

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 03/16/2016
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301	
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, family and staff interviews, and record reviews, the facility failed to assess observed bruising on 1 of 3 residents when reported by Resident #1's family and facility staff. Findings included: Resident #1 was admitted to the facility on 11/26/14 with diagnoses which included: osteoarthritis, dementia, peripheral vascular disease, and a history of cerebral vascular accident. Review of the most recent Minimum Data Set (MDS) dated 1/31/16 indicated Resident #1 had short term and long term memory problems with severely impaired decision-making skills, but no behaviors. The MDS also indicated the resident required extensive assistance with bed mobility and transfers; limited assistance with walking and locomotion; no falls since admission; and no skin problems. The Care Plan revealed Resident #1 had activities of daily living deficits due to limited mobility; potential for falls due to weakness and cognitive loss due to dementia. Approaches included transferring and ambulating the resident with walker and one staff to assist.</p>	F 309	<p>F: 309 483.25 Quality of Care</p> <p>Specific action taken to correct the deficiency:</p> <ul style="list-style-type: none"> Assessment for interventions to help reduce recurrence of any bruising on this identified resident e.g. gait belt use and geri-sleeves were initiated 3/31/16. Village staff where resident is located were in-serviced (4/1-4/16) on these interventions to prevent additional bruising/injury, signage was posted and the C.N.A. care guide was updated. In order to prevent recurrence of a staff member not assessing a reported issue, in-services related to the reporting, assessment/evaluation, first aid, RP/supervisor notification, monitoring and documentation of bruises and other injuries of unknown origin completed 4/1-7/16 with all nursing staff. Charge Nurse who failed to evaluate bruise/document is no longer employed as of 3/22/16 Meeting with resident's daughter held 4/4/16 to discuss actions taken for bruises 	4/14/16

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

TITLE

(X6) DATE

Electronically Signed

04/08/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1</p> <p>The Care Plan also revealed Resident #1 was at risk for the adverse effects/unusual bleeding related to anticoagulation use. Approaches included: observe resident for bleeding, hematuria, excessive bruising, tarry stools, bleeding gums, nose bleeds etcetera. Notify the physician/general nurse practitioner for further intervention, if indicated.</p> <p>Review of a Nurse's Note dated 2/29/16 revealed Resident #1's Responsible Party (RP) was notified by the facility of a scabbed area observed to the outer aspect of the resident's upper left arm and that the resident was unable to tell nurse how it occurred. The resident denied pain. There were no open areas, swelling, or signs/symptoms of infection noted.</p> <p>A Progress Note from the Nurse Practitioner, dated 3/2/16 during a routine visit, included no concerns from staff and no recent falls or skin issues reported. Resident #1's skin was noted to be warm and dry with no rash or diaphoresis. The resident had a long term use of anticoagulants.</p> <p>During an observation on 3/14/16 at 8:00pm, Resident #1 was in her room, sitting in a leather, lounge chair (no tears or sharp edges noted to chair). The resident's family member was visiting with the resident at the time of the observation.</p> <p>During an interview on 3/14/16 at 8:00pm, Resident #1's family member revealed that a couple of weeks prior to this date, the family member was notified by SN#1 (Staff Nurse) of a healing curved scab and bruising of unknown origin on the resident's left elbow. The family member described the area as appearing to be a hand print and there was a green to purple bruise on the resident's elbow and a round, reddish bruised area where the left shoulder and upper arm met. The family member provided pictures</p>	F 309	<p>and for the prevention or recurrence.</p> <p>Measures to be put into place or systemic changes made to ensure that the deficit practice will not recur:</p> <ul style="list-style-type: none"> • Hey Therapy sent to Rehab on 4/1/16 for evaluation of transfer status on identified resident and observation of staff to ensure correct technique being used • On 4/1/16, all residents in facility who were on an anticoagulant were assessed by the 7-3 supervisors for any current bruising and actions taken to prevent an occurrence e.g. geri-sleeves. • 4/6/16 – order placed to increase stock of geri-sleeves and geri-legs in village stock rooms for preventive needs as appropriate • New hire orientation, effective 4/13/16, to reiterate expectation for <ul style="list-style-type: none"> o reinforcement of thorough admission skin evaluation and regular skin checks o timely response (evaluation of and documentation of actions taken) to reported issues, o initiation of preventive measures, if susceptible to bruising e.g. long sleeves, geri-sleeves, gait belt use • Week of 3/21/16: 100% of facility employees in-serviced on: Potential abuse identification, reporting and investigation in-services completed. <p>We will monitor our performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Baseline audit of current status of weekly skin checks completed by 4/8/16 • Addition of quality monitor for rapid skin check completion to 2016 monthly QI 		

