STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045421	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASHLEY REHABILITATION AND HEALTH CARE CENTER	**2600 N 22ND STREET ROGERS, AR 72756**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 047) was substantiated, all or in part, with these findings: Based on record review and interviews, the facility failed to ensure a gait belt was used during transfers for 2 of 2 (Residents #4 and #6) sample residents who required extensive assistance from 1 or 2 persons with transfers. This failed practice had the potential to affect 43 residents who required assistance with transfers per a list provided by the Administrator on 8/6/2020 at 3:00 PM. The findings are: 1. Resident #4 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an ARD (Assessment Reference Date) of 6/17/2020 documented the resident scored 14 (13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS); and was dependent on 2 plus persons for transfers, and had falls prior to admit and no falls since admission. a. A facility Incident and Accident Report with a revision date of 7/23/2020 documented, .7/1/20 .Nursing Description: Called to shower room to find resident sitting on floor on his bottom with wheelchair behind him and he was holding on the grab bar. Resident was in shower room and they went to pull up his brief and he said his legs were not strong enough and was sat on the floor by staff. Staff denied that he fell or hit head. No gait belt was being used at the time. Resident Description: My legs were giving out and so they sat me down on the floor. Denies falling or hitting head. Description: Resident assessed. No injuries noted. Assisted X (times) 3 from chair back into wheelchair with gait belt. Staff educated that they must use gait belt when getting up or transferring a resident. No injuries noted at time of him going to floor. C/O (complained) pain a couple of hours later to left knee. Xray ordered of left knee. . 7/9/20 Based on root cause analysis: Who: (Resident #4) What: After shower, staff members attempted to stand resident up to assist with application of brief, while standing resident's legs became weak and he was lowered to the floor by staff. This resident is alert and oriented x 4 and is able to make needs known to staff. He presents with a BIMS score of 14. He requires extensive assist x 2 staff with gait belt with transfers. At time of incident, staff members assisting resident were not utilizing a gait belt. Resident also stated that when he stands he feels dizzy. When: 7/1/2020 Where: 100 hall shower room . b. A Health Status Note dated 7/1/2020 at 17:29 (5:29 PM) documented, . X-ray ordered to left knee. X-ray negative for any injury. Physician and son notified. . c. On 8/6/2020 at 11:21 AM, the Administrator was asked if she was aware of a fall Resident #4 had experienced and no gait belt was in use. She stated, I was aware he was transferred without using a gait belt. She was asked if the staff were educated regarding gait belt use after this incident and she stated, The DON (Director of Nursing) might have. I will have to talk to her. She was then asked if there had been any monitoring done after this incident and she stated, That's something I will have to check with DON. d. On 8/6/2020 at 12:01 PM, the DON was asked if Resident #4 was supposed to have a gait belt used with transfers and she stated, If extensive times 2 that means a gait belt to be used. If not a mechanical lift or independent a gait belt is to be used. The DON was asked if monitoring for gait belt use was put into place after the incident and she stated, No. It wasn't. The DON was asked if staff education was provided and she stated, Only the 2 staff involved in the fall with (Resident #4) were one-on-one in-serviced regarding gait belt use. The DON was asked how did she know the other staff knew to use a gait belt and she stated, Great question. We do have in-services. There was not one done after this incident. During my rounds every day I have not had to remind staff to use gait belt. During my rounds that's something I look for. e. On 8/6/2020 at 12:53 PM, Certified Nursing Assistant (CNA) #1 was asked how she knew what residents to use a gait belt on and she stated, Gait belts are used on all residents unless they are a mechanical lift or if they are independent with ambulation. CNA #1 was asked if she had taken care of Resident #4 and she stated, I did take care of (Resident #4). He was a Hoyer lift when he came then therapy switched him I think to extensive 2 with a gait belt. I did not take care of him after he was changed to that. f. On 8/6/2020 at 1:12 PM, CNA #2 was asked if she had ever taken care of Resident #4 and if so, how was he transferred. She stated, When I took care of him, he was a Hoyer lift. I had heard he had been changed to extensive 2 person, but I never took care of him then. She was asked how she knew when to use a gait belt and she stated, If a resident is not independent with ambulation or transfers or if they are a mechanical lift a gait belt is used. You are taught that in CNA school. We have been told to make sure we always have a gait belt. g. On 8/6/2020 at 1:17 PM, a phone interview was conducted with CNA #3. She was asked to explain the incident that occurred with Resident #4 on 7/1/2020 while in the shower room. She stated, I was helping with showers that day and I did his shower. When finished with shower I put the call light on to let someone know I needed help with his transfer. Another CNA came to help, and we had resident hold to the grab bar so he could stand so can pull up brief. He did hold the bar and stand. We then pulled his pants up. I was drying his back. After I got his brief up, he was incontinent of bowel. We got some wipes to clean him. Got him cleaned, then his legs started getting loose. We tried to sit him in the chair. He did not fall, we sat him in the floor. CNA #3 was asked if they had a gait belt on resident and she stated, No we did not. We forgot. CNA #3 was asked if a gait belt should have been used on him and she stated, Yes. We should have. She was asked if she and the other CNA received any education after this and she stated, Yes. I was told it was part of my uniform and to use it on every resident that's not a mechanical lift or if they get up on their own. We were both in-serviced one-on-one. The other CNA doesn't work here anymore. h. On 8/6/2020 at 1:42 PM, DON was asked if she was aware of any other falls when a gait belt had not been used. She stated, (Resident #6) did have a fall when no gait belt was being used. 2. Resident #6 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/7/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS; and required extensive 1 person assist with transfers. a. A facility Incident and Accident Report dated 7/10/20 at 11:00 AM documented, . Nursing Description: While CNA was transferring resident to toilet, resident's knees weakened. CNA lowered resident to the floor. . No injuries noted at this time. . Resident Description: Resident states that her knees weakened during transfer. Immediate Action Taken Description: Staff education; gait belt must be used while transferring resident. . 7/13/20 Based on root cause analysis: Who: (Resident #6) What: During a staff assisted transfer from w/c (wheelchair) to toilet resident's knees became weak and resident was lowered to the floor. Per direct care staff report there was not a gait belt in use at time of fall. This resident is alert and oriented to person, place, time and situation. She requires extensive assist x1 staff member with transfers. She is also currently receiving part B services working with PT/OT (Physical Therapy/Occupational Therapy). When: 7/10/20 Where: Resident bathroom Intervention: Staff education with (CNA #4) regarding using gait belt with transfers. . b. On 8/6/2020 at 1:42 PM, the DON was asked after this fall what was done to prevent this from occurring again and she stated, We did one-on-one education with the CNA. I felt it was more a problem with just the individual CNA's. I don't see it being a facility wide problem. I see my aides wearing the gait belts. The CNA's that were involved in these incidents, I had never had to remind them about using gait belts. The DON was asked if education had been provided after this incident and she stated, After the incident with (Resident #6) (CNA #4) was the only staff educated regarding the gait belt use and it was one-on-one. The last facility wide transfer in-service was September 2019. 3. A form titled

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

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Transfer Activities Policy and Procedure provided by the Administrator on 8/6/2020 at 1:32 PM documented, . PURPOSE *Transfer the resident from bed to chair, toilet or tub safely . EQUIPMENT . * Transfer belt (also called a gait belt) PROCEDURE 5. Apply transfer belt snugly around the resident's waist, positioning the buckle off center. Tuck excess strap under the belt. Grasp the belt from beneath to provide support during the transfer as well as when assisting the resident to walk. . 10. Hold the transfer belt from underneath straighten your hips and legs slightly and lift the client to a standing position on a count of three. .