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 _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, the medical doctor (MD) Physician's Assistant (PA-C), and the resident (Resident	F 157	Specific action taken to correct the deficiency: * Immediate in-service with staff on	6/6/16

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

Electronically Signed | 06/02/2016

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F 157	Continued From page 1 #24), the facility failed to notify the MD of a change in condition for 1 of 4 sampled residents (Resident #24) after Resident #24 verbalized thoughts of killing herself. Findings included: A review of the annual Minimum Data Set (MDS) dated 4/20/16 revealed Resident #24 was admitted to the facility 5/1/15. Resident #24 was cognitively intact, displayed no moods, behaviors, or rejection of care during the look back period, required extensive assistance with at least 2 people for all activities of daily living (ADLs) except eating, and had limb impairment in 1 upper limb and both lower limbs. Active diagnoses included Hypertension (HTN), diabetes mellitus (DM), non-Alzheimer ' s dementia, dementia with behavioral disturbances, and contractures. A review of the care plans dated 4/21/16 included a care plan related to " History of CVA (Cerebrovascular accident) with noted episodes of confabulation with behavior patterns: Goals included " Resident will make accurate statements about care and needs. " Interventions included NCEPS (Behavioral health services) follow ups. A review of a behavioral health note dated 4/7/16 revealed Resident #24 had normal thought content, adequate insight, anxiety, and was generally unhappy. An additional behavioral health note dated 5/5/16 revealed Resident #24 refused the scheduled session. A review of a nursing noted dated 5/11/16 at 11:54 PM read, in part, " At the nurses station [resident ' s name] Resident #24 was overheard yelling to family members on her cell phone. When I (Nurse #1) went to the room she was crying and saying, ' Everybody is turning against me. Y ' all might as well go on and dig my grave	F 157	protocol for suicidal ideation on 05/12/16 * 100% of staff in-service completion by 05/14/16 * PHQ9 initiated for all current residents on 05/12/16, and completed same date * Resident assessed for current status/plan by MD and NP on 05/12/16; resident deemed not at risk * Charge nurse involved in the deficiency re-educated 05/12/16 and more formal discussion held on 05/13/16. Measures to be put into place or systemic changes made to ensure that the deficit practice will not recur: * 24-hours report form revised on 05/18/16 to list resident names on one village and not just room numbers to help aid the Charge Nurse to remember issues/concerns for communication to oncoming shifts. This proved to be successful and expanded to all village report sheets * A "significant change" column was added to the 24-hour report form on 05/26/16 for the Charge Nurse to check so attention could be drawn to a specific resident * The Staff Development Coordinator discussed, and continues to discuss, significant change notifications and follow-through in orientation * Supervisor meeting on 05/17/16 included discussion of how to track issues/changes as well as communication strategies for supervisor to ensure proper notifications and follow up. We will monitor our performance to make	

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F 157	Continued From page 2 because I ' m going to kill myself. ' " A review of the MD progress note dated 5/12/16 read, in part, " Upon arriving to [the name of the facility], I was advised that staff reported resident had suicidal thoughts last night. " A review of the Nurse Practitioner (NP) note dated 5/12/16 read, in part, " Last night at 11 pm, nursing documented that patient had suicidal thoughts. Patient is seen in her room today. " The note also read, in part, " I made this statement in anger and people say things when they are angry. I have no thoughts to kill myself or harm myself. I am done explaining this again and again. " The NP assessment read, in part, " Suicidal thoughts verified with patient. Denies any suicidal or homicidal thoughts. She acknowledges making the above statement during an argument with a family member out of anger. " An interview was conducted with Social Worker #1 (SW #1) on 5/12/16 at 9:20 AM. She stated Resident #24 received behavioral health services. She also stated Resident #24 had never had suicidal thoughts or ideation in the past. She stated if a resident verbalized suicidal thoughts it should immediately be reported to the Director of Nursing (DON). She stated after it was reported to the DON it would be reported to the physician and family. New physician orders would be followed, and staff ensured resident safety. An interview was conducted with the PA-C on 5/12/16 at 11:00 AM. she stated, "I take care of this resident (Resident #24). Coming in this morning, her FM actually called me and said Resident #24 wants to get her own apartment. I asked if this was a possibility and the FM stated she has planned this before. Her FM also asked if I heard about the big fight. Apparently, Resident #24 and her roommate had a big argument. Arguing is not unusual for Resident #24. On the	F 157	sure that solutions are sustained: * PHQ9 audit to be completed monthly for 3 months * Audit form developed for tracking of significant changes and includes RP and MD notifications as well as verification that nurse's notes reflect actions taken * Results of the audit will be reported at the QI meetings for the remainder of 2016. Issues identified will be dealt with on an individual basis.	

