

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345174</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASHEVILLE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>91 VICTORIA ROAD</b> <b>ASHEVILLE, NC 28801</b>		
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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225		10/23/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/14/2015

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 225	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, the facility failed to report an alleged allegation of mistreatment within 24 hours to the State agency and failed to complete a 5 working day report to the State agency regarding the same incident for 1 of 4 sampled residents (Resident #80). The findings included:</p> <p>Resident #80 was admitted to the facility on 1/23/15 with active diagnoses of a below-the-knee amputation, generalized muscle weakness and lack of coordination, chronic obstructive pulmonary disease, hypertension, joint pain, and atrial fibrillation. The most recent minimum data set (MDS) was a quarterly assessment, completed on 7/21/15 indicated the resident was moderately cognitively impaired and required a 1-person assist for transfers, toileting, and mobility.</p> <p>A review of the facility ' s Incident/Accident reports revealed an Incident/Accident Report for the resident, initiated on 4/29/15, where the resident reported back pain to the nurse (Nurse #1) and alleged that the pain occurred as a result of " rough handling " by a nurse ' s aide during a transfer to the toilet.</p> <p>Further record review revealed the facility completed an internal investigation of the alleged incident, which was completed on 4/30/15 by the Staff Development Nurse (Nurse #2).</p> <p>Interview on 9/23/15 at 10:10 AM with Nurse #1 revealed she initiated the Incident/Accident Report on 4/29/15 after the resident complained to her of back pain and told her it was caused by rough handling from an unidentified nurse ' s aide. She further stated that the resident was unable to tell her when the incident occurred, or which aide was involved.</p>	F 225	<p>"This plan of correction is the facility's credible allegation of compliance"</p> <p>Preparation and execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared or executed solely because it is required by provisions of federal and state law.</p> <p>The facility will ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown origin and misappropriation of resident property are reported immediately to the Administrator or Director of Nursing of the facility and to other officials in accordance with State and Federal laws. The facility will thoroughly investigate all allegations of abuse and will take the necessary actions to prevent potential abuse while the investigation is in progress. The results of the investigation will be reported in a 5 day report to the proper state or licensing agency by the Administrator or Director of Nursing within 5 working days of the alleged allegation. An allegation verified appropriate will have corrective action taken.</p> <p>Resident #80 has had no complaints of any "rough handling" by staff or made any other allegations of alleged abuse.</p> <p>*A 24 hour report and 5 day report was completed on 10/20/2015 as part of our</p>		

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F 225	<p>Continued From page 2</p> <p>Interview on 9/23/15 at 10:45 AM with Nurse #2 revealed she completed the facility investigation into Resident #80 ' s allegation of rough handling, and that this is typically her responsibility. She stated she did not initiate a 24 hour report to the State agency, as that would have been the responsibility of the Director of Nursing (DON) or the Administrator.</p> <p>Interview on 9/23/15 at 11:09 AM with the DON revealed the Incident/Accident Report completed for Resident #80 on 4/29/15 was reviewed in a daily morning meeting of all administrative staff. She stated she spoke with the resident herself regarding his allegation, and that the resident could not tell her when the rough handling occurred, or which aide was involved-only that it was " a big black girl. " The DON stated she personally interviewed all aides who fit that description who worked at the facility at that time. She further stated that due to the results of the facility ' s internal investigation it was determined no abuse occurred, so the facility did not initiate a 24 hour report to the State agency.</p> <p>Interview on 9/23/15 at 3:09 PM revealed the Administrator she was aware of the allegations by Resident #80 and resulting investigation. She stated her understanding of the requirement for facilities to report all allegations and incidents of abuse to the State agency. The administrator further stated that based on the facility ' s internal investigation, she did not feel the allegation from resident #80 fit this requirement and so she did not make a report.</p>	F 225	<p>plan of correction regarding this deficiency for Resident #80. The investigation done by the facility found that no abuse occurred however it was reported to the appropriate state agency for further review. The Regional Quality Assurance Nurse was made aware of the report made on 10/20/2015 *</p> <p>The Administrator and Director of Nursing will be notified immediately of any allegations of abuse including nights, weekends and holidays. An immediate investigation will begin upon notification.</p> <p>All facility staff was re-educated by the Director of Nursing or RN Supervisor on the abuse policy from September 25, 2015 to October 22, 2015. Re-education of all staff will be done *on a quarterly* and an annual basis or more frequently if necessary.</p> <p>*Signs are posted at each nurses station, the employee time clock, housekeeping bulletin board, therapy bulletin board and dietary bulletin board on the signs and types of abuse and their responsibility to report suspected or known abuse immediately including making sure that resident is safety is the first concern.*</p> <p>The Director of Nursing reviewed 100% of the incident reports since March 28th to ensure there were no other allegations of abuse or rough handling by residents. The report of the review was communicated to the Administrator and Regional Quality Assurance Nurse that no</p>		

