STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING ______ B. WING ______	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY CARE CENTER	3625 WILLARD FARROW DRIVE CHARLOTTE, NC 28215

(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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update a care plan to include geri-sleeves (protective sleeves) for 1 of 5 residents reviewed for accidents (Resident #116). The findings included: Resident #116 was admitted to the facility with diagnoses including dementia. Review of the quarterly Minimum Data Set (MDS) dated 04/29/15 revealed Resident #116 had short and long-term memory deficits and severely impaired cognitive skills for daily decision making. The	F 280	All resident care plans were immediately audited to ensure that if geri-sleeves were ordered, it was reflected on the resident's care plan. Completed on 7/3/15 by the MDS Coordinator Nurses. Care plans audited weekly X 4 weeks, then monthly X 5 months (for a total of 6 months) to ensure care plans are up-to-date to reflect geri-sleeves if ordered. Completed on 7/3/15, 7/10/15, 7/17/15,	7/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE: | (X6) DATE: 07/24/2015

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 280	Continued From page 1 quarterly MDS indicated Resident #116 required extensive assistance with bed mobility, transfers, and dressing. Review of a care plan last updated on 05/05/15 revealed Resident #116 was at risk for skin breakdown due to advanced age, decreased mobility, and incontinence. The goal stated Resident #116 would not have skin tears or bruising. Interventions included to check skin weekly and notify the would nurse of any new skin breakdown for areas. Review of an accident/incident investigation dated 06/02/15 stated a nurse noted three bruises on Resident #116's right forearm. The action taken was to apply bilateral geri-sleeves. Review of the medical record revealed a Physician's order dated 06/02/15 for staff to apply bilateral geri-sleeves to Resident #116's upper extremities at all times. An interview with Nurse Supervisor #1 at 07/02/15 at 1:16 PM revealed the Minimum Data Set (MDS) Nurse received copies of all new orders and updated resident care plans. During an interview on 07/02/15 at 1:41 PM MDS Nurse #1 stated she was typically notified of changes or updates to resident care plans either during the weekday morning meetings or the "Residents at Risk" meeting which meets every Tuesday. MDS Nurse #1 further stated Resident #116's care plan should have been updated to include the geri-sleeves and could not explain why this did not occur. An interview was conducted with the Director of	F 280	7/24/15 and then monthly X 5 months by the MDS Coordinator Nurses/designee. The care plan audits will be discussed in the monthly QA meetings X 6 months. Completed on a monthly basis X 6 months with next scheduled meeting on July 27, 2015.	

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F 280	Continued From page 2 Nursing (DON) on 07/02/15 at 2:07 PM. The DON stated she would have expected Resident #116's care plan to be updated to include the bilateral geri-sleeves to be worn daily within 5 days of the written order.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to secure loose side rails on one hall on the facilty's third floor for 2 of 3 sampled residents (Resident #20 and #43) and also failed to implement a physician ordered intervention to protect against skin tears and bruises for 1 of 4 residents reviewed for accidents (Resident #116). The findings included: 1. Resident #20 was admitted on 05/12/15 with diagnoses including dementia and Parkinson's disease. Review of the admission Minimum Data Set (MDS) dated 05/26/15 revealed Resident #20 had short and long-term memory and moderately impaired cognitive skills for daily decision making. The admission MDS further revealed Resident #20 required extensive assistance with bed	F 323	Loose assist rails of residents #20 and #43 immediately corrected on 7/2/15 by the maintenance technician. All assist rails that are utilized at Asbury Care Center were audited for safety by maintenance technician. Monthly monitoring of assist rails for safety completed 7/21/15 by the maintenance technician/designee. Monthly monitoring by maintenance technician for duration of side rail use on each bed. Report submitted to QA Committee monthly. Nursing staff education of reporting loose side rails to their appropriate manager or	7/25/15

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Continued From page 3

mobility and transfers.

Review of the medical record revealed a Physician's order dated 06/09/15 which stated Resident #20 could use assist side rails for bed mobility.

Review of a care plan dated 06/09/15 revealed Resident #20 needed side rails for positioning and bed mobility. Interventions included a therapy evaluation for use of the side rail and explain the risk and benefit of side rails to the resident.

