

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 12/03/2018
NAME OF PROVIDER OR SUPPLIER ASHTON HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301	
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F 558 SS=D	<p>Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident and staff interviews the facility failed to accommodate resident ' s preferences to attend activities due to not being up and ready in time for the scheduled activity. This was evident for 4 of 6 residents reviewed for accommodation of needs (Resident #9, Resident #11, Resident #10 and Resident #13).</p> <p>Findings Included:</p> <p>Resident #9 was admitted to the facility on 9/6/16 and diagnoses included hypertensive heart disease with heart failure and chronic kidney disease.</p> <p>An annual minimum data set (MDS) dated 11/18/18 for Resident #9 revealed she required extensive, one-person assist with ADL ' s and her cognition was intact.</p> <p>An interview with Resident #9 on 12/2/18 at 3:42 pm revealed there were times the staff didn ' t have her up and ready to attend activities. She stated it was important to her to have things to do and for the staff to have her ready for activities.</p> <p>Resident #11 was admitted to the facility on 12/21/17 and diagnoses included diabetes,</p>	F 558	<p>Ashton Health & Rehabilitation acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance.</p> <p>Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on December 2-3, 2018. Ashton Health & Rehabilitation response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Furthermore, Ashton Health & Rehabilitation reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures.</p> <p>F558</p>	12/21/18

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

TITLE

(X6) DATE

Electronically Signed

12/20/2018

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 558	<p>Continued From page 1</p> <p>depressive disorder and left sided hemiplegia.</p> <p>A quarterly MDS dated 10/3/18 for Resident #11 revealed she required extensive assistance to total dependence with ADL ' s and her cognition was intact.</p> <p>An interview on 12/3/18 at 11:45 am with Resident #11 revealed she liked to attend Bingo and sometimes she was not gotten up in time to attend.</p> <p>Review of a grievance dated 9/10/18 submitted by Resident #11 revealed the resident had requested to be up in time to attend Bingo. Corrective action stated on 9/13/18 the resident was up for Bingo and the Administrator assured the resident she would be up in time to attend.</p> <p>An interview on 12/3/18 at 2:57 pm with the Activity Assistant (AA) revealed she had worked in this position for 7 months. She stated the facility did not currently have an Activity Director; she believed the position had been open since the 1st or 2nd week of November. The AA added resident attendance at the morning activity which typically started at 10:30 am was less than the afternoon activity. She stated some residents had told her that they weren ' t up and dressed in time to attend the morning activity. The AA added she recalled Resident #9, Resident #10 and Resident #13 had voiced concerns about missing activities due to not be ready. She stated she had reported these resident concerns to the previous Activity Director.</p> <p>Resident #10 was admitted to the facility on 5/9/17 and diagnoses included congestive heart failure and muscle weakness.</p>	F 558	<ol style="list-style-type: none"> 1. Facility will obtain activity preferences from Residents 9, 10, 11, and 13 and will educate staff of these preferences. Completed on 12/21/18. 2. Facility will conduct interviews with current residents and resident representatives to determine whether residents have been able to attend activities they wish to attend. Interviews were completed on 12/20/18. 3. Activity Department will coordinate with Unit Managers to facilitate residents are afforded the opportunity to attend scheduled activities of their choice. 4. Facility will audit 10 residents per village per week for 4 weeks. Facility will then audit 10 residents per village every 2 weeks for 4 weeks, then monthly afterward. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI monthly 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. <p>Facility Administrator is responsible for ensuring the completion of Plan of Correction and ongoing POC compliance.</p> <ol style="list-style-type: none"> 5. Corrective action was completed on 12/21/18. 		

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F 558	Continued From page 2 A quarterly MDS dated 11/2/18 for Resident #10 revealed she required supervision one-person assist with ADL ' s and her cognition was intact. An interview with Resident #10 on 12/3/18 at 4:02 pm revealed there were times that she missed the morning activity because she wasn ' t dressed yet. Resident #13 was admitted to the facility on 11/13/17 and diagnoses included deep vein thrombosis and depression. An annual MDS dated 11/20/18 for Resident #13 revealed she required extensive one-person assist with ADL ' s and her cognition was intact. An interview with Resident #13 on 12/3/18 at 4:35 pm revealed she loved to go to activities and if there was one going on she wanted to attend. She stated she reported a concern at the resident council meeting that there were times she wasn ' t up and dressed in time to attend the 10:30 am activity. Resident #13 added there really hadn ' t been any change since she reported her concern and there were still times she wasn ' t up and ready to go to the morning activity. Review of a grievance dated 11/14/18 for Resident #13 revealed a concern that she had not been able to go to activities in the morning due to not getting up and having her bath until close to lunch time or after. Investigation findings stated the resident had been attending activities as preferred. An interview on 12/3/18 at 4:53 pm with Nursing Assistant (NA) #5 revealed there wasn ' t a list or	F 558			

