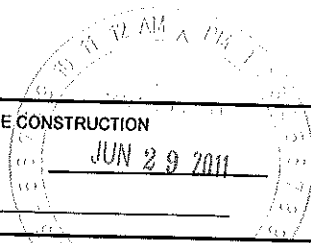


DEPARTMENT OF HEALTH AND HUMAN SERVICES
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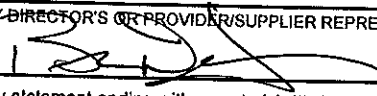
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FORM APPROVED
OMB NO. 0938-0391



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 05/18/2011
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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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(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)	(X6) COMPLETION DATE
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and family member interviews and record review the facility failed to notify the</p>	F 157	<p>Submission of the response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly cited and/or require correction.</p> <p>F 157</p> <ol style="list-style-type: none"> 1. Resident #2 RP was notified of resident's status by ADON and NP on 5/06/2011. 2. Residents with a change in condition have the potential to be affected by this practice therefore the RN Supervisor did an audit of resident charts to verify notification of RP/MD. No issues noted on Audit. Nursing Management will monitor responsible party notification through review of the telephone orders, incident reports, 24 hr. 	6/15/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE 6/10/2011

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.

Revised 6/28/2011

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F 157	<p>Continued From page 1</p> <p>responsible person (RP) when Resident#2 " s experienced pain and the right leg was bruised and swollen. This was evident in 1 of 3 residents in the survey sample.</p> <p>Resident#2 had cumulative diagnoses which included Alzheimer ' s disease, osteoporosis (abnormal loss of bony tissue resulting in fragile porous bones and osteopenia (a condition where bone mineral density is lower than normal).</p> <p>Review of the Minimum data set (MDS) assessment dated 4/5/11 revealed Resident#2 had severe cognitive impairment.</p> <p>On 5/3/11 at 3:45 p.m. the nurses ' notes revealed " bruise to the left shin. Swollen & warm to touch (referring to the right leg). Yells when touched. " The resident was seen by NP (nurse practitioner) who wanted a board across the foot pedals of the wheelchair.</p> <p>Review of the incident report initiated by Nurse#1 indicated on 5/3/11 at 3 a.m., the resident was in bed. The description of what happened had an entry of " resident right shin swollen and bruised and warm to touch. Resident expresses pain to touch. " There was no written entry under whether the RP was notified. Another incident report dated 5/3/11 at 7 a.m. revealed a comment indicating " an old open area with scab intact " with a line drawn to a diagram of the right lower leg.</p> <p>Interview on 5/18/11 at 12:58 p.m. with Nurse#2 revealed she did not contact the responsible party about the condition of the right leg.</p> <p>Review of the nurses ' notes dated 5/4/11 (no</p>	F 157	<p>report and acute charts during the morning clinical meetings.</p> <p>3. The Staff Development Coordinator and/or Director of Nursing will in-service the staff nurses on notification of any changes of care to the responsible party and to the MD on or before 6/15/2011.</p> <p>4. The DON will audit for RP/MD notification 5 times per week for 8 weeks during daily clinical morning meeting to ensure RP/MD have been notified of changes. The DON will report findings to the Monthly QA&A meeting for 2 months.</p>		

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F 157	<p>Continued From page 2</p> <p>time) revealed the right shin was still swollen and warm to touch.</p> <p>Review of the nurses ' notes from 5/2/11 until 5/5/11 revealed no documentation that the RP was notified of the status of the right leg.</p> <p>The nurses ' notes on 5/5/11(no time noted) revealed the RP of Resident#2 was in the facility and voiced concerns about Resident#2 ' s right lower leg bruising and edema to the right ankle (also the right leg). This was the first evidence that the RP was aware of the status of the right leg. The NP was notified and ordered an x-ray for the right lower extremity.</p> <p>Review of the x-ray report dated 5/6/11 revealed a history of " pain swelling. " The results of radiology interpretation included the right tibia and fibula showed a spiral fracture extending across the distal shift of the tibia.</p> <p>Interview on 5/17/11 at 5:30 p.m. with the RP revealed no staff notified her regarding Resident ' s #2 right leg/ankle. The RP indicated it was not until she came to the facility on 5/5/11 that she knew anything about the right leg. On 5/6/11 at 11:45 a.m. x-rays were done on the right shin and ankle.</p> <p>Interview on 5/17/11 at 2 p.m. with the ADON (assistant director of nurses t revealed Nurse#2 informed her on 5/6/11 and note left under my door regarding _____ (name of RP) concerns about why no one about the bruising and swelling of the right ankle (referring to the right leg). The ADON indicated she then called _____ (name of</p>	F 157			