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F 225	Continued From page 3	F 225	<p>other potential abuse allegations were found.</p> <p>The abuse policy is included in the orientation packet which is facilitated by the Staff Development Nurse. Each new employee signs off on the abuse policy and the Human Resources person will verify that all new staff are in compliance with the policy. No staff person will be allowed to work unless they have signed off on the abuse policy.</p> <p>The Administrator or Director of Nursing will thoroughly investigate all allegations of abuse and will initiate a 24 hour report as soon as possible but not to exceed 24 hours after discovery of the event. Any person suspected of abuse will be suspended pending investigation. A 5day report will be submitted to the appropriate State agency.</p> <p>The Director of Nursing will submit all alleged allegations of abuse including the investigations to the Regional Quality Assurance Nurse for additional oversight for a period of at least 3 months.</p> <p>The Administrator, Director of Nursing and Staff Development person will meet daily Monday-Friday and on Monday for Saturday and Sunday to review any incidents or allegations of abuse including investigation cutcomes.</p> <p>The Abuse Policy and Investigation protocal will be added to our monthly QAPI process for a period of 3 months.</p>		

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F 225	Continued From page 4	F 225	The Administrator or Director of Nursing are responsible for reporting on compliance with the abuse policy including the results of the investigations to the QAPI committee for a period of 3 months.		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to: repair holes in the wall, maintain a clean floor, and keep an unused freestanding tub free of debris in 1 of 1 tub rooms and failed to: secure a toilet, maintain a clean floor, and maintain a clean shower curtain in 1 (Shower Room #2) of 4 shower rooms: The findings included:</p> <p>1. On 9/25/15 at 9:50 AM a resident was observed leaving the tub room after her shower, accompanied by Nursing Assistant #1.</p> <p>On 9/25/15 at 9:51 AM the tub room was observed. On the wet floor to the right side of the room, dark brownish-black matter was observed moderately to heavily disbursed in clumps over an area of approximately 4 feet long by two feet wide. In addition, at the back of the room there was a freestanding tub that appeared to be out of use. Inside the tub there was a sheet of plastic, a</p>	F 253	<p>The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.</p> <p>All holes in the tub room walls have been repaired. All dirty matter and brown clumps were immediately removed from the floor in the tub room and remains clean. All items in the tub have been removed. All shower curtains were replaced in 8 of the 8 shower rooms.</p> <p>F253 as been part of our QAPI process since March 2015.</p> <p>March to current there have been audits conduted by the Maintenance Director and Maintenance Assistant 1-3x per week to ensure that no toilets were found loose and if one did not meet compliance it was</p>	10/23/15	

