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ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

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E 000	Initial Comments An unannounced recertification, complaint and follow-up survey was conducted 11/15/21 through 11/19/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GWJN11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification, complaint and follow-up survey was conducted 11/15/21 through 11/19/21. 16 of the 62 complaint allegations were substantiated. Event ID: GWJN11	F 000		
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced	F 569		12/14/21

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

Electronically Signed | 12/17/2021

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F 569	Continued From page 1 by: Based on staff interviews and review of the resident trust accounts, the facility failed to forward the balance of expired residents ' trust accounts within 30 days for3 of 5 residents reviewed for personal funds (Resident #196, Resident #197, and Resident #198) Findings included: Review of Resident #196 ' s closed medical record revealed she was admitted to the facility on 03/27/2019 and expired on 07/17/2019. A review of the resident trust fund account revealed that Resident #196 ' s funds were not conveyed to the resident estate within 30 days of her death. A check was written out to the facility on 08/22/2019. . Interview with the Regional Accounts Receivable Specialist on 11/19/2021 at 10:00 am indicated she had been employed with the facility effective 01/04/2021. She indicated during her review of the personal fund account the resident ' s balance had not been refunded to the resident's estate. She stated the process for closing accounts for deceased residents was as follows: " If we are representative payee, refund to Social Security and all other accounts are refunded to the resident's estate". Interview with the Administrator on 11/19/2021 at 12:30 pm revealed her expectation for closing an account of deceased residents was if the facility was representative payee, they would refund Social Security. All other accounts would be refunded to the resident's estate.	F 569	The statements included in this plan of correction 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. An alleged deficiencies cited have been or will be completed by the dates indicated. Review of resident's trust account revealed that 3 out of 5 residents balances were not refunded to the resident's estate within 30 days. Resident #196, #197, and #198 estates were refunded on 12/14/2021. All residents have the potential to be affected by the cited deficient practice. A 100% audit was completed by Regional Accounts Receivable Specialist from 2019 to present to ensure no additional deficient practices related to conveyance of personal funds upon discharge were identified. Education was provided to the new Business Office Manager by the Regional Accounts Receivable Specialist regarding the requirements to forward balances of expired residents on 12/7/2021.	

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F 569	Continued From page 2 2. Review of Resident #197 ' s closed record indicated she was admitted to the facility on 04/03/2018 and expired on 07/06/2019. A review of the resident trust fund account revealed that Resident #197 ' s funds were not conveyed to the resident estate within 30 days of her death. A check was written out to the facility on 08/22/2019. Interview with the Regional Accounts Receivable Specialist on 11/19/2021 at 10:00 am indicated she had been employed with the facility effective 01/04/2021. She indicated during her review of the personal fund account the resident ' s balance had not been refunded to the resident's estate. She stated the process for closing accounts for deceased residents was as follows: " If we are representative payee, refund to Social Security and all other accounts are refunded to the resident's estate ' . Interview with the Administrator on 11/19/2021 at 12:30 pm revealed her expectation for closing an account of deceased spell residents was if the facility was representative payee, they would refund Social Security. All other accounts would be refunded to the resident's estate. 3. Review of Resident #198 ' s closed medical record indicated that Resident #198 was admitted to the facility on 10/10/2018 and expired on 07/20/2019 A review of the resident trust fund account revealed that Resident #198 ' s funds were not conveyed to the resident estate within 30 days of her death. A check was written out to the facility on 08/22/2019.	F 569	Education was provided to the new Business Office Manager by the Regional Accounts Receivable Specialist regarding the requirements to forward balances of expired residents on 12/7/2021. Administrator and/or designees will conduct an audit monthly of the Resident trust accounts of expired residents to monitor compliance for 3 months, then monthly times 1 month using a monitoring tool. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator or designee monthly for three 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 569	Continued From page 3 . Interview with the Regional Accounts Receivable Specialist on 11/19/2021 at 10:00 am indicated she had been employed with the facility effective 01/04/2021. She indicated during her review of the personal fund account the resident ' s balance had not been refunded to the resident's estate. She stated the process for closing accounts for deceased residents was as follows: " If we are representative payee, refund to Social Security and all other accounts are refunded to the resident's estate". Interview with the Administrator on 11/19/2021 at 12:30 pm revealed her expectation for closing an account of deceased residents was if the facility was representative payee, they would refund Social Security. All other accounts would be refunded to the resident's estate.	F 569		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for the following areas: falls (Resident #78); gradual dose reduction (GDR) for an antipsychotic medication (Resident #78), administration of an anticoagulant medication (Resident #40) and hallucinations (Resident #35) for 3 of 39 sampled residents reviewed for MDS accuracy. The findings included:	F 641	The statements included in this plan of correction 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	12/10/21

