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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	**5533 BURLINGTON ROAD MCLEANSVILLE, 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 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		8/7/17

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

Electronically Signed | 08/07/2017

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 225	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility hired a nurse who had a finding of abuse from the North Carolina (NC) Board of Nursing. This affected 1 of 5 employees (Nurse #15) reviewed for abuse prohibition. Findings included: 1. Nurse #15 was hired by the facility on 3/23/17. A review of Nurse #15's license status verification completed by the facility's Human Resources department on 3/14/17 revealed Nurse #15's license was active but had charges/discipline against the license.	F 225	F225 No patients were listed in this deficiency. Nurse #15 is no longer employed at this facility. The facilities policies concerning the hiring of staff will be followed as written. All staff will have their license and criminal background screened prior to hire and any negative findings concerning abuse, assault or any felony level misconduct will prevent them from being hired by the facility. The facility is currently participating in the Employee Notification	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 225	Continued From page 2 A review of the NC Board of Nursing Findings of Fact dated 9/23/16 revealed, "Licensee's conduct, as set out in the Findings of Fact, constitutes grounds for discipline pursuant to NC General Statute 9-171.37 as follows: harassing, abusing, or intimidating a client either physically or verbally." Further review of the Findings of Fact revealed an order that stated, "Licensee will be issued a reprimand." An interview was completed with the Human Resources (HR) Director on 7/12/17 at 4:09 PM. She explained the facility's screening process for potential nurse employees was that the Director of Nursing (DON) asked HR that the license information be pulled and reviewed. HR Director stated she obtained the information from the NC Board of Nursing and if she saw a negative response on the license verification she gave it to the DON who reviewed it and decided whether employment should be offered to the applicant. An interview was completed with the DON on 7/12/17 at 4:45 PM. She stated the HR Department completed the background check and if they found an issue with a nursing license they reviewed the situation, presented the information to the Administrator or Vice President and then decided if an offer was made to the applicant. The DON said the facility would not hire someone that had a finding of "assault or sexual issue." She stated the facility hired Nurse #15 because the Board of Nursing's conclusion, "didn't affect her license." She couldn't recall who hired Nurse #15. A review was completed of all facility abuse investigations from March 2017-July 2017. There	F 225	System by the NCBON. All current CNA's will be rescreened by the HR Director on the nurse aide registry to ensure that no other employee has a similar abuse issue. The department managers and human resources manager have been in serviced concerning our abuse policy as well as our hiring policies. Each background or registry check will be viewed by the human resources director, DON, the department head and administrator if there is a questionable finding. A tool has been created to keep track of findings. The Employee Notification System will be checked quarterly for any flagged staff that may have had occurrences at other facilities This information will be brought for review to the Quality Assurance Committee each month for 3 months and then annually thereafter	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 225	Continued From page 3 were no abuse allegations involving Nurse #15. An interview was completed with Administrator #1 on 7/12/17 at 4:54 PM. He reported that the DON interviewed nurse applicants. When a license verification was completed, the Administrator stated, "if it's something major such as patient abuse, sexual abuse or anything illegal we just don't hire them." He recalled that prior to an offer of employment, the DON spoke with Nurse #15 about the situation involving her license and that Nurse #15 explained her side of the situation. He said that since the Board of Nursing issued a reprimand the facility gave her a "second chance" and if something came up during her employment at the facility she "would be released." The Administrator further stated his expectation was that if a potential employee had a finding of abuse, even though the license status was a reprimand, that the employee would not be hired.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95,	F 226		8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 226	Continued From page 4 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to follow its abuse policy to prohibit employment of individuals with a history of disciplinary action for "harassing, abusing or intimidating" a resident. This affected 1 of 5 employees (Nurse #15) reviewed for abuse prohibition. Findings included: The facility's policy titled, "Abuse/Neglect/Misappropriation of Resident Property" was reviewed. The "Policy Statement for Screening" stated, "The facility will not knowingly employ individuals whose personal histories render them at risk for resident abuse, neglect, mistreatment or misappropriation of property." 1. Nurse #15 was hired by the facility on 3/23/17.	