the physician for Resident #126. 4. Resident #38 was readmitted to the facility 07/27/2007 with diagnoses including Diabetes Mellitus Type II (DM). Review of the medical record revealed an original physician's order dated 12/04/2008 to obtain a Hemoglobin A1c (HgbA1c - laboratory [lab] test used to determine how well diabetes is controlled) every six months in April and October. Review of the monthly "Physician Orders" sheets form October 2010 through March 2011 reflected the original order for HgbA1c to be completed in April and October. Review of the medical record from October 2010 through March 2011 and Laboratory test results provided by the facility revealed Resident #38's HgbA1c was last completed in April 2010. During an interview on 03/10/2011 at 09:15 AM the nursing supervisor, currently responsible for the unit where Resident #38 resided, confirmed the October 2010 HbA1c was not completed as ordered by the physician. The interview revealed the previous unit supervisor, who was no longer employed, was responsible for reviewing monthly physician's order sheets and documenting ordered labs on the residents' MAR as an "FYI" (for your information). The "FYI" was to remind Licensed Nursing (LN) staff to complete a requisition and schedule the lab. The nursing supervisor stated Resident #38's HgbA1c and "FYI" should have been, but was not, documented on the resident's October 2010 MAR therefore LN staff failed to schedule and complete the lab. The nursing supervisor confirmed Resident #38's last HgbA1c was completed April 2010.	F 281		

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F 281	Continued From page 10 During an interview, 03/10/11 at 09:20 AM, the facility Director of Nursing (DON) stated the unit nurse supervisor, who was no longer employed, was responsible for monitoring to ensure residents' labs were completed as ordered by the physician. The DON stated the facility had no specific system in place to ensure routine labs were completed as ordered. The DON stated, prior to the survey, she was unaware that Resident #38's HgbA1c was not completed October 2010 as ordered.	F 281		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, facility and medical record reviews, and resident and staff interviews the facility failed to remove facial hair and provide nail care for four (4) of five (5) sampled residents dependent on staff assistance with personal hygiene and/or bathing. (Resident #41, #51, #55, and #63). The findings are: 1. Resident #41 was readmitted to the facility 10/20/2009 with diagnoses including Rheumatoid Arthritis. On an annual Minimum Data Set (MDS) assessment, dated 01/11/2011, Resident #41 was assessed as having moderately impaired cognition and aware of the current week, month,	F 312	1. Resident # 41 had their nails trimmed by the Certified Nursing Assistant on 03/10/11. Resident #51 had their nails trimmed by the Certified Nursing Assistant on 03/10/11. Resident #55 had their facial hair trimmed by the Certified Nursing Assistant on 3/10/11. Resident # 63 had their nails trimmed by the Certified Nursing Assistant on 3/10/11 2. A 100% audit of all facility residents was conducted by the Unit Coordinators and Director of Nursing on 3/11/11 to ensure all residents had nails and facial hair trimmed. 3. An inservice was conducted by the Staff Development Coordinator on 3/11/11 through 4/4/11 for all licensed nurses and Certified Nursing Assistants in regards to activities of daily living care with specific emphasis on the grooming needs of residents.	4/4/11

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(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 312	Continued From page 11 and year. Resident #41 was assessed as requiring limited assistance with personal hygiene and needing physical assistance with part of bathing. On the 01/25/2011 Care Plan, Resident #41 was identified as having a problem with self-care deficit due to limited range of motion (contractures), Rheumatoid Arthritis, Muscle Weakness, and Mixed Dementia. The goal of the Care Plan was for Resident #41 to remain clean and to continue participating in activities of daily living (including personal hygiene and bathing). Approaches established toward meeting the Care Plan goal included; staff to provide AM/PM (morning and afternoon) care, showers or complete bed baths twice weekly, set-up grooming/hygiene and bathing supplies, and encourage resident to participate in tasks with assistance provided as needed. The March 2011 "Bath and Hygiene" report utilized by Nursing Assistant (NA) staff for documentation of care was provided by the facility and reviewed. The "Bath and Hygiene" report revealed Resident #41's last bath, a bed bath, was documented on 03/07/2011 at 8:53 PM. Additional documentation revealed Resident #41 was provided with AM (daily) and HS (hour of sleep) care on 03/08/2011 and 03/09/2011. On 03/07/2011 at 12:30 PM Resident #41 was observed with nails on both hands extending approximately one half (1/2) inch beyond and over the fingertips with medium and dark brown debris. All nails were turning downward toward the fingertips and the nails on the left thumb and index finger as well as the right index finger were covering the entire fingertips resembling hooks.	F 312	4. Audits will be conducted by the Unit Coordinators and RN Supervisor for all facility residents to ensure that nails and facial hairs are trimmed. This audit will be conducted three times per week for four weeks, then weekly for four weeks and/or 100% compliance. The results of this audit will be noted and reviewed in the monthly Quality Assurance. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director .	

