| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **676430** | A. BUILDING _____ B. WING _____ | **05/13/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **ASHTON MEDICAL LODGE** | **801 SOUTH LOOP 250 WEST MIDLAND, TX 79703** |

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) |
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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 resident reviewed for transfers (Resident #2). The facility failed to ensure Certified Nurse Aides A demonstrated appropriate transfer techniques for Resident #2 which resulted this resident requiring 13 sutures to her left lower leg. This failure could place residents who required assistance during transfers at risk for injuries. Findings included: Review of Resident #2's 12/21/19 significant change Minimum Data Set Assessment documented she was an [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She needed extensive assistance of two staff for transfers. Review of Resident #2's 3/27/2020 quarterly Minimum Data Set Assessment documented She was [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>She needed extensive assistance of two staff for transfers. Review of his 1/2[DATE]9 Care Plan documented, in part: Problem: Resident requires extensive assist with activities of daily living. Goal: Resident is able to perform self-care to optimal level and maintains strength and endurance for 90 days. Approach: Support to complete transferring needs every shift. During an interview on 5/12/2020 at 3:30 PM CNA A said she had worked at the facility for one and half years. She said she entered Resident #2's room to transfer her to bed. She said Resident #2 usually fights them during care. She said Resident #2 would try and hit and scratch staff during care. She said no one was in the room with her when she transferred Resident #2. She said Resident #2 was a two person transfer but the other aid was busy down the hall. She said she did not use the gait belt. She said she thought she might have put the gait belt on the resident but did not use it. She said she lifted Resident #2 up by putting her arms around her waist. She said as she was sitting Resident #2 down on the bed, when Resident #2 tried to scratch and hit her. CNA A said she pulled back away from Resident #2 to keep from being hit or scratched. CNA A said as soon as she put the resident into bed she noticed a scratch on the resident's leg and it was bleeding a little. CNA A said she thought the resident hit her leg on the bottom rail of the bed while she was putting her in bed. CNA A said the scratch was deep so she got the nurse. She said the nurse sent Resident #2 to the emergency room . CNA A said she was aware that Resident #2 always tried to hit staff during care. Review of the nurse's notes dated [DATE] at 10:36 PM documented at 6:25 PM, CNA A came to this writer (nurse) and informed him that when she was assisting Resident #2 to bed, the resident became combative and attempted to hit staff member. Resident got a laceration about 5 centimeters by 2 centimeters by 1 centimeter to her lower left outer leg. At 6:40 PM the doctor was called and informed of incident he gave verbal order to send out to the emergency department. Review of the emergency department notes dated [DATE] documented in part: Chief Complaint: Patient presents to emergency department via ambulance from nursing home with complaint of left lower leg laceration. Per tech, patient was being transferred to bed around 5:00 PM and after nurses noticed bleeding. Unsure of how laceration occurred (Resident #2 received 13 sutures at this time). Review of the nurse's notes dated [DATE] at 11:36 AM documented New Medication Change. Resident to begin new medication [MEDICATION NAME] (antibiotic) twice a day for 10 days. DX: wound infection to left lower extremity. Contacted hospice about discoloration to wound with redness and not healing, order placed. Review of the nurse's notes dated [DATE] at 2:38 PM documented a wound consultant in to consult resident (Resident #2) and assess wound. New orders to DC (discontinue) sutures to left leg. Apply steri-strips and dress with island dressing for 1 week and change dressing every other Tuesday, Thursday and Saturday, continue if there is continuous bleeding/drainage. Should drainage/bleeding stop, DC dressing and LOTA. During an interview on 5/12/2020 at 4:30 PM the DON said there was documentation that showed Resident #2 was not a 2-person transfer only because during the month of February the resident was transferred by 1-person several times. The DON said Resident #2 always fought with staff during care. The DON said that Resident #2 should have been a two person transfer. Review of the document the DON brought in was Interventions/Task for transfers dated February 2020 and documented that on February 1st, 3rd, 4th, 16th, 18th, 19th, 25th and the 29th during the day shift, Resident #2 was transferred by only one staff. It documented that all the rest of the day during the day shift she was transferred using 2-person. The night shift staff documented they used 2 person for all transfers during the month of February. This documentation did not specify whether Resident #2 was a one person, just showed documentation of either 1 person or 2 person performed the transfer. Review of the facility policy for Accidents, undated, documented the facility shall remain as free from accident hazards as possible. Each resident receives adequate supervision and assistance devices, based on the comprehensive assessment to prevent accidents. |

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