F 226	F226 No patients were listed in this deficiency. Nurse #15 is no longer employed at this facility. The facilities policies concerning the hiring of staff will be followed as written. All staff will have their license and criminal background screened prior to hire and any negative findings concerning abuse, assault or any felony level misconduct will prevent them from being hired by the facility. The facility is currently participating in the Employee Notification System by the NCBON. All current CNA's will be rescreened by the HR Director on the nurse aide registry to ensure that no other employee has a similar abuse issue. The department managers and human resources manager have been in serviced	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 226	Continued From page 5 A review of Nurse #15's license status verification completed by the facility's Human Resources department on 3/14/17 revealed Nurse #15's license was active but had charges/discipline against the license. A review of the NC Board of Nursing Findings of Fact dated 9/23/16 revealed, "Licensee's conduct, as set out in the Findings of Fact, constitutes grounds for discipline pursuant to NC General Statute 9-171.37 as follows: harassing, abusing, or intimidating a client either physically or verbally." Further review of the Findings of Fact revealed an order that stated, "Licensee will be issued a reprimand." An interview was completed with the Human Resources (HR) Director on 7/12/17 at 4:09 PM. She explained the facility's screening process for potential nurse employees was that the Director of Nursing (DON) asked HR that the license information be pulled and reviewed. HR Director stated she obtained the information from the NC Board of Nursing and if she saw a negative response on the license verification she gave it to the DON who reviewed it and decided whether employment should be offered to the applicant. An interview was completed with the DON on 7/12/17 at 4:45 PM. She stated the HR Department completed the background check and if they found an issue with a nursing license they reviewed the situation, presented the information to the Administrator or Vice President and then decided if an offer was made to the applicant. The DON said the facility would not hire someone that had a finding of "assault or sexual issue." She stated the facility hired Nurse #15 because the Board of Nursing's conclusion,	F 226	concerning our abuse policy as well as our hiring policies. Each background or registry check will be viewed by the human resources director, DON, the department head and administrator if there is a questionable finding. A tool has been created to keep track of findings. The Employee Notification System will be checked quarterly for any flagged staff that may have had occurrences at other facilities This information will be brought for review to the Quality Assurance Committee each month for 3 months and then annually thereaft	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 226	Continued From page 6 "didn't affect her license." She couldn't recall who hired Nurse #15. An interview was completed with Administrator #1 on 7/12/17 at 4:54 PM. He reported that the DON interviewed nurse applicants. When a license verification was completed, the Administrator stated, "If it's something major such as patient abuse, sexual abuse or anything illegal we just don't hire them." He recalled that prior to an offer of employment, the DON spoke with Nurse #15 about the situation involving her license and that Nurse #15 explained her side of the situation. He said that since the Board of Nursing issued a reprimand the facility gave her a "second chance" and if something came up during her employment at the facility she "would be released." The Administrator further stated his expectation was that if a potential employee had a finding of abuse, even though the license status was a reprimand, that the employee would not be hired.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide meal service with dignity and respect to 1 of 1 sampled resident receiving Hospice Services, Resident #126.	F 241	F241 Patient #126 and all of our other residents are being treated with dignity. All drinks whether regular or thickened are being placed in a cup for each patient.	8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 241	Continued From page 7 Findings included: Resident #126 was admitted to the facility on 2/17/12 with diagnoses which included: dementia, cerebral atherosclerosis, epilepsy, and a history of pulmonary embolism. The quarterly Minimum Data Set (MDS) dated 5/14/17 indicated Resident #126 was moderately cognitively impaired, had no behaviors, and required limited assistance with eating. Review of the Physician's Progress Note dated 6/26/17 updated Resident #126's diagnoses with adult failure to thrive, severe protein-calorie malnutrition, advanced dementia, and decreased oral intake requiring assistance with feeding. The resident's prognosis was poor, decline anticipated and a Palliative Care consult was ordered. The review of the clinical records revealed Resident #126 was hospitalized on 6/27/17 for hypernatremia and returned to the facility on 7/6/17 with a recommendation for Hospice Services. Resident #126 was admitted to Hospice Services on 7/7/17 with the diagnosis of cerebral atherosclerosis. The resident's Care Plan was updated on 7/10/17 to include Hospice. During an observation on 7/9/17 at 4:28 p.m., Resident #126 was awake in bed with oxygen concentrator on and nasal cannula in place. The resident was verbally non-responsive to questions but would make eye contact. During an interview on 7/11/17 at 2:20 p.m., the	F 241	Staff have been in serviced on dignity and instructed to place any liquids for consumption in a cup. Extra cups have been ordered and received and are now being placed on each residents tray or table. Staff will be monitored by the charge nurses, RN supervisors, Staff Development as well as social workers and department heads to ensure all beverages, thickened and non-thickened are provided correctly and in a dignified manner. Any identified problems will have immediate remediation and be brought to the attention of the DON and administrator. The thickened liquid audit tool has been redesigned to monitor for cup usage. This tool will be monitored weekly for 4 weeks and then monthly for 3 months. The DON and administrator will review weekly or more often if a problem is found to exist. Any staff member that is found not treating patients with respect and dignity will be reported for a violation of patient rights and disciplined according to facility policy. Any issues will be brought to the quality assurance committee monthly for a period of 6 months and then annually thereafter.	