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F 253	<p>Continued From page 5 plastic crate and a hanger.</p> <p>On 9/25/15 at 10:00 AM the tub room was observed with the Maintenance Director (MD). There was a hole in the tiled wall under the wall mounted sink, close to the floor, that was approximately 18 inches long by 6 inches high. The hole was partially covered by two vinyl 12 inch by 12 inch floor tiles which were crookedly placed on the wall and not yet secured, as the mortar was still wet. There was also an uncovered hole along a tiled wall near the free standing tub. This hole was also close to the floor and was approximately 36 inches long by 4 inches wide.</p> <p>Interview with the Maintenance Director on 9/25/15 at 10:00 AM revealed that he discovered the hole under the sink on his rounds on Monday 9/21/15. He stated that he had secured a wooden board over the hole but that on his rounds the morning of 9/25/15 he noticed it had been knocked loose so he quickly devised a temporary repair with the vinyl tile. The MD said that he did not implement a permanent repair under the sink because the bathroom was going to be renovated. He added that the facility had someone out to prepare a quote recently although there were no firm plans in place as yet. In regards to the hole near the free standing tub he stated that the Health Department told him it was fine to leave it that way. The MD stated that he had put the plastic sheeting over the tub to prevent staff from leaving items inside it but acknowledged there were still items in the tub that didn ' t belong there.</p> <p>On 9/25/15 at 10:10 AM interview with NA #1 indicated that she had seen similar looking dark</p>	F 253	<p>immediately corrected.</p> <p>June 1, 2015 revisit of survey from March 2015 was conducted and no problems were found with toilets in any of the shower rooms. Staff was re-educated to report and complete a maintenance form if there was a problem with any mechanical or structural piece of the equipment in the facility.</p> <p>July 15, 2015, toilet was found loose in *Shower Room 2* and the toilet was reset with new wax ring and flush valve due to damage. The audits resumed and all toilets were in compliance.</p> <p>August 6, 2015, Plumber from Bolton was requested to come on 8/9/2015 and look at toilet *in shower room 2*. At this time, a new toilet was purchased, the flange was raised and new brass bolts were installed to secure toilet to floor. There were tile modifications done and the toilet was able to be secured tightly. A new wax ring was installed and new toilet was installed. The audits continued and all toilets were in compliance.</p> <p>September 14, 2015, toilet was found loose *in shower room 2*, the plumber was called for additional interventions but did not need to come on-site and it was indicated that the floor would possibly need to be removed and a new floor installed. The Corporate Regional Director of Maintenance came to the facility and looked at shower rooms and various other renovations that the facility</p>		

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F 253	<p>Continued From page 6</p> <p>brownish-black matter on the floor in the shower room on many occasions. She indicated that she thought it was possibly coming out of the tile grout, which was a dark color, whenever the floor got wet so she didn ' t think much could be done about it.</p> <p>On 9/25/15 at 10:12 AM the tub room was observed with the Housekeeping Supervisor (HS), the Assistant Housekeeping Supervisor (AHS) and the Maintenance Director (MD). On the wet floor to the right side of the room, dark brownish-black matter was observed moderately to heavily disbursed in clumps over an area of approximately 4 feet long by two feet wide. The AHS stated that the shower room had been last cleaned on the afternoon of 9/24/15. The Maintenance Director indicated that when he came in early today (9/25/15) he saw that staff had been cleaning resident wheelchairs in the tub room and indicated that was likely the source of the matter on the tub room floor. The Maintenance director reported that night shift staff cleaned a number of wheelchairs every night. The AHS and HS acknowledged that the floor was not clean and that the resident tub room should be cleaned after it has been used for other purposes and prior to resident use. The HS stated that he would change the tub room cleaning schedule so that it would be cleaned in the morning before resident use and again in the afternoon.</p> <p>On 9/25/15 at 10:32 NA #1 was observed leaving the shower room with another resident, while housekeeping was waiting outside the tub room to go in and clean it. After she returned the resident to her room she was interviewed and stated that she didn ' t think about asking to have</p>	F 253	<p>is working to achieve. Audits continued with compliance being maintained for all shower room toilets.</p> <p>September 25,2015 the Director of Maintenance checked Shower Room #2 at approximately 6:20 a.m. and the toilet was secure.</p> <p>*September 25, 2015, the Maintenance staff were re-educated on the repair of holes in walls in the facility.**</p> <p>September 25, 2015 the Administrator notified the Regional Director Maintenance and indicated that shower room#2 needed to be renovated as a priority. The completion date of the Shower room #2 is October 23, 2015. The audits continue with compliance being maintained on a daily basis for all shower room toilets.</p> <p>The Housekeeping Manager, Housekeeping staff and Maintenance Staff will monitor on a *written log sheet* daily basis every 2 hours the cleanliness of each shower room from 7:00 a.m. to 7:00 p.m.and nursing will do the final check at 9:00p.m.*The Housekeeping Manager will collect the documented sheet on a monthly basis*.</p> <p>The Housekeeping Manager educated housekeeping staff on checking the shower/tub rooms every 2 hours to ensure they remain clean and free of debris or dirty matter. *The Housekeeping Manager educated all Department Managers on the</p>		

