STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345418	A. BUILDING _____ B. WING _____	C 01/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHEVILLE HEALTH CARE CENTER	1984 US HIGHWAY 70 SWANNANOA, NC 28778

(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 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to operationalize policy and procedures to check or make attempts to check employee references from previous or current employers for newly hired employees for 5 of 5 personnel records reviewed for abuse prohibition. (Nurse Aide (NA) #1, Nurse #2, NA#2, NA#3, NA #4). Findings included: A review of a facility policy and procedure titled Abuse/Neglect/Misappropriation/Crime Prevention/Screening/Training with an effective date of 07/14/15 indicated in part criminal background and reference checks are performed on all employees. A review of personnel records with the Administrator on 01/06/16 at 11:45 AM of 5 employees hired in the last 4 months revealed the following: NA #1 had a criminal background check completed on 09/16/15 but had no documentation of reference checks or attempts to check references from former employers. Nurse #2 had a criminal background check completed on 11/19/15 but had no documentation	F 226	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F226 How the corrective action will be accomplished; at the time of the discovery the HR Manager called the references of the five employees identified. How corrective action will be accomplished for those employees with the potential to be affected by the same practice. An audit of employee files back to September 1, 2015 was accomplished	1/28/16

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

Electronically Signed | 01/28/2016

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F 226	Continued From page 1 of reference checks or attempts to check references from former employers NA #2 had a criminal background check completed on 11/26/15 but had no documentation of reference checks or attempts to check references from former employers. NA #3 had a criminal background check completed on 12/02/15 but had no documentation of reference checks or attempts to check references from former employers. NA #4 had a criminal background check completed on 12/24/15 but had no documentation of reference checks or attempts to check references from former employers. During an interview on 01/06/16 at 11:55 AM the Administrator explained the Human Resources (HR) Manager was hired 10/20/15 and had received orientation to the hiring process. He confirmed the HR Manager had not checked references according to facility policy and procedure and today was the first time he had been made aware the reference checks had not been done by the HR Manager. During an interview on 01/06/16 at 12:01 PM with the HR Manager he explained when he was hired corporate staff provided an overview of his job responsibilities. He stated they covered licensure and background checks but he did not see the reference checks as a primary piece to complete as long as he had the licensure and criminal background check information. He further explained he had checked references on a potential new hire in the last 2 weeks who had completed an application with information that was questionable and he felt he needed to check the information more thoroughly. He stated he now realized the Administrator expected for	F 226	to ensure reference checks were completed/attempted and results documented. Measures in place to ensure practices will not reoccur. All new employee files will be reviewed by the HR Manager and Administrator for completeness prior to the individuals start date. How the facility plans to monitor and ensure correction is achieved and sustained. Audits will be completed prior to new hires beginning employment and these results will be reported to QA committee monthly for review and revision if needed for a period of 3 months.	

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F 226	Continued From page 2 reference checks to be completed or attempts be made to obtain reference checks from previous or current employers for every new employee before they began work in the facility. During a follow up interview on 01/06/16 at 12:12 PM with the Administrator he explained the HR Manager had not seen reference checks of new employees as a priority and had focused on getting licensure and certification and criminal background checks. He stated it was his expectation that attempts at getting reference checks from previous or current employers should be done and documented and verified the facility policy indicated for references to be checked on all new hires. He further stated he expected department mangers to also take part and to follow up with completion of reference checks if the HR Manager was unable to obtain them.	F 226		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and	F 315	F315	1/28/16

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F 315	Continued From page 3 resident, staff and physician interviews, the facility failed to replace an indwelling urinary catheter with the size indicated on the physician's orders for 1 of 3 resident's sampled with urinary catheters. (Resident #4). Findings included: Resident #4 was readmitted to the facility on 07/22/15 with diagnoses which included chronic kidney disease and retention of urine. A review of the most recent quarterly Minimum Data Set (MDS) dated 12/22/15 revealed Resident #4 was cognitively intact for daily decision making. The MDS also indicated Resident #4 required extensive assistance with toileting and had an indwelling urinary catheter and was always incontinent of bowel. A review of a physician's order dated 09/17/15 indicated indwelling urinary catheter #14 French (Fr) with 10 cubic centimeters (cc) bulb, may change as needed for leakage or occlusion related to unspecified retention of urine and provide catheter care and monitor urine output every shift. A review of a physician's order dated 11/25/15 indicated to flush urinary catheter with 200 cc of normal saline every day and evening shift. A review of a care plan with a revised date of 12/02/16 revealed Resident #4 had a #14 Fr indwelling urinary catheter with 10 cc bulb due to obstructive outlet and the goals were Resident #4 would show no signs or symptoms of urinary infection and would be free from catheter related trauma. The interventions indicated catheter care	F 315	How the corrective action will be accomplished for the resident(s) affected. The order was obtained for the 18 Fr. Foley that the patient had on January 6, 2016. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Completed an audit, of the remaining patients in the building with foley□s. All other foleys□ were found to have the correct order and size in place. Measures in place to ensure practices will not occur. All nurses were/will be educated on using a sterile catheter of appropriate size and per MD order prior to being allowed to return to work. An audit will be completed weekly for a period of three months to ensure appropriate size and order is in place for all foley□s in house. Measures in place to ensure practices will not occur. The results of the audits will be presented to the QA committee monthly for review and revision if needed for a period 3 months.	

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every shift, position catheter bag and tubing below the level of the bladder, monitor and document intake and output as ordered, monitor for signs and symptoms of discomfort on urination and frequency, monitor and document for pain and discomfort due to catheter and monitor and record and report to physician for signs or symptoms of urinary tract infection.

