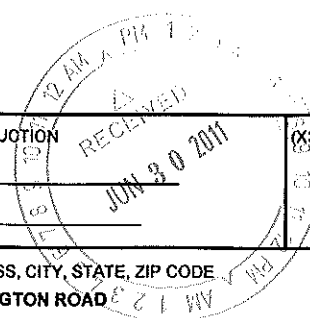


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/14/2011
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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5633 BURLINGTON ROAD MC LEANSVILLE, NC 27301
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(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 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews the facility failed to implement bed and chair alarms to prevent falls. This was evident in 2 of 3 sampled residents. (Residents #1, #2)</p> <p>The findings include:</p> <p>1. Resident # 1 was admitted to the facility on 05/26/11 with cumulative diagnoses of status post CABG (coronary artery bypass graft) and aortic stenosis. There was no MDS (minimum data set) available.</p> <p>According to the initial nursing assessment dated 05/26/11, Resident # 1 was alert and oriented with periods of confusion, but easily oriented to time and place. Resident #1 was independent in transfers, and required the assistance of 1 person with ambulation.</p> <p>A fall risk assessment dated 05/26/11 revealed the resident had a normal gait but had problems with balance while walking and required assistive devices for walking</p>	F 323	<p>Submission of the response to the statement of deficiency by the undersigned does not constitute an admission that the deficiencies existed and/or correctly cited and/or require correction.</p> <p>F 323</p> <p>1. Resident #1 is no longer a resident in the facility. Resident #2 has alarm placed in bed and chair with an order in resident chart and noted on the MAR/care plan.</p> <p>2. Any resident who requires the use of an alarm has the potential to be affected by this practice therefore the DON/ADON audited residents with alarms to make sure that physician orders were in place, alarms were noted on the MAR's and care plans were updated appropriately. Any issues noted were updated as</p>	7/02/2011

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

[Signature]

TITLE

Executive Director

(X6) DATE

7/01/2011

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.