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way to see the resident (Resident #24) the social worker told me there had been a suicidal ideation. I asked Resident #24 about this and she burst into tears. I asked about her telling the staff she would kill herself. She denied it and said putting her in an institution would kill her so she said, 'I might as well be dead'."

An interview was conducted with Nurse #2 on 5/12/16 at 9:45 AM. She stated, " If a resident states they want to kill themselves they should be placed on checks every 15 minutes, If it ' s day shift we bring them out to the nursing station to keep a check on them. We check the room for harmful objects. The family and MD should be notified and then we follow the MD orders to monitor the resident or send them to the hospital. "

An interview was conducted with Nurse #3 on 5/12/16 at 9:50 AM. She stated, " I get report on a resident if something ' s going on like antibiotics, appointments, or changes in condition. If a resident stated they were going to kill themselves I would expect to hear about that in shift report. If a resident threatens to kill themselves we immediately tell our supervisor or Director of Nursing (DON), and we tell the MD and family. "

An interview was conducted with Resident #24 on 5/12/16 at 9:55 AM. She stated, " My family member called last night and told me the facility told him I have 30 days to leave here. I don ' t know why everybody is mad at me. I ' m sorry. Everyone is turning against me. I only have 1 friend and that ' s God. I ' m going to kill myself since I ' d be better off dead. "

An interview was conducted with NA #1 on 5/12/16 at 11:00 AM. NA #1 was the NA assigned to care for Resident #24 and heard her as she spoke to her FM. He stated, " She was angry

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with her children and said they were against her. She said she ' d be better off dead. I tried to comfort her and reported it to her nurse. (Nurse #1).
An interview was conducted with Nurse #1 on 5/12/16 at 11:10 AM. She stated, " I overheard her crying and upset. Her family told her everything going on in the facility and she told them she ' d be better off being with her dead son, then they wouldn ' t ' t have to worry about her anymore. She said, ' Just go ahead and dig a hole. I might as well kill myself. ' She ' s never said anything like that before. Me and the NA (NA #1) talked about it, but I didn ' t ' t report it to my supervisor. She didn ' t ' t outline a plan about what she going to do to kill herself so I didn ' t ' t think she would really try to kill herself. I just thought she was upset. I did tell the on-coming nurse about what happened. I am supposed to document what a resident says and report it to the doctor, but I just thought she was upset so I didn ' t ' t report it to anyone. "
An interview was attempted with Nurse #4 on 5/12/16 at 11:30 AM. A message was left to return the call, but the interview was not able to be completed.
An interview was conducted with the facility medical doctor (MD) on 5/12/16 at 11:30 AM. She stated, " I was asked to evaluate (resident name) Resident #24 this morning related to some statements she made last night. She actively denies suicidal thoughts or ideation and was getting upset about everyone asking her about this. She denies any depressive symptoms. She has never said anything like this before and said she was angry with her children because she thought they were going to put her in a state mental institution. She said she ' d be better off dead so she should just kill herself. I would

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F 157	Continued From page 5 expect the facility to talk to her and find out if she had a plan, assess her environment for safety and notify me or the provider. I should have been notified. "	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		6/6/16

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F 278	Continued From page 6 Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 3 residents (Resident #43 and Resident #197.) 1.) Resdient #43 was reviewed for Hospice Services and 2.) Resident #197 was reviewed for PASRR (Preadmission Screening and Resident Review). Findings included: 1. Resident #43 was admitted to the facility on 10/2/13 with diagnoses which included bi-polar disorder, depression, dyskinesia, and neuropathy. Review of the resident's annual MDS assessment dated 10/2/15 revealed Resident #43 was not coded as receiving PASRR (Preadmission Screening and Resident Review) Level II services. During an interview with the MDS Coordinator on 5/11/16 at 10:38 AM, she stated Resident #43 had psychiatric diagnoses and received mental health services, but that the resident was not a PASRR Level II resident. She stated the resident had lived at the facility for more than two years and had never been a PASRR Level II resident. At 10:45 AM on 5/11/16 the Director of Nursing (DON) provided a printed copy of the PASRR Level II Determination Notification for Resident #43, dated 12/3/13. The MDS Coordinator was re-interviewed on 5/11/16 at 10:53 AM where she stated she did not know anything about Resident #43 being evaluated as a PASRR Level II resident. She stated she had never seen the documentation before and that was why Resident #43 was not coded for PASRR Level II services on her MDS.	F 278	Level II PASRRs * List has been made of all level two PASARRs that MDS Coordinators will have to refer to when doing the MDS * The listing includes the resident name, PASARR number, date issued and date expired (if applicable) as well as diagnoses contributing to the PASARR level if known * As new residents are admitted, PASARRs that are any level other than A will be added to this listing * Before transmitting any full MDS Assessments, the MDS Coordinator that did not complete the assessment will check to make sure that PASARR questions on section A have been completed correctly. FYI: PASRR Questions are only on full MDS Assessments. TO MONITOR THE PROCEDURE WE WILL: *MDSs will be audited weekly times 4 weeks, then monthly for 2 months then as determined by the QAPI Team, Director of Clinical Reimbursement/MDS or other qualified designee for accuracy of MDS coding with requard to PASRR level II. TO AVOID RECURRANCE: *The Director of Clinical Reimbursement/MDS or other qualified designee will monitor MDS Assessments once every two months for coding accuracy related to PASRR level II. Coding Hospice Services on MDS Assessments * List will be maintained of all Hospice residents	