Observations of Resident #20's assist side rails were as follows:
- on 06/30/15 at 11:51 AM the right rail was loose and leaned away from the edge of the mattress approximately 2 inches. The left rail was also loose and leaned away from the edge of the mattress approximately 1 inch.
- on 07/01/15 at 9:04 AM the right rail was loose and leaned away from the edge of the mattress approximately 2 inches. The left rail was also loose and leaned away from the edge of the mattress approximately 1 inch.
- on 07/01/15 at 3:26 PM the right rail was loose and leaned away from the edge of the mattress approximately 2 inches. The left rail was also loose and leaned away from the edge of the mattress approximately 1 inch.
- 07/02/15 at 8:15 AM the right rail was loose and leaned away from the edge of the mattress approximately 2 inches. The left rail was also loose and leaned away from the edge of the mattress approximately 1 inch.

An interview was conducted with the Director of Maintenance and the Director of Nursing (DON)

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maintenance technician for immediate correction completed by 7/25/15 by the Assistant Director of Nursing/designee.

All geri-sleeve orders will be reflected on the MAR for assigned nurse to check daily. Completed on 7/20/15 and ongoing by the Assistant Director of Nursing/designee.

RN Supervisor to check residents for wearing of geri-sleeves, if ordered. Completed daily X 1 month, then weekly X 3 months, then randomly every quarter by the RN Supervisor/designee.

The geri-sleeve audit will be reflected in the ongoing QA meetings and completed on an ongoing basis with next scheduled QA meeting on July 27, 2015.

Geri-sleeves were immediately applied to Resident #116 on 7-2-15. All other residents with geri-sleeves were checked to ensure they were on the appropriate resident.

All resident care plans and resident care sheets were immediately audited to ensure accuracy on 7/3/15.

CNA's educated by ADON to utilize care sheets and to follow the instructions contained on the sheets (completed 7/23/15). Monitoring for adherence to care sheet instructions performed by floor supervisors on each shift weekly for 3 months and monthly X 6 months. Report sent to QA Committee each month.

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F 323	Continued From page 4 during an observation of Resident #20's assist side rails on 07/02/15 at 2:38 PM. The Director of Maintenance stated it was not good that the assist side rails were this loose and they would need to be tightened up. The Director of Maintenance further stated he did not conduct scheduled monitoring of side rails in the facility and had expected the nurse aides would notify him if they observed a loose side rail. During an interview on 07/02/15 at 3:40 PM the DON stated the facility would need to develop and implement a corrective plan to maintain secure side rails in the facility and monitor regularly to assure a safe environment for the resident. 2. Resident #43 was admitted on 08/18/11 with diagnoses including history of cerebrovascular accident and hemiplegia. Review of the quarterly Minimum Data Set (MDS) dated 04/06/15 revealed Resident #43 had moderately impaired cognition and required extensive assistance with bed mobility and transfer. Review of a Occupational Therapy evaluation dated 06/15/15 revealed Resident #43 was able to demonstrate safe and appropiate use of side rails. Review of a care plan last reviewed and continued on 04/06/15 revealed Resident #43 had a self care deficit related to generalized weakness, memory loss, and impaired motor control. Interventions included use of half side rails for positioning in bed. Observations of Resident #43's bilateral half side rails were as follows:	F 323	Care plans audited weekly X 4 weeks, then monthly X 5 months (for a total of 6 months) to ensure care plans are up-to-date to reflect geri-sleeves, if ordered. Completed on 7/3/15, 7/10/15, 7/17/15, 7/24/15 and then monthly X 5 months by the MDS Coordinator Nurses/designee. The care plan audits will be discussed in the monthly QA meetings X 6 months. Completed on a monthly basis X 6 months with next scheduled meeting on July 27, 2015.	

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F 323	Continued From page 5 - on 06/29/15 at 4:43 PM the right side rail was loose and leaned away from the edge of the mattress approximately 1 inch. The left was also loose and leaned away from the side of the mattress approximately 2 inches. - on 06/30/15 at 11:55 the right side rail was loose and leaned away from the edge of the mattress approximately 1 inch. The left was also loose and leaned away from the side of the mattress approximately 2 inches. - on 07/01/15 at 3:31 PM Resident #43 was resting in bed with the bilateral side rails in use. The right side rail was loose and leaned away from the edge of the mattress approximately 1 inch. The left was also loose and leaned away from the side of the mattress approximately 2 inches. - on 07/02/15 at 8:14 AM Resident #43 was resting in bed with the bilateral side rails in use. The right side rail was loose and leaned away from the edge of the mattress approximately 1 inch. The left was also loose and leaned away from the side of the mattress approximately 2 inches. An interview was conducted with the Director of Maintenance and the Director of Nursing (DON) during an observation of Resident #43's bilateral half side rails on 07/02/15 at 2:41 PM. The Director of Maintenance stated both side rails were loose and they would need to be tightened up. The Director of Maintenance further stated he did not conduct scheduled monitoring of side rails in the facility and had expected the nurse aides would notify him if they observed a loose side rail. During an interview on 07/02/15 at 3:40 PM the DON stated the facility would need to develop	F 323		

