STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING ______ B. WING ______	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/17/25 through 2/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #G40711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/17/25 through 2/20/25. Event ID# G40711. The following intakes were investigated NC00215902, NC00216996, and NC00220482. Five of the five complaint allegations did not result in deficiency.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		3/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/10/2025

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
	345198	A. BUILDING ______ B. WING ______	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	**380 BREVARD ROAD** **ASHEVILLE, NC 28806**

(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 732	Continued From page 1 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets were filled out completely for 9 of 110 days reviewed during the period 10/31/24 through 2/17/25. Findings included: Review of the facility's nursing daily staffing sheets for 10/31/24-2/17/25 revealed the following: On 10/31/24 the total number of Nursing Assistants (NAs) and total number of NA hours worked was blank for the evening shift (3:00 PM-11:00 PM). On 11/4/24 the total number for each staff discipline (Registered Nurse (RN), Licensed Practical Nurse (LPN), NAs) and total hours	F 732	Aston Park Health Care Center□s response to this statement of Deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Aston Park Health care Center understands its right to refute any deficiency in this statement of deficiencies through informal dispute resolution, formal appeal and/or other administrative or legal procedures Corrective Action: SDC provided retraining to all licensed nurses on completing the required staffing sheet and leaving no sections blank. This information includes the facility name,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING ______ B. WING ______	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	**380 BREVARD ROAD** **ASHEVILLE, NC 28806**

(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 732

Continued From page 2

worked for each staff discipline for the evening and night shift (11:00 PM-7:00 AM) were blank.

On 11/5/24 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.

On 12/25/24 the census was blank.

On 1/3/25 the census was blank.

On 1/5/25 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.

On 1/15/25 the total hours worked for each staff discipline for the evening and night shift were blank.

On 1/23/25 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.

On 2/1/25 the total number of NA's and total number of NA hours was blank for the night shift.

An interview was conducted with the Administrator on 2/20/25 at 11:36 AM. The Administrator verbalized the nursing daily staffing sheet for posted staffing was supposed to be completed at the beginning of each shift by the Nurse Supervisor. She stated the total number of staff for each discipline and the total number of hours worked by each discipline was supposed to be filled out for every shift. She said the census was also supposed to be completed on the

F 732

date, current census, total number of employees and total number of hours worked by licensed and unlicensed nursing staff per shift. Re-education also included CMS regulatory and facility policy for completing, updating and posting of staffing information.

Identification of other potential problems:
All licensed nursing staff will complete education prior to beginning their next scheduled shift.

Systematic Changes:
Director of Nursing or SDC will complete an auditing tool. The auditing tool will include:
1, Staffing information is posted in a prominent location readily accessible to residents and visitors.
2. Staffing information is accurate and current
3. Staffing information is complete with no missing information for all shifts.

Monitor Performance:
Auditing of all sections of the posted assignment sheet will be completed by DON or SDC daily X 7 days; weekly X 4 weeks and then monthly ongoing and/or until QAPI Committee, which will include at least the Medical Director, Administrator, DON, Infection Preventionist and 2 other members, to assure compliance is achieved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING ______ B. WING ______	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	**380 BREVARD ROAD ASHEVILLE, NC 28806**

(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 732	Continued From page 3 nursing daily staffing sheet. The Administrator stated the prior Director of Nursing (DON) had left in November 2024. She reported the prior DON had reviewed the daily staffing sheets to ensure they were completed correctly. She explained there had been a gap between when the prior DON left in November 2024 and when the new DON started at the end of January 2025. She said reviewing the daily staffing sheets to ensure they were completed had been missed during the gap between when the prior DON left the new DON had started. An interview was conducted with the DON on 2/20/25 at 11:46 AM. The DON stated the nursing daily staffing sheet was supposed to be completed by the Nurse Supervisor at the beginning of each shift. She stated the daily staffing sheet should be completed and include the total number of staff for each discipline for each shift, total hours worked for each discipline for each shift, and the census.	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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.	F 812		3/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING ______ B. WING ______	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	380 BREVARD ROAD ASHEVILLE, NC 28806