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F 157	Continued From page 3 RP) and left a message about no staff had called the ____ (name of RP). The ADON indicated she conducted an in service with the staff on the expectation to always contact the responsible party when changes occur.	F 157			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan, including measurable goals and timetables, for 1 of 1 resident (Residents #2) with osteoporosis and a cast to the right lower leg due to a fractured right leg.	F 279	F 279 1. The Care Plan for resident #2 has been corrected. 2. Resident requiring a Care Plan has the potential to be affected by this practice therefore the MDS Nurses did a Care Plan audit to verify that the Care Plan reflects the care and needs of the resident. Any issues noted were updated as appropriate. The MDS Nurse will identify through the morning clinical meeting, review of the 24 hour report, and telephone orders for the past 24 hours to ensure their Care Plans reflect the resident's needs. 3. The Staff Development Coordinator and/or Director of Nursing will in-service the	6/15/2011	

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F 279	<p>Continued From page 4</p> <p>Findings included: Resident#2 had cumulative diagnoses which included Alzheimer ' s disease, osteoporosis (abnormal loss of bony tissue resulting in fragile porous bones and osteopenia (a condition where bone mineral density is lower than normal).</p> <p>Review of the care plans dated 1 /17/11, 4/5/11 and last revised on 4/12/11 revealed no written care plans to address how to handle and care for Resident #2 ' condition of osteoporosis and osteopenia. An inquiry was made on 5/17/11 at 10:15 a.m. with MDS#1 revealed she was unable to produce this written care plan.</p> <p>Record review revealed on 5/6/11 at 11:45 a.m. x-rays were done on the right shin and ankle.</p> <p>Review of the x-ray report dated 5/6/11 revealed a history of " pain swelling. " The results of radiology interpretation included the right tibia and fibula showed a spiral fracture extending across the distal shift of the tibia.</p> <p>Review of the nurses ' notes dated 5/9/11 at 3:30 p.m. revealed the resident left the facility for an orthopedic appointment at 1:15 p.m. At 6 p.m. the resident returned with a cast to the lower right leg.</p> <p>Review of the care plans dated 1/17/11, 4/5/11 and last revised on 4/12/11 revealed no updated resident centered plan of care was developed which included measurable goals and/or objectives after Resident ' s #2 had a cast applied due to a fractured right leg.</p> <p>Interview on 5/17/11 at 10:15 a.m. with MDS#1</p>	F 279	<p>MDS Nurses on reviewing of 24 hour report and new orders to update care plans to meet resident's needs by 6/15/2011.</p> <p>4. The DON will audit 5 Care Plans weekly for 8 weeks to ensure that Care Plans reflect the resident's current condition. The DON will report findings to the Monthly QA&A meeting for 2 months.</p>		

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F 279	Continued From page 5 (Minimum Data Set Coordinator) indicated the last revised care plan for the resident was 4/12/11 and she needed to check on whether the care plan had been revised after the fractured with a cast applied. Interview on 5/17/11 at 2:30 p.m. with MDS#1 and MDS#2 regarding the care plan revisions that included changes regarding the right leg fracture with a cast was held. MDS#1 indicated that in the morning meeting (referring to 5/17/11) a discussion was held about placing a pillow in between the resident ' s legs due to the cast rubbing the skin. MDS#1 provided a care plan with problems, goals and approaches regarding the resident ' s impaired mobility related to a cast to the lower extremity. When asked when this care plan was developed the response from MDS#1 was " I just did it. " MDS#2 indicated that she was responsible for developing the care plan and one should have been developed immediately after the cast was applied. Interview on 5/18/11 at 1:40 p.m. with the administrator, director of nurses, assistant director of nurses (DON), staff development coordinator, and corporate representative was held. During the interview the DON indicated that she expected documents written by her staff be accurate, nursing assessments of the resident be done as needed and a care plan be developed to address the resident ' s current needs.	F 279			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309	F 309 1. The NP was made aware of fracture to RLE on 5/06/2011 and an order for pain medication was	6/15/2011	