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F 253	<p>Continued From page 7</p> <p>the floor cleaned until she was already showering the resident. She added that before it was pointed out to her this morning she was just busy and didn ' t notice it.</p> <p>On 9/25/15 at 11:12 AM during an interview with the Administrator she indicated that she expected resident tub and shower areas to be clean. In addition, she indicated that she had not been aware of the holes in the bathroom said that she expected holes in the wall to be properly repaired.</p> <p>2. On 9/25/15 at 9:55 AM Shower Room #2 was observed. The toilet was observed to be shifted approximately 4 inches to the right of its normal 90 degree angle to the wall position. The two bolts that were intended to secure the toilet were appeared rusted. In addition, the floor appeared to have what looked like a haze of dried dirt throughout as well as boot/shoe prints. The shower curtain was observed to have dried black matter on the bottom right corner which covered an area of approximately 12 inches high and 6 inches wide.</p> <p>On 9/25/15 at 9:57 AM Shower Room #2 was observed with the Maintenance Director (MD). He checked the security of the toilet and in doing so the toiled was able to be moved approximately 4 inches to the right and 4 inches to the left of its normal 90 degree angle to the wall. The MD stated that he fixed that particular toilet regularly and that he had not been aware that it was loose again. He added that when staff wheeled residents in the room their wheelchairs would hit and dislodge the toilet. He stated that no one had reported to him that this toilet needed to be repaired.</p>	F 253	<p>audit tool and responsibility of each respective department*. The Director of Nursing and Maintenance Director educated their staff on the time frames responsible for completing the audit*.</p> <p>*All* staff were re-educated by the Director of Nursing or Nursing Managers on the reporting of mechanical problems by completing a maintenance form in the maintenance book located at both nursing stations.</p> <p>*All* staff were re-educated by the Director of Nursing or Nursing Managers on the reporting that they should contact the Housekeeping Manager or any housekeeping staff personnel to ensure that shower and tub rooms remain free of dirt and debris ensuring a comfortable environment for the resident.</p> <p>The Maintenance Director or Assistant Maintenance Director will check all toilets 3-5 times per week to ensure compliance with toilets being secure *n a written audit tool.*</p> <p>The maintenance repair book will be checked 2 times per day for *maintenance repair request form* by the Maintenance Director or Assistant Maintenance Director with appropriate follow up on maintenance request including a summary of what was done to correct the problem.</p> <p>This will remain as part of the QAPI process with these new interventions put in place which includes shower room</p>		



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F 253	Continued From page 8 On 9/25/15 at 9:59 AM Nurse #1 was interviewed. She stated that Shower Room #2 was used by staff for resident showers.  On 9/25/15 at 10:25 AM Shower Room #2 was observed with the Housekeeping Supervisor (HS), the Assistant Housekeeping Supervisor (AHS) and the Maintenance Director (MD). All three staff members acknowledged that the floor was not sufficiently clean, or appealing, for resident use at that time. The AHS stated that the room had been cleaned on 9/25/15 in the afternoon but he did not know how the floor could have gotten that dirty in that period of time. Both the AHS and HS indicated that the room would need a more frequent cleaning schedule if it was getting that dirty between cleanings. The MD stated that he had last check the shower room on his daily rounds on 9/24/15 and said he had not observed any issues at that time and had not noticed anything wrong with the shower curtain. He added that he would ensure the shower curtain was replaced.  On 9/25/15 at 11:12 AM during an interview with the she stated that the toilets coming loose in the facility was an ongoing problem. She also acknowledged that while the bath rooms were old and outdated they still needed to be clean and in good repair for resident use	F 253	renovations and revised auditing of the shower/tub rooms.  The Maintenance Director is responsible for reporting any findings from the audits to the Administrator. All previous day findings or concerns will be discussed in the morning department manager meeting Monday - Friday and on Monday for the weekend.  The Housekeeping Manager is responsible for reporting any findings from the audits to the Administrator. All previous day findings or concerns will be discussed in the morning department manager meeting Monday-Friday and on Monday for the weekend.  The Maintenance Director is responsible to report monthly to the QAPI committee on the audits and the progress of renovations of shower rooms for a period of 3 months.  The Housekeeping Director is responsible for reporting monthly to the QAPI committee all results of shower room cleanliness audits for a period of 3 months.		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		10/23/15	

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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 278	<p>Continued From page 9 participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code PASRR ( Preadmission Screening Resident Review) on the MDS ( Minimum Data Set) for eight of ten residents admitted with a PASRR level 2 ( Resident # 108, # 15, # 115, # 1, # 46, # 14, # 3 and # 53). The findings included: 1. Resident # 108 was admitted to the facility on 4/22/2015. Cumulative diagnoses included bipolar disorder and Symbolic Dysfunction. A review of resident # 108 ' s medical record revealed she was admitted with a level 2 PASSR.</p>	F 278	<p>The facility will ensure that a Registered Nurse accurately completes the resident assessment to correctly reflect the resident status.</p> <p>Resident #108 has an accurate MDS reflective of their PASSR status Resident #15 ha an accurate MDS relective of their PASSR status Resident #115 has an accurate MDS reflective of their PASSR status Resident #1 has an accurate MDS reflective of their PASSR status</p>		