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F 323	Continued From page 6 and implement a corrective plan to maintain secure side rails in the facility and monitor regularly to assure a safe environment for the resident. 3. Resident #116 was admitted to the facility with diagnoses including dementia. Review of the quarterly Minimum Data Set (MDS) dated 04/29/15 revealed Resident #116 had short and long-term memory deficits and severely impaired cognitive skills for daily decision making. The quarterly MDS indicated Resident #116 required extensive assistance with bed mobility, transfers, and dressing. Review of a care plan last updated on 05/05/15 revealed Resident #116 was at risk for skin breakdown due to advanced age, decreased mobility, and incontinence. The goal stated Resident #116 would not have skin tears or bruising. Interventions included to check skin weekly and notify the would nurse of any new skin breakdown for areas. Review of accident/investigations revealed on 04/15/15 the nurse noted a small skin tear on Resident #116's right wrist. On 04/20/15 the night supervisor noted a quarter sized bruise on Resident #116's right lower arm. An accident/incident investigation dated 06/02/15 stated the nurse noted three bruises on Resident #116's right forearm. The action taken was to apply bilateral geri-sleeves (protective sleeves). Review of the medical record revealed a Physician's order dated 06/02/15 for staff to apply bilateral geri-sleeves to Resident #116's upper extremities at all times.	F 323		

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F 323	Continued From page 7 Review of a nurse aide (NA) care guide printed on 06/29/15 noted Resident #116 was to wear bilateral geri-sleeves at all times. Observations of Resident #116 were as follows: - on 07/01/15 at 9:00 AM Resident #116 was observed in the dining room wearing a 3/4 length sleeve shirt. Geri-sleeves were not observed on either upper extremity. - on 07/01/15 at 1:25 PM Resident #116 was observed in the dining room wearing a 3/4 length sleeve shirt. Geri-sleeves were not observed on either upper extremity. - on 07/01/15 at 3:22 PM Resident #116 was observed resting in bed wearing a 3/4 length sleeve shirt. Geri-sleeves were not observed on either upper extremity. - 07/02/15 at 9:32 AM Resident #116 was observed in the dining room wearing a short sleeved shirt. Geri-sleeves were not observed on either upper extremity. - 07/02/15 at 10:07 AM Resident #116 was observed in the day area wearing a short sleeved shirt. Geri-sleeves were not observed on either upper extremity. - 07/02/15 at 12:55 PM Resident #116 was observed in the dining room wearing a short sleeved shirt. Geri-sleeves were not observed on either upper extremity. An interview with NA #1 on 07/02/15 at 1:25 PM revealed she was assigned to Resident #116 on 07/02/15 but was not aware she was to wear bilateral geri-sleeves at all times. NA #1 stated she was a floater and had not noticed the information about the geri-sleeves on the NA care guide. During an interview on 07/02/15 at 2:07 PM the	F 323		

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F 323	Continued From page 8 Director of Nursing (DON) stated Resident #116 had bruising issues and she expected the NAs to apply the geri-sleeves to her upper extremities as ordered by the Physician.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334		7/25/15

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F 334	Continued From page 9 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to administer a requested influenza vaccine to 1 of 5 residents reviewed for immunizations. (Resident #40) The facility also failed to provide educational materials to		Revision of the policy and procedure for influenza and pneumovax vaccines was completed on 7/2/15 by the Assistant Director of Nursing.	

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F 334	Continued From page 10	F 334		

residents or legal resident representatives regarding the benefits and potential side effects before offering influenza immunization at the beginning of the October 2014 through March 2015 flu season.

The findings included:

1. A review of the facility's Immunization and Vaccination of Residents policy dated March 2005 specified in part individuals that come into the facility after November 30 but before March 20 for the following year, the facility shall determine the individual's status for the influenza immunization and if found to be deficient, the facility shall provide the immunization.

Resident #40 was admitted to the facility 02/11/15 with diagnoses which included end stage renal disease and congestive heart failure.

A review of Resident #40's medical record revealed a consent for administration of an influenza vaccine. The consent was signed by the resident's legal representative and dated 02/11/15. Continued medical record review revealed no documentation was found to confirm the influenza vaccine was administered as requested.