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' F 309	<p>Continued From page 6 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, interviews with the nurse practitioner (NP) and record review the facility staff failed to assess the pain level of Resident#2 and provide pain relief when Resident#2 displayed signs of pain upon movement of the left leg from 5/3/11 through 5/6/11. The facility staff failed to conduct an ongoing assessment of a bruised and swollen right leg. The facility staff failed to conduct an initial assessment or ongoing assessments of a skin tear to the right leg. On 5/6/11 Resident #2 was diagnosed with right tibia and fibula spiral fracture. On 5/6/11 Resident #2 was diagnosed with cellulites (a skin infection). This was evident in 1 of 2 residents in the survey sample reviewed for pain management and 1 of 3 residents in the sampled survey reviewed for accidents. (Resident#2)</p> <p>Findings include: The facility has a pain management tool (date unclear). Review of the pain tool revealed guidelines for assessing a resident (who was unable to verbally express pain) using facial and body language, Interview on 5/18/11 at 11:08 a.m. with staff development coordinator (SDC) revealed there was no written procedure on using the pain management tool. If pain is present the nursing assistant (NA) should notify the nurse and the nurse should use the tool to conduct an assessment. The SDC indicated the nurse</p>	F 309	<p>obtained on 5/06/2011 to address resident #2 pain. Treatment to skin tear on RLE was initiated on 5/06/2011 to resident #2.</p> <p>2. Any resident with pain and/or change in skin condition can be affect by this practice therefore the DON/ADON completed 100% chart audit to make sure pain is being assessed and interventions are in place. Any issues noted were updated as appropriate. Residents will be assessed for pain utilizing the Wong-Baker Faces Pain Rating Scale every shift and documented on the MAR and MD/NP will be notified for any pain management needs. The wound nurse is now attending the morning clinical meeting to review the 24 hour reports for any change in skin conditions.</p> <p>3. The DON and/or ADON and/or SDC and/or RN</p>	

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F 309	<p>Continued From page 7</p> <p>should check whether there was a prn (when ever necessary) order or contact the MD (medical doctor) or NP. The SDC also indicated the facility documents by exception and has not provided training to staff on nursing assessments other than during orientation.</p> <p>The skin care policy was provided by DON (Director of nurses) who indicated the policy has been in effect since 11/2009. The policy in part addressed to cleansing the wound applying non-adhering protective dressings and to check the wound daily and change the dressings as necessary.</p> <p>A. Resident#2 had cumulative diagnoses which included Alzheimer ' s disease, osteoporosis and osteopenia.</p> <p>Review of the May 2011 physician orders revealed orders for Acetaminophen 325 milligrams (mg) 1 tablet twice a day (as far back as 8/30/10 , Duragesic patch 12 mcg/hr every 72 hours (renewed on 4/5/11) and Ben Gay patch once a day due to chronic back pain.</p> <p>Review of the Minimum data set (MDS) assessment dated 4/5/11 revealed Resident#2 had severe cognitive impairment, required the 2 person total dependence on staff for transferring between surfaces. The MDS indicated functional limitation in range of motion on both sides that interfered with the daily functions or placed the resident at risk for injury. The MDS indicated no signs of pain had been observed or documented.</p> <p>Review of the care plans dated 1/17/11 and revised 4/5/11 revealed no written care plan to</p>	F 309	<p>Supervisor will do a 100% chart audit to be completed by 6/15/2011 for pain management needs and skin assessment. The ADON and/or RN Supervisor and/or Wound Care Nurse have completed a 100% skin audit for skin changes that was completed on 5/31/2011.</p> <p>4. The DON and/or ADON will review 100% resident charts for pain management and change in skin conditions weekly for 8 weeks and then 50% of the charts weekly for 4 weeks and then 100% of the charts monthly for 2 months. The DON will report findings to the Monthly QA&A meeting for 5 months.</p>		