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F 278	Continued From page 7 2. Resident #197 was admitted to the facility on 12/9/5 with diagnoses which included coronary artery disease (CAD), high blood pressure (HTN), Alzheimer ' s disease, and calculus of the kidney. Review if a significant change MDS dated 4/22/16 revealed Resident #197 was severely cognitively impaired, needed extensive assistance for all activities of daily living (ADLs), and was always incontinent of stool and urine. No special services, which included hospice care, was coded on this MDS. A review of the nursing notes revealed a note dated 4/26/16 by the MDS Coordinator. It read, " Significant change MDS completed. Resident is on hospice services. New care plans initiated to address current status/needs/problems and included potential for constipation, risk for falls, risk for dehydration, impaired vision, impaired communication/hearing, Hospice. " A physician progress note dated 5/9/16 read " Goal of treatment-comfort and quality of life/hospice. " An interview was conducted with the MDS Coordinator on 5/11/16 at 4:05 PM. She stated, " We get information about a significant change from the previous MDS, physician orders for changes, staff interviews, and resident assessments. Anything I can get my hands on. I use medication administration records, treatment administration records, wound notes, things like that. Becoming a Hospice resident is a significant change. If they are actually receiving Hospice services Section ' O ' should be coded as Hospice. It looks like I didn ' t check it for her (Resident #197). That ' s my mistake. The whole	F 278	* As new residents are initiated on Hospice Services, listing will be updated * Before transmitting any MDS Assessments, the MDS Coordinator that did not complete the assessment will check to make sure that Hospice item in Section O and 6 months or less to live in section J are correctly coded TO MONITOR THE PROCEDURE WE WILL: *MDSs will be audited weekly times 4 weeks, then monthly for 2 months then as determined by the QAPI Team, Director of Clinical Reimbursement/MDS or other qualified designee for accuracy of MDS coding with requard to Hospice Services. TO AVOID RECURRANCE: *The Director of Clinical Reimbursement/MDS or other qualified designee will monitor MDS Assessments once every two months for coding accuracy related to coding of Hospice Services.	

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F 278	Continued From page 8 reason for doing a significant change MDS on her (Resident #197) was for Hospice. I did neglect to mark it on here. I guess I ' m human. I ' ll go fix it right now. " An interview with the DON was conducted on 5/12/16 at 9:00 AM. She stated her expectation was for the MDS to be completed accurately.	F 278		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. The facility must maintain the posted daily nurse	F 356		6/6/16

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F 356	Continued From page 9 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 interview, the facility failed to post the current daily nurse staffing form. The findings included: The Daily Nurse Staffing form dated 5/8/16 was observed to be posted at the receptionist desk in the main lobby on 5/9/16 at 10:15 AM. An interview was conducted with the Director of Nursing (DON) on 5/9/16 at 10:41 AM. The DON stated she was responsible for posting the current daily nurse staffing form Monday through Friday. She stated she has routinely posted the daily nurse staffing form after the completion of the morning meeting. The DON stated there was a delay in posting the daily nurse staffing form on 5/9/16.	F 356	Specific action taken to correct the deficiency: * 11p-7a shift supervisor/coordinator began placing the daily staffing form at the receptionist desk prior to the end of their shift for the upcoming 24 hours effective 05/13/16 Measures to be put into place or systemic changes made to ensure that the deficit practice will not recur: * 11p-7a shift supervisor/coordinator responsibilities now include posting of daily staffing sheet prior to the end of their shift at the receptionist desk for the upcoming 24-hour period * Blank staffing sheet added to shared drive for easy access by any supervisor/coordinator * An e-mail to all supervisors was sent on 05/19/16 with the blank form attached for their personal files * The receptionist duties now include verification that form is in place upon arrival for their shift We will monitor our performance to make sure that solutions are sustained: * The receptionist will verify the current staffing sheet is in place on a daily basis and note verification on the "Staffing Verification Sheet" that is kept at the receptionist desk	