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F 641	Continued From page 4 1-a. Resident #78 was admitted to the facility on 9/1/20 with a cumulative diagnoses which included a progressive neurological disorder and visual hallucinations. Documentation in Resident #78 ' s electronic medical record (EMR) revealed the resident sustained a fall without injury on 7/31/21, 8/2/21, 8/14/21, 8/28/21 and 10/5/21. Resident #78 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/29/21. Section J (Health Conditions) of the MDS reported the resident did not have any falls since her prior assessment. An interview was conducted on 11/19/21 at 10:31 AM with the Regional MDS Consultant in the presence of the facility ' s MDS Coordinator. During the interview, the MDS nurses were asked to review Section J from Resident #78 ' s quarterly MDS dated 10/29/21. Upon review, the Regional MDS Consultant reported it appeared the MDS should have been coded to report resident did experience falls between 7/29/21 (the prior MDS assessment) and 10/29/21. The Consultant stated she would review the 10/29/21 MDS in more detail and submit a modification to the assessment as needed. A follow-up interview was conducted on 11/19/21 at 11:10 AM with the Regional MDS Consultant. During the interview, the Consultant reported a modification was completed for Resident #78 ' s quarterly MDS dated 10/29/21. She stated the MDS should have been coded to indicate Resident #78 did experience falls since the last assessment. The Regional MDS Consultant also	F 641	allegation of compliance. An alleged deficiencies cited have been or will be completed by the dates indicated. Modifications of the Minimum Data Set (MDS) for Residents #78, #39, and #40 were completed on 11/19/2021 by the Regional Reimbursement Manager. Education was provided to MDS Coordinator by the Regional Reimbursement Manager regarding the accuracy of coding MDS Assessments for residents on 12/10/2021, new MDS Coordinator will be educated on hire. All residents have the potential to be affected by this deficient practice. 100% audit of all in house residents was completed on 11/19/2021 by the Regional MDS Nurse to address areas for falls, anticoagulants, hallucinations, and GDR for residents on an antipsychotic. Education was provided to MDS Coordinator by the Regional Reimbursement Manager regarding the accuracy of coding MDS Assessments for residents on 12/10/2021, new MDS Coordinator will be educated on hire. Regional Reimbursement Manager-Triad and/or designees will conduct random audit of 5 MDS assessments weekly for 4 weeks, 2 MDS assessments weekly for 4 weeks, the 5 MDS assessments and correlating documentation for 1 month.	

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F 641	Continued From page 5	F 641	Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator or designee monthly for three months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

reported the MDS should have specified the resident had two or more falls without injury between the 7/29/21 and the 10/29/21 MDS assessments.

An interview was conducted on 11/19/21 at 12:10 PM with the facility's Interim Director of Nursing (DON). During the interview, concerns regarding the inaccuracy of MDS coding for Resident #78 ' s falls were discussed. When asked, the Interim DON stated, "My expectation is that the MDS be coded accurately."

1-b. Resident #78 was admitted to the facility on 9/1/20 with a cumulative diagnoses which included a progressive neurological disorder and visual hallucinations.

Resident #78 ' s medications included 12.5 milligrams (mg) quetiapine (an antipsychotic medication) to be administered by mouth two times a day (last ordered on 8/4/21).

The resident ' s medical record included a "Consultant Pharmacist Communication to Physician" dated 9/13/21. The communication recommended Resident #78 ' s provider evaluate each psychotropic medication for the possibility of a trial dose reduction (gradual dose reduction or GDR) or taper to discontinuation. A psychotropic medication is any drug that affects brain activities associated with mental processes/behavior and includes antipsychotic medications. The provider responded to the communication on 9/27/21 by indicating, "GDR not possible clinically without a negative effect on the underlying psychiatric illness."