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PRINTED: 01/04/2019
FORM APPROVED
OMB NO. 0938-0391

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F 558	Continued From page 3 documentation that told the NAs what residents needed to be up in time to go to activities. He stated the residents or someone that worked in activities would tell them if they wanted to go to a specific activity. A follow-up interview on 12/3/18 at 5:17 pm with the AA revealed she would try and verbally remind the nursing staff if there was a specific activity that a resident wanted to be up for. She stated if it was her weekend to work she would sometimes leave a list of residents that needed to be up and ready for activities. The AA added she would sometimes go and get the residents herself if they were up and dressed. She stated Bingo had been changed from the morning to the afternoon because residents weren ' t up and ready to attend at 10:30 am. An interview on 12/3/18 at 5:47 pm with the Administrator revealed the facility was in the process of hiring an Activity Director. She stated the previous Activity Director ' s last day of employment was 11/9/18. The Administrator stated it was her expectation that residents would be up and ready in time to attend activities of their choice.	F 558			
F 641 SS=D	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 record review and staff interviews , the facility failed to accurately code the MDS (Minimum Data Set) for 1 out of 3 residents	F 641	F641 1. Resident number 2 <input type="checkbox"/> quarterly	12/21/18	

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F 641	<p>Continued From page 4</p> <p>(Resident #2) reviewed for incontinence and for 1 out of 3 residents (Resident #7) reviewed for oxygen.</p> <p>Findings include:</p> <p>1. Resident #2 was admitted to the facility on 4/11/18 with diagnoses that included other psychotic disorder not due to a substance or known physiological condition, dysphagia, and fractured right radius.</p> <p>A review of Resident #2's Significant Change MDS dated 8/26/18 revealed the resident was cognitively impaired. Resident #2 was coded as needing extensive assistance with all ADLs (Activity of Daily Living). Resident #2 was coded as occasionally incontinent of bladder and frequently incontinent of bowel.</p> <p>A review of Resident #2's most recent quarterly MDS assessment dated 11/5/18 revealed the resident was rarely understood. The resident was coded as needing extensive assistance with all ADLs. Resident #2 was coded as always continent of bladder and bowel. Active diagnoses included Non-Alzheimer's dementia, malnutrition, and Benign Prostatic Hyperplasia.</p> <p>A review of Resident #2's most current care plan dated 9/2/18 revealed the resident was care planned for potential skin breakdown due to incontinence of bowel and bladder. The interventions read that the staff was to provide incontinence care as needed.</p> <p>An observation was made on 12/3/18 at 2:00pm with NA #1 and NA #2 with Resident #2 in the bathroom. Observed NA #1 and NA #2 transfer Resident #2 from the wheelchair to the toilet and removed brief. Brief was moderately wet and had small amount stool in it. Resident #2 finished large bowel movement in toilet. NA #1 cleansed the resident when he was finished defecating and applied new brief. NA #1 and NA #2 then</p>	F 641	<p>assessment of 11/15/18 has been modified on 12/3/18 in section H to reflect the correct coding. The modified MDS was transmitted on 12/3/18 to the state data base.</p> <p>Resident number 7 <input type="checkbox"/> quarterly assessment of 10/30/2018 has been modified on 12/3/18 in section I to reflect the correct coding. The modified MDS was transmitted on 12/3/18 to the state data base.</p> <p>2. 100% audit of the most recent OBRA assessments on all active residents will be completed to review section H and I for accuracy by Regional Reimbursement Nurse by 12/21/18.</p> <p>3. MDS nurses have been in-serviced on correct coding of the MDS by the Regional Reimbursement Nurse on 12/3/18. The Regional Reimbursement Nurse will conduct weekly audits of 5 OBRA MDS <input type="checkbox"/>s for accuracy of section I and H for 12 weeks, then monthly for 3 months.</p> <p>4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.</p> <p>Facility Administrator will be responsible for Plan of Correction completion and ongoing POC compliance.</p>		