An interview was conducted with the Director of Nursing (DON) on 07/02/15 at 8:14 AM. The DON explained the process for obtaining consents and providing immunizations to the resident on admission to the facility during flu season. She stated the admissions nurse (AN) does all the new admissions that come in to the facility. The AN was expected to obtain consents for immunizations and to write the request for the

Resident consents audited immediately to ensure influenza and pneumovax have been administered accordingly. Completed by 7/6/15 by the RN Supervisor.

Revision of the process of obtaining consents for pneumovax vaccines completed on 7/3/15 by the Assistant Director of Nursing.

Revision of the process of documenting and administering influenza and pneumovax vaccines completed on 7/3/15 by the Assistant Director of Nursing.

Education of the health unit coordinators, social workers, and staff nurses on the new processes related to consents, documentation, and administration of vaccines completed on 7/25/15 by the Assistant Director of Nursing/designee.

Audit of new admits for their influenza and pneumovax consents and administration records via the Point Click Care dashboard completed weekly X 1 month, then monthly X 3 months by the RN Supervisor/designee.

QA monitoring of vaccination audits completed monthly X 3 months, with next scheduled meeting on July 27, 2015.

Revision of the process of obtaining consents for pneumovax vaccines completed 7/3/15 by the Assistant Director of Nursing.

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F 334	Continued From page 11 immunization on the resident's medication administration record (MAR). When the AN placed the newly admitted resident's chart containing the MAR on the desk in the nurse's station, the chart was flagged. The DON explained the medication nurse on the resident's hall was expected to administer the immunization within 24 hours of admission. An interview was conducted on 07/02/15 at 8:26 AM with Unit Manager (UM) #1. She confirmed Resident #40 did not receive the influenza immunization that was requested 02/11/15. She added the resident's consent was not flagged when the chart was delivered to the nurse's station and the administration of the influenza vaccine was missed. UM #1 explained flagged meant extending the consent above the chart when leaving the chart on the desk at the nurse's station. 2. A review was conducted of the facility's Immunization and Vaccination of Residents policy dated March 2005. The policy specified in part upon admission the facility shall notify the resident or responsible party (RP) of the immunization recommendations and provide written information on vaccines. The policy did not contain a statement to specify the consenting resident or RP would be notified of benefits and risk of the influenza vaccine each year. A review was conducted of the facility's undated influenza vaccine administration record (consent) for long term residents. The consent contained "I have been informed in advance about influenza and the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits	F 334	Education to be provided to RP prior to the annual administration of the influenza vaccine via the CDC handout on risks/benefits completed annually during the administration of the flu vaccine by the social workers/designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. BUILDING ______ B. WING ______	07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY CARE CENTER	3625 WILLARD FARROW DRIVE CHARLOTTE, NC 28215

(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 334	Continued From page 12	F 334		

and risks of influenza vaccine and ask that the vaccine be given yearly to me or given yearly to the person named below for who I am authorized to make this request."

An interview was conducted with Social Worker (SW) #1 on 07/02/15 at 9:31 AM. SW #1 stated the consents for residents' immunizations were obtained upon admission to the facility. She explained the consent was used each year unless a change was requested. SW #1 further explained no information regarding risks and benefits of the influenza vaccine was sent out to alert residents or RPs each year.

An interview was conducted with the Director of Nursing (DON) on 07/02/15 at 10:28 AM. The DON stated the facility had 2 consents for vaccines. One was for the short term resident, the other for the long term resident. The DON explained the long term resident form contained a paragraph which stated the RP or resident had been informed in advance about influenza and the influenza vaccine. She stated the statement further contained the consenting party had a chance to ask questions that were answered to their satisfaction. The DON added the consent also contained a statement that the signing party understood the benefits and risks of the influenza vaccine and the vaccine may be given yearly to the resident as authorized by this request. The DON stated the facility stopped giving out the yearly education because it seemed to be the same every year.

A continued interview was conducted with the DON on 07/02/15 at 11:25 AM. The DON stated so many of their long term residents were cognitively impaired. She added these residents

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F 334	Continued From page 13 always had family present at admission and they might not visit regularly. The DON explained the facility went to a rolling consent that was used year to year for this reason. She stated the facility's intent was to follow the required procedure for acquiring consents and informing alert residents and RPs of risks and benefits of vaccines. The DON agreed the facility's immunization policy did not address education information on a yearly basis.	F 334		