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F 309	<p>Continued From page 8</p> <p>address how to handle and care for Resident #2 ' condition of osteoporosis and osteopenia. An inquiry was made on 5/17/11 at 10:15 a.m. with MDS#1 revealed she was unable to produce this written care plan.</p> <p>Review of the care plan dated for problem onset dated 4/5/11 revealed " unable to independently perform all activities of daily living secondary to needeing (needing) total assistance with ADL ' s [activities of daily living] ". The goal included staff to perform ADL every shift to assure resident was clean, dry, and comfortable. The approaches included " assist with positioning, transfers 2 person assist with Hoyer (mechanical lifting device) as necessary and/or requested by resident and to monitor skin condition for signs of breakdown or redness. "</p> <p>Interview on 5/17/11 at 3 p.m. with NA#5 (who worked night shift and assigned to resident) revealed she arrived on duty on 5/2/11 and started her 1st round. NA#5 stated that Resident#2 was asleep and was dry (referring to not experiencing an episode of urine incontinence). Then she did her second round at 2 a.m. on 5/3/11 when the ankle part of her right leg was purple looking. I told nurse Nurse#1 and he assessed her. When she moved her in the bed she was acting like she was in pain. NA#5 indicated she knew her from _____ (name of a previous nursing facility) and Resident#2 was in pain.</p> <p>Review of the medical record revealed on 5/3/11 at 6 a.m. the nurses ' notes indicated Resident#2 ' s right shin was swollen and bruised. The " Resident expresses extreme pain when touch " .</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>A note was left for NP (nurse practitioner). An interview via the phone was conducted on 5/18/11 at 12:39 p.m., with Nurse#1 (author of the note) who indicated that the resident 's right shin was bruised. When he touched the resident 's right leg she closed her eyes and had a facial grimace of pain. When inquiring about pain management Nurse#1 indicated " I informed the NA [nursing assistant] to be careful when changing her. " It was 3 a.m. and I spent much time telling the oncoming nurse about the bruise. Nurse#1 indicated he followed protocol by placing a note in the NP 's box because she was coming in that morning. Nurse#1 indicated " I would have called the on call person if it was an emergency. "</p> <p>Review of the incident report initiated by Nurse#1 indicated on 5/3/11 at 3 a.m., the resident was in bed. Under the description of what happened had an entry of " resident right shin swollen and bruised and warm to touch. Resident expresses pain to touch. " A second incident report dated 5/3/11 at 7 a.m. authored by Nurse#2 revealed a comment indicating " an old open area with scab intact " with a line drawn to a diagram of the right lower leg. This same incident report revealed the NP assessed the resident onsite on 5/3/11.</p> <p>On 5/3/11 at 3:45 p.m. the nurses ' notes revealed " bruise to the left shin. Swollen & warm to touch (referring to the right leg. Yells when touched. " The resident was seen by the NP who requested a board across foot pedals of the wheelchair. Interview on 5/17/11 at 11:40 a.m. with Nurse#2 revealed she asked the NP to check on the resident. We thought that the resident had placed her leg behind the leg rest of</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/18/2011
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 6533 BURLINGTON ROAD MC LEANSVILLE, NC 27301		
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F 309	<p>Continued From page 10</p> <p>the wheelchair and we thought the bruises came from that. Nurse#2 indicated the NP told us to elevate her leg, get a bar across the wheelchair and to monitor the leg.</p> <p>Review of the NP notes dated 5/3/11 revealed a bruised area right lower leg with minimal swelling and a skin tear to the right lower leg was opened to air without signs of infection or inflammation present.</p> <p>Interview with the NP on 5/18/11 at approximately 10:30 am indicated that when she assessed the resident on 5/3/11 she actually touched the resident ' s right leg she did not complaint of pain. The NP indicated that she read the film and at the time did not appear to be spiral in nature but a clean break. The NP indicated that her plan was and that she had expected the staff to monitor the status of the resident ' s right foot. The NP indicated that if the staff had notified her that the resident was in pain she would have increased Resident#2 ' s pain medicine.</p> <p>Review of the nurses ' notes dated 5/4/11 (no time) revealed the right shin still swollen and warm to touch. There was no assessment about the resident ' s pain.</p> <p>Interview on 5/17/11 at 4:48 p.m. with Nurse#2 revealed she worked on 5/5/11 and monitored her leg condition but did not write it down in the nurses ' notes. Nurse#2 indicated that the nurses ' notes on 5/4/11 were most likely written after 3 p.m. as routine.</p> <p>Interview on 5/17/11 at 11:35 a.m. with NA#3 (working the day shift for almost a year) revealed</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>on May 2, 2011 " I got off from work at 12 noon and nothing was wrong " with Resident#2. The next day on 5/3/11, I noticed a bruise during bathing the resident and I contacted Nurse#2. Nurse#2 then reported the bruise to the NP. When I got Resident#2 out of bed or moved her in bed she complained of pain. She (referring to Resident#2) can ' t tell you verbally that she was in pain but she did act like she was in pain by her " non-verbal " expressions on her face. We always used 2 people or Hoyer lift to transfer her.</p> <p>Interview on 5/17/11 at 2:15 p.m. with the (RA) restorative nursing assistant (for 2 years) revealed she provided restorative care for Resident#2. The RA indicated she usually used 2 people or the lift to transfer. RA indicated she usually provides restorative transferring, range of motion to her arms and legs, performed knee extensions, abduction and adduction her legs. RA indicated she saw a bruise on Resident#2 ' s right shin on 5/2/11. On interview RA indicated that as soon as she touched her right leg she had a facial expression like she was in pain and she does not usually act like this. I stopped during any range of motion or transferring her that day. RA indicated she reported this immediately to Nurse#3. Then on 5/3/11 she tried to do range of motion and noticed the bruise again and she tried to do range of motion on 5/3/11 in the morning (no specific time) but Resident#2 again expressed pain in her face. RA indicated she reported this to Nurse#2 but she already knew about it.</p> <p>Review of the " Restorative Care Flow Record " form provided on 5/18/11 revealed on 5/2/11, 5/3/11, 5/5/11 and 5/6/11 documentation that 15</p>	F 309			

