

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345548</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/04/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ASHTON HEALTH AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5533 BURLINGTON ROAD</b> <b>MCLEANSVILLE, NC 27301</b>
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F 000	INITIAL COMMENTS  A Complaint Investigation was conducted from 10/27/20 through 11/04/20. Event ID# P38C11. 2 of 3 complaint allegations were substantiated resulting in a deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §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 observations, record reviews, the nurse practitioner and staff interviews, the facility failed to stop providing care when a resident became combative to prevent skin tears and bruising for 1 of 2 sampled residents reviewed for accidents. (Resident #2).  Findings included:  Resident #2 was admitted to the facility on 7/10/18 with diagnoses which included: dementia with behavioral disturbance, schizoaffective disorder, psychotic disorder with delusions due to known physiological condition, and insomnia.  The review of the quarterly minimum data set dated 9/11/20 indicated Resident #2 had short and long term memory problems with severely impaired decision-making skills; required	F 689	F689 Residents are Free of Accident Hazards/Supervision/Devices 483.25(d)(1)(2)  • NA# 1 was in-serviced by DON on September 25th, 2020 on the proper protocols and techniques for approach and providing care to Res #2 should he become resistant to care and/or become combative during care. Res# 2 was assessed on 9/28/2020 by Psych Service Nurse Practioner related to combative behaviors. Res# 2 BIM score is 00. NP did a medication review and made no changes to medications. Advises staff to terminate care if Res#2 becomes agitated and allow Res #2 time to deescalate. NP will continue to monitor. • NA# 1 was in-serviced by DON on September 25th, 2020 on the proper	11/29/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE 11/29/2020
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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 689	<p>Continued From page 1</p> <p>extensive assistance of two staff with bed mobility, transfers, and hygiene; was always incontinent of bowel and bladder; and had two or more falls with no injuries.</p> <p>Review of the revised care plan dated 10/6/20 revealed Resident #2 had physical behaviors at times; combative towards staff while staff was attempting to assist in care (hitting, kicking, pushing, scratching). Approaches included: staff would avoid power struggles with the resident; maintain a calm environment and approach to resident at all times; staff would not force resident to do a task; and if the resident was to become physically abusive or combative, STOP and try the task later.</p> <p>The review of a nurse's progress note dated 9/25/20, a nursing assistant reported to the nurse that Resident #2 became combative during care. The nurse observed several skin tears to the resident's bilateral upper extremities with bruising and swelling to his right eye. The nursing supervisor was made aware who applied dressings to the areas. The NP (nurse practitioner) who was in the facility at the time of the incident examined the resident's injuries.</p> <p>Review of the NP's progress note dated 9/25/20 revealed Resident #2 had multiple new skin tears, bruising on his right arm, and bruising under his right eye. The exact mechanism of injury was unclear. Nursing staff reported the resident was observed with these injuries after receiving his morning personal care. The resident was cooperative with the exam without combative behavior and showed no distress regarding injuries.</p>	F 689	<p>protocols and techniques for approach and providing care to residents with Dementia and/or who are resistant to care and/or become combative during care. These techniques include terminating care should resident become resistant or combative and then re-approaching resident after resident has calmed down in a gentle, calm manner.</p> <ul style="list-style-type: none"> <li>Facility found that all residents had the potential to be affected by this practice.</li> <li>100% of Licensed nurses and nurse aides were in-serviced by Director of Nursing on proper protocols and techniques for approach and providing care to residents with Dementia and/or who are resistant to care and/or become combative during care. These techniques include terminating care should resident become resistant or combative and then re-approaching resident after resident has calmed down in a gentle, calm manner. This was completed by 10/1/2020. 100% of cognitively intact residents were interviewed for knowledge of abuse or rough care and 100% of non-interview able residents had a skin sweep. Completed on 10/1/2020, by Social Services and licensed nursing, no other issues or concerns were found</li> <li>Facility instituted QAPI audits to review 100% of all skin sweeps for bruising and/or skin tears weekly to determine issues with care. These audits will be conducted by the Director of Nursing or designee and will continue for three months. Additional in service and training will be provided.</li> </ul>		