Resident #78 ' s most recent Minimum Data Set

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(MDS) was a quarterly assessment dated 10/29/21. A review of Section N (Medications) of the MDS revealed the resident received an antipsychotic medication routinely on 7 out of 7 days during the look back period. Information in Section N also included an antipsychotic medication review. This review indicated Resident #78 ' s provider documented on 5/10/21 that a gradual dose reduction (GDR) of her antipsychotic medication was clinically contraindicated. However, it also reported a GDR of her antipsychotic medication was last attempted on 5/14/21.

An interview was conducted on 11/19/21 at 10:31 AM with the Regional MDS Consultant in the presence of the facility ' s MDS Coordinator. During the interview, the MDS nurses were asked to review Section N (Medications) from Resident #78 ' s quarterly MDS dated 10/29/21. Upon review, both the Regional MDS Consultant and MDS Coordinator reported the two dates entered into the antipsychotic medication review appeared to be confusing. The Consultant stated she would review this MDS in more detail and submit a modification to the assessment if needed.

A follow-up interview was conducted on 11/19/21 at 11:10 AM with the Regional MDS Consultant. During the interview, the Consultant reported the date indicated on the 10/29/21 MDS for Resident #78 ' s last GDR attempt was not accurate. She stated no GDR attempt was made. Additionally, the provider ' s response to the pharmacist ' s consult report on 9/27/21 was the most recent documentation to indicate a GDR for the resident ' s antipsychotic medication was clinically contraindicated. The Regional MDS Consultant

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F 641	Continued From page 7	F 641		

reported modifications to the MDS record were made.

An interview was conducted on 11/19/21 at 12:10 PM with the facility's Interim Director of Nursing (DON). During the interview, concerns regarding the inaccuracy of MDS coding for Resident #78 ' s antipsychotic medication review were discussed. When asked, the Interim DON stated, "My expectation is that the MDS be coded accurately."

2. Resident #40 was admitted to the facility on 7/8/17 with a cumulative diagnoses which included a history of venous thrombosis (when a blood clot blocks a vein) and embolism (a blocked artery caused by a foreign body, such as a blood clot).

The resident ' s Electronic Medical Record (EMR) revealed her medications included 20 milligrams (mg) rivaroxaban (an anticoagulant medication) to be given by mouth once daily (last ordered on 2/7/21).

Resident #40 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/1/21. Section N (Medications) of the MDS assessment did not indicate the resident received an anticoagulant medication during the 7-day look back period.

An interview was conducted on 11/18/21 at 3:05 PM with the facility ' s MDS Coordinator. During the interview, the MDS Coordinator was asked to review Section N (Medications) on Resident #40 ' s quarterly MDS (dated 10/1/21). Upon review, the MDS Coordinator stated, "Unfortunately, it (the anticoagulant medication) was not coded, it

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was an oversight." The MDS Coordinator confirmed Resident #40 ' s MDS should have been coded to indicate she received an anticoagulant medication on a daily basis.

An interview was conducted on 11/19/21 at 12:10 PM with the facility's Interim Director of Nursing (DON). During the interview, concerns regarding the inaccuracy of MDS coding for Resident #40 ' s anticoagulant medication were discussed. When asked, the Interim DON stated, "My expectation is that the MDS be coded accurately."

3. Resident #35 was admitted to the facility on 12/28/2020 with diagnoses that included coronary artery disease, hypertension, and diabetes mellitus.

A review of the nursing progress notes for the date of 6/28/2021 for Resident #35, documented a hallucination.
A review of the quarterly MDS assessment dated 7/2/2021 for Resident #35, did not document hallucinations for the 14 day look back period.

A review of the nursing progress notes for the date of 9/13/2021 for Resident #35, documented a hallucination of seeing bugs that others did not see.

A review of the quarterly MDS assessment dated 9/17/2021 for Resident #35, did not document hallucinations for the 14 day look back period.

On 11/18/2021 at 11:53 AM an interview was conducted with the Regional MDS consultant.