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F 278	<p>Continued From page 10</p> <p>An admission MDS dated 4/29/2015 indicated " No " to question A 1500 which asked if resident # 108 was PASRR level 2.</p> <p>On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet.</p> <p>On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administartor revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>2. Resident # 15 was admitted to the facility on 7/20/2009. Cumulative diagnoses included Schizophrenia, Intellectual Disability, Epilepsy, and Symbolic Dysfunction.</p> <p>A review of resident # 15 ' s medical record revealed he was admitted with a level 2 PASRR. An annual MDS dated 4/30/2015 indicated " No " to question A 1500 which asked if resident # 15 was PASRR level 2.</p>	F 278	<p>Resident #46 has an accurate MDS reflective of their PASSR status</p> <p>Resident #14 has an accurate MDS reflective of their PASSR status</p> <p>Resident #3 has an accurate MDS reflective of their PASSR status</p> <p>Resident #53 has an accurate MDS reflective of their PASSR status</p> <p>All residents requiring as Level II on the MDS were modified on 9/24/2015 and transmitted. The transmission was accepted.</p> <p>The MDS nurse completed a facility audit on all PASSR's to reflect current PASSR level on 9/17/2015. On 9/17/2015 the Admissions person contacted PASSR regarding expiration dates and all were found to be current.</p> <p>The Admissions person will continue to enter the PASSR on the facesheet and place a copy in the chart. A copy of the PASSR letter will be given to the MDS Nurse.</p> <p>A list of all Level II Passr's was given to the MDS Nurse to maintain.</p> <p>The Social Worker will monitor on a monthly basis all PASSR statuses and will keep MDS informed of any changes. *The Social Worker will enter the information in the facility calendar which is shared with the interdisciplinary team and pass out a paper calendar to the interdisciplinary team on a monthly basis or more frequently if needed*</p>		

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F 278	<p>Continued From page 11</p> <p>On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet.</p> <p>On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrator revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>3. Resident # 115 was admitted to the facility on 6/04/2015. Cumulative diagnoses included Idiopathic auto neural disorder.</p> <p>A review of resident # 115 ' s medical record revealed he was admitted with a level 2 PASRR. An admission MDS dated 6/11/2015 indicated " No " to question A 1500 which asked if resident # 115 was a PASRR level 2.</p> <p>On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR</p>	F 278	<p>*The Social Worker will take the list 1 time per month to see if a any comprehensive assessments were done and was it coded for Level II PASSR.*</p> <p>*The Social Worker will complete the audit tool monthly and will discuss audit findings on a monthly basis with the Administrator, MDS Staff and MDS Consultant."</p> <p>"The Social Worker will report the results of the audit to the QAPI committee for a period of 12 months to ensure accuracy of coding and compliance to the QAPI committee."</p>		

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F 278	<p>Continued From page 12</p> <p>residents present in the facility. All administrative nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet.</p> <p>On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrator revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>4. Resident # 1 was admitted to the facility on 6/26/1997. Cumulative diagnoses included Intellectual Disability, cerebral palsy, non-psychotic brain syndrome, epilepsy and symbolic dysfunction.</p> <p>A review of resident # 1 ' s medical record revealed she had a level 2 PASRR initiated on 12/10/2013.</p> <p>An annual MDS dated 1/20/2015 indicated " No " to question A 1500 which asked if resident #1 was PASRR level 2.</p> <p>On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative</p>	F 278			

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F 278	<p>Continued From page 13</p> <p>nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet.</p> <p>On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrator revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>5. Resident # 46 was admitted to the facility on 10/17/2006. Cumulative diagnoses included psychomotor retardation, intractable seizures, symbolic disorder, expressive and receptive language disorder, intellectual disability, mental retardation.</p> <p>A review of resident # 46 ' s medical record revealed that she was admitted with a level 2 PASRR.</p> <p>An annual MDS dated 8/25/2015 indicated " No " to question A 1500 which asked if resident # 46 was PASRR level 2.</p> <p>On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative</p>	F 278			