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F 312	Continued From page 12 The condition of Resident #41's nails was observed unchanged as follows: 03/7/2011 at 12:30 and 3:30 PM, 03/08/2011 at 9:15 AM and 1:30 PM, 03/09/2011 at 8:45 AM and 4:10 PM, and 03/10/2011 at 10:40 AM. On 03/10/2011 at approximately 3:00 PM Resident #41's nails were observed to be short and clean. During an interview on 03/10/2011 at 10:40 AM Resident #41 stated his nails were too long and needed to be cut/trimmed. Resident #41 stated he was left handed and was not able to clip his nails due to Rheumatoid Arthritis. The interview revealed facility staff were not offering or providing nail care to Resident # 41. Resident #41 stated his nails were getting hung on his clothing while dressing and that last week he asked day shift NA staff, unable to provide name, to clip his nails. Resident #41 stated staff had not cleaned or clipped his nails since before Christmas 2010. During an interview, 03/10/2011 at 1:25 PM, NA #3 stated she had been assigned to Resident #41 on a regular basis for the past three months. NA #3 stated Resident #41 self performed and was assisted with bed baths on the second shift, per his preference. The interview revealed NA staff were responsible for providing nail care during bed baths and showers/baths routinely and with daily care as needed. NA #3 stated, today 03/10/2011, she clipped and cleaned Resident #41's nails when she noticed they were heavily soiled and extremely long. NA #3 reported that Resident #41 usually asked for an "orange stick" to clean his own nails and that he had not requested nail care. NA #3 stated Resident #41's nails grow fast but it "had to have been" at least three weeks since his nails were clipped and cleaned.	F 312		

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F 312	Continued From page 13 During an interview on 03/10/2011 at 2:05 PM the Licensed Nurse (LN) #3, assigned to Resident #41, stated NA staff were responsible for providing nail care during residents' weekly baths/showers. LN #3 stated NA staff should also observe residents' nails during the course of their day and provide care as needed. LN #3 stated she observed residents grooming during medication pass and delegated needs to NA staff and/or took care or them herself. LN #3 stated she had not observed Resident #41's nails and had not performed or directed NA staff to provide nail care. During an interview on 03/10/2011 at 4:00 PM the facility Director of Nursing (DON) revealed NA staff were responsible for providing nail care during weekly baths/showers and during daily care as needed. The DON stated NA staff were responsible for and expected to keep residents' fingernails clean and trimmed. 2. Resident #51 was admitted to the facility 07/27/2009 with diagnoses including Alzheimer's Disease, Dementia, Lack of coordination, and Muscle Weakness. On the most recent Minimum Data Set (MDS), a quarterly dated 01/04/2011, Resident #51 was assessed as being cognitively intact and requiring extensive assistance with personal hygiene with physical help needed in part of the bathing activity. On the 01/06/2011 Care Plan Resident #51 was identified as requiring assistance with Activities of Daily Living (including personal hygiene and bathing) due to Senile Dementia, Alzheimer's Disease, Encephalopathy, Lack of Coordination, and Muscle Weakness. The goal of the Care	F 312		