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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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F 309	<p>Continued From page 12</p> <p>minutes of restorative care for bilateral range of motion, that included " pull a parts and scissor kick " was performed despite the presence of pain and diagnoses of a fracture on 5/6/11. Additionally, the documentation indicated 15 minutes of standing program on 5/3/11 in the a.m. RA was not available on 5/18/11 to be interviewed about the documentation. Interview on 5/18/11 at 1:20 p.m. with the DON revealed she spoke with RA who indicated to her that she only did restorative care to her left leg and not the right leg as documented. The DON indicated that these were " documentation errors. "</p> <p>Review of the nurses notes from 5/4/11 (no time indicated) there were no follow-up assessments about the bruised shin, leg edema, pain or skin tear until 5/5/11 (no time indicated).</p> <p>Review of the nurses ' notes on 5/5/11(no time noted) revealed the responsible party was visiting and voiced concerns about Resident#2 ' s right lower leg bruising and edema to the right ankle. The NP was notified and ordered an x-ray for the right lower extremity. Interview on 5/17/11 at 3:15 p.m. with Nurse#3 (author of this note) revealed the first time she knew about Resident#2 ' s bruised ankle and swelling was on 5/5/11 when the ---_____(family member) approached her that Resident#2 ' s leg looked bad. Her right ankle was really bruised and swollen. Nurse#3 indicated at that point " I called the NP and she ordered the resident to either go to the hospital or get an x-ray in the am, Nurse#3 indicated that the family member decline for Resident#2 to be transported to the hospital, so the x-ray was scheduled for the next morning. Nurse#3 indicated that the nurses ' notes written on 5/5/11</p>	F 309		
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F 309	<p>Continued From page 13</p> <p>were at 6 p.m. Nurse#3 indicated the restorative aide never told her on 5/2/11 about Resident#2 ' s leg swelling or bruises.</p> <p>The nurses ' notes indicated on 5/6/11 at 11:45 a.m. x-rays were done to the right shin and ankle.</p> <p>Review of the x-ray report dated 5/6/11 revealed a history of " pain swelling. " The results of radiology interpretation included the right tibia and fibula showed a spiral fracture extending across the distal shift of the tibia.</p> <p>The nurses ' notes dated 5/6/11 (no time) indicated the NP was notified of the x-ray results and ordered Vicodin 7.5/325 mg every 6 hours for 1 week (and increased the Duragesic patch dose to 25 mg. An ace wrap was applied to the lower right extremity and elevated on a pillow.</p> <p>Review of the nurses ' notes dated 5/9/11 at 3:30 p.m. revealed the resident left the facility for an orthopedic appointment at 1:15 p.m. At 6 p.m. the resident returned with a cast applied to the lower right leg.</p> <p>Interview on 5/17/11 at 5 p.m. with NA#2 (who was assigned to care for the resident) revealed she usually works with the resident during the 3-11 p.m. shift. NA#2 indicated that on 5/5/11 Resident#2 started hollering when she turned her in bed. " I called Nurse#3 down to look at her then the next day [on 5/6/11] Nurse#3 told me to make her comfortable because her leg was broken. NA#2 indicated she used the sit to stand lift to transfer Resident#2 into and out of bed before the leg fracture.</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>Interview on 5/17/11 at 5:30 p.m. with the Resident#2 's family member revealed several nursing assistants indicated Resident#2 was in pain each time that touched her leg.</p> <p>Observation on 5/17/11 at 11 a.m. revealed Resident #2 was sitting in a lounge chair with a cast applied to her right leg.</p> <p>Interview on 5/18/11 at 1:40 p.m. with the administrator, director of nurses, assistant director of nurses (DON), staff development coordinator, and corporate representative was held. During the interview the DON indicated that she expected documents used by her staff be accurate, nursing assessments of the resident be done as needed and a care plan be developed to address the resident ' s current needs.</p> <p>B. Review of the NP notes dated 5/3/11 revealed a skin tear to the right lower leg opened to air without signs of infection or inflammation present.</p> <p>Review of the treatment sheet or nurses notes revealed no treatments had been initiated or an initial or ongoing assessment of the resident ' s skin tear by the nurses which was noted in the NP ' s 5/3/11 note.</p> <p>Review of the addendum NP note dated 5/18/11 at 11:51 a.m. revealed the skin tear on the resident ' s right lower leg was approximately 1 cm (centimeters); there was erythema (redness) present.</p> <p>Review of the medical record revealed from 5/3/11 until 5/6/11 there were no follow-up assessments or treatment of the skin tear to the</p>	F 309			