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F 278	<p>Continued From page 14</p> <p>nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet. On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrator revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>6. Resident # 14 was admitted to the facility on 2/18/2015. Cumulative diagnosis included Epilepsy without intractable Epilepsy, bipolar disorder, mild intellectual ability, schizophrenia, symbolic dysfunction, developmental delay, cerebral palsy.</p> <p>A review of resident #14 ' s medical record revealed he had a level 2 PASRR.</p> <p>An annual MDS dated 9/23/2015 indicated " No " to question A 1500 which asked if resident # 14 was admitted with a level 2 PASRR.</p> <p>On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative nurse staff, administrator and the social worker</p>	F 278			

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F 278	<p>Continued From page 15</p> <p>had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet. On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrator revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>7. Resident # 3 was admitted to the facility on 5/17/2012. Cumulative diagnosis included Intellectual Disability, schizophrenia, schizoaffective disorder, paranoid schizophrenia. A review of resident # 3 ' s medical record revealed she had a level 2 PASRR. An annual MDS dated 4/21/2015 indicated " No " to question A 1500 which asked if resident # 3 was admitted with a level 2 PASRR. On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the</p>	F 278			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 278	<p>Continued From page 16</p> <p>facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS. The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet. On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrator revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.</p> <p>8. Resident # 53 was admitted to the facility on 9/11/2015. Cumulative diagnosis included Traumatic brain injury and depression. A review of resident # 53 ' s medical record revealed he had a level 2 PASRR. An annual MDS dated 7/01/2015 indicated " No " to question A 1500 which asked if resident # 53 was admitted with a level 2 PASRR. On 9/24/2015 at 4:00 PM the MDS Nurse stated that she had completed a chart review of all residents over the previous two weeks to confirm and develop a list of the ten level 2 PASRR residents present in the facility. All administrative nurse staff, administrator and the social worker had been provided with the updated list of ten residents. The MDS nurse also revealed that the facility had made changes to resident face sheets to include PASRR status at the bottom of the form and that the MDS Nurse would be responsible for coding item A 1500 on the MDS.</p>	F 278			

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F 278	Continued From page 17 The MDS nurse also revealed that on 9/17/2015, a level 2 PASRR report and detailed history report was obtained for all level 2 PASRR residents and had been attached to each face sheet. On 9/24/2015 at 4:13 PM an interview with Director of nurses and Administrartor revealed that upon completion of the chart review and a current PASRR level 2 list distribution, that the expectation was that the social worker would be responsible for updating and notifying the appropriate staff of PASRR status as well as updating the face sheets with PASRR levels. The MDS nurse would continue to code A 1500 on the MDS and verify PASRR status with the social worker.	F 278			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		10/23/15	

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F 520	<p>Continued From page 18</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility ' s Quality Assessment and Assurance committee (QAA) failed to implement, monitor and revise as needed the action plan developed for the recertification surveys dated 09/12/14 and 3/28/1 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies for housekeeping and maintenance (F253) on the surveys dated 09/12/14, 3/28/15 and 09/25/15. The continued failure of the facility during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The findings included:</p> <p>The tag is cross referenced to F253 - the facility failed to repair holes in the wall and clean the floor in 1 of 1 tub rooms and failed to secure a toilet and clean the floor in 1 (Shower Room #2) of 4 shower rooms.</p> <p>Review of the 3/28/15 F253 citation revealed, " failed to secure toilets to the floor for 3 of 5 sampled bathrooms and failed to secure ceiling tiles for 1 of 5 bathrooms " . Further review of this citation revealed " In Shower Room 2 on the 100 hall the toilet was observed to be loosened from its attachment to the floor and easily moveable 2-4 inches to the left and right. "</p> <p>Review of the 9/12/15 F253 citation revealed "</p>	F 520	<p>The facility has a quality assessment and assurance committee that meets monthly that includes a physician, Administrator, Director of Nursing, Nursing Managers, Therapy, Dietary, Business Office and Maintenance Manager.</p> <p>The facility meets to identify issues with respect to which quality assessment and assurance activities that are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>The University of North Carolina Chapel Hill has been an integral part of our QAPI process including in-service education, via conference call or in person attendance for QAPI meetings.</p> <p>The reference to F253 for the ceiling tiles from March 28, 2015 has been resolved and remains in compliance.</p> <p>The reference of F253 from 9/12/2014 has been resolved regarding air conditioner covers and remains in compliance.</p> <p>The reference of loose toilets in F253 has remained on our QAPI project since</p>		