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F 641	Continued From page 9 She reviewed the MDS assessments for the dates of 7/2/2021 and 9/17/2021. She confirmed the 14 lookback periods for both MDS assessments contained documentation of hallucinations in the nursing progress notes. She stated the hallucination area should have been marked as present. She added it was her expectation that the MDS coordinator review progress notes prior to completing an MDS assessment and document accurately. She competed an MDS modification to include hallucinations for the 7/2/2021 and 9/17/2021 MDS reports on 11/18/2021.	F 641		
F 689 SS=G	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 observation, record review, staff and resident interviews, the facility failed to implement effective interventions to prevent further burns for a resident that experienced burns while smoking in 1 of 3 residents (Resident #35) reviewed for smoking. The findings included: Resident #35 was admitted on 6/29/2018 and readmitted on 12/28/2020 with diagnoses that included diabetes mellitus, right below the knee	F 689	The statements included in this plan of correction 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. An alleged	12/16/21

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F 689	Continued From page 10 amputation and muscle weakness. An admission Minimum Data Set (MDS), dated 1/3/2021, revealed Resident #35 was cognitively intact for decision making and was documented as not a current tobacco user. A nurse progress note, dated 3/19/2021, written by Nurse #6 read during a dressing change to abdomen, this writer noticed area presented like a full thickness burn. Due to presentation, Resident #35 was asked how this happened. Resident #35 admitted to smoking outside and later finding a burnt hole in her sweater. After this admission and going forward, the wound will be treated as a full thickness burn. A review of Resident #35's treatment orders revealed an order dated 3/19/2021 to clean burn with normal saline, apply skin prep to peri wound, apply Silvadene 1% cream to wound bed for suspected bioburden (the number of bacteria living on the surface that has not been sterilized), cover with collagen sheet to stimulate granulation, add calcium alginate to wick away exudate every three days. A review of Resident #35's care plan dated 3/29/2021 had a focused area that read, Resident is at risk for burns related to cigarette burns with a history of burns to the abdomen. The interventions did not include prevention plans. A second focused area read; I use tobacco products in the form of cigarettes. I am my own responsible party and sign myself in and out to smoke. A review of a progress note, dated 6/3/2021, written by the Administrator read Resident #35	F 689	deficiencies cited have been or will be completed by the dates indicated. Due to the resident□s history of noncompliance Resident #35□s smoking materials were obtained to prevent resident from unsafe smoking practices. Resident was educated that the facility was smoke-free community. Education completed by the Administrator. [Completion date: 12/16/2021] 100% residents who sign themselves out to smoke had a skin assessment completed on 12/16/21 by Unit Manager or designee. No concerns were found during the audit. 100 % of residents currently residing in the facility were educated regarding the facility□s nonsmoking policy by Administrator or designee. [Completed by: 12/16/2021] All newly admitted residents and/or representatives will be educated regarding the facility□s nonsmoking policy upon admission by Administrator or designee. [Completed by: 12/16/2021] Weekly skin assessments will be performed for any resident identified as a someone who signs themselves out to smoke.	

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F 689	Continued From page 11 was noted to be driving her motorized wheelchair into the wall in the hallway. Resident was then outside, and she stated she wanted to see the dogs outside of her window. Writer did not see any dogs in the parking lot and requested the Resident to come back inside. Resident agreed and the Resident's nurse was notified of the change of condition. An interview with this nurse was not able to be completed. A review of Resident #35's care plan revealed an update dated 6/7/2021 that read, I use tobacco products in the form of cigarettes. I am my own responsible party and sign myself out to smoke. On 6/7/2021, I am no longer able to safely smoke cigarettes independently. Resident refused nicotine patches. Resident no longer safe to use motorized wheelchair. History of cigarette burns. The interventions included Resident will sign herself out to smoke. A review of a progress note, dated 6/8/2021 at 4:47 AM, written by Nurse #7, read Resident #35 noted with intermittent confusion and status post fall day two. The Assistant Director of Nursing has requested that the Resident be accompanied by staff when outside of the facility. She has also requested that the Resident's lighter be kept on the medication cart and the motorized wheelchair be replaced with a manual wheelchair. A review of a progress note, dated 6/8/2021 at 6:50 AM, written by Nurse #7, read Resident #35 has been seeing things and people that are not there. On call physician notified. A review of a progress note, dated 6/8/2021 at 2:08 PM, written by Nurse #6, read Resident #35 During wound care, full thickness burn also found	F 689	100% residents or appropriate responsible party currently residing in the facility were educated regarding the facility□s nonsmoking policy by Administrator or designee. [Completed by: 12/16/2021] All newly admitted residents and/or representatives will be educated regarding the facility□s nonsmoking policy upon admission by Administrator or designee. [Completed by: 12/16/2021] 100% Staff including nursing, housekeeping, dietary, and therapy were educated on non-smoking policy and reporting and intervention protocol for identified resident noncompliance by Administrator or designee. Any employee who did not receive the education by 12/16/21 will not be allowed to work until it□s completed. This education will be included in orientation of all new hires. [Completed by: 12/16/2021] Weekly skin assessments will be performed for any resident identified as someone who signs themselves out to smoke. Staff interviews with results tracked via audit tool to identify potential resident noncompliance. Administrator and/or designees will monitor resident□s skin assessments identified residents who smoke off property for adherence to the smoking	