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 241	Continued From page 8 Hospice Social Worker revealed the facility currently provided all of the resident's ADL (activities of daily living) care. She observed that the resident was non-verbal, but would make eye contact and showed no signs of distress or pain. On 7/12/17 at 9:41a.m., Resident #126 was observed in bed receiving assistance with breakfast of pureed food and thickened liquids from a nursing assistant (NA). The NA was observed holding each of the original four ounce plastic containers of the thickened cranberry juice and the thickened orange juice to the resident's mouth. There was no glass or cup noted on the resident's meal tray. During an interview on 7/13/17 at 12:00 p.m., RD#2 (Registered Dietician) acknowledged Resident #126 should have been given her thickened liquids from a glass or cup. RD#2 revealed the dietary staff were in-serviced this week on ensuring glassware were included on meal trays of residents receiving fluids in containers and/or in cartons. She indicated the facility staff who assisted residents with their meals would also be educated on pouring the beverages into glassware.	F 241		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 281	Continued From page 9 by: Based on record reviews, staff, pharmacy and physician interviews the facility failed to follow physician orders for 1 of 4 sampled residents. The facility failed to complete admission orders and provide ordered medications that were available for Resident # 293. The findings included: Resident #293 was admitted to the facility on 10/16/16 with diagnoses that included acute on chronic congestive heart failure, atrial fibrillation, hypertension, anxiety, and osteoporosis. PM Review of the face sheet revealed Resident #293 was admitted to the facility at 4:18 PM on 10/16/16. Review of the hospital discharge orders dated 10/16/16 included the following: - Cardizem 90 milligrams (mg) (used to control high blood pressure) every 8 hours - Metoprolol 25 mg one 2 times a day (used to control high blood pressure) - Coumadin 3 mg (prevents blood clots) every day at 6:00 PM and - Caltrate 600+ D (calcium supplement) 2 tablets 2 times a day. Review of the printout of medications kept for back up administration included the Cardizem, Coumadin and Caltrate. These medications were available for administration from back up in the facility's automated medication dispensing machine. Review of Resident #293's the Medication Administration Record (MAR) for October 2016	F 281	F281 1. Admissions Nurse was hired in January, 2017 to help facilitate the admissions/order entry process and reduce delays. Admission process reviewed with all Supervisors at the Nursing Management meeting held on 8/8/17. Neil Medical Policy for order initiation reviewed with supervisors 8/8/17. Copy of the order initiation policy placed on all medication carts on 8/7/17 for staff reference. Protocol for all use of back-up pharmacy to ensure a timely initiation of any critical medication was reviewed via email (8/4/17) and Nursing Management meeting on 8/8/17. Verification that all supervisors have an active emergency kit access code was completed by 8/8/17. Charge nurses with expired passwords for the emergency kit were processed for reactivation by 8/10/17. 2. The Staff Development Coordinator will ensure that all new hires receive emergency kit access code and are activated into the system. Medication Administration Audit tool developed to monitor critical orders and timely initiation/administration daily x 30 days then weekly x4 followed by monthly x 4 and reported at the QA/QI meeting each month. 3. Identified concerns will be addressed	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 281	Continued From page 10 revealed the medications were scheduled for the following times: Cardizem 90 mg to be given at 6:00 AM, 2:00 PM and 10:00 PM. Coumadin 3 mg to be given at 6:00 PM Caltrate 600 +D to be given 8:00 AM and 8:00 PM and Metoprolol 25 mg to be given at 8:00 AM and 8:00 PM. Review of the resident's MAR for the date of 10/16/16 at 6:00 PM revealed the Coumadin was not administered, at 8:00 PM revealed the Caltrate and Metoprolol were not administered and at 10:00 PM revealed the Cardizem was not administered. Review of the resident's MAR for the date of 10/17/16 revealed the Cardizem 90 mg was administered at 9:00 AM. The administration of Cardizem on 10/17/16 at 9:00 AM was three hours later than the scheduled morning administration time of 6:00 AM noted on the MAR and was the first administration of this medication the resident received since being admitted to the facility on 10/16/16 at 4:18 PM. Record review for vital signs included a blood pressure on 10/17/16 at 1:59 PM of 142/91. Interview with the primary physician on 07/12/17 at 11:02AM revealed the Cardizem should have been given on the ordered scheduled basis every 8 hours (three times per day). She could not remember if she was notified or not regarding the Cardizem administered at wrong timeframes. The physician explained it would be important to give the Cardizem on the scheduled basis to control the heart rate and blood pressure.	F 281	immediately with the staff involved and corrective action taken as appropriate.	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 281	Continued From page 11	F 281		