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F 520	Continued From page 19 failed to secure and maintain unit air conditioners in 5 of 12 resident rooms " .  During an interview with the Administrator on 9/25/15 at 2:00 PM she indicated that when a deficiency was cited and a plan of correction was put in place audits were conducted for a period of three months and additional steps were taken if the issue was not resolved. In regards to housekeeping and maintenance she said that securing toilets in the facility was an ongoing issue that maintenance worked hard to fix. She added that the 3 of the 4 facility shower rooms had not yet been renovated and therefore took more effort to maintain but acknowledged they still needed to be clean and in good repair for resident use. The Administrator added that environmental rounds were conducted daily to identify areas that needed to be cleaned and items in disrepair, however she had been unaware of the holes in the tub room that had not been repaired once identified.	F 520	3/28/2015 when it was cited that 3 of 5 toilets were not secured to the floor. All of the toilets have remained in compliance and Shower Room #2 has had several interventions including:  June 1, 2015 revisit of survey from March 2015 was conduted and not problems were found with any of the surveyed shower rooms.. Staff was re-educatd at that time to report and complete a maintenace form if there was a problem with a menchanical of structural piece of the equipment in the facility.  July 15, 2015 toilet was found loose in Shower Room #2 and the toilet was reset with a new wax ring and flush valve due to damage. The audits continued on all shower room toilets. All toilets were found to be in compliance.  August 6, 2015, a plumber from Bolton was requested to come on 8/9/2015 and look at toilet. At this time, a new toilet was purchased, the flange was raised and new brass bolts were installed to secure toilet to the floor. There was tile modifications done to ensure toilet was able to be secured. A new toilet was installed including a wax ring. The audits continued and all toilets were in compliance.  September 14, 2015 toilet was reported as loose. The Maintenance Director was notified. The room was put out of service, the Maintenance Director called a plumber for additional interventions and the suggestion was to raise the flange		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345174</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/25/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASHEVILLE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>91 VICTORIA ROAD</b> <b>ASHEVILLE, NC 28801</b>		
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F 520	Continued From page 20	F 520	<p>more. The Maintenance Director completed that task. The Administrator called the Regional Maintenance Director and asked that he come on-site to look at various projects. The toilet was secure and the audits continued with all toilets being in compliance.</p> <p>September 25, 2015 the Administrator notified the Regional Director of Maintenance that Shower Room #2 would be a priority for renovation.</p> <p>Shower Room #2 will be renovated by October 23, 2015.</p> <p>All holes in the have been repaired in the tub room. This has been added to the Maintenance Audit tool as a general building tour sheet which will be done 3-5 times per week.</p> <p>All staff have been re-educated that any problems with mechanical or structural equipment must have "an out of order sign" posted and it is to be written in the Maintenance Repair book. If it is determined to be serious the Maintenance Department is available 24 hours a day and on the weekends.</p> <p>The audits of toilets has been increased to 3-5 times per week to ensure continued compliance.</p> <p>The Maintenance Director will report the results of the audits to the Department Managers in the morning meeting and will report on Monday for Saturday and</p>		

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F 520	Continued From page 21	F 520	<p>Sunday.</p> <p>The Maintenance Director will be responsible for reporting the results of the audits to the QAPI committee for a period of 3 months.</p> <p>The Housekeeping Manager and staff will check shower rooms every 2 hours during the day, the maintenance assistant will monitor in the evening and the nursing staff will monitor in the evening and overnight.</p> <p>The Housekeeping Manager is responsible for reporting the results of the audits to the Department Managers in the morning meeting, and The Housekeeping Manager will report on Monday for Saturday and Sunday.</p> <p>Staff was re-educated to inform the Housekeeping Manager or housekeeping staff member if there is debris or dirt on the floor.</p> <p>The Housekeeping Manager will put a bucket and mop in the utility room so staff has access to clean any area that is dirty in the shower rooms after 7:00 p.m.</p> <p>The QAPI committee will be adding F225 to the QAPI program. The Regional Quality Assurance Nurse will provide additional oversight to ensure compliance with F225.</p> <p>The Administrator or Director of Nursing will report monthly to the QAPI committee</p>		

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F 520	Continued From page 22	F 520	any abuse allegatons and the outcome of the investigation.		