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F 309	<p>Continued From page 15 right leg.</p> <p>Review of the " non-pressure skin condition report " dated 5/6/11 revealed a right lower extremity skin tear measuring 0.9 by 1.0 centimeters (cm) that has a scant amount of exudates with a wound bed that was described as " pink/beefy red " in color.</p> <p>Review of the physician orders dated 5/6/11 revealed new orders for Doxycycline 100 mg bid (twice a day) for 2 weeks (an antibiotic to treat the cellulitis at the skin tear site)</p> <p>Interview with the NP indicated that when she assessed the resident on 5/3/11 she actually touched the resident ' s right leg she did not complaint of pain. The NP indicated that she made an addendum to a 5/6/11 because they (did not indicate who) stated the note on 5/6/11 about the skin tear was unclear.</p> <p>Review of the weekly documented skin checks on 5/9/11, Nurse#2 documented " I " to indicate the resident ' s skin was intact when in fact dressing to the skin tear was in progress under the cast.</p> <p>Interview on 5/17/11 at 4:48 p.m. and 5/18/11 at 12:58 p.m. with Nurse#2 indicated that the resident ' s ankle was swollen but did not remember seeing a skin tear to the leg and when an observation on 5/3/11 with the NP; Nurse#2 thought the area was a scab.</p> <p>Interview on 5/18/11 at 10:45 a.m. with Treatment nurse revealed on 5/6/11 she noted a scab on the right leg. The wound bed was pink and red measuring approximately 0.2 cm. The treatment</p>	F 309			

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F 309	Continued From page 16 nurse indicated she was not aware of the scab, skin tear or bruising until 5/6/11. Further interview with the treatment nurse revealed orders were obtained to clean the wound bed with Normal Saline, then apply Hydro gel with silver and foam dressing every day.	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on interviews with staff, interviews with the nurse practitioner (NP) and record review the facility failed to consistently transfer Resident#2 using a 2 person (staff) assist or Hoyer lift. On 5/6/11 Resident #2 was diagnoses with right tibia and fibula spiral fracture extending across the distal shift of the tibia. This was evident in 1 of 3 residents in the survey sample reviewed for accidents. (Resident#2) Findings included: Resident#2 had cumulative diagnoses which included Alzheimer 's disease, osteoporosis (abnormal loss of bony tissue resulting in fragile porous bones and osteopenia (a condition where bone mineral density is lower than normal). Review of the physician orders revealed orders	F 323	F 323 1. Facility staff has been instructed that resident #2 is to be transferred with assist of 2 utilizing the Hoyer Lift. 2. Any resident that requires assistance for transfers has the potential to be affected by this practice therefore CNA assignment sheets where audited and updated by DON/ADON and/or RN Supervisor. The CNA assignment sheet will be updated by RN Supervisor and/or MDS nurse when change in transfer status is required on Care Plan. 3. The SDC and/or MDS Nurse and/or RN Supervisors will complete a 100% audit by 6/15/2011 on accuracy of	6/15/2011

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F 323	<p>Continued From page 17</p> <p>for Oscal 500 mg (milligrams) three times a day by mouth and Vitamin D-2 50,000 Units 1 capsule by mouth each month. These medications are used to treat osteoporosis.</p> <p>Review of the Minimum data set (MDS) assessment dated 4/5/11 revealed Resident#2 had severe cognitive impairment, required the 2 person total dependence on staff for transferring between surfaces. The MDS indicated functional limitation in range of motion on both sides that interfered with the daily functions or placed the resident at risk for injury.</p> <p>Review of the care plan for problem onset dated 4/5/11 revealed "unable to independently perform all activities of daily living secondary to needing (needing) total assistance with ADL 's [activities of daily living]". The goal included staff to perform ADL every shift to assure resident was clean, dry, and comfortable. The approaches included "assist with positioning, transfers 2 person assist with Hoyer (mechanical lifting device) as necessary and/or requested by resident and to monitor skin condition for signs of breakdown or redness. It should be noted that the resident cognition would not allow the resident to request the use of the Hoyer lift.</p> <p>The facility conducted a fall risk assessment updated as recent as 4/12/11 in which the resident scored 10. A score of 10 or more indicated high risk for falls.</p> <p>Interview on 5/17/11 at 2:15 p.m. with the (RA) restorative nursing assistant (for 2 years) revealed she provided restorative care for Resident#2. The RA indicated she usually used 2</p>	F 323	<p>CNA assignment sheet to Care Plan for assistive level that resident require. MDS nurses will complete an in-service to facility</p> <p>CNA's/Restorative aids on proper documentation of transfer assistance by 6/15/2011.</p> <p>4. The DON and/or ADON will review CNA assignment sheets 5 times per week for 8 weeks and then weekly for 4 weeks and then monthly for 2 months. The DON will report findings to the Monthly QA&A meeting for 5 months.</p>		