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F 689	<p>Continued From page 2</p> <p>A progress note dated 9/25/20, indicated additional bruising was observed to the back of the resident's head. The resident showed no signs or symptoms of pain or distress. The wound nurse applied dressings to the skin tears.</p> <p>The facility reported the incident to the State Agency as resident abuse and injury of unknown origin on 9/25/20. A signed statement was obtained from the nursing assistant who provided morning ADL (activities of daily living) care to Resident #2 when the resident became combative. The nursing assistant's statement indicated he continued providing care to the resident while the resident was hitting and kicking him, the small siderail, and himself in the head. The nursing assistant was suspended pending the investigation. The facility concluded the allegation of abuse was unsubstantiated.</p> <p>The x-ray results dated 9/26/20 revealed no evidence of displaced fracture or osseous destructive process of the resident's right eye. Also, there was no gross acute process of the resident's right eye and right shoulder.</p> <p>During an observation on 10/30/20 at 2:06 p.m., Resident #2 was in a wheelchair in the dining room calmly feeding himself. The resident was wearing eyeglasses and dressed in daywear including a white tee shirt covered by an unbutton, long-sleeved shirt, tennis shoes, and a baseball cap on his head. There was no discoloration observed to the resident's right eye. There was no response from the resident to questions.</p> <p>An interview was conducted on 10/30/20 at 12:17 p.m. with the nursing assistant (NA) #1 who</p>	F 689	<ul style="list-style-type: none"> <li>QAPI audits will be used to identify care issues that require further education/training which will be provided at the time that failure to comply with requirements and corrections secured at that time. QAPI audits will be submitted to monthly QAPI meetings by the Director of Nursing to review for additional actions if needed or to determine when substantial compliance has been obtained. Audits will continue for a minimum for three months and at that time if the QAPI team has determined that substantial compliance has been secured and maintained the audits will be discontinued.</li> </ul>		

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F 689	Continued From page 3 provided Resident #2's ADL care during the morning of 9/25/20. NA#1 stated that Resident #2 was alert with confusion and was frequently agitated but not combative. NA#1 recalled on 09/25/20, he observed the resident attempting to stand from a sitting position on the side of his bed. NA#1 indicated he entered the room to assist the resident because he was concerned the resident would fall due to his non-ambulatory status. He immediately became aware of the foul odor on the resident. NA#1 stated the resident allowed him to assist him in lying down on the bed so that NA#1 could provide incontinent care. He stated as he removed the resident's eyeglasses (so he could remove the resident's shirt which contained fecal material) he noticed a slightly dark, puffy discoloration beneath the resident's right eye. When NA#1 attempted to wash the left side of the resident's face, the resident began kicking and swinging his legs knocking over the washbasin from the overbed table and kicking NA#1 in the legs, arms, and ribs. NA#1 stated that he stopped attempting to clean the resident's face and calmly explained to the resident what he was doing. The resident became less agitated, stopped being combative and NA#1 continued providing care. When NA#1 rolled the resident over onto his right side, the resident attempted to hit him with his elbow 2 or 3 times and swung his arm at him 1 or 2 times when NA#1 placed his opened hand on the resident's shoulder. The resident calmed down. NA#1 denied restricting the resident's movement because the resident was able to hold onto the top of the ¼ siderail. After completing ADL care, NA#1 assisted the resident to his wheelchair and then to the nursing station. NA#1 stated he reported to Nurse #1 the resident's combativeness during care and asked if she was	F 689			

