

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2025
NAME OF PROVIDER OR SUPPLIER Elevate Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 91 Victoria Road Asheville, NC 28801	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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.

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

TITLE

(X6) DATE

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record reviews, observations and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions (EBP) for two residents with chronic wounds when the Treatment Nurse did not wear Personal Protective Equipment while providing wound care for Resident #7 and Resident #8. In addition, the Treatment Nurse failed to change her gloves and perform hand hygiene during wound care. This deficiency occurred for 1 of 3 staff members reviewed for infection control practices (Treatment Nurse). The findings included: A review of the facility's policy titled Enhanced Barrier Precautions, revised on 6/4/25, indicated: Enhanced Barrier Precautions (EBP) referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) by using gowns and gloves during high-contact resident care activities. High-contact activities included dressing, bathing, transferring, providing hygiene, changing linens or briefs, assisting with toileting, device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters), and wound care if deemed chronic by a medical provider or if MDRO was present. An order for EBP was required for residents with chronic wounds (such as pressure ulcers, diabetic foot ulcers, chronic venous stasis ulcers) and/or indwelling medical devices, even if the resident was not known to be infected or colonized with MDRO. The facility's policy titled Hand Hygiene, revised on 1/1/25, stated under section 6, Additional Considerations: The use of gloves did not replace hand hygiene. If a task required gloves, staff were to perform hand hygiene before donning gloves and immediately after removing gloves. Under the Hand Hygiene Table, staff were required to use either soap and water or alcohol-based hand rub when performing the following tasks: Before and after handling clean or soiled dressings or linens After handling items potentially contaminated with blood, body fluids, secretions, or excretions When moving from a contaminated body site to a clean body site during resident care. An observation of wound care for Resident #7 by the Treatment Nurse was made on 12/22/25 at 10:12 AM. Resident #7's room door did not have a sign for enhanced barrier precautions. The Treatment Nurse entered the room without wearing a gown. She washed her hands and put gloves on. She removed the dressing which was partially soiled with stool from Resident #7's coccyx. Resident #7 had a stage 2 pressure ulcer to his coccyx. Without removing gloves and performing hand hygiene, the Treatment Nurse proceeded to wipe the ulcer with gauze sprayed with wound cleanser. She discarded the gauze and applied a collagen dressing directly to the wound and covered it with a bordered dressing. She then discarded any unused supplies and her gloves and proceeded to wash her hands with soap and water at the sink. An interview with the Treatment Nurse on 12/22/25 at 10:47 AM revealed Resident #7 was recently admitted with a stage 2 pressure ulcer to his coccyx, but she couldn't find an order for enhanced barrier precautions for Resident #7. The Treatment Nurse stated she wasn't sure whether Resident #7 was supposed to be on enhanced barrier precautions which was why she did not wear a gown when providing wound care to Resident #7. She also stated that she knew she was supposed to change her gloves after cleaning Resident #7's wound, and she insisted that she did, but she wasn't sure about doing hand hygiene after removing her gloves. The Treatment Nurse stated that she received education on hand hygiene, but she would need to check the facility's infection policy before answering any more questions. The Treatment Nurse stated that she knew she needed to wash her hands before and after providing care but was not sure whether she had to do hand hygiene after removing gloves and before putting new gloves on. b. An observation of wound care for Resident #8 by the Treatment Nurse was made on 12/22/25 at 10:28 AM. Resident #8's room door did not have a sign for enhanced barrier precautions. The Treatment Nurse entered the room without wearing a gown. She washed her hands and put gloves on. Resident #8 had dressings around both ankles. The Treatment Nurse cut the dressings off from each ankle. She sprayed the left ankle wound with wound cleanser and then sprayed the right ankle wound with wound cleanser and started wiping the right ankle wound with a gauze. The Treatment Nurse then sprayed another gauze with wound cleanser and wiped Resident #8's right ankle wound. Without removing gloves and performing hand hygiene, the Treatment Nurse proceeded to spray another gauze with wound cleanser and wiped Resident #8's left ankle wound. The Treatment Nurse removed her gloves from both hands and without doing hand hygiene, put on new gloves to both hands. She applied collagen powder to the right ankle wound, placed a petrolatum-based gauze on the wound bed, covered it with a non-stick wound pad and wrapped the right ankle with rolled gauze. The Treatment Nurse then proceeded to apply collagen powder to the left ankle wound, place a petrolatum-based gauze on the wound bed, cover it with a non-stick wound pad</p>		