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F 689	Continued From page 12 to the right 3rd finger. Resident stated, "I must have fallen asleep with my cigarette." New orders obtained, responsible party and physician both notified. A review of Resident #35's care plan revealed an update dated 6/8/2021 that read, Resident is at risk for burns related to cigarette burns with a history of burns to the abdomen and right 3rd finger. The interventions did not include prevention plans and were not updated with new interventions. A review of the modified quarterly MDS, dated 7/2/2021, revealed Resident #35 continued to hallucinate during the 14 day look back and was not back to the baseline of hallucination free. A review of the modified quarterly MDS, dated 9/17/2021, revealed Resident #35 continued to hallucinate during the 14 day look back and was not back to the baseline of hallucination free. An observation was conducted on 11/16/2021 at 2:15 PM of Resident #35 with cigarettes and a lighter in her right pocket of her jacket that was lying in the floor by the closet. An interview was conducted on 11/16/2021 at 2:15 PM with Resident #35 and she revealed she was responsible for storing her own cigarettes and lighter. She revealed she keeps them in her jacket by the closet. She stated that was where they remain when she sleeps and when she leaves the room for a shower or activity. She stated when she smokes, she signs herself out and goes alone to sit at the bottom of the hill. She denied staff accompanying here to smoke unless they had a smoke break at the same time.	F 689	policy weekly x 4 weeks and monthly x 2 months. 5 staff interviews will be completed weekly x 4 weeks, 3 staff interviews will be completed weekly x 4 weeks, and 2 staff interviews monthly x 2 months. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator or designee monthly for three 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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An interview was conducted on 11/17/2021 at 10:55 AM, with the Administrator and Regional Manager. The Administrator revealed the 3 residents that smoke were all alert and oriented and were independent with smoking. She stated they were required to sign themselves out and there was a section off of the facility property that the residents go to smoke. The areas located up a hill and the residents should go to this area. They should not smoke at the bottom of the hill because this areas on the facility property. She stated the facility does not provide supervision for any of these three residents since they are signing themselves out and are supposed to smoke in the designated area off of the property. She added the facility does not provide accommodations based on weather. The Regional manager then stated these 3 residents have been allowed to keep their cigarettes and lighters in their rooms. He added the facility had not had any incidents related to this and so the company had not changed anything. He added the facility was a smoke free campus and these 3 residents were "grandfathered" in since they are independent smokers. The facility does not accept any other new admissions that smoke.

A review of the facility sign in and sign out log for Resident #35 revealed she signed herself out of the facility on 4/25/2021, 4/29/2021, 6/3/2021, 6/27/2021, 8/1/2021, 10/17/2021 and 11/8/2021.

An interview was conducted on 11/17/2021 at 12:11 PM with Staff #1 and she revealed that Resident #35 signed herself out to go smoke, unaccompanied, in the last few months.

An interview was conducted on 11/18/2021 at

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10:11 AM with the Administrator and she revealed that the term Grandfathered in, regarding smoking, means that a resident had a previous right or privilege, at the time a policy change occurred and were able to keep the right or privilege and new residents would fall under the new guidelines. The Administrator stated Resident #35 was a smoker at the facility when the facility became smoke free and was grandfathered in as a smoker. She revealed she was aware Resident #35 burned herself on March 19, 2021 and stated a smoking assessment was completed by the Director of Nursing (DON), and she was assessed to be a safe smoker. She stated she was aware the care plan stated the Resident was at risk for burns related to smoking on 3/19/2021. She revealed she was aware the Resident had a change of mental condition from 3/19/2021 through 6/8/2021 when the Resident was documented to hallucinate and had begun to require assistance from nursing staff to navigate how to return into the facility from the parking lot. She added she was aware the Resident had a full thickness burn to her 3rd Right finger on 6/8/2021 and that a nurse reported this was from the Resident falling asleep from smoking. She stated a smoking assessment was completed by the DON in June and the Resident was assessed to be safe for smoking because she returned to her baseline without hallucinations after a hospitalization in June 2021. She stated the Resident was not able to go off of the property to smoke any longer because she was not strong enough to wheel herself up the hill and off of the property. The Resident wheels herself to the bottom of the hill to smoke, on property. She stated another smoking assessment had not been completed since the one in June and should have been completed due to the two burns but