MT P/B ✓

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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 6633 BURLINGTON ROAD MC LEANSVILLE, NC 27301
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F 323	<p>Continued From page 1</p> <p>Interview with Nurse #4 (admission nurse who completed the initial nursing assessment and fall risk assessment dated 05/16/11) on 6/13/11 at 3:00 PM revealed that Resident # 1 did not have any alarms in place upon admission. The nurse revealed that she assessed the resident while lying in bed</p> <p>During a telephone interview with the family on 06/13/11 at 12:25 PM the family member revealed during a preadmission interview at the facility they (the family) requested a personal alarm and safety measures to be put in place for the resident since he was confused at times and had an unsteady gait. The ADON (assistant director of nursing) agreed to have the bed alarm placed on the resident ' s bed prior to his admission. The family member also indicated they (the family) contacted the doctor on 05/31/11 after the resident had fallen and insisted the resident be sent to the emergency room because they (the family) noticed a change in the resident ' s mental status.</p> <p>An interview with the ADON (assistant director of nursing) on 06/13/11 at 4:40 PM revealed there was a pre-admission conference held for Resident #1. The RP (responsible party/family member) expressed the concern for Resident #1 safety, she requested personal alarms be used for him. The ADON stated " I explained to the RP we would place his bed in the lowest position, place falls mats on the floor next to his bed and place an alarm on his bed before he is admitted, I took this information and gave the paper with the interventions for the resident to the RN Supervisor #2 to get this done before the resident</p>	F 323	<p>appropriate. Nursing Management will monitor for alarm use and changes through review of the telephone orders, incident reports, 24 hr. report and acute charts during the morning clinical meetings. Also, during Pre-admission Conferences, nursing will be completing the Pre Admit Conference Check List for potential resident needs.</p> <p>3. An Audit of the residents requiring alarms was completed on 6/14/2011. The Staff Development Coordinator and/or DON will in-service nursing staff on resident alarms on or before 7/02/2011.</p> <p>4. The DON and/or ADON will audit resident alarms weekly for 8 weeks and then monthly for 2 months. DON will report monthly findings to the Monthly QA&A meeting for 4 months.</p>	
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F 323	<p>Continued From page 2</p> <p>was admitted that afternoon. " " I even checked before I left for the day to make sure this was completed. "</p> <p>An interview with the RN Supervisor #2 on 06/13/11 at 4:55 PM revealed she assigned this task (putting in place the interventions that were discussed in the pre-admission conference) to one of the nursing assistants (NA #1) and made sure it was completed before she left for the day. She stated " I also informed the nurse (Nurse #3) who would be admitting the resident the things we had set up for him. The nurse is responsible to place the alarms on the MAR (medication administration record) so the nurse checks them each shift. "</p> <p>During the interview on 6/13/11 at 3:20 PM NA#1, who worked with the resident, stated " he was alert, he would ring the call bell and I would just assist him to get up or go to the bathroom, he used a sitting walker to ambulate. He had a bed alarm, and I put it on his bed before he was admitted; I put it on the bed when I set up the room. " She indicated he did not have chair in his room. She further indicated two days after the resident was admitted the family brought in a recliner for the resident and an alarm was placed on the recliner too. The alarm would sound if he tried to get out of bed or sit up by himself to use the urinal. She indicated she knew a resident had an alarm from getting report or if she saw the connection cord for the device on the bed or chair. She further indicated she was responsible to make sure the alarms worked each shift and " you knew that by the flashing lights. If it was not working I would tell the nurse and replace the battery or device. "</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301
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F 323	<p>Continued From page 3</p> <p>A telephone interview on 6/13/11 at 4:42 PM with Nurse #1, (the nurse who responded to the incident) revealed (referring to the incident of 5/29/11) she was called by NA#2 that the resident was standing outside his room. The nurse stated " He had a bed alarm and one on his chair. I did not hear them sounding. " The nurse got a wheelchair, and sat him in the wheelchair in the hallway. There was no alarm on the wheelchair. She left the resident in the wheelchair in the hallway because she stated " I was to keep an eye on him. I returned to the desk and when I turned around to check on him again, I did not see him in the hallway, and then I heard him scream. " He was found on the floor in his room beside his wardrobe. When he fell he hit his elbow, he stated ' get me up from here, I did not hit my head. ' He said he fell on the water, but " I did not see any water on the floor. " She indicated she assessed his whole body, and found no other injuries, just the left elbow skin tear, a cut between the pinkie and 4th finger of his left hand and a bruise on the lower side of his back. She cleaned both areas with normal saline. She and NA#2 placed the resident in bed. Nurse #1 indicated the alarm that was on the resident ' s bed was checked at the start of the shift and it was working. She further indicated she was not sure if he was at risk for falls. Nurse #1 stated " if a resident has an alarm it was documented in the MAR, so we check it each shift. "</p> <p>Review of Resident #1 ' s MAR dated May and June 2011 revealed no documentation of bed or chair alarms.</p> <p>During a telephone interview on 6/13/11 at 4:58</p>	F 323		