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F 689	<p>Continued From page 4</p> <p>aware of what happened to the resident's right eye.</p> <p>During an interview on 10/30/20 at 2:06 p.m., Nurse #1 stated Resident #2 was alert with confusion with combative behaviors (pushing, hitting, verbal) during care. Nurse #1 stated she did not observe Resident #2 with any skin issues when she administered his medication between 7:30 a.m. - 8:30 a.m. on 9/25/20. She stated she did not observe, and no one reported to her that the resident was combative on the morning of 9/25/20. She recalled that on 9/25/20 at approximately 9:30 a.m., she overheard a nurse speaking to the resident about his skin tears. When the nurse escorted the resident to the nursing station, she observed 4 or 5 open areas on the bilateral upper and lower arms and on the knuckles of his right two end fingers. The resident's right lower eyelid began to blacken and swell. Staff Nurse #1 stated she asked the resident what happened, and he replied, "look what they done to me". When she asked who did this to him, the resident did not know. Nurse #1 indicated that when she questioned NA#1 about the resident, he responded that the resident was combative during care.</p> <p>During a telephone interview on 11/2/20 at 10:50 a.m., the former assistant director of nursing (ADON) revealed she observed Resident #2's wounds on the day of the incident. She stated the resident had a black, raised area beneath his right eye and 2-minimum surface skin tears above the left elbow (size of a nickel) with small amount of bleeding. She stated that NA#1 informed her that Resident #2 became combative when he attempted to wash the resident's face.</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>She stated she asked NA#1 the facility's protocol if a resident became combative. She stated NA#1 responded he was to walk away until the resident calmed, but instead he completed his task. The ADON stated NA#1 was informed that he was suspended pending investigation. She revealed she notified the resident's responsible party of the resident's injuries.</p> <p>During an interview on 11/2/20 at 1:20 p.m., the Treatment Nurse revealed she had observed Resident #2 when he had infrequent periods of behaviors where he would have episodes of combativeness (including swinging, hitting, grabbing staff by the arms or hair) during care, especially during bathing when staff remove his shirt. She stated these episodes would occur suddenly. She revealed she had observed the resident become more combative with the male nursing assistants during care. She indicated the sound of the female nursing assistants voices appear to calm the resident when agitated. She stated the resident was never combative towards her during treatments/evaluations. The Treatment Nurse revealed she evaluated Resident #2 for skin tears and bruising on 9/25/20. She stated she removed the bandages that had been applied by the nursing staff and observed 2 or 3 skin tears with mild to moderate bleeding. She revealed orders were initiated: tegaderm plus pad (transparent film dressing) every 3 days for a superficial skin tear (size of a dime) on the resident's left forearm and a tiny superficial skin tear on the right knuckle near the pinky finger; and leave steri-strips in place, cover with added pad, wrapped with kerlex gauze roll every 3 days for the full thickness skin tear with jagged flap (approximately 1-2 cm (centimeters) in length on the resident's right outer, upper arm. She stated</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>all areas healed pretty quickly. She stated that the resident bruised, easily and had some bruising beneath his eye and surrounding the skin tears.</p> <p>During a telephone interview on 10/28/20 at 11:56 a.m., the Nurse Practitioner (NP) stated that Resident #2 was not always cooperative with care and assessments (he would push away). The resident was alert but not oriented; only able to answer yes or no questions. She recalled that on 9/25/20 she was asked to assess the resident due to his right upper arm had bruising and two skin tears. There was also small, light linear bruising with some swelling under the right eye (lower lid). The resident was wearing his eyeglasses. The resident was cooperative during the assessment with no distress observed. The NP revealed it was difficult to determine if someone hit the resident in the eye because there were no definitive marks indicating a strike or a fist. The skin tears appeared triangular as though caused by friction. She stated no treatment was required.</p> <p>During a telephone interview on 10/29/20 at 3:59 p.m., the Interim Administrator stated he was notified of the bruising and skin tears on Resident #2 on 9/25/20. He stated he interviewed the resident's nursing assistant who informed him that while providing incontinent care and a bath to Resident #2, the resident became combative (swinging his arms and hitting the nursing assistant). To avoid being hit by the resident, the nursing assistant informed him that he placed his arm on the resident's shoulder. The nursing assistant laid the resident on the bed and continued to clean the resident who was combative. The Interim Administrator stated that the nursing assistant informed him that when</p>	F 689			

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F 689	Continued From page 7 care was completed and the resident calmed, he observed the resident had multiple skin tears and discoloration beneath his right eye. The Interim Administrator stated that he reminded the nursing assistant when the resident became combative during care, he should have de-escalated the situation by leaving the resident so that the resident could calm down. The nursing assistant responded he was afraid to leave the resident unattended due to the risk of the resident falling from the bed. The Interim Administrator stated the nursing assistant was suspended pending investigation.	F 689			