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F 323	<p>Continued From page 18</p> <p>people or the lift to transfer. RA indicated she usually provides restorative transferring, range of motion to her arms and legs, performed knee extensions, abduction and adduction her legs. RA indicated she saw a bruise on Resident#2 's right shin on 5/2/11. On interview RA indicated that as soon as she touched her right leg she had a facial expression like she was in pain and she does not usually act like this. I stopped during any range of motion or transferring her that day. RA indicated she reported this immediately to Nurse#3. Then on 5/3/11 she tried to do range of motion and noticed the bruise again and she tried to do range of motion on 5/3/11 in the morning (no specific time) but Resident#2 again expressed pain in her face. RA indicated she reported this to Nurse#2 but she already knew about it.</p> <p>Review of the " Restorative Care Flow Record " form provided on 5/18/11 revealed on 5/2/11, 5/3/11, 5/5/11 and 5/6/11 documentation that 15 minutes of restorative care for bilateral range of motion, that included " pull a parts and scissor kick " was performed despite the presence of pain and diagnoses of a fracture on 5/6/11. Additionally, the documentation indicated 15 minutes of standing program on 5/3/11 in the a.m. RA was not available on 5/18/11 to be interviewed about the documentation. Interview on 5/18/11 at 1:20 p.m. with the DON revealed she spoke with RA who indicated to her that she only did restorative care to her left leg and not the right leg as documented. The DON indicated that these were " documentation errors. "</p> <p>Review of the " Completed Care Tasks " form</p>	F 323			

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F 323	Continued From page 19 used by the nursing assistants to document care provided revealed: A statement " Time recorded does not necessarily reflect time care provided. Care provided within corresponding shift. " On 5/1/11 at 9:23 p.m., 1:20 a.m. and 1:25 a.m. NA#1 documented " one person physical assist " was used to provide bed mobility and/or transfer support to Resident#2. On 5/2/11 at 12:34 a.m. NA#1 documented " one person physical assist " was used to provide bed mobility and transfer support to Resident#2. On 5/2/11 at 12.35 a.m. NA# 1documented " one person physical assist " was used to provide toilet use support to Resident#2. NA#1 was not available to be interviewed during the survey. On 5/1/11 at 2:32 p.m. and 2:33 p.m. NA#2 documented " one person physical assist " was used to provide bed mobility and transfer support to Resident#2. On 5/3 /11 at 9:39 p .m. NA#2 documented " one person physical assist " was used to provide transfer support to Resident#2. On 5/4 /11 at 10:01 a.m. NA#2 documented " one person physical assist " was used to provide bed mobility and transfer support to Resident#2. On 5/5/11 at 9:26 p.m. NA#2 documented " one person physical assist " was used to provide bed mobility and transfer support to Resident#2. Interview on 5/17/11 at 5 p.m. with NA#2 (who was assigned to care for the resident) revealed she usually works with Resident#2. during the 3-11 p.m. shift. NA#2 indicated she transferred Resident#2. with the use of a sit to stand lift before the fracture. There was no comment about the documentation on the Completed Care	F 323			

