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 09/16/2021

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

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F 000	INITIAL COMMENTS The survey team entered the facility on 9-13-21 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 9-15-21 and 9-16-21. Therefore, the exit date was 9-16-21. 2 of the 6 complaint allegations were substantiated resulting in a deficiency. Event ID# TPSJ11.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and physician interview, the facility failed to provide the prescribed wound care when the nurse did not apply the physician ordered dressing to the residents wound and when wound care was not provided for 1 of 3 residents (Resident #2) observed for wound care. Findings included: Resident #2 was admitted to the facility on 4-26-18 with multiple diagnoses that included non-pressure chronic ulcer of other part of left foot with unspecified severity. The quarterly Minimum Data Set (MDS) dated	F 684	Education was provided to nurses by the Regional Clinical Manager and Unit Managers in regards to completion of all orders and documentation of completion on the EMAR/TAR on 9/28/21. New hires will be provided this education during orientation prior to taking an assignment. An audit was completed on current residents for compliance on all current treatments on the EMAR/ETAR on 9/28/21. Director of Nursing, unit managers and/or designees will monitor treatment administration 5 times a week for four weeks, then three times a week for four	9/29/21

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

Electronically Signed | 09/29/2021

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 684	Continued From page 1 7-9-21 revealed Resident #2 was severely cognitively impaired. Resident #2's care plan dated 8-17-21 revealed a goal the resident's arterial ulceration to left 5th toe would show signs and symptoms of healing without infection. The interventions for the were in part; prevelon boots and skin assessment/inspection every shift. Physician order dated 8-23-21 for Resident #2's arterial ulceration left lateral 5th toe read; clean with normal saline, apply skin prep wipe to peri wound, apply gauze moistened with betadine to wound bed and cover with dry dressing Monday, Wednesday and Fridays. Resident #2's Treatment Administration Record (TAR) for September 2021 revealed no documentation of wound care being completed for the arterial ulceration to left 5th toe on 9-10-21. Observation of wound care occurred on 9-13-21 at 11:32am with the facility's Assistant Director of Nursing (ADON). Resident #2 was observed to be laying on an air mattress with prevelon boots on bilateral feet. The ADON removed old dressing which was dated 9-8-21 and began, while maintaining a clean field, to clean Resident #2's wound with normal saline, wiped wound bed with betadine gauze and covered with a dry dressing. The wound was observed not to have any drainage, no signs of infection and no odor. The ADON was interviewed on 9-13-21 at 11:40am. The ADON acknowledged the date on the old dressing was 9-8-21 and she stated "the wound care nurse usually did all the wound care,	F 684	weeks, then once a month times one month. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing 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 684	Continued From page 2 but she has not been here for 2 weeks. I'm not sure why the care was not completed on 9-10-21." The ADON reviewed the physician order and commented, "there wasn't any betadine on the wound from the last dressing change." She acknowledged the order stated to apply gauze moistened with betadine to wound bed and that was not what she had done. During a telephone interview with the facility's wound care physician on 9-14-21 at 11:42am, the physician confirmed that the gauze moistened with betadine was to be left on the wound bed and covered with a dry dressing. He also discussed Resident #2's wound was a chronic wound and stated if the wound care was not completed as ordered it could cause a deterioration of the wound. The physician stated he expected his orders to be followed. The Administrator was interviewed on 9-14-21 at 12:00pm. She explained the wound care nurse had not been working so it was the responsibility of the nurse caring for the resident to complete wound care as ordered. Nurse #1 was interviewed by telephone on 9-15-21 at 2:14pm. The nurse confirmed she worked with Resident #2 on 9-10-21 but stated she did not perform the residents wound care. She explained she was informed by facility management that another nurse would complete the wound care.	F 684		
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 -	F 689		9/29/21