Continued interview revealed the resident had diastolic heart failure. The blood pressure and heart rate could be effected by administration of the medication sooner than ordered. Continued interview revealed she would expect the nurse to assess the resident for side effects of low blood pressure or slow heart rate by checking the vital signs.

Interview with Nurse #6 on 07/12/2017 at 11:15 AM revealed she had verified the admission orders for Resident #293 on 10/17/16. Nurse #6 explained orders would be faxed to the pharmacy and if faxed before 5:00 PM the facility would receive the medications that night. She explained the next step would be to put the orders in the computer electronic chart. Nurse #6 was not sure who put Resident #293's admission orders of 10/16/16 in the computer. Further interview revealed if medications were due to be given on the night of admission, the admitting nurse would have to enter them in the computer. During the interview, while reviewing the MAR and orders for Resident #293, Nurse #6 explained, 10/16/16 was a weekend day. She had not reviewed the orders until Monday 10/17/16. The 7 P to 7 A floor nurse did the admission orders later on her shift (night shift). There were corrections she made to the orders after her review which included the times of administration for Cardizem and Metoprolol. The first dose of Cardizem was put in the computer for 9:00 AM. She had made the correction to give Cardizem every 8 hours at 6 AM, 2 PM and 10 PM. The Metoprolol was in the computer for 6:30 AM daily. That was corrected to 8 AM and 8 PM. Nurse #6 could not explain how the medications were entered incorrectly, or why the evening doses were not administered on 10/16/16. There were weekend supervisors that

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 281	Continued From page 12 would have checked the admission orders. Review of the "Daily Staffing Report" for the date of 10/16/16 revealed Nurses #2, #3 and #4 had worked on 10/16/16. Nurses #3 and #4 were the shift supervisors and Nurse #2 was the floor nurse. These nurses were called on 7/12/17 between 12:19 PM and 12:23 PM with a message to return the call. Further attempts to interview the nurses were unsuccessful. Interview with the Pharmacy Consultant on 7/12/17 at 3:29 PM revealed the medications were filed for Resident #293 on 10/17/16 by the pharmacy. The Pharmacy consultant stated the Cardizem would be available to staff in the Omni facility's automated medication dispensing machine which contained back up medications. The Pharmacy Consultant explained the Cardizem would be a tablet and the 90 mg dose could be accommodated by splitting one pill and taking a whole pill with the half. The process for obtaining medications was explained as follows: At the nurse's discretion, medication could be obtained from the faciliity's automated medication dispensing machine. If the medication needed was not in the dispensing machine, the nurse would call the on call pharmacist. The on call pharmacist would contact a local pharmacy to fill the order. A taxi would deliver the medication to the facility. Further interview revealed administration of the Cardizem at intervals of 9:00 AM and again at 2:00 PM would not be significant, as it is sometimes dosed three times a day at four hour intervals. The Pharmacy Consultant explained a wide range of medications were provided in the automated dispensing machine which included Coumadin and Caltrate.	F 281		