A review of a nurse's note dated 01/04/16, written by Nurse #1, indicated at 10 PM the nurse was unable to flush catheter with 200 cc's of normal saline. The note revealed the catheter was plugged and Nurse #1 placed a new #18 Fr catheter with 30 cc bulb and Resident #4 tolerated the procedure but experienced some pressure during placement. The note further indicated the bulb was filled with 20 cc of normal saline and the catheter was draining and flushing well.

During an observation and interview on 01/06/16 at 1:32 PM with the Staff Development Coordinator (SDC) she checked Resident #4's indwelling urinary catheter and confirmed he had a size #18 Fr with 30 cc bulb in place. After review of Resident #4's physician's orders and nurse's notes she stated the physician's orders indicated a #14 Fr urinary catheter and she could find no documentation of physician's orders to increase the catheter size to #18 Fr with 30 cc bulb or documentation to justify the increase in catheter size that was used.

During an interview on 01/06/16 at 1:35 PM with Resident #4 in the presence of the SDC he stated the catheter had to be changed a couple of days ago because it had stopped up. He further stated it was painful when the nurse inserted the new

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catheter.

During an interview on 01/06/16 at 1:57 PM the West Unit Coordinator confirmed Resident #4 had a physician's order for a #14 Fr catheter with a 10 cc bulb. She explained most catheters had a 10 cc bulb and stated Resident #4 probably was admitted to the facility with that size catheter but she was not sure. After review of nurse's notes she confirmed Nurse #1 had placed a new #18 Fr catheter with 30 cc bulb on 01/04/16 when Resident #4's catheter was plugged. She further confirmed this new catheter size was not what was indicated on the physician's orders. She stated nurses were supposed to get a physician's order if they were going to change the size of the catheter and confirmed she did not see where the nurse obtained a new physician's order for the size #18 Fr catheter or documentation of the reason the increased size catheter was used. She also explained the bulb size was different than what was indicated on the physician's orders. She stated Resident #4 had gone to see a kidney specialist earlier that morning for evaluation of his chronic kidney disease and inability to urinate and they were awaiting further diagnosis and treatment information from the physician.

During an interview on 01/06/16 at 2:48 PM with Nurse #1 he confirmed he changed Resident #4's indwelling urinary catheter on 01/04/16. He explained there was a treatment order to flush Resident #4's catheter with 200 cc normal saline in the evening and when he went in to flush the catheter it wouldn't flush because it was plugged. He stated Resident #4 was in discomfort and the urine in the tubing was cloudy. He explained he called the second shift Nursing Supervisor and

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she went to Resident #4's room and confirmed Resident #4's catheter was plugged and would have to be changed. He stated the catheter that was plugged had no writing on it to indicate the size so he took a #16 Fr catheter and a #18 Fr catheter to Resident #4's room and decided to use the #18 Fr catheter because it looked like the one he had taken out. He confirmed he did not look at the physician's orders for the catheter size. He stated Resident #4 had some discomfort when he inserted the catheter but he did not think it was anything out of the ordinary and Resident #4 was relieved when the catheter was in place and had about 700 cc output. He further stated the urine was clear and there was no sign of blood. He confirmed the bulb size was 30 cc but he only put 20 cc in it because that's what was in the one he took out. He further stated he did not realize he had done anything wrong until it was pointed out to him today.

During an interview on 01/06/16 at 2:57 PM with the second shift Nursing Supervisor she explained nurses were expected to flush Resident #4's urinary catheter every night and Nurse #1 had asked her to check Resident #4's catheter on 01/04/16. She stated she tried to flush it but was not able to so they decided to change the catheter. She explained there was no information on the catheter that indicated the size so they compared it to the catheters they had in supply and it looked like a #18 Fr catheter. She further stated when Nurse #1 took the old one out it was corroded and clogged and when he inserted the 18 Fr catheter he got an immediate return of cloudy yellow urine but there was no blood and Resident #4 seemed to be fine during the insertion of the catheter. She confirmed she did not check the physician's orders to see what

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catheter size was ordered but stated she should have gone and checked the orders herself. She explained the catheter size should also be documented on the care plan and nurses should refer to care plans for resident care but she had not looked at it.

During a telephone interview with on 01/06/16 at 3:30 PM the physician who was also the facility's Medical Director stated it was his expectation for nursing staff to follow physician's orders. He explained when residents were admitted with indwelling urinary catheters the nursing staff documented the size of the catheter on admission and that was the size indicated on the physician's orders for them to use. He further explained if there were problems with the catheter or bleeding or difficulty putting it in he expected to be notified. He stated he was not aware of any harm from the insertion of the larger catheter when Nurse #1 inserted the larger size indwelling urinary catheter.

During an interview on 01/06/16 at 2:59 PM with the Director of Nursing she stated it was her expectation any time there was a problem with a resident's indwelling urinary catheter, nurses should look at physician's orders to check for size and orders before changing the indwelling urinary catheter and there should be no question as to the size of the catheter to be inserted. She explained she was not aware Nurse #1 had replaced the indwelling urinary catheter with a larger size one when Resident #4's catheter was plugged on 01/04/16 and she was surprised to hear about it today. She further stated Resident #4 had gone for an appointment earlier that morning for evaluation of his kidney disease and they were waiting for further diagnosis and

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F 315	Continued From page 8 treatment information. During a follow up interview on 01/06/16 at 3:10 PM with Resident #4 and the Unit Coordinator Resident #4 explained his catheter had to be changed on 01/04/16 because "it was corroded on the inside." He clarified before the catheter was changed he had pain in his bladder like stabbing from a screwdriver but when the nurse took the catheter out and after the new catheter was put in he had relief from the pain. He further stated he saw a kidney specialist earlier today and decisions needed to be made about his chronic kidney disease and catheter but he needed time to think about it.	F 315		