STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____ DEC 06 2011	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	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 279 SS=B	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 provide measurable goals for 3 of 19 sampled residents. (Resident #82, #180 and #21) Findings include: 1. Resident #82 was admitted to the facility on 11/27/09. Diagnoses included Hypertension, Paranoid Schizophrenia, Depression, Anxiety, Osteoporosis, Alzheimer's, Insomnia and Chronic Kidney Disease Stage III (moderate).	F 279	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. F 279 1. Residents #82, #180, and #21's Care Plan has been corrected. 2. Residents requiring a Care Plan has the potential to be effected by this practice therefore the MDS Nurses will do a Care Plan audit to verify that the Care Plans reflect measurable goals. Any issues noted were updated as appropriate by 11/09/2011. 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	11/10/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/02/2011

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 1 A review of the significant change Minimum Data Set dated 9/13/11 revealed the cognition was severely impaired with long and short term memory problems. The Behaviors identified were physical behavioral symptoms directed toward other and verbal behavioral symptoms directed at others which occurred 1 to 3 days during a 7 day period. Also identified were the resident rejected care and wandering which occurred 1 to 3 days during a 7 day period. The resident was incontinent of bowel and bladder. a. The 9/14/11 anxiety and depression care plan goal stated "resident will respond positively to support and reassurance when needed X 90 days" b. The 9/14/11 Alzheimer's care plan goal stated; "accept judgement of staff/significant other as appropriate X 90 days." c. The 9/27/11 potential for discomfort and side effects of psychotropic medications care plan goal stated "Resident will be free of any discomfort or adverse side effects over next 90 days." 10/12/11 at 10:55am Nurse #2 stated the resident was disoriented; "oriented only maybe to self." You can tell her something but she forgets it right away you know, " I just told her to not get up out of bed but she did and fell." On 10/12/11 at 3:45 pm, MDS assessment nurse #1 reviewed Resident #82's current care plans and stated the care plan goals were not measurable.	F 279	Care Plans reflect the resident's needs. 3. An in-service will be completed by the Corporate MDS Consultant to the Care Plan Team to cover how to write measurable goals on the Care Plan by 11/10/2011. 4. The DON and/or the ADON will audit 5 Care Plans weekly for 12 weeks to ensure that the Care Plans reflect measurable goals. The DON will report monthly findings to the Monthly QA&A meeting for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	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 279	Continued From page 2	F 279		

2. A. Resident #180 was admitted to the facility on 6/1/11. His admission diagnoses included dementia, osteoarthritis, anemia, anxiety and multiple falls. His 8/29/11 Minimum Data Set (MDS) quarterly assessment indicated he had moderately impaired cognition. He required extensive assistance with transfers and locomotion. He had two or more falls since his last assessment.

His 9/8/11 fall care plan goal stated he will "have decreasing number of falls with no significant injuries for the next 90 days."

On 10/12/11 at 2:45 pm, Nurse #1 stated Resident #180 had multiple falls prior to admission and since his admission. Nurse #1 stated the fall care plan goal was not measureable.

On 10/12/11 at 3:20 pm, MDS assessment nurse #1 stated the fall care plan goal was not measureable and decreasing number of falls was not clear.

2. B. Resident #180 was admitted to the facility on 6/1/11. His admission diagnoses included dementia, osteoarthritis, anemia, anxiety and multiple falls. His 8/29/11 Minimum Data Set (MDS) quarterly assessment indicated he had moderately impaired cognition. He had mood issues of being figety and restless. He required

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	345548	A. BUILDING _____ B. WING _____	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	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 279	Continued From page 3 extensive assistance with transfers and locomotion. He received antianxiety medication. His 9/8/11 care plan for the use of Ativan (antianxiety medication) stated he will "have no injury related to medication usage/side effects for 90 days." During an interview, on 10/12/11 at 245 pm, Nurse #1 stated Resident #180 does have episodes of anxiety. He requires twice daily dosing of Ativan. Nurse #1 stated the Ativan care plan goal was not clear. During an interview, on 10/12/11 at 3:20 pm, MDS nurse #1 stated the Ativan care plan goal was not measureable. She stated the goal did not include any specific side affects for the medication. 3. Resident # 21 was admitted to the facility on 9/16/10. Her diagnoses included hypothyroidism, vascular dementia, hypertension, osteoporosis, insomnia and failure to thrive. The clinical record revealed she was admitted to hospice services on 1/20/11. The 9/26/11 hospice care plan goal stated her "weakness, pain, depression, weight loss will be minimized over the next 90 days." During an interview, on 10/12/11 at 3:00 pm, Nurse #1 confirmed that Resident #21 was on hospice services. Nurse #1 stated the hospice care plan goal was confusing and not measureable.	F 279		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 279	Continued From page 4 During an interview, on 10/12/11 at 3:20 pm, MDS nurse #1 stated the care plan goal was not measureable.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to ensure Care Plans for falls and pressure sores were revised for 1 of 19 residents. (Resident #82) Findings include:	F 280	F 280 1. Resident #82's Care Plan has been corrected. 2. Residents requiring a Care Plan have the potential to be effected by this practice therefore the MDS Nurses will do a Care Plan audit to verify that the Care Plan reflects the current level of care and needs of the resident. Any issues noted were updated as appropriate by 11/09/2011. 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 current needs. 3. An in-service will be completed by the Corporate MDS Consultant to the Care Plan Team to cover how to	11/10/2011