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 281	Continued From page 13 Interview with the Director of Nursing on 07/12/17 at 4:03 PM revealed she did not know what had happened to the admission orders for Resident #293 and why the nurse had not entered them into the computer sooner. She further explained there were 3 admissions that day which may have impacted the process. The DON confirmed Resident #293 missed scheduled doses of medications including; Cardizem, Coumadin, Metoprolol and Caltrate due to staff's failure to process the resident's admission medication orders correctly.	F 281		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328		8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 328	Continued From page 14 (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interviews and record review, the facility failed to obtain podiatry services as ordered by the physician for 1 of 3 residents (Resident #188) reviewed for foot care.	F 328	F328 Resident #188 has been seen by the Podiatrist on 7/17/17. The podiatrist company has been verbally instructed to let the facility know if anyone on their list to be seen is not seen for whatever	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 328	Continued From page 15 Findings included: 1. Resident #188 was admitted to the facility on 10/8/15 with diagnoses that included gastroesophageal reflux disease and Lewy body dementia. A review of Resident #188's medical record revealed a physician referral form for foot care services was signed and dated 1/3/17. A review of the "Visit Recap Report for North Carolina-Ashton Place for the date of Wednesday, 1/4/17" (a list of residents that were seen by the podiatrist on that date) revealed Resident #188 had not received podiatry services. A review of the comprehensive Minimum Data Set assessment (MDS) dated 3/7/17 revealed resident had impaired memory and severely impaired decision making skills. She was totally dependent on staff for personal hygiene. A review of the care plan last updated on 6/28/17 indicated Resident #188 was care planned for activities of daily living (ADL's). A care plan intervention stated "record personal hygiene performed." An observation of the resident's foot on 7/12/17 at 10:08 AM revealed her right big toe was curved to the right and the toenail was pressing into the side of the second toe. The skin on the second toe was intact. An interview was completed with Resident #188's family member (FM #1) on 7/10/17 at 12:55 PM. The family member reported, "They don't take care of her toenails." FM #1 stated she requested about a month ago that the toenails be	F 328	reason. They realize the mistake that was made by not informing the facility of their failure to notify a staff member that the insurance was not accepted and the procedure was not completed so an alternate appointment could be made. The scheduler has been in serviced concerning the follow through and of assuring that patients that are scheduled for appointments are being seen. A procedure has been set in place to check to make sure that all patients on the podiatrist's list have been seen or why they were not seen so alternate arrangements could be made. Each visit by the podiatrist will have the scheduler check off all residents that were seen in the presence of the podiatrist. This will verify that no one was missed. In the event that the podiatry procedure was not completed, it will be noted as to the reason why and the MD.NP/PA will be notified for further action by the scheduler. Since the podiatrist comes every other month the scheduler will bring the results to the quality assurance committee every other month for a period of one year for review	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 328	Continued From page 16	F 328		

cut. FM #1 stated, "The facility has a podiatrist but he didn't see her when he came in and I was told by the staff the podiatrist didn't have time."

An interview was completed with Nurse #15 on 7/11/17 at 10:01 AM. She stated there was a notebook at the nurse's station for staff to write down the names of residents who needed podiatry services. She said Resident #188 was placed on the podiatry request list on 4/15/17.

An interview with the Scheduler on 7/12/17 at 10:51 AM revealed the podiatrist came to the facility every three months. She stated the podiatrist's next two scheduled visits were 7/17/17 and 10/2/17. She reported the process for podiatry services was as follows: On each of the four villages in the facility, nurses wrote names of residents who needed podiatry services. When the podiatrist notified her of dates he would come to the facility, the Scheduler pulled the names of residents from the notebook at the nurse's station, ensured there was an order from the primary physician and then added those names to the list to be seen by the podiatrist. The Scheduler stated Resident #188 was added to the list in the notebook on 4/15/17 but she didn't know which date the resident would receive services.

A follow up interview was completed with the Scheduler on 7/13/17 at 8:12 AM. She stated she reviewed the podiatrist's schedule since the beginning of the year which revealed Resident #188 was on the schedule to be seen 1/4/17 for a toenail trim. The Scheduler stated she didn't realize the resident was not seen that day. She reported she contacted the podiatrist's office on 7/12/17 and received a letter the same date that

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 328	Continued From page 17 stated Resident #188 "was not seen at the 1/4/17 foot clinic because of her insurance." The Scheduler said that the resident was on the schedule to be seen by the podiatrist on 7/17/17. An interview was completed with the Administrator on 7/13/17 at 1:40 PM. He stated it didn't matter what kind of insurance a resident had, he expected that an order for podiatry services would be carried out.	F 328		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 371	Continued From page 18 by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not ensuring food service equipment were maintained clean and free from debris and in good working condition; by not ensuring canned foods were not stacked on the floor to keep the door to the storage room open; and by not ensuring dented/damaged cans of food were stored separately from other foods. The facility also failed to serve milk at an acceptable temperature of 41 degrees Fahrenheit or below during 1 of 1 meal tray line service observation. Findings included: 1. During a meal trayline service observation with the Food Service Supervisor in the kitchen on 7/11/17 at 1:14 p.m., temperatures were taken of the eight ounce cartons of milk which were covered with ice in a large plastic bin next to the trayline. The temperature of the milks ranged between 55-56 degrees Fahrenheit which was above the acceptable level of 41 degrees Fahrenheit. However, dietary staff continued to place cartons of the milk from the plastic bin onto the meal trays as they were placed into the meal delivery cart. The Food Service Supervisor indicated the meal trays in the delivery cart were ready to be served to the residents. The meal delivery cart was stopped by the Surveyor before it left the kitchen and the meal trays containing milk cartons (two) were removed from the meal delivery cart. 2a. During the initial tour of the kitchen on 7/9/17 at 12:13 p.m., the Dietary Cook was observed	F 371	F371 The facility will store, prepare, distribute and serve food in accordance with professional standards for food service safety. The storage room door is no longer propped open. All dented cans are stored separate and apart from undented cans. The double sided plate warmer has been repaired and cleaned appropriately. Milk has a temperature check at each meal service and served at 41 degrees or below. Any food item that is not at the appropriate temperature prior to serving will not be sent to a patient. Dietary staff have been in serviced concerning sanitation, proper cleaning procedure and proper temperatures for hot and cold foods that are served. The dietary supervisor or his assistant will observe the tray line during meal service to ensure that the temperatures are correct, the equipment is clean and in working order and the tray contents are accurate. The supervisor has created a temperature log and a sanitation check list that he uses to monitor the above. The dietary supervisor will bring information and concerns to the quality assurance committee meeting each month for a period of 3 months and then quarterly for the rest of the year.	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 371	Continued From page 19	F 371		