(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 812	Continued From page 4 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean and maintain 1 of 1 walk-in refrigerator in the main kitchen free from debris. The facility also failed to refrigerate opened jelly containers stored in the dry food storage area, remove expired thickened beverages from the dry food storage area and expired thickened beverage from a dining area refrigerator (Azalea dining room). This practice had the potential to affect food served to residents. Findings Included: a. On 2/17/25 at 9:46 AM an observation with the Dietary manager (DM) in the kitchen's walk-in refrigerator found a whiteish in color and fuzzy in appearance substance on the floor beneath the food storage rack on the left side of the refrigerator. The substance was concentrated in some areas and speckled in other areas on the floor and on the baseboard spanning the length of the wall. Further observation of the walk-in refrigerator found the ceiling area near the circulatory fan to contain grey fluffy matter. The grey matter was crumbly to touch. The DM stated during the observation that he mopped the refrigerator 2 times daily and had not noticed the substance under the storage rack and had overlooked the ceiling.	F 812	Aston Park Health Care Centers response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Aston Park Health care Center understands its right to refute any deficiency in this statement of deficiencies through informal dispute resolution, formal appeal and/or other administrative or legal procedures. Corrective Action: The Dining Services Manager provided retraining of all dietary teammates on proper labeling, storing and checking expiration dates on all food items in refrigerators and stockroom on a daily basis. The Dining Services Director pulled all the shelves out in the walk-in and scrubbed floors and walls, cleaning the corners in the floor and around the baseboards. Maintenance removed the fan grill and cleaned and repainted it. Identification of other potential problems: The Dining Services Director scheduled a deep cleaning of the kitchen which included the walk-ins and storage areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345198	A. BUILDING ______ B. WING ______	C **02/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTON PARK HEALTH CARE CENTER	**380 BREVARD ROAD** **ASHEVILLE, NC 28806**

(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 812	Continued From page 5 b. On 2/17/25 at 9:50 AM an observation of the kitchen's dry food storage area with the DM found 2 opened jars of jelly located on the second shelf of the storage rack. The jelly jars did not contain an opened date, and the manufacturers label read "refrigerate after opening". The observation also found one un-opened 48 ounce container of thickened beverage with an expiration date of 10/3/24 stored on the shelf. The DM removed the 2 jelly jars and thickened beverage container from the shelf. The DM stated during the observation he did not know how long the opened jelly jars had been on the shelf and stated they should have been refrigerated after they were opened. The DM also said the thickened beverage container was overlooked and that the dry food storage area was checked weekly on food delivery days. c. On 2/17/25 at 9:57 AM an observation of the Azalea dining room refrigerator found one container of opened thickened beverage with an expiration date of 10/3/24. The DM stated during the observation the refrigerator was stocked regularly each day by the dietary staff and the container had been overlooked. The Administrator stated on 2/20/25 at 9:18 AM the facility had switched from using and purchasing 48 oz thickened beverage containers to individual sized containers the previous summer and fall. The 48 oz thickened beverage containers should have been removed at that time. The Administrator also said the walk-in refrigerator was mopped 2 times each day by the DM, and that all areas of the walk-in refrigerator should have been cleaned.	F 812	All areas were checked for expired items to identify any other issues. Systematic Changes: The Dining Service Director will schedule a monthly deep cleaning of the kitchen and all storage and walk-in areas and assign the Asst. Dining Services Director or Lead Dietary Aide to check for expired items on a daily basis using a QA log. Quality Assurance: The storage area and refrigerators will be audited by DSM, Asst DSM or Lead Dietary Aide Q/meal X 7 days, then weekly X 4 weeks, then monthly ongoing and/or until QAPI Committee, which will include at least the Medical Director, Administrator, DON, Infection Preventionist and 2 other members, to assure compliance is achieved.	