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F 280	Continued From page 5 Resident #82 was admitted to the facility on 11/27/09. Diagnoses included Hypertension, Paranoid Schizophrenia, Depression, Anxiety, Osteoporosis, Alzheimer's, Insomnia and Chronic Kidney Disease Stage III (moderate). A review of the significant change MDS (Minimum Data Set) dated 9/13/11 revealed the cognition was severely impaired with long and short term memory problems. The MDS also identified the resident had falls. The MDS did not indicate the resident had pressure sores. a. The current care plan dated 9/27/11 identified a problem as "Potential for skin breakdown related to impaired mobility and use of psychotropic medications." The goal read resident will maintain intact skin integrity over 90 days. A review of the medical record for Resident #82 revealed she developed a pressure sore on 9/15/11 which was currently being treated. b. The current care plan dated 9/27/11 identified a problem as being at risk for further falls related to history of fall. One of the approaches listed was provide walker, cane, quad cane, and so forth for use when ambulating resident; give resident MDS Nurse #1 stated this was no longer being done. On 10/12/11 at 10:00am the resident was observed sitting in merri walker going through nurses station into the dining room propelling merri walker with her feet. On 10/12/11 at 3:45 the current care plans for resident #82 were reviewed with MDS Nurse #1.	F 280	write updates on the Care Plans to meet resident needs by 11/10/2011. 4. The DON and/or the ADON will audit 5 Care Plans weekly for 8 weeks to ensure that the Care Plans reflect the current level of care and needs of the resident. The DON will report findings to the Monthly QA&A meeting for 2 months.	

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F 280	Continued From page 6 The nurse confirmed that the current approaches being used for the resident were not listed on her care plan. "The care plan approaches are not current." The Nurse stated "the scoop mattress, floor mats, the bed being placed in the lowest position and the sensor alarm are not on the care plan." The MDS Nurse did not provide an answer to why the care plans had not been updated other than to say "the pressure sore occurred after he care plan was completed." On 10/13/11 at 10:20am resident was observed lying in a scoop mattress with floor mat beside the bed. An sensory alarm pad was observed in the bed. The bed was observed in the lowest position.	F 280		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring staff wore hairnets in the kitchen; by not ensuring opened and resealed food items were dated/labeled; and, by not ensuring dented/damaged cans of food were	F 371	F 371 1. Dietary employees are now wearing hairnets at all times while in all areas of the kitchen; now all opened food items are tightly secured, labeled and dated appropriately; and all dented cans were removed from the can storage rack and placed in designated area. 2. Sanitation of the kitchen has the potential to be effected by this practice therefore the Kitchen Supervisor audited the	11/10/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	10/13/2011

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ASHTON PLACE HEALTH AND REHAB	5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301

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F 371	Continued From page 7 stored separately from other foods. Findings included: 1. Review of the facility's policy for the kitchen staff on "Employee Sanitary Practices" (not dated) included: "All employees shall: wear hair restraints and clean clothes." During the initial tour of the kitchen, accompanied by the Dietary Manager on 10/10/11 at 10:37am, the Dietary Manager's hair was not covered. The tour included observations of the cold and dry storage areas and the food preparation area. 2. Review of the facility's policy on "Food Storage" (not dated) included: "Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 2-3 days or discarded. Refrigeration: All foods should be covered, labeled and dated." During the initial observation of the kitchen's storage areas on 10/10/11 at 10:37am, a resealed container of egg salad was not dated in the reach-in refrigerator. There were resealed bags of cream of wheat, rice, and barbeque sauce stored on the storage racks in the dry storage room that were not dated	F 371	affected areas including hairnets, open stored items, and dented cans and any issues noted were corrected as appropriate by 10/15/2011. 3. An in-service will be completed by the Kitchen Supervisor to include dietary employees wearing hairnets at all times while in all areas of the kitchen; properly securing, labeling and dating food items that are being stored; and placing all dented cans in the designated area. These in-services will be completed by 10/15/2011. 4. The Dietary Manager and/or the Kitchen Supervisor and/or the Cook will audit the hair restraints; that foods are wrapped, tightly secured, dated and labeled; and dented cans are stored in a designated area daily for 1 month and then once weekly for 2 months.	