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F 323	<p>Continued From page 4</p> <p>PM with NA #2 she indicated she remembered (referring to the incident on 5/29/11) she saw the resident walking down the hallway holding on to the rails. She called to the nurse, (Nurse #1) got the wheelchair and sat him in the wheelchair, and left the resident with the nurse in the hallway. She later heard him yell and they found him on the floor in his room. He had a skin tear on his elbow; he was in a sitting position on the floor. She helped the nurse assist him to the bed. She took his vitals signs, and brought them to the nurse at the desk. She revealed when she had last checked on him (before the fall), he was sitting in the recliner chair. She indicated she was unsure of how long it had been since she saw him in the recliner. She stated " he did have an alarm on the bed and the recliner chair, but I do not remember hearing the alarms sounding when I saw him in the hallway. " NA #2 explained her responsibility was to make sure the resident had them (the alarms) on the chair or bed and answer them when they went off. She stated " When I placed a resident in the bed or chair with an alarm, I checked it; it beeps twice when I removed the cord, that ' s how I knew it was working. "</p> <p>During an interview with RN Supervisor #1 on 6/13/11 at 5:10 PM revealed on Sunday evening about 2 hours before the shift ended (5/29/11 at 6:45 PM) she was informed by Nurse #1 that a resident had fallen. He sustained a skin tear on his elbow. He had a bed alarm and she added a chair alarm to his recliner after his fall. She explained it was her responsibility to assess the resident and to determine additional methods to prevent further injury, so a chair alarm was added to the recliner chair. She indicated Nurse #1</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>spoke with the family. She stated " I put the staff on alert to watch him and wrote the information on the 24 hour report (internal document utilized to document pertinent information of the residents for the upcoming shifts.). I think I added it to his care plan too. " " I should have also written an order for the chair alarm, but I did not. I completed the incident report from the information I received from (Nurse #1) and our assessment. "</p> <p>Review of the 24 hour report dated 5/29/11 (dated of fall) revealed no documentation of the resident ' s fall.</p> <p>Review of the incident report dated 5/29/11 at 6:45 PM which was completed by RN Supervisor #1 revealed " resident fell attempting to stand and walk from w/c (wheelchair). He had earlier been observed walking, was placed in the w/c (wheelchair) and evidently attempted to stand once out of sight of staff. Sustained laceration to left elbow between ring and pinkie finger. Also bruise to L (left) flank area. MD (physician) notified at 7:25 PM, RP responsible party notified at 7:25 PM. resident was not seen by physician first aid administered to abrasion, cleansed and dressed. Resident was not taken to the hospital. " The resident was documented as confused and disoriented.</p> <p>Review of a document titled " Investigation follow-up " (Documentation completed to review the occurrence and interventions to prevent further occurrences) dated 5/29/11 completed by RN Supervisor # 1 revealed: " Description of Situation " " Resident observed</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>earlier walking outside room, Placed in w/c(wheelchair) and wheeled back to his room, CN (NA) later heard noise and found resident on floor in room next to wardrobe. No lumps, bump bruises, laceration to head. "</p> <p>" Summary of Investigation " revealed " resident apparently stood from w/c (wheelchair) and fell against left side of body. Bruise L (left) flank/side area, skin tear laceration L (left) elbow, skin tear between pinkie and ring finger. Resident had refused O2 and becomes more confused at night. "</p> <p>" Past Interventions Attempted (include dates) " revealed no dates. " Bed Alarm " .</p> <p>" Recommendations/ New Interventions " revealed " 1, Chair alarm- this is to be used in recliner or wheelchair when resident is seated in chair. 2, Check frequently throughout the day, especially in the evening and night. " There was no documentation in the care plan update section.</p> <p>" Notification Summary " revealed no documentation in sections titled " Reported to QA (quality Assurance) committee, " Follow-up needed " and " No Follow-up needed " . Family notification was documented, with date and time. Under " Follow-up with family on revisions to the Care Plan " documented " Chair alarm added to care plan, Daughter informed "</p> <p>Review of interim care plan (not dated) revealed an intervention dated 5/28/11 " fall without injury, found resident sitting on floor stated he slid from w/c (wheelchair) x-ray, showed fx (fracture) to fourth finger to left hand, sent to ER (emergency</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>room) on 5/30/11 for fx (fracture). Bed and chair alarm and mat, low bed, 15 minute checks and keeping common area when OOB (out of bed). "</p> <p>An interview with the MDS coordinator on 6/13/11 at 2:45 PM revealed she updated the interim care plan in the morning meeting following the incident of 5/29/11 as a result of the interventions discussed. She further indicated the nurse was to document the alarms on the MAR, and inform the NAs too.</p> <p>Review of the Nurses Notes dated 5/31/11 at 2AM revealed a call from the physician with orders to send Resident #1 to the hospital for evaluation " per daughter ' s request for a change in his mental status. "</p> <p>Review of the hospital records dated 05/31/11 revealed Resident #1 was being evaluated " per the daughter ' s request of confusion that he has experienced ever since arriving at the nursing home. " He sustained a fracture of his left fifth finger after he fell on Sunday evening. A CAT scan of the head was performed resulting in no evidence of an acute infarction, hemorrhage, mass lesion, mass effect, midline shift or abnormal extra-axial fluid collection. He was released back to the nursing home that evening.</p> <p>Review of Nurses Note dated 05/31/11 at 11:22 AM revealed Resident #1 returned to the facility. " He was alert and responsive. "</p> <p>Interview with the DON (Director of Nursing) on 06/13/11 at 5:45 PM revealed her expectation was that residents that required personal alarms have them in place. She further indicated the</p>	F 323		

