STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/10/2023 to 10/12/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2JQH11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/10/2023 to 10/12/2023. Event ID# 2JQH11. The following intakes were investigated: NC00199405, NC00199414, NC00203042, and NC00208179. 6 of the 6 complaint allegations did not resulted in deficiency.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		

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

Electronically Signed | 10/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews the facility failed to follow a resident's care plan when transferring 1 of 5 residents reviewed (Resident #307). Findings included: Resident # 307 was admitted into the facility on 12/15/2021 with the diagnoses of: non-Alzheimer's dementia with mood disturbance, anxiety, bipolar disorder, and expired on 3/5/2023.	F 656	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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 656	Continued From page 2	F 656		

Resident #307's quarterly Minimum Data Set dated 12/19/2022 revealed she was severely cognitively impaired, required extensive assistance with her bed mobility, toilet use and transfers.

A review of Resident #307's most recent comprehensive care plan dated 12/30/2022 stated two-person assistance with transfers.

A review of Nurse #2 progress notes dated 2/26/2023 at 8:04 AM revealed that at 6:00 AM she was alerted Resident #307 had a seizure episode during a transfer.

A telephone interview was conducted with Nursing Assistant #1 on 10/12/2023 at 7:45 AM who relayed that she had used a sit-to-stand lift by herself to take Resident #307 to the restroom on 2/26/23, she stated that during the transfer Resident # 307 became red in the face and would not respond when Nurse Assistant #1 called her name. Nurse Assistant #1 then stated that she laid Resident #307's head and upper body on the bed but could not get her legs on the bed because Resident #307 was so stiff, Nurse Assistant #1 then yelled for help and the nurse came into the room. Nurse Assistant #1 also revealed that at no time did Resident #307 fall either from the lift or off the bed. Nursing Assistant #1 indicated that Resident # 307 had become too heavy to transfer so she used the assist lift for the transfer. Nurse Assistant #1 also revealed that she knew that Resident # 307's care plan did not include using a sit-to-stand lift for transfers and had indicated two-person extensive assist with all transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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 656	Continued From page 3	F 656		

An interview with the Director of Nursing on 10/11/2023, at 2:00 PM revealed that during the transfer on 2/26/2023 it appeared that Resident #307 had seizure like activity. The Director of Nursing further revealed that at the time of the incident that the facility investigation concluded Resident #307 had not been transferred by Nurse Assistant #1 in accordance with her care plan.

An interview with the Administrator on 10/11/2023, at 2:45 PM revealed that Nursing Assistant #1 did not transfer Resident #307 in accordance with the care plan. She further revealed that the facility had assessed Resident #307 and contacted the physician regarding her pain and seizure activity. When the facility had found out a plan of correction was established.

The plan of correction initiated on 2/27/2023 included:

Root cause analysis: Resident's care plan stated 2-person assist with transfers. Certified Nursing Assistant transferred resident with a sit to stand lift with one person assist.

Corrective Action: Certified Nursing Assistant was counseled and re-educated on facility transfer policy and following the care plan for transfers was completed on 2/27/2023.

Corrective Action for Potential Deficient Practice: All current resident's care plans checked to assure they match the resident profiles was completed on 2/27/2023.

Systematic Changes: Retraining of all staff in the facilities transfer policy, following the Resident's profile for all transfers was completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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 656	Continued From page 4 2/27/2023. Monitor Plan of Facility: The Staff Development Coordinator or designee will monitor transfers to ensure correct techniques and the transfer matches the plan of care and report to the facilities Quality Assurance Performance Improvement Committee for a 3-month period and then randomly thereafter to ensure compliance. Review of the plan of correction was completed on 2/28/2023. The facility's plan of correction was validated by observations of transfers during the survey that revealed transfers with and without mechanical lifts were completed by the staff in accordance with the care plan and resident profiles. Staff interviews were completed to verify they had received training on resident transfer status. And a review of staff training material regarding the proper procedures for transfers and audits completed by the facility was completed.	F 656		