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F 641	<p>Continued From page 5</p> <p>transferred Resident #2 back into wheelchair. An interview was conducted with NA #1 and NA #2 on 12/3/18 at 2:25pm. NA #2 reported Resident #2 was able to let the staff know when he needed to urinate or have a bowel movement when he first arrived at the facility, but over the last several months he had declined. NA #2 reported Resident #2 has a bowel movement every day after lunch around 2:00pm. She reported when the resident was asked if he had to go to the bathroom, he would say no but always started the bowel movement in his brief if the staff was unable to get him to the bathroom on time. NA #1 reported she had to check him at least every 2 hours as he never let the staff know if he had to go to the bathroom.</p> <p>2. Resident #7 was admitted to the facility on 4/23/18 with diagnoses that included hypertension, cardiomegaly, and chronic respiratory failure with hypoxia. A review of Resident #7's most recent MDS was coded as a quarterly assessment and dated 10/30/18. The resident was coded as mildly cognitively impaired. Active diagnoses were hypertension, Non-Alzheimer's dementia, muscle weakness, unspecified osteoarthritis, and repeated falls. Resident #7 was coded under special treatments as having oxygen. A review of Resident #7's most current care plan dated 11/3/18 revealed Resident #7 was care planned 4/23/18 for oxygen use: potential risk for impaired breathing pattern related to diagnosis of chronic respiratory failure. A review of Resident #7's October 2018 MAR (Medication Administration Record) revealed the resident received Oxygen at 3 liters per minute per nasal cannula every day in October 2018. Observations were made of Resident #7 on 12/3/18 at 10:23am and at 5:55pm. Each</p>	F 641	5. Plan of correction was completed on 12/21/18.		

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F 641	Continued From page 6 observation revealed Resident #7 wearing Oxygen. An interview was conducted on 12/3/18 at 5:20pm with MDS nurse #1 and MDS nurse #2. They both report it is their responsibility to accurately code all MDS assessments. MDS nurse #1 reported Resident #2's 11/5/18 quarterly MDS was coded incorrectly as Resident #2 was incontinent of bowel and bladder. MDS nurse #2 reported she inaccurately coded Resident #7's quarterly MDS on 10/30/18 as the resident had a diagnosis of chronic respiratory failure and she did not capture that diagnosis on the active diagnosis section of the MDS. An interview was conducted on 12/3/18 at 5:55pm with the administrator. She reported it was the responsibility of the MDS nurses to accurately code all MDS assessments. She reported it was her expectation that all MDS assessments would be coded correctly.	F 641			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide oxygen per physician's order on 1 out of 3 residents (Resident #7) reviewed for oxygen therapy.	F 695	F695 1. Resident # 7 oxygen liter flow was corrected according to physician order on	12/21/18	

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F 695	<p>Continued From page 7</p> <p>Findings include: Resident #7 was admitted to the facility on 4/23/18 with diagnoses that included hypertension, cardiomegaly, and chronic respiratory failure with hypoxia. A review of Resident #7's most recent MDS was coded as a quarterly assessment and dated 10/30/18. The resident was coded as mildly cognitively impaired. Active diagnoses were hypertension, Non-Alzheimer's dementia, muscle weakness, unspecified osteoarthritis, and repeated falls. Resident #7 was coded under special treatments as having oxygen. A review of Resident #7's most current care plan dated 11/3/18 revealed Resident #7 was care planned 4/23/18 for oxygen use: potential risk for impaired breathing pattern related to diagnosis of chronic respiratory failure. A review of Resident #7's medical record revealed a physician's order dated 10/1/18 that read Oxygen at 3 liters per min via nasal cannula continuous. A review of Resident #7's MAR (Medication Administration Record) dated 12/3/18 revealed the nurse documented the resident was wearing oxygen at 3 liters per minute on the 7am-3pm shift. Observations were made of Resident #7 on 12/3/18 at 10:23am and at 5:55pm. Each observation revealed Resident #7 had on oxygen at 2 liters per minute via nasal cannula. An interview was conducted with Nurse #1 on 12/3/18 at 5:55pm. Nurse #1 reported Resident #7 was on continuous oxygen at 3 liters per minute. She reported she had not had time to observe the resident's oxygen on her shift yet. She reported she worked 3pm-11pm. An interview was conducted with the Administrator and DON (Director of Nursing) on</p>	F 695	<p>12/3/18.</p> <p>2. All residents with physicians orders for oxygen were audited and validated to ensure oxygen liter flow rate matched the physicians orders by the Director of Nursing and Nurse Managers on 12/17/18.</p> <p>3. Audits will be performed by Nurse Managers on all residents with physicians orders for oxygen to validate oxygen liter flow rate matches physicians orders for 12 weeks.</p> <p>4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.</p> <p>Facility Administrator will be responsible for ensuring Plan of Correction completion and ongoing POC compliance.</p> <p>5. Plan of correction was completed on 12/21/18.</p>		

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F 695	Continued From page 8 12/3/18 at 6:30pm. They both reported it was their expectation that physician orders are followed and the nurse on 7am -3pm on 12/3/18 should have assessed Resident #7's oxygen and increased the liters to 3 per physician order.	F 695		