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F 309	<p>Continued From page 2</p> <p>of bruised areas of an arm on a celular phone. The family member revealed that Resident #1 had not had any falls nor was the family ever notified of any falls. The resident was not a wanderer and the resident was not capable of communicating how she obtained the bruising and the scar.</p> <p>On 3/14/16 at 8:15pm, observation of Resident #1's left arm revealed no bruising, but there was a healed, curve scratch, (approximately three inches), pale, flesh tone in color, located directly above the left elbow. The resident was unable to provide information about the incident involving bruises or the scar.</p> <p>During an interview on 3/15/16 at 2:41pm, SN#1 stated that she had worked with Resident #1 since admission. SN#1 described the resident as alert with confusion, spoke very few words, stoic and would only speak if asked a question. SN#1 revealed that on 2/29/16 at 7:30am, NA#1 (nursing assistant) reported that while providing morning care, she noted an area on the resident's left arm. SN#1 stated that she observed an approximate three inch abrasion on the resident's upper left arm (directly above the elbow) which had already began scabbing over. SN#1 conducted an assessment, asked the resident if the abrasion was painful and if she knew what happened. The resident's response was that she wasn't even aware it was there. SN#1 indicated that she notified the resident's RP, the NS#1 (nurse supervisor), NP, and discussed with the treatment nurse who said no treatment was needed due to scabbing. SN#1 stated that she did not observe any bruising around the area. SN#1 indicated skin assessments were completed by the nurse weekly and documented as "intact or not intact". If a resident had a new skin issue, the nurse would document a</p>	F 309	<ul style="list-style-type: none"> Follow-up counseling with staff who are identified as failing to appropriately evaluate/assess, treat or report instances of bruises/injuries of unknown origin 		

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F 309	Continued From page 3 description in the Nurse's Notes, report it to the Supervisor and the RP. She also revealed Resident #1 received 20 milligrams of Xarelto (anticoagulant) with supper everyday. During an interview on 3/15/16 at 3:47pm, NA#2 revealed that a couple of weeks ago, prior to this date she noticed a large (purplish/blue) bruise on Resident #1's left arm, near her elbow. The bruise was not fresh, it appeared to be older and she did not notice any scratches. She stated that she reported the observation to SN#2. She also revealed the resident required minimal assistance with transfers and the resident was not a wanderer. NA#2 indicated that when the resident was assisted to a chair, wheelchair, or bed, the resident would not attempt to get up unassisted. During an interview on 3/15/16 at 4:08pm, SN#2 recalled the first time she was made aware of Resident #1 having bruising on her arm was when the resident's family member showed her pictures on a cellular phone of the resident's arm with bruising. SN#2 indicated that she continued with administering medications to her assigned residents. She said that a day later she asked the third shift nurse if she knew how the bruising occurred on the resident ' s arm, but she did not. SN#2 indicated that SN#1 informed her that she had already notified the RP about the area on the resident's left arm. SN#2 revealed that she did not report or investigate or document any of the incident or the alleged bruising. During an interview on 3/15/16 at 4:19pm, NA#3 revealed he last worked with Resident #1 on 3/1/16. He indicated that he and SN#2 discussed and agreed on removing the resident permanently from his assignment due to the resident's family's dissatisfaction with his care. NA#3 revealed that sometime near the last of February, on a Monday before showertime, the	F 309			

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F 309	<p>Continued From page 4</p> <p>resident's family member asked him if he had noticed the scar on the resident's elbow, which he had not. The family member then had him remove the resident's sweater and he saw a scratch for the first time. It had already scabbed over. NA#3 stated that he did not remember seeing any bruising. NA#3 indicated he reported the conversation, including the "scratch" which was scabbing, to SN#2 who was administering medications at the time. NA#3 indicated the protocol for observing bruising, skin tears, ecetera on a resident was to immediately report the observation to the staff nurse.</p> <p>During an interview on 3/16/16 at 10:46am, NS#1 stated that on a Monday (unsure of date) in the morning, SN#1 notified her that Resident #1 had a "two lined scabbed, scratched area on lateral upper left arm " and she (SN#1) would be completing an Incident Report and notifying the resident's RP. NS#1 revealed she did not go to the resident's room and assess the area. It had already been assessed by SN#1. At no time, during that day or afterwards, did anyone report to her that the resident had any bruising on her arm or anywhere else on her body, therefore no incident report or investigation of injury of unknown origin was completed. Her expectation was that the bruising should have been assessed by the SN#2 when it was reported to her; then SN#2 was to report it to the supervising nurse on duty and the RP, as well as communicate with the physician or nurse practitioner. NS#1 concluded, at a minimum, because the resident received an anticoagulant, the bruising should have been assessed by the staff nurse.</p> <p>Review of a faxed letter from the facility's Medical Director dated and received on 3/16/16 included: the anti-coagulant therapy and chronic prednisone could predispose Resident #1 to</p>	F 309			

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F 309	Continued From page 5 higher risk of bruising. The Medical Director concluded that the bruising was most likely an incidental finding related to the use of anti-coagulant therapy.	F 309			