preparing plated meals at the meal trayline. One side of the double plate warmer located next to the meal trayline was not heating the plates within. The inside of the double plate warmer had brown stains on the cylinder walls and brown particles in the bottom. The Dietary Cook revealed one side of the double plate warmer did not always work properly; but she did not know if the problem was reported. During a second kitchen observation on 7/1117 at 12:08 p.m., the double plate warmer on the trayline service contained stained, dried brown debris on the inside where clean plates were stacked. One side of the double plate warmer was lukewarm to touch but contained plates which were used to plate meals. The Food Service Supervisor revealed he was employed at the facility for approximately three weeks and was not aware the double plate warmer was not working properly. He stated it was usually extremely hot to touch.

2b. There were greasy crumbs noted in and on the deep fryer which contained a brown/blackened color cooking oil. The dietary staff revealed the cooking oil was changed in the deep fryer three days prior then fish was fried in the new oil the next day. The dietary staff indicated the cooking oil used to fry the fish (two days prior) was also used to cook the hashbrowns for breakfast and the squash for lunch this day. The cooking oil used to fry the fish was not discarded from the deep fryer before the hashbrowns and the squashed were cooked in the deep fryer. The dietary staff stated the cooking oil used in the deep fryer was changed once or twice each week depending on the menu.

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 371	Continued From page 20 3. During the tour of the kitchen on 7/9/17 at 12:45 p.m., the door to the dry food storage room was held open by the placement of 2(#10) cans (corn, sliced apples) stacked on the floor against the door which opens into the kitchen. Also, one dented (#10) can of banana pudding was stored on the same storage rack with other food items ready for use. Dietary Staff #1 did not why the two cans of food were used as a door jam. She stated dented cans were to be stored in a room located behind the Food Service Supervisor's office.	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 428		8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 428	Continued From page 21 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to perform a drug regimen review for 1 of 5 residents (Resident #154) for medication that was administered outside of the one-time parameter ordered. Resident #154 was admitted to the facility on 10/21/16. During record review of the most recent Minimum Data Set (MDS) Assessment for resident #154 dated 10/28/16 for coded as an Admission assessment documented the resident's BIMS (Brief Interview for Mental Status) Evaluation Score as a 14 (Cognitively Intact). For	F 428	F 428 The drug regime review was completed each month. The medication was ordered 12/20/16, less than 24 hours prior to the pharmacist completing the review on 12/21/16 and at that time, the drug was not out of compliance. When the medication was noted out of compliance, an incident report was filed and appropriate staff addressed. Staff in-services on order entry were completed on 1/16/17 and 1/17/17 for new hires and repeated June 6-7, 2017 for all staff.	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 428	Continued From page 22 assessment of Activities of Daily Living (ADL) the resident required 2-person physical assistance for bed mobility, transfers, and 1 person assist for dressing, toilet use, personal hygiene, and for eating meals. The MDS coded the following cumulative list of diagnoses: hypertension, diabetes mellitus, hyperlipidemia, depression and chronic atrial fibrillation. The MDS coded that within 5 days of the assessment the resident had pain that did not limit daily activity and was not on a scheduled pain medication regimen. A review of the MAR for December 201-January 2017 revealed the following order for pain: Acetaminophen (Tylenol) 500mg tablet, take 2 tablets by mouth twice daily as needed for pain. Order date: 10/26/16 (admission), State date: 11/02/16 and discontinue date 4/17/17. A review of current MAR revealed the following pain medication order: Oxycodone acetaminophen 5-325mg 1tab every 6 hours as needed for MODERATE PAIN A review of the medical record revealed a GDR Review dated 6/19/17 and monthly pharmacy reviews were completed and in the resident medical record and did not address the Tylenol dosage and frequency. A review of the facility incidence log dated 1/25/17 revealed an incident involving a medication error for resident #154. The incident write up revealed ..... "Tylenol was ordered 12/20/16 times 1 for comfort. Order never written on POS but was entered into medication administration record (MAR). MAR entry was listed for "once" but no stop date was entered therefore the medication had been firing once a day and was given." Post	F 428	A tool to monitor new orders and those that require a specific stop date has been developed and the protocol for order entry in-serviced to the Nursing staff. On 8/2/17, the Director of Nursing and the 11-7 shift supervisor met to review the proper chart check procedure, including verification of back screen information. 7-3 supervisors will recheck all orders on a daily basis. End of month change over completed by assigned staff and who rechecks all orders since the prior month to ensure proper order entry. The DON will randomly monitor new orders on a weekly basis for 4 weeks and then monthly for 5 months. Identified issues will be dealt with immediately. The DON will work with the consulting pharmacist for any identified new order trends. The quality assurance committee will review any issues that arise each month for 6 for 6 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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 428	Continued From page 23	F 428		