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	345548	A. BUILDING _____ B. WING _____	10/13/2011

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ASHTON PLACE HEALTH AND REHAB	5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301

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F 371	Continued From page 8 On 10/12/11 at 12:15pm, the observation in the walk-in freezer revealed 2-resealed bags of pork patties that were not dated or labeled. The walk-in freezer also contained: 1-opened bag of mini pizzas in an opened box; 1-opened bag of roll dough in an opened box; and, 1-opened bag of cheese garlic breadsticks in an opened box. Did we interview staff about who opened the items and when? 3. Review of the facility's kitchen policy on "Dented Cans" (not dated) included: "When cans are damaged upon delivery or when dropped by an employee, and dented, the damaged cans will be put in a separate area identified as "Dented Cans" These items will not be taken out of service." During an observation of the dry storage room in the kitchen on 10/10/11 at 12:23pm, 2-dented cans of food items (strawberry glaze and tomato sauce) were stored on the same storage rack as the ready-for-use cans of foods. The Food Service Supervisor removed the dented cans and indicated the dented cans should have been placed in the back of the storage room in the designated area for dented cans.	F 371	The Dietary Manager will report finding to the Monthly QA&A meeting for 3 months.	
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and a staff interview, the	F 372	F 372 1. The facility dumpster doors and lid are now kept closed and the area around and on the dumpster is free from debris.	11/10/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ASHTON PLACE HEALTH AND REHAB	5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301

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F 372	Continued From page 9 facility failed to dispose of garbage and refuse by not ensuring 1of 1 garbage dumpster properly concealed the waste within; and by not ensuring the area surrounding the dumpster was free from refuse and debris. Findings included: During the initial tour of the facility on 10/10/11 at 10:45am, the garbage dumpster, the kitchen's food oil container, and the cardboard dumpster were observed in an enclosed area behind the facility. The 2-side doors of the garbage dumpster were open; and approximately 5 bees were observed on some rice and potatoes which were on the ground next to the dumpster. During an interview on 10/10/11 at 10:45am, the Dietary Manager stated that the dumpster must have been emptied earlier that morning because the staff would not have left the area in that condition. She indicated she would have staff clean the dumpster area. During a second observation of the dumpster area on 10/12/11 at 2:30pm, the 2-side doors and 1/2 of the top lid of the dumpster were open. The inside of the dumpster contained 2-3 large white bags of garbage and several books immersed in several inches of water (there was a heavy rain storm the night before and earlier that morning).	F 372	2. Facility sanitation has the potential to be effected by this practice therefore the Kitchen Supervisor audited the dumpster area including the doors/lid to make sure the doors and lids are closed and the area around and on the dumpster is free from debris and any issues noted were corrected as appropriate by 10/17/2011. 3. An in-service will be completed by the Kitchen Supervisor and/or Housekeeping Manager to include how to properly close dumpster doors and lid, remove any debris noted on the ground and dumpster itself by 10/13/2011. 4. The Dietary Manager and/or the Kitchen Supervisor and/or the Cook and/or the Housekeeping Manager will audit the dumpster area to make sure it is free from debris and the doors/lid is closed daily for 1 month and then once weekly	

for 2 months. The Dietary Manager will report findings to the Monthly QA&A meeting for 3 months.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
DEC 2 8 2011

PRINTED: 10/31/20
FORM APPROVE
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING 01 - MAIN BLDG 01 B. WING	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation, on October 27, 2011 at approximately 11:10am onward, the smoke barrier located within the attic area contains many splices without structural framing behind horizontal and vertical joints - located near room 602 on the 600 corridor. 42 CFR 483.70	K 025	Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly sighted and/or require correction. Please see attached pages for Provider's Plan of Correction.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1	K 029		