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F 689	Continued From page 15 had not been completed since the facility was smoke free and the Resident was back to baseline and independent for smoking. A review of the electronic medical record for Resident #35 did not reveal the two smoking assessments referred to in the interview with the Administrator and copies of the two smoking assessments were not provided.	F 689		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		12/18/21

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F 880	Continued From page 16 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 17 Based on observations, staff interviews, and record review, the facility staff failed to label, store, and clean/disinfect blood glucose meters (glucometers) dedicated for individual-resident use in a manner that would protect against the inadvertent use for additional residents and/or cross-contamination from contact with other meters or equipment. This occurred for 3 out of 4 sample residents (Resident #12, Resident #64, and Resident #30) who required a blood glucose check. The findings included: A review of the facility policy entitled "Blood Sampling - Capillary (Finger Sticks)" (Revised December 2018) read, in part: "The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees." General Guidelines #1 (of 3): "Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses with EPA (Environmental Protection Agency) registered disinfectant per directions on package if it is a shared glucometer. Individual resident blood glucose meters should be cleaned from any visible materials after use or before use." "Steps in the Procedure: 1. Wash hands. 2. Don gloves. 3. Place blood glucose monitoring device on clean field (paper towel or cup). 4. Wipe the area to be lanced with an alcohol pad. 5. Use sterile lancet to obtain blood sample 6. Obtain the blood sample, following the manufacturer's instructions for the device.	F 880	The statements included in this plan of correction 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. All (100% of all in house) residents that require a glucometer to be used during blood sugar checks has the ability to affected by this deficient practice. Education was provided by Dione Roal, RN to all active Nurses and active Medication Aides to ensure appropriate disinfectant wipes are used, and appropriate cleaning procedure takes place after each use as described in manual of glucometers ordered. Education was also given to Central Supply personnel on which disinfectant wipes can be used on medication carts. All education was completed as of 12/18/21. 100% audit was completed of all residents required blood sugar checks to ensure individual glucometer was located on the medication cart. Audits to be conducted consist of: 20 nurse observations from week 1-4, 10 nurse observations from week 5-8, 5 nurse observations from	

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F 880	Continued From page 18 7. Discard lancet into the sharps container. 8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts (if glucometer is shared, or if visible material on individual glucose meters), and/or devices after each use and store in/on a clean surface. (Company Name) prefers individual resident use glucometers. 9. Remove gloves, and discard into appropriate receptacle. 10. Wash hands. 11. Replace blood glucose monitoring device in storage area. Individual blood glucose monitoring device should be stored in a baggie or separate storage container to keep from cross contamination of other devices. Each baggie or storage container should be labeled with the resident name." The manufacturer instructions for the glucometer used at the facility indicated the cleaning and disinfection procedure should be performed as recommended to minimize the risk of transmitting blood-borne pathogens. These instructions read in part, "The meter should be cleaned and disinfected after use on each patient. The (Brand Name) multi Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer ' s disinfection procedures are followed." For Cleaning and Disinfection, "The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. Only wipes with EPA registration numbers listed below have been validated for use in cleaning and disinfecting the meter. Any disinfectant product	F 880	week 9-12. Observations consist of ensuring each resident has personal glucometer on the medication cart and appropriate cleaning procedure took place. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	

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containing these EPA registration numbers may be used on this device ...Wipes with EPA registration numbers not listed below should not be used to clean and disinfect the (Brand Name) multi Meter..." The list of approved and tested products for this glucometer did include (Brand Name) Surface Disinfectant Wipes; however, it did not include alcohol wipes or the (Brand Name) Bleach Germicidal Disposable Wipes.

