STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 6/16/20. One of the two allegations were substantiated resulting in a deficiency. Event ID FSFU11	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a two-person mechanical lift for transfers and failed to have fall floor mats on both sides of the bed for 1 of 1 resident (Resident #1) reviewed for falls. The findings included: Resident #1 was admitted to the facility on 9/6/16 with diagnoses of cerebrovascular accident with hemiplegia and hemiparesis to right side and osteoarthritis. A quarterly Minimum Data Set assessment dated 4/11/20 revealed Resident #1 did not exhibit behaviors and required extensive assistance with two persons for transfers and toileting. She was non-ambulatory and utilized a wheelchair. Resident #1 had poor balance during transfers and had limitation in her range of motion on one	F 689	F689 Residents are Free of Accident Hazards/Supervision/Devices 483.25(d)(1)(2) • NA#1 was in-serviced by DON on May 1st 2020 on the requirements of prior to implementing care (transfers, ambulation, feeding, toileting, etc.) of reading the Resident Profile to obtain how to properly care for resident. A second fall mat was placed down on the left side of the bed on 6/16/2020 by ADON. • An audit was done by RN supervisor, SDC, ADON, DON for all residents who presently have fall mats as an intervention for falls to ensure safety of each resident. The correct number of mats were visually confirmed by observation to be in the room of any resident care planned to have either 1 or 2 fall mats. Completed by	6/29/20

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

Electronically Signed | 06/29/2020

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F 689	Continued From page 1 side. Resident #1 was always incontinent of bowel and bladder. A review of the care plan updated 4/15/20 revealed a problem of risk for falls due to impaired mobility and a problem of requiring physical assistance daily with activities of daily living. Resident has diagnoses of pain, hemiplegia and hemiparesis affecting right side following a stroke. The goals were for Resident #1 to have no serious injury from a fall and for Resident #1 to participate in activities of daily living as able. Interventions included no toileting due to incontinence, staff educated to read care guide before transferring resident, fall mats to both sides of bed and assistance with activities of daily living. A review of Resident #1 ' s profile under "Alerts" in the electronic health record indicated Resident #1 required a mechanical lift for transfers and fall mats beside bed. An incident report dated 4/28/20 indicated Resident #1 had a fall from her wheelchair at approximately 8:20 PM. Nurse Aide (NA) #1 was attempting to push Resident #1 out of the bathroom and Resident #1 attempted to stand up and fell from the wheelchair on her forehead. Resident #1 sustained a hematoma skin excoriation to her forehead. A written statement from NA #1 on 5/1/20 revealed on 4/28/20 she took Resident #1 to the bathroom and when she was finished, NA #1 successfully transferred Resident #1 to the wheelchair. She stated when she went to push Resident #1 out of the bathroom, Resident #1 leaned forward and attempted to stand up and	F 689	6/28/2019 • Licensed nurses and nurse aides were in-serviced by SDC, that paper Resident Care Guides are no longer placed on the inside of closets. Completed 4/9/2020. Licensed nurses and nurse aides were in-serviced on the requirement of prior to implementing care (transfers, ambulation, feeding, toileting, etc.) of reading the Resident Profile to obtain how to properly care for resident by SDC. Completed 5/1/2020 • Weekly audits will be performed on the correct number and proper placement of fall mats according to care plans for 3 months, then monthly for 3 quarters by DON or designee. Random audits will be performed by DON or designee of Licensed nurses and nurse aides on the requirement that prior to performing direct care on a resident (transfers, ambulation, feeding, toileting, etc.) that the Resident Profile is reviewed to ensure care is administered properly for weekly for 3 months, then monthly for 3 quarters. • Data obtained during the audit process will be analyzed by the interdisciplinary team for irregularities, patterns and trends, and reported to QAPI by Director of Nursing monthly x 4 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 689	Continued From page 2	F 689		

she fell forward onto the floor.

During an interview with NA #1 on 6/16/20 at 11:17 AM, she revealed she and NA #2 were making rounds during the 3-11 shift on 4/28/20. She stated she was toileting Resident #1 unassisted while NA #2 assisted Resident #1 ' s roommate. NA #1 stated after she transferred Resident #1 unassisted from the toilet to her wheelchair, she was rolling Resident #1 out of the bathroom when Resident #1 tried to stand up and fell forward. NA #1 stated she told NA #2 to get the nurse while she stayed with the resident. She stated Resident #1 had an injury to her forehead. NA #1 stated she did not review Resident #1 ' s care plan on the tablet prior to her shift and she was unaware that Resident #1 was not to be toileted or that a mechanical lift was required for transfers.

A written statement from NA #2 dated 5/1/20 revealed on 4/28/20 she witnessed NA #1 transferring Resident #1 back into the wheelchair from the toilet.

An interview was conducted with NA #2 on 6/17/20 at 10:03 AM. She stated she was working on 4/28/20 and was assisting Resident #1 ' s roommate when she heard a bump coming from the bathroom. She stated NA #1 was toileting Resident #1 by herself and she didn ' t see Resident #1 fall but "probably saw NA #1 transferring Resident #1". NA #2 stated she did not know Resident #1 required a mechanical lift for transfers because she was not assigned to her care. NA #2 stated Resident #1 was a one person assist for transfers.

A nurse ' s note dated 5/1/20 at 3:46 PM read,

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F 689	Continued From page 3	F 689		

"requires extensive assistance x 2 with transfers".

On 6/16/20 at 9:30 AM, an observation was made of Resident #1 lying in her bed. There was one fall mat on the floor on the right side of the bed, but there was no fall mat on the floor on the left side of the bed.

A second observation on 6/16/20 at 11:40 AM revealed Resident #1 still only had one fall mat on the floor on the right side of the bed. There was not a mat on the left side of the bed.

An interview was conducted with NA #3 on 6/17/20 at 11:25 AM. NA #3 stated she worked at the facility on an as needed basis and usually worked about 3 days a week. She was familiar with Resident #1 and stated she needed total assistance with her activities of daily living. She stated she was incontinent of bowel and bladder and she did not toilet her. She demonstrated to the surveyor where to look for the resident ' s care needs but admitted she did not read through the care plan every day. She was unaware that Resident #1 had an intervention to have fall mats on both sides of the bed.

An interview was conducted with the Minimum Data Set (MDS) Nurse on 6/16/20. She stated when she completed the care plan, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) put the resident care information on the resident ' s profile in the electronic health record.

An interview was conducted with the DON on 6/16/20 at approximately 11:30 AM. She stated the resident care information was updated on the resident profile under alerts by herself, the ADON

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F 689	Continued From page 4 and other supervisory staff. She stated they transitioned to paperless in October 2019 and no longer use care guides on the resident ' s closet doors. The DON stated Resident #1 had an intervention for no toileting because she was always incontinent of bowel and bladder and wouldn ' t need to be put on the toilet, her incontinence care would be done in the bed. The DON stated NA #1 failed to check the care guide at the start of her shift. The DON showed the surveyor Resident #1 ' s profile that indicated mechanical lift x 2 and fall mats. The DON stated NA #1 neglected to check the care guide before providing care and confirmed on 4/28/20 NA #1 should not have toileted Resident #1 or transferred her by herself.	F 689		