incident action: nurse was reminded to add stop date for all "once" entries.

A review of MARs for December 2016-January 2017 revealed an entry for Tylenol 325mg table give 2 tablets by mouth NOW X1 comfort; order date 12/20/16, start date 12/20/16, discontinue date 1/25/17 time coded at 1:00pm. There was an entry as "given" on each day/date between 12/20/16 through 1/25/17 and signed off by multiple nurses. Further review confirmed that the discontinuation of the medication was modified by the DON on 1/25/17.

A review of nurse progress notes on 12/20/16 revealed no entries regarding new order necessity for pain medication, who administered the medication and pain relief reported by resident.

A review of nursing audits on 12/20/16 revealed that an audit was not completed of the new medication order of Tylenol since there was no hard copy of the order to compare it to.

A review of thinned medical records revealed that there was no handwritten order dated 12/20/16 for Tylenol 325mg 2 tabs by mouth NOW x1 comfort and confirmed that it was on the MAR.

On 7/12/17 at 11:20am, an interview with the DON revealed an incident report describing a medication error on 12/20/16 confirmed that the error should have been caught during monthly drug regimen reviews, audit checks and when reading the MAR entry in its entirety before administering medication to resident to prevent continuation of medication through 1/25/17.

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 428	Continued From page 24	F 428		

On 7/12/17 at 11:50am, an interview with the Physician confirmed that giving a medication after a stop date or after a one-time dose is complete is significant and should be reported. Nurses should always check orders with MAR and perform audits.

On 7/12/17 at 2:35pm, an observation of resident #154 revealed that he was in his room watching TV while lying in his bed, he did not verbalize complaints of pain or any issues and reported that his teeth/mouth "are feeling better than yesterday after dentist."

On 7/12/17 at 4:45pm, an interview with nurse #8 revealed that the resident has not had notable pain issues or behavioral issues and has adjusted well to the program and unit since coming to the facility.

On 7/13/17 at 1:25pm, an interview with nurse #9 on Birch Village confirmed when a one-time order is given as ordered, it is to be documented on the MAR and in the nurse's notes. It should immediately be discontinued in the computer after it is given. She stated that the MAR should have a stop date to prevent continuation of the medication. It is the responsibility of the nurse who administered the medication to discontinue it. She confirmed that nightly audits of new orders and MARs are completed by 3rd shift nurses and drug regimen reviews by the pharmacy are performed monthly.

On 7/13/17 at 1:45pm, an interview with nurse #1 confirmed that when a nurse receives an order (verbal or written), it is transcribed into the computer, he/she is to always make sure that there is a start and stop date and a copy is faxed

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 428	Continued From page 25	F 428		

to the pharmacy. If this is placed in the computer correctly, the medication will go away at the end of the stop date. She confirmed that night shift nurses are responsible for nightly audits of all new orders for that day.

On 7/13/17 at 2:30pm, an interview with nurse #1 revealed that the pharmacy should have received a copy of the order if it were faxed. She confirmed that the order entry in the computer had her named attached to "who" entered the ordered. She stated that it had been so long ago and that it is possible that she could have received a verbal order and did not transcribe it. She confirmed that the order was on the MAR correctly without a stop date for December 2016 through January 2017.