1) On 11/16/21 at 5:13 PM, Nurse #2 was observed standing at the 200 Hall Med Cart. Upon approach, a glucometer was observed sitting directly on top of the med cart next to a vial of glucometer test strips. Nurse #2 reported Resident #12's blood glucose had just been checked. This nurse was observed as he administered medication to Resident #12. A follow-up interview was conducted with the nurse upon his return to the medication cart. During the interview, Nurse #2 reported each resident had his/her own individual glucometer. The nurse opened a drawer of the med cart which revealed one glucometer was currently stored on the cart. The glucometer was not labeled with a resident's name or other identifying information; it was not stored in a baggie or any other container to prevent cross-contamination. Nurse #2 reported this glucometer belonged to Resident #12. When asked how he knew for certain the glucometer was intended for Resident #12, he reported he had just used it for the resident and placed it in the cart. He stated, "There's a bag for this one somewhere," as he looked in the other drawers of the med cart for a baggie labeled with the resident ' s name. None was found on the med cart. At that time, the nurse was asked to identify the glucometer observed to be placed on top of the cart. When asked which resident this

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glucometer was used for, Nurse #2 stated, "I need to find out where that came from." He was then asked whether or not the glucometer observed on top of the med cart was already there when he started his shift. He stated it was not. The nurse repeated, "I need to find out where that came from." Upon further inquiry as to how he could be sure the glucometer in the drawer belonged to Resident #12, the nurse reported he would "get rid of both of them (referring to the two glucometers)."

A telephone interview was conducted on 11/17/21 at 10:26 AM with Nurse #2. During the interview, the nurse was asked if he could provide any additional information about the glucometer observed on top of his med cart the previous evening. Nurse #2 reported when he took over the med cart, he could not find any glucometers in the bottom drawer of the cart (where the glucometers were normally stored). The nurse reported he went to the med room, found a "brand new" glucometer, and brought it to his med cart to be used for both Resident #62 and Resident #12. Nurse #2 stated he was very nervous when an inquiry was made about this glucometer on 11/16/21 and was not sure what he should say. When asked if the glucometer was cleaned/disinfected between using it for Resident #62 and Resident #12, the nurse stated he typically wiped the glucometer with either "bleach wipes" or two alcohol wipes after each use. Nurse #2 added that he "mostly used bleach wipes" to clean/disinfect a glucometer after use.

An interview was conducted with the facility ' s Interim Director of Nursing (DON) on 11/17/21 at 11:40 AM. During the interview, the infection control concerns related to the facility ' s failure to

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label, store, and clean/disinfect glucometers were discussed. The DON reported she would expect staff to store the individual glucometers in the drawer of the med cart in a baggie labeled with the resident's name. The DON stated the glucometer should be disinfected after each use before being stored on the med cart, even if the glucometer was dedicated to a single resident.

A follow-up telephone interview was conducted on 11/18/21 at 11:03 AM with Nurse #2. During the interview, the nurse was asked for additional details about using the shared glucometer on the evening of 11/16/21. Nurse #2 reported only two residents on his assigned hall needed their blood glucose to be checked that evening. The nurse stated he did "wipe down" the new meter he obtained from the med room with (Brand Name) Bleach Germicidal Disposable Wipes before placing the glucometer on top of tissues on the med cart to let it air dry. Nurse #2 reported he first checked Resident #62's blood glucose level with the glucometer, then wiped it off "the same way" with the (Brand Name) Bleach Germicidal Disposable Wipes. The nurse reported he liked to use the "bleach wipes" for the glucometers because he felt "they were stronger" than the other disinfectant wipes stored on the med cart. When asked how certain he was that he used the "bleach wipes" to clean / disinfect the shared glucometer between residents, the nurse stated he was "absolutely sure."

A follow-up interview was conducted with the Interim DON on 11/18/21 at 1:46 PM. During the interview, findings related to the infection control concerns for glucometer disinfection were again discussed, along with the most recent telephone interview conducted with Nurse #2. Information

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provided by the glucometer ' s user manual was also discussed. The user manual provided by the manufacturer specified the tested and approved disinfectant products for use on the glucometers used at the facility. During this interview, the DON reported she was unaware the (Brand Name) Bleach Germicidal Disposable Wipes were being used by Nurse #2 to disinfect glucometers. When asked, the DON stated she would refer to the glucometer ' s user manual as to which disinfectant wipes were tested and approved for disinfection of the facility ' s glucometers.

