

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345548</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>10/4/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASHTON HEALTH AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5533 BURLINGTON ROAD MCLEANSVILLE, NC</b>
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<b>F 580</b>	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to notify the responsible person of a fall for 1 of 3 sampled residents. (Resident #5).</p> <p>The findings included:</p> <p>Resident #5 was admitted on 9/28/18. The diagnosis included Alzheimer ' s Dementia, cerebral atherosclerosis, hypertension, cerebrovascular and dysphagia. The Minimum Data Set(MDS) was not available due to Resident #5 was a respite admission. The care plan dated 9/28/18 indicated Resident #5 has some cognition impairment and required total assistance with activities of daily living. The hospice care plan dated 9/20/18 indicated Resident #5 was on fall precautions; but did not document any falls had occurred. During an observation on 10/3/18 at 1:25 PM, Resident #5 was seated in the recliner with several pillows surrounding her for proper upright positioning. Resident #5 had 2 stitches under a bandage across the left</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 580</b>	<p>Continued From Page 1</p> <p>forehead above the eye brow. There were additional small scars on the left side of face and cheek area. She also had a small knot the right side of the head above eye brow.</p> <p>During an interview on 10/3/18 at 1:28 PM, Nurse Aide #6(NA) stated Resident #5 was seated in her room awaiting lunch around 12:00 PM. NA#6 further stated NA#7 had come to ask her what assistance the resident needed because the resident had been leaning over in the wheelchair. When NA#7 returned to the room, the resident was found on the floor. Resident #5 was found on the left side at the foot of the bed in front of the wheelchair with her head toward the tray table. The resident was bleeding from the head area. NA#7 called for Nurse #4 who was in the hall area near the room.</p> <p>During an interview on 10/3/18 at 2:15 PM, Nurse #4 stated she was called to the room around noon due the resident ' s fall from the wheelchair. Upon arrival Resident #5 was found on the left side of the body and blood was coming from the resident ' s head. Due to the positioning of the resident it appeared the resident had hit the base of the tray table as there was small amount of blood on the base of the table. The resident was checked for bleeding and it was noted on the left side of the forehead above the eye brow and several other small scars on the side of her face. The Director of Nursing and the Nurse Practitioner was in the building at the time, therefore they were immediately involved in checking and assessing the resident. The resident was assessed from head to toe and the Nurse Practitioner stated to send the resident to the emergency room for further evaluation. The hospice nurse was notified per facility protocol and direction from the Director of Nursing. The process for notification included if a resident was being followed by hospice the 1st call would be to hospice and hospice was responsible for notifying the family since the resident was respite and under the care of hospice.</p> <p>Review of the falls report dated 10/2/18, indicated Resident #5 was lying face down on the floor in a pool of blood. Pressure dressing applied to head where a deep laceration and abrasion to left side of her face. Onsite NP evaluated Resident #5 and ordered resident to be sent to emergency room.</p> <p>During an interview on 10/3/18 at 2:35 PM, the Nurse Practitioner(NP) stated she was called to the room due to the resident ' s fall from the wheelchair. Upon her entry to the room the resident was lying on her left side with blood coming from the top of her head and staff were supporting the resident ' s head and trying to stop the bleeding. "In my assessment the resident had a gash above the forehead and several small scars across the side of her face on left and right side. Resident was confused and disoriented. Due to the size of the gash on her head "I made the decision to send the resident to the hospital. The NP the facility NP nor the physician followed hospice residents. The expectation would be for the nurse to contact hospice and inform them of the resident status, care needs and transfer. The hospice staff would then call the family per facility protocol. The facility and hospice would collaborate on the treatment plan.</p> <p>During an interview on 10/3/18 at 2:45 PM, the Director of Nursing stated the expectation would be for the facility nurse to contact hospice and inform them of resident ' s status. Hospice was responsible for contacting the family since they were under hospice care per facility protocol for hospice/respite residents.</p> <p>During a telephone interview on 10/3/18 at 4:03 PM, Nurse Aide #7(NA) stated she observed the resident</p>
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<b>F 580</b>	<p>Continued From Page 2</p> <p>leaning forward in wheelchair as she passed by Resident #5 ' s room. She went in to checked on the resident and the resident stated she was looking for something on the floor. She was repositioned back in chair. NA#7 went to NA#6 to ask what type of assistance Resident #5 needed since she was new to the facility and hall. Upon return the resident was on the floor on the side at the foot of bed in front of the tray table. Nurse #4, DON and the NP were all called to the room. Nurse #4 was the first to assess the resident and attempt to stop the bleeding. At which time the NP arrived and assessed the resident before the resident was sent to the emergency room.</p> <p>During a telephone interview on 10/4/18 at 8:05 AM, the concern caller stated she came to visit Resident #5 and she was not in the room. She indicated when she inquired about the whereabouts of Resident #5 the nursing staff presented as though they were unaware of Resident ' s 5 location. It was not until a tech asked the concern caller how Resident #5 was doing that she became aware that Resident #5 had been transferred to the hospital. The primary family was out of time and additional family were listed as backups, however none of them had been called to inform them of the fall or the transfer. The concerned caller contacted the backup family members/friends that were on the contact list and informed of the status of Resident #5. The facility nor the hospice staff had contacted anyone from the call list.</p> <p>During a telephone interview on 10/3/18 at 8:58, the Hospice Nurse Manager stated the facility had called the call center around 1:19 PM to inform them of Resident #5 ' s fall and the transfer to the hospital. The Nurse Manager indicated the expectation was for the hospice and facility to make sure the family was called. Nurse Manager further stated there was no documentation that hospice had called the family to notify them of the fall. The expectation would be for the facility and hospice to follow-up with the family.</p> <p>During an interview on 10/4/18 at 9:25 AM, Nurse #3 stated she was in the nursing office when an aide told her to come and speak with a person who had come to visit Resident #5. The individual was very upset that Resident #5 was not in the room and no one had contacted the family to inform them of her whereabouts. Nurse #3 spoke with Nurse #4 who stated she had called the hospice nurse and informed them of the resident ' s discharge to the hospital due to the fall. The verification of contact was made at the time which indicated the primary person was out of town and additional relatives were listed. The individual that was visiting was informed of the transfer once her identity was established. The person then contacted other family members. The facility process included calling hospice first since resident was respite and a patient of the hospice program. The expectation was for hospice to notify the family.</p> <p>During an interview on 10/4/18 at 11:06 AM, the Responsible Person left in charge indicated that she nor any of the individuals on the contact sheet had been contacted by the facility or hospice. She indicated a family friend who had attempted to visit Resident #5 found out she had fallen and was sent to the hospital and had been in the hospital several hours prior to the family ' s knowledge. The facility reported it was hospice responsibility to contact the family. "It was very upsetting to find out by chance what happened, had it not been for the family friend Resident #5 family would not have known anything."</p> <p>Review of the hospice contract undated did not indicate the specific notification process and who/facility would be responsible.</p> <p>During a follow-up interview on 10/4/18 at 11:30 AM, the Administrator, Director of Nursing and Nurse Consultant indicated changes would occur in the notification process for all hospice and respite residents to</p>
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