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F 323	<p>Continued From page 8</p> <p>nurse was responsible to check the alarms; it should be listed on the MAR, as a reminder for the nurses to check the alarms each shift. It should also be on the care plans. The NAs were also responsible to make sure the alarms were used properly and working.</p> <p>2. Resident #2 was admitted to the facility on 1/13/97 with cumulative diagnoses of L (left) side hemiplegia, muscle spasms, muscular wasting and depressive disorder.</p> <p>According to his MDS dated 6/3/11 Resident #2 required total care from the staff for all activities of daily living including transfers and toileting. He was continent of bowel and bladder intermittently. He had poor memory deficits with visual function deficit, communication deficit, at risk for falls and was intermittently disoriented. He was unable to ambulate independently and had poor sitting and standing gait/balance.</p> <p>Review of the falls care plan dated 3/15/11 revealed the resident had potential to falls due to the use of psychotropic drugs and diagnosis of seizure. The interventions did not include a bed or chair alarm.</p> <p>During a tour of the facility 09:45 AM a pad alarm was noted on the side rail of Resident #2 's bed. Resident #2 was in the bathroom with his wheelchair next to him with no alarm noted on the wheelchair.</p> <p>On 6/13/11 at 10:50 AM NA # 3 was observed applying the personal alarm to the Resident #2 's wheelchair. She states " He has had the alarms for as long as I can remember. "</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>Interview with NA#3 on 06/13/11 at 10:50 AM revealed Resident #2 had one alarm that needed to be moved from the bed to the chair when the resident was transferred. The resident attempted to transfer to the commode too, but required assistance from 1-2 persons. She stated " I am not sure how he got in the bathroom. The night shift gets him out of bed and dressed in the mornings so, they must have put him in his wheelchair. I think that was probably at 6:30 AM. "</p> <p>Several unsuccessful attempts were made to contact NA #4 who was assigned to Resident #2 during the 11-7 shift on 6/13/11.</p> <p>Interview with Resident #2 at 10:55 AM on 6/13/11 revealed the night nursing assistant got him out of bed this morning before breakfast because he likes to propel himself to the TV (television) room after breakfast.</p> <p>An interview with the DON on 06/13/11 at 11:00 AM revealed Resident #2 should have had the alarm on the wheelchair when he was put in the wheelchair this morning. She indicated he attempted to get up without assistance and we (the nurses) implemented the alarms for his bed and chair as a safety measure, he really only needs the chair alarm, but we put it on his bed just to be safe.</p> <p>During an interview with Nurse #4 on 06/13/11 at 1:45 PM she indicated " we (nurses) are responsible to mark off on the MAR that the alarms are working and in place. " She reviewed Resident #2 ' s MAR; she stated " I do not see the alarms listed on this MAR. "</p>	F 323			

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F 323	Continued From page 10 Review of Resident #2 's MAR dated April 2011, May 2011 and June 2011 revealed no documentation of this resident having a chair or bed alarm. Interview with the DON (Director of Nursing) on 06/13/11 at 5:45 PM revealed her expectation was that residents that require personal alarms have them in place. She further indicated the nurse was responsible to check the alarms; it should be listed on the MAR, as a reminder for the nurses to check the alarms each shift. It should also be on the care plans. The NAs were also responsible to make sure the alarms were used properly and working.	F 323			