2) An observation was made on 11/16/21 at 4:30 PM as Nurse #1 pulled a glucometer from the medication cart in preparation to check Resident #64 ' s blood glucose. The glucometer was stored in a drawer of the medication cart in a baggie labeled with Resident #64 ' s name. The nurse removed the glucometer from the baggie and set it on top of the med cart (not a clean field) as she collected supplies for the blood glucose check. She donned gloves and entered Resident #64 ' s room carrying the glucometer and supplies. After entering the resident's room, the nurse placed the glucometer on the resident's tray table (not a clean field). She then used the glucometer to check Resident #64's blood glucose. After checking the resident's blood glucose, the nurse returned to the medication cart and placed the glucometer directly on top of the cart (not a clean field) as she disposed of the lancet and test strip. She removed her gloves and used hand sanitizer. The nurse put the results of the blood glucose check into the laptop on the med cart. She used her key to unlock the med cart, then moved the glucometer and set it on the baggie labeled with Resident #64 ' s name on top of the med cart.

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 11/19/2021

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 880	Continued From page 23	F 880		

The nurse wiped the glucometer with an alcohol wipe for approximately 2-3 seconds, then placed the glucometer back on top of the baggie. Approximately two minutes later the nurse put the glucometer inside the baggie and placed the labeled baggie containing the glucometer back into the drawer of the med cart.

Upon completion of the blood glucose check for Resident #64, inquiry was made as to whether there were any disinfectant wipes stored on the med cart. Nurse #1 opened the bottom drawer of the med cart to reveal a container of (Brand Name) Surface Disinfectant Wipes stored there. The nurse reported these disinfectant wipes were used to disinfect the medication cart at the beginning of her shift. When asked, Nurse #1 reported she worked a 12-hour shift.

An interview was conducted with the facility ' s interim Director of Nursing (DON) on 11/17/21 at 11:40 AM. During the interview, the infection control concerns related to the facility ' s failure to label, store, and clean/disinfect glucometers were discussed. The DON reported she would expect staff to store the individual glucometers in the drawer of the med cart in a baggie labeled with the resident's name. The DON stated the glucometer should be disinfected after each use before being stored on the med cart, even if the glucometer was dedicated to a single resident.
3) On 11/17/21 at 4:20 pm a medication pass with Nurse #8 was observed. Nurse #8 obtained a glucometer from the medication cart bottom drawer. The glucometer was in a small plastic bag with the resident's name on the bag. There were 4 other labeled, bagged resident glucometers in the same drawer. Nurse #8 placed gloves and took the resident's bagged

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glucometer and test strip to the resident's room. Nurse took the glucometer out of the plastic bag and placed the bag on the tray table and the glucometer on top of the plastic bag. Nurse #8 drew and tested the blood using the glucometer. She carried the glucometer, plastic bag, test strip, and lancet with blood to the garbage and discarded the strip. She carried the glucometer and plastic bag together and the lancet to the medication cart. She placed the glucometer in the plastic bag and placed the bag into the medication cart lower drawer with the same dirty gloves on top of the other resident's bagged glucometers. The lancet was discarded in the sharps container. She removed her gloves and started the same resident's (Resident #30) medication pour. She touched the cart and poured the medication. Medication was administered and the nurse used hand hygiene. Upon return to the medication cart interview began. Nurse #8 stated she was not aware she should clean the glucometer after each use and not take the plastic bag into the resident's room and make contact with the resident's surfaces without being cleaned afterward. The nurse placed gloves and cleaned (manufacturer and EPA approved wipes) the glucometer and the plastic bag after being instructed on how to perform and why. The nurse placed the bagged glucometer back into the medication cart drawer, removed her gloves, and began to pour medication for another resident. The nurse was asked to stop and complete hand hygiene.

An interview was conducted with the facility ' s Interim Director of Nursing (DON) on 11/18/21 at 1:10 PM. During the interview, the infection control concerns related to Nurse #8' s failure to clean/disinfect the glucometer and perform hand

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F 880	Continued From page 25 hygiene were discussed. She stated that staff were required to clean the glucometer after use with an approved cleanser, were not to take the glucometer storage bag into the resident's room to prevent contamination, and to perform hand hygiene after the glucometer was cleaned and between resident contact.	F 880		