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F 312	Continued From page 14 Plan was for Resident #51 to remain clean and to participate in self-care tasks as tolerated. Approaches established toward meeting the Care Plan goals included; staff to provide AM/PM (morning and afternoon) care, showers/complete bed bath twice weekly, and set-up grooming, hygiene and bathing supplies, and encourage resident to participate in task with assistance provided as needed. The March 2011 "Bath and Hygiene" report utilized by Nursing Assistant (NA) staff for documentation of care was provided by the facility and reviewed. The "Bath and Hygiene" report revealed Resident #51's last bath/shower was documented on 03/07/2011 at 8:28 PM. Additional documentation revealed Resident #51 was provided with AM (daily) and HS (hour of sleep) care on 03/08/2011 and 03/09/2011. On 03/7/2011 at 2:30 PM Resident #51 was observed with nails on both hands extending approximately one fourth (1/4) inch beyond the fingertips and pink/red polish that was heavily chipped and worn. Nails on the right and left thumb, index and third finger were observed with medium and dark brown debris underneath each nail. The condition of Resident #51's nails was observed unchanged as follows: 03/8/07/2011 at 10:30 AM and 4:10 PM, 3/09/2011 at 1:45 PM, 3/10/2011 at 1:15 PM, 1:30 PM, and 1:55 PM. During an interview, 03/10/2011 at 1:20 PM, NA #4 stated she was providing care for Resident #51 today, 03/10/2011, but that the resident was not usually on her assignment. NA #4 stated she had not noticed Resident #51's fingernails and had not provided nail care. The interview further revealed NA staff were responsible for providing	F 312		

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F 312	Continued From page 15 routine nail care during baths/showers and daily nail care as needed. During an interview on 03/10/2011 at 1:35 PM the Unit Manager/Supervisor (UM #1), assigned to the hall where Resident #51 resided, observed the resident's fingernails and confirmed the nails were slightly long, with debris, and the polish was chipped and worn. The interview revealed NA staff were responsible for providing routine nail care during showers/baths and daily as needed. UM #1 stated LN staff were responsible for supervising residents' care and for delegating unmet needs to NA staff. During the interview UM #1 reported Resident #51 was not able to do and/or maintain her own nails due to impaired cognition and physical limitations. During an interview on 03/10/2011 at 1:50 PM the Licensed Nurse (LN) #6, assigned to Resident #51, stated NA staff were responsible for providing nail care during residents' weekly baths/showers. LN #6 stated NA staff should also observe residents' nails during the course of their day and provide care as needed. LN #6 stated she observed residents grooming while on the hall during medication pass and delegated needs to NA staff and/or took care or them herself. LN #6 stated she had not observed Resident #51's nails and had not performed or directed NA staff to provide nail care. During an interview on 03/10/2011 at 4:00 PM the facility Director of Nursing (DON) revealed NA staff were responsible for providing nail care during weekly baths/showers and during daily care as needed. The DON stated NA staff were responsible for and expected to keep residents' fingernails clean and trimmed.	F 312		

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3. Resident # 55 was readmitted to the facility 03/05/2011 with diagnoses including Dementia, Alzheimer's Disease, and Muscle Weakness. On the most recent Minimum Data Set (MDS), a quarterly dated 02/01/2011, Resident #55 was assessed as having severe cognitive impairment and as being independent with personal hygiene and bathing during the assessment period.

On the 02/02/2011 Care Plan Resident #55 was identified for potential for self care deficit due Dementia, Depression, and Muscle Weakness. The goal of the Care Plan was for Resident #55 to remain clean and continue to perform self-care tasks independently as tolerated or with staff minimal assistance. Approaches established toward meeting the Care Plan goals included; staff to assist with AM and PM (morning and afternoon) care as needed, assist with showers twice weekly, and set-up grooming, hygiene and bathing supplies and assist with tasks as needed.

The March 2011 "Bath and Hygiene" report utilized by Nursing Assistant (NA) staff for documentation of care was provided by the facility and reviewed. The "Bath and Hygiene" report revealed Resident #55's last bath/shower was documented on 03/09/2011 at 10:00 PM.