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F 689	Continued From page 3 §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 record review, observation and staff interviews, the facility failed to protect a resident from a fall during bed mobility causing the resident to be lowered to the ground which resulted in a nondisplaced radial neck fracture (elbow). This was evident in 1 of 2 residents (Resident #2) reviewed for accidents. Findings included: Resident #2 was admitted to the facility on 4-26-18 with multiple diagnoses that included hemiplegia and hemiparesis affecting left non-dominant side and diabetes. The quarterly Minimum Data Set (MDS) dated 5-11-21 revealed Resident #2 was severely cognitively impaired and required total assistance with 2 people for bed mobility and personal hygiene. Resident #2's care plan dated 7-20-21 revealed a goal that Resident #2's needs would be met by staff. The interventions for the goal were in part; Bed mobility total dependent on nursing staff, call light within resident reach, uses incontinence products with total dependance on nursing staff. Resident #2 also had a goal that she would not have a serious injury from a fall. The interventions for the goal were in part; staff education on how to position resident during care, place fall mats	F 689	Resident #2 was sent to the hospital. Fall mats were placed at the bedside for the resident. The Director of Nursing provided education to the Certified Nursing Assistant regarding proper positioning and body alignment during ADL care on 6/11/2021. [Completion date: 6/11/2021] An audit of residents coded for total dependence was completed by MDS Coordinator(s) from the most recent resident assessment. [Completion date: 9/29/2021] Education was provided to Certified Nursing Assistants and Nurses by the Regional Clinical Manager and Unit Managers in regard, to following the plan of care for the resident in bed mobility and positioning. New hires will be provided this education during orientation prior to taking an assignment. If additional assistance was necessary due to an acute situation or a change in status of the resident, it is to be reported to the nurse. [Completion date: 9/29/21] The Director of Nursing or designee will monitor compliance by observing bed mobility and appropriate assistance needed during ADL care for 10 residents weekly x 2 weeks, then 5 residents weekly x 2 weeks, then 5 residents every two	

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F 689	Continued From page 4	F 689		

beside the bed and maintain bed wheels in lock position.

The hospital emergency room documentation dated 6-10-21 revealed the hospital performed an assessment which included lab work, electrocardiogram, a head computed tomography (CT) scan and an x-ray of Resident #2's pelvis and chest. Documentation showed no pertinent findings, and the resident was discharged back to the facility.

Nursing documentation dated 6-11-21 at 1:09am revealed Resident #2 was in her room lying face down. The nurse documented that she assessed for injuries, bleeding and bruising but did not find any. The documentation revealed Resident #2's legal representative was notified and had requested the resident be sent to the emergency room for further evaluation.

Nursing assistant (NA) #1 was interviewed on 9-13-21 at 3:04pm. The NA stated he was working on 6-10-21 providing incontinence care to Resident #2. He explained when he turned the resident towards him the resident's upper body started coming off the bed, so he stated he cradled the resident and lowered her to the floor. The NA said he immediately received help from the nurse and an assessment was completed. The NA discussed Resident #2 being uncommunicative but had noticed the resident grimacing when she was being placed back into bed. NA #1 stated he did not know if Resident #2 was a 2 person assist in bed mobility but explained he had "always" provided care to Resident #2 by himself.

During a telephone interview with Nurse #2 on

weeks x 4 weeks, and then 5 residents monthly x 1 month. Observations will be documented by monitoring tool.
Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing 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 689	Continued From page 5	F 689		

9-15-21 at 9:40am, the nurse confirmed she was working with Resident #2 the evening of her fall. She explained NA #1 had informed her that he had to lower the resident to the floor. Nurse #2 said she performed an assessment and did not find any injuries so Resident #2 was placed back in bed using an electric patient lift. She stated she did not see any signs Resident #2 was in pain. The nurse confirmed there was usually one NA to perform bed mobility. Nurse #2 discussed calling the residents legal representative and when the legal representative came to the facility, she requested Resident #2 be sent to the emergency room for further evaluation.

Nursing documentation dated 6-14-21 at 6:05pm was reviewed and revealed Resident #2's family was visiting with the resident and had noticed a hardened area and swelling in the residents left arm. The nurse documented Resident #2 did not have any facial grimacing when touching the area and that she contacted the resident' provider and received an order for an x-ray to be completed.

The emergency room record dated 6-14-21 was reviewed. The documentation showed the emergency room performed x-rays on Resident #2's left elbow, left forearm, left wrist, left ankle, left shoulder, left humerus and left foot due to a fall that had occurred a week ago. The emergency room records indicate a diagnosis of a nondisplaced left radial neck fracture and the resident was provided a sling then discharged back to the facility.

The Director of Nursing (DON) was interviewed by telephone on 9-14-21 at 4:12pm. The DON discussed that staff had not noticed anything wrong with Resident #2's left arm until the family

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F 689	Continued From page 6	F 689		

brought the concern to the nursing staff. She stated she had not assessed the resident's arm because she was not in the facility.

Nurse #3 was interviewed by telephone on 9-15-21 at 11:35am. The nurse discussed not working with Resident #2 on 6-14-21 but had been asked by the resident's nurse to help with assessing Resident #2's left arm. Nurse #3 stated she did perform an assessment on Resident #2's left arm and found a hardened area and the arm was swollen. She explained she obtained a set of vitals and notified the Nurse Practitioner who ordered an x-ray but stated the family had requested the resident be sent to the emergency room for further evaluation.

The facility's Nurse Practitioner (NP) was interviewed by telephone on 9-16-21 at 10:44am. The NP stated she could not state for certain if Resident #2's radial neck fracture came from the fall she sustained on 6-10-21 but acknowledged Resident #2 had not had any further falls since 6-10-21.