On 7/13/17 at 2:37pm, an interview with nurse #9 confirmed that it was her responsibility to have read that order correctly on the MAR and discontinued it after it was given. She did reveal that she did not transcribe the order into the computer.

On 7/13/17 at 2:45pm, a telephone interview with pharmacist #2 confirmed that they typically do not receive one time orders if the medication is in house. She stated that her search for a fax received on 12/20/16 was unsuccessful. She stated that they never entered the order for Tylenol for resident #154 because it was not faxed to them.

On 7/13/17 at 3:00pm, an interview with pharmacist #1 confirmed that their computer system never displayed information that the medication order existed in the computer or should have been stopped.

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 428	Continued From page 26 On 7/13/17 at 3:30pm, an interview with Administrator #2 confirmed that the order should have been discontinued after it was given, a nightly audit of new orders and pharmacy drug regimen review were other ways of discovering the medication error. She stated that she was unaware of how the medication error was discovered and confirmed that the MAR entry on December 20, 2016 was a NOW, one time only order and the error should have been avoided. On 7/13/17 at 4:00pm, an interview with the Administrator confirmed that his expectation is that all physician orders are to be followed as written, audited daily by the nurses and a drug regimen review by the pharmacy should be completed to prevent medication errors.	F 428		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520		8/7/17

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 520	Continued From page 27 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 5/12/2016 certification survey. This was for a recited deficiency in the area of Food Procure, Store/Prepare/Serve - Sanitation (F371). The deficiency was cited again on the current recertification survey on 7/13/2017. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings include:	F 520	F520 The Quality Assurance Committee meets each month and has the DON, Administrator, Medical Director and department heads present in the meeting. Each quarterly meeting, the Pharmacist attends. In the event that a problem should arise outside the regular meeting times, a QAPI is completed and a meeting is held to make staff aware and work toward solving any situations that may arise. This is then brought before the regularly scheduled meeting for review and resolution. QAPI meetings held on 5/17/17 concerning dietary concerns. This QAPI	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 520	Continued From page 28 This tag is cross referenced to: F371- Food Procure, Store/Prepare/Serve - Sanitation: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not ensuring food service equipment were maintained clean and free from debris and in good working condition; by not ensuring canned foods were not stacked on the floor to keep the door to the storage room open; and by not ensuring dented/damaged cans of food were stored separately from other foods. The facility also failed to serve milk at an acceptable temperature of 41 degrees Fahrenheit or below during 1 of 1 meal tray line service observation. During the recertification survey of 5/12/2016 the facility failed to properly label and date food and beverage items, and to discard out of date food and beverage items in 4 of 4 nourishment room refrigerators. On the current recertification survey of 7/13/2017, the facility failed to maintain sanitary conditions in the kitchen. An Interview was conducted with the facility's Regional Nurse Director on 7/13/2017 at 4:07:29 PM When asked who attends the meeting she stated that the Administrator and Director of Nursing led the meeting, the medical director attended, as well as all of the department heads and unit managers. The meetings were held every month, and the committee reviewed medication errors, pressure ulcers, trends in infection control, falls, weight loss, and any other areas that needed attention. She stated a performance improvement project and a new care delivery model was developed by the committee, that involved staff training and different staffing ratios on the units to allow for	F 520	was presented to the surveyor. The contents of this meeting concerned food quality, tray accuracy, and cleaning of the dietary department. This was in process upon the team's arrival. The dietary supervisor has been given the task to make sure that all sanitary tasks are being performed and stay in place to prevent any further sanitation issues. Either the Dietitian, contract dietary consultant or the administrator will inspect the dietary department at least weekly and will correct any problems immediately. The dietary supervisor has a tool to utilize and document findings in need of correction during his inspections. All information will be brought to the quality assurance committee meeting each month for a period of a year to discuss progress in all aspects of the dietary department.	

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 _____	C 07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, 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 520	Continued From page 29 more patient teaching. A FISH diagram was also being used to involve staff in answering why things happen in the facility, then after the committee reviewed the staff's suggestions and concerns, a smaller committee was assigned to set up an action plan and to report progress to QA committee. When asked what expectations the facility's administration had for preventing reoccurring problems, specifically previous citations in the kitchen, she stated that the expectation was that the kitchen staff follow all protocols and procedure guidelines provided to them by the facility.	F 520		