On 03/07/2011 at 2:25 PM Resident #55 was observed ambulating in the hallway with scattered white hair stubble over the chin. Eight (8) to ten (10) of the chin hairs ranged from one fourth (1/4) to one half inch (1/2) long and were obvious from a distance of three (3) to four (4) feet. The hair stubble as well as the longer hairs remained on Resident #55's chin as follows: 03/08/2011 at 4:05 PM, 03/09/2011 at 1:25 PM, and 03/10/2011

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F 312	Continued From page 17 at 1:15 PM and 1:35 PM. During an interview, 03/10/2011 at 1:20 PM, NA #4 stated she was providing care for Resident #55 today, 03/10/2011, but that the resident was not usually on her assignment. NA #4 stated she had not noticed or attempted to remove Resident #55's facial hair. The interview further revealed NA staff were responsible for removing facial hair/shaving of residents during baths/showers and daily as needed. During an interview on 03/10/2011 at 1:35 PM the Unit Manager/Supervisor (UM #1), assigned to the hall where Resident #55 resided, observed the resident's chin and confirmed multiple facial hairs were present and obvious. The interview revealed NA staff were responsible for removing/shaving residents' facial hair during scheduled baths/showers and daily as needed. UM #1 stated LN staff were responsible for supervising residents' care and for delegating unmet needs to NA staff. During the interview UM #1 reported due to impaired cognition and for safety reasons Resident #55 was not able to self-perform or request removal of unwanted facial hair . During an interview on 03/10/2011 at 1:50 PM the Licensed Nurse (LN) #6, assigned to Resident #55, stated NA staff were responsible for providing removal/shaving of facial hair during residents' weekly baths/showers. LN #6 stated NA staff should also observe residents' for facial hair during the course of their day and provide care as needed. LN #6 stated she observed residents grooming while on the hall during during medication pass and delegated unmet needs to NA staff and/or took care or them herself. LN #6	F 312		

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F 312	Continued From page 18 stated she had not observed facial hair on Resident #55 and had not delegated NA staff to remove/shave the resident's facial hair. During an interview on 03/10/2011 at 4:00 PM the facility Director of Nursing (DON) revealed NA staff were responsible for hair removal/shaving during weekly baths/showers and during daily care as needed. The DON stated NA staff were expected to groom residents' appropriately which included removal/shaving of unwanted facial hair. 4. Resident #63 was admitted to the facility 08/12/08 with diagnoses including Alzheimer's disease, aphasia, and vascular dementia. A Minimum Data Set (MDS) dated 02/22/11 indicated impairment of memory and cognition and required staff assistance for all care. A Resident Assessment Protocol (RAP) dated 06/14/10 described Resident #63 with impaired function to maintain activities of daily living (ADLs: bathing, transfers, eating, and toileting) and was bed/chair bound. The RAP continued the resident received extensive assistance with bed mobility and was dependent on staff for dressing, hygiene, and bathing. The RAP stated the resident was at risk for infections. A care plan dated 03/01/11 stated Resident #63 required assistance with all ADLs related to cognitive impairment and Alzheimer's disease. The care plan goal stated the resident will remain clean, dry, and odor free through next review. Interventions listed with the care plan included: provide morning and evening care, shower/complete bed bath twice a week, staff to anticipate and provide ADLs due to the resident's inability to verbalize needs.	F 312		

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F 312	Continued From page 19 A review of the facility shower schedule revealed Resident #63's scheduled shower days were Tuesday and Friday on the 3:00 p.m. to 11:00 p.m. shift. An interview on 03/08/11 at 11:07 a.m. with Resident #63's guardian revealed a concern for the length of the resident's fingernails. The guardian stated if the facility does not trim the resident's nails, he scratches his face with them. An observation on Tuesday, 03/08/11 at 4:22 p.m. revealed Resident #63's fingernails on both hands were up to and extended over the finger tips. The fingernails were observed square shaped making sharp corners. Continued observations on Wednesday, 03/09/11 at 9:36 a.m., 4:37 p.m., and 5:42 p.m. revealed fingernails remained long and square shaped. An observation during the evening meal on 03/09/11 at 6:03 p.m. revealed his right hand was positioned on his neck. While he was assisted with his meal, he continuously messaged his neck with the fingers and thumb of his right hand. As the meal progressed, the resident moved his hands up to his chin and to the left side of his face with his fingers and thumb in constant motion. The fingernails were unchanged in appearance. An interview on 03/10/11 at 10.47 a.m. with Nursing Assistant (NA) #1 revealed part of the shower process was to clean fingernails and cut them if needed on shower days. An interview was conducted on 03/10/11 at 11:56 a.m. with the Director of Nursing (DON) as she observed Resident #63's fingernails. The DON stated the fingernails were too long and should	F 312		