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F 323	<p>Continued From page 20 Tasks form.</p> <p>Interview on 5/17/11 at 5 p.m. with NA#2 (who was assigned to care for the resident) revealed she usually works with the resident during the 3-11 p.m. shift. NA#2 indicated that on 5/5/11 Resident#2 started hollering when she turned her in bed. " I called Nurse#3 down to look at her then the next day [on 5/6/11] Nurse#3 told me to make her comfortable because her leg was broken. NA#2 indicated she used the sit to stand lift to transfer Resident#2 into and out of bed before the leg fracture.</p> <p>On 5/2 /11 at 11:52 a.m. NA# 3 documented " one person physical assist " was used to provide transfer support to Resident#2. On 5/3 /11 at 2:50 p.m. NA# 3 documented " one person physical assist " was used to provide bed mobility support to Resident#2. On 5/3 /11 at 2:31 p.m. NA#3 documented " one person physical assist " was used to provide bed mobility and transfer support to Resident#2. Interview on 5/17/11 at 11:35 a.m. with NA#3 (working the day shift for almost a year) revealed we always used 2 people or a Hoyer lift to transfer Resident#2. There was no explanation provided regarding the Completed Care Tasks documentation.</p> <p>Interview on 5/17/11 at 11:35 a.m. with NA#3 (working the day shift for almost a year) revealed on May 2, 2011 " I got off from work at 12 noon and nothing was wrong " with Resident#2. The next day on 5/3/11, I noticed a bruise during bathing the resident and I contacted Nurse#2. Nurse#2 then reported the bruise to the NP. When I got Resident#2 out of bed or moved her</p>	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/02/2011
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 05/18/2011
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301		
(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	Continued From page 21 in bed she complained of pain. She (referring to Resident#2) can 't tell you verbally that she was in pain but she did act like she was in pain by her " non-verbal " expressions on her face. We always used 2 people or Hoyer lift to transfer her. On 5/2 /11 at 8:09 p.m. NA# 4 documented " one person physical assist " was used to provide bed mobility and two plus persons for transfer support to Resident#2. NA#4 was not available to be interviewed during the survey. On 5/3 /11 at 12:37 a.m. NA#5 documented " one person physical assist " was used to provide bed mobility support to Resident#2. On 5/ 5/11 at 1:14 a.m. NA#5 documented " one person physical assist " was used to provide bed mobility support to Resident#2. Interview on 5/17/11 at 3 p.m. with Na #5(who worked the night shift) revealed the staff on the night shift does not transfer Resident #2 out of bed. There was no comment about the documentation on the Completed Care Tasks form. An inquiry was made on 5/18/11 at 1:20 p.m. with the (DON) director of nurses regarding the Completed Care Tasks form documentation of the use of a one person assist. The DON had no response except we need to work on our documentation. Review of the medical record revealed on 5/3/11 at 6 a.m. the nurses ' notes indicated Resident#2 ' s right shin was swollen and bruised. Review of the incident report initiated by Nurse#1 indicated on 5/3/11 at 3 a.m., the resident was in	F 323			

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F 323	<p>Continued From page 22</p> <p>bed. Under the description of what happened had an entry of " resident right shin swollen and bruised and warm to touch. Resident expresses pain to touch. " A second incident report dated 5/3/11 at 7 a.m. authored by Nurse#2 revealed a comment indicating " an old open area with scab intact " with a line drawn to a diagram of the right lower leg. This same incident report revealed the NP assessed the resident onsite on 5/3/11.</p> <p>On 5/3/11 at 3:45 p.m. the nurses ' notes revealed " bruise to the left shin. Swollen & warm to touch (referring to the right leg). Yells when touched. " The resident was seen by NP who wanted a board across the foot pedals of the wheelchair.</p> <p>Interview on 5/17/11 at 11:40 a.m. with Nurse#2 revealed I asked the NP to check on the resident. We (Nurse#2 and NP) thought that the resident had placed her leg behind the leg rest of the wheelchair and thought the bruises came from the leg rest. The NP told us to elevate her leg, get a bar across the wheelchair and to monitor the leg.</p> <p>Review of the nurses ' notes dated 5/4/11 (no time) revealed the right shin was still swollen and warm to touch.</p> <p>The nurses ' notes on 5/5/11(no time noted) revealed the responsible party of Resident#2 was in the facility and voiced concerns about Resident#2 ' s right lower leg bruising and edema to the right ankle. The NP was notified and ordered an x-ray for the right lower extremity.</p> <p>On 5/6/11 at 11:45 a.m. x-rays were done on the</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		
(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	Continued From page 23 right shin and ankle. Review of the x-ray report dated 5/6/11 revealed a history of "pain swelling." The results of radiology interpretation included the right tibia and fibula showed a spiral fracture extending across the distal shift of the tibia.	F 323			
	The nurses' notes dated 5/6/11 (no time) indicated the NP was notified and ordered Vicodin 7.5/325 mg every 6 hours for 1 week and increased the Duragesic patch to 25 mg for pain management. An ace wrap was applied to the lower right extremity and elevated on a pillow. The nurses' notes dated 5/9/11 at 3:30 p.m. revealed the resident left the facility for an orthopedic appointment at 1:15 p.m. At 6 p.m. the resident returned with a cast to the lower right leg.				