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

Executive Director 11/10/11

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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	345546	A. BUILDING 01 - MAIN BLDG 01 B. WING	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation, on October 27, 2011 at approximately 11:10am onward, the smoke barrier located within the attic area contains many splices without structural framing behind horizontal and vertical joints - located near room 602 on the 600 corridor. 42 CFR 483.70	K 025	Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly sighted and/or require correction. Please see attached pages for Provider's Plan of Correction.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1	K 029		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING 01 - MAIN BLDG 01 B. WING _____	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	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
K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, on October 27, 2011 at approximately 11:10am onward, fire door to laundry room will not self-latch. 42 CFR 483.70	K 029		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based on observation, on October 27, 2011 at approximately 11:10am onward, the emergency light in the family room is not functioning - located across corridor from room 508. 42 CFR 483.70	K 046		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 1. Based on observation, on October 27, 2011 at approximately 11:10am onward, the sprinkler accelerator valves are not electrically supervised. 2. Based on observation, on October 27, 2011 at approximately 11:10am onward, the sprinklers located throughout the kitchen area are green	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING 01 - MAIN BLDG 01 B. WING _____	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	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
K 062	Continued From page 2 bulb sprinklers - the heat sensitive elements are rated excessively above the ambient temperature in the kitchen. 42 CFR 483.70	K 062		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, on October 27, 2011 at approximately 11:10am onward, the facility is noncompliant with the National Electrical Code; Article 517, due to the following: 1. the EPS supplying load indicator is not functioning with loss of normal power to the automatic transfer switch #1 or the largest automatic transfer switch. 42 CFR 483.70	K 147		

Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly sighted and/or require correction.

K 025

Completion Date:
12/11/2011

1. The smoke barrier located within the attic area near room 602 on the 600 corridor will be corrected per regulations.
2. All smoke barriers located within the attic can be affected by this practice therefore the Maintenance Director with Scott Niebauer from Samet Corp. audited the smoke barriers located within the attic to verify that they meet regulation per attached paperwork highlighting UL 425 (4A).
3. The Maintenance Director and/or Executive Director will verify that the repairs will be completed per regulations by December 11, 2011 as noted on the cover letter to the 2567 sent on November 2, 2011.
4. The Maintenance Director will bring the paperwork if required showing the completion of the work to

the Monthly QA&A meeting to have In record.

K 029

Completion Date: 11/07/2011

1. The fire door to the laundry room has been corrected.
2. All fire doors within the facility have the potential to be effected by this practice therefore the Maintenance Director audited all fire doors to make sure they latched correctly. Any issues noted were corrected appropriately.
3. The Maintenance Director developed an audit tool to add to his weekly inspection book so that he will audit the interior fire doors within the facility weekly for proper latching.
4. The Maintenance Director will complete a weekly audit sheet for 8 weeks and then monthly ongoing to verify that fire doors latch correctly to maintain compliance. Results of the audit will be brought to the Monthly QA&A meeting monthly.

K 046

Completion Date: 11/07/2011

1. The light bulb was replaced with a working bulb

in the family room across the corridor from room 508.
2. All emergency lighting can be affected by the practice therefore the Maintenance Director audited all emergency lighting within the facility to make sure the bulb was functioning. Any issues noted were correct appropriately.
3. The Maintenance Director developed an audit tool to add to his weekly inspection book so that he will audit the emergency lights throughout the facility weekly for proper functioning.
4. The Maintenance Director will complete a weekly audit sheet for 4 weeks and then monthly ongoing to verify that emergency lights are functioning correctly to maintain compliance. Results of audit will be brought to the Monthly QA&A meeting monthly.

K 062

Completion Date:
12/11/2011

1. The sprinkler accelerator valves will be corrected by Modern Electric by 12/11/2011 and the green sprinkler heads throughout the kitchen will be corrected per regulations by J&S

Sprinkler Company by 12/11/2011 if required.
2. All sprinkler accelerator valves and sprinkler heads can be affected by this practice therefore the Maintenance Director audited the sprinkler accelerator valves in the facility and reviewed sprinkler heads throughout the facility to verify that the proper temperature class sprinkler heads are installed per regulation. Any issues noted were corrected appropriately.
3. The Maintenance Director and/or Executive Director will verify that the repairs will be completed per regulations by December 11, 2011 per noted on the cover letter to the 2567 sent on November 2, 2011.
4. The Maintenance Director will bring the paperwork showing the completion of the work as required to the Monthly QA&A meeting to have in record.

K 147

Completion Date: 12/11/2011

1. The EPS supplying load indicator is being corrected by Modern Electric Company by 12/11/2011.

2. All the indicators on the generator enunciator panel can be affected by the practice therefore the Maintenance Director will audit the indicators on the generator enunciator panel to make sure they light up and make sure they are working correctly. Any issues noted will be corrected as appropriate.
3. The Maintenance Director developed an audit tool to add to his weekly inspection book so that he will audit the indicators on the generator enunciator panel are working correctly.
4. The Maintenance Director will complete a weekly audit sheet for 8 weeks and then monthly ongoing to verify the indicators are working correctly. Results of the audit will be brought to the Monthly QA&A meeting monthly.