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F 312	Continued From page 20 have been cut. She added a nursing assistant was bought in on 03/07/11 for the purpose of trimming residents' fingernails. The DON stated she expected resident's fingernails were kept trim.	F 312		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to administer three (3) medications correctly out of fifty-nine (59) opportunities resulting in a 5.1% medication error rate. Two (2) of ten (10) residents observed during medication pass had errors in administration. (Residents #96 and #114). The findings are: 1. Resident #96 was readmitted to the facility 04/25/10 with diagnoses including dysphagia and cirrhosis of the liver. A review of Resident #96's medical record revealed a physician's order dated 09/29/10 for Lasix 40 milligrams (mg) twice a day at 8:00 a.m. and 2:00 p.m. The medical record also contained an order dated 06/16/10 for Potassium 80 millequivalents (meq) twice a day. An observation on 03/09/11 at 4:11 p.m. revealed Licensed Nurse (LN) #1 administered one (1) Lasix 40 mg tablet and one (1) Potassium 20 meq	F 332	1. The attending physician and family were notified of the doses of Lasix and Potassium received by Resident #96. No new orders were received. No adverse outcomes noted. The attending physician and family were notified of the dose of Artificial Tears resident #114 received. No new orders were received from the physician. No adverse outcomes noted. 2. LN #1 and LN # 5 were immediately inserviced by the Director of Nursing on 3/9/11 in regards to Medication Administration. LN # 1 and LN # 5 had three additional medication pass reviews on 3/25/11 conducted by the Director of Nursing. No additional areas of concerns were identified. 3. An inservice was conducted by the Director of Nursing and Staff Development Coordinator on 3/10/11 through 4/4/11 for all licensed nurses in regards to Medication Administration. 4. Medication Pass Reviews will be conducted by the Director of Nursing, RN Supervisor, and Staff Development Coordinator, for two nurses per day, three times per week for four weeks, then two nurses per day weekly for four weeks and/or 100% compliance. The results of this audit will be noted and reviewed in the monthly Quality Assurance. Any issues or trends identified will be addressed by the Quality Assurance	4/4/11

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F 332	Continued From page 21 tablet. An interview on 03/09/11 at 4:17 p.m. with LN #1 revealed he should not have administered the Lasix 40 mg with the 4:00 p.m. medication pass. He stated he did not notice until after it was administered the second dose of Lasix was given at 2:00 p.m. as ordered. LN #1 explained the Potassium 20 meq tablet was so large, he thought it was an 80 meq tablet. During this interview, LN #1 was observed reading the instructions on the Potassium package. He stated the directions instructed four (4) tablets should be administered to equal 80 meq. An interview on 03/10/11 with the Director of Nursing (DON) revealed she expected medications were administered as ordered by the physician. The DON stated she expected the staff to compare the instructions on medication packages with the Medication Administration Record. If the nurse was unsure of the directions or dosage, the DON expected the nurse should not administer the medication until they solicit assistance from other facility licensed staff. 2. Resident #114 was admitted to the facility 12/22/10. Resident #114's medical record and Medication Administration Record (MAR) for March 2011 revealed a 01/11/2011 physician's order for Artificial Tears two (2) drops to each eye to be administered four (4) times daily. Observations on 03/08/2011 at 4:40 PM revealed Licensed Nurse (LN) #5 administered one (1) drop of Artificial Tears in each eye of Resident #114. During an interview, 03/08/2011 at 5:00 PM, LN	F 332	Committee as they arise and the plan will be revised as needed to ensure continued compliance. The Quality Assurance Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ASHEVILLE	91 VICTORIA RD 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 332	Continued From page 22 #5 confirmed Resident #114 received one drop of Artificial Tears in each eye. LN #5 reviewed the MAR along with the medication pharmacy label and stated Resident #114 should have received two drops to each eye. LN #5 stated she did not recognize, from the MAR and label instructions, that two drops of Artificial Tears should have been administered. During an interview, 03/10/2011 at 09:30 AM, the facility Director of Nursing (DON) stated, LN staff were responsible for administering medications according to the physician's order documented on the medication pharmacy label and MAR. The DON reviewed the MAR and the pharmacy label along with the 01/11/2011 physician's order and confirmed LN #5 should have administered two drops of Artificial Tears in each eye of Resident #114.	F 332		