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F 356	Continued From page 10	F 356	* If the sheet was not in place, the receptionist is to notify the Director of Nursing or her in-house designee (i.e. shift supervisor) so a form is immediately placed * The previous day's form will be placed in the Director of Nursing's mailbox for storage maintenance	
F 371 SS=F	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 observation, interview, and record review 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. The findings included: 1. Observations made on 5/9/16 at 10:35 AM of Nourishment Room #1 (NR #1) on the ' Pine ' hall revealed the following resident food and beverage items that were either not properly labeled with both a name and a date or had not been discarded in a timely manner: a. One (1) bottle of orange juice approximately 2/3 full with no name or date.	F 371	Corrective action: * Inserviced staff on the proper label and dating procedures of resident items in nourishment room cooler / freezer * % of staff inserviced: 100% * The dietary staff is responsible for checking the nourishment room cooler / freezer for proper label and dating daily * Dietary aides responsible for initialing label and date to ensure procedures are followed properly with each label generated	6/1/16

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F 371	Continued From page 11 b. Two (2) reusable plastic storage containers which contained fresh fruit labeled with a name, but no date. c. One (1) blue plastic grocery bag which contained 6 clementine citrus fruits, with no name or date. The Certified Dietary Manager (CDM) was present for this inspection. He stated dietary employees were responsible for stocking nourishment room refrigerators with drinks and snacks for residents, cleaning the interior of the refrigerators, and discarding old or improperly labeled items. He stated the items should have been discarded and would be discarded immediately. 2. Observations made on 5/9/16 at 10:50 AM of Nourishment Room #2 (NR #2) on the ' Evergreen ' hall revealed the following resident food and beverage items that were either not properly labeled with both a name and a date or had not been discarded in a timely manner: a. One (1) foil pan of partially consumed pastry with a name, but no date. b. Two (2) 12 ounce containers or prepared chicken salad wrapped in a plastic grocery bag with no name or date on the bag or the containers. c. One (1) pint of ice cream, partially consume with visible freezer burn on the ice cream with a name, but no date. d. One (1) half-gallon ice cream tub wrapped in a plastic grocery bag with no name or date. The Certified Dietary Manager (CDM) was present for this inspection. He stated dietary employees were responsible for stocking nourishment room refrigerators with drinks and snacks for residents, cleaning the interior of the refrigerators, and discarding old or improperly labeled items. He stated the items should have	F 371	Measures put in place: * Temperature logs have been updated to include the assignment to check label and dating before meal service at breakfast and dinner * Signage has been posted for residents, visitors and staff on nourishment room refrigerators stating the policy of labeling and dating * Any resident items that do not follow proper label and dating procedure will be discarded immediately with nourishment room refrigerator checks being done daily. Performance monitoring procedures: * Dietary Manager/CDM or RD will follow up daily with dietary staff to ensure proper labeling and dating procedures are being followed. Each member of dietary management is responsible for auditing proper labeling and dating procedures daily. * Assistant Manager - audit label and dating daily * Manager-in-Training - Audit label and dating daily * Dietary Manger - Audit label and dating daily * Any errors in procedure noted will result in re-training or counselling of the employee involved with further action as indicated.	

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 _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH AND REHAB	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

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F 371	Continued From page 12	F 371		

been discarded and would be discarded immediately.
3. Observations made on 5/9/16 at 11:00 AM of Nourishment Room #3 (NR #3) on the ' Birch ' hall revealed the following resident food and beverage items that were either not properly labeled with both a name and a date or had not been discarded in a timely manner:
a. One (1) plastic reusable container with three (3) red apples with a name, but no date.
b. One (1) bottle of apple juice, partially consumed, with a name but no date.
The Certified Dietary Manager (CDM) was present for this inspection. He stated dietary employees were responsible for stocking nourishment room refrigerators with drinks and snacks for residents, cleaning the interior of the refrigerators, and discarding old or improperly labeled items. He stated the items should have been discarded and would be discarded immediately.
4. Observations made of Nourishment Room #4 (NR #4) on 5/9/16 at 11:10 AM on the ' Oak ' hall revealed the following resident food and beverage items that were either not properly labeled with both a name and a date or had not been discarded in a timely manner:
a. One (1) box of Italian ice frozen desserts with a name but no date.
b. One (1) shell egg with no container or packaging, and no name or date.
c. Six (6) slices of American cheese wrapped in a plastic grocery bag with no name or date.
d. One (1) bag from McDonald ' s with a date of ' 5/5 ' written on the bag, but no name.
e. One (1) reusable glass container full of soup which was wrapped in a paper bag with a date of ' 5/9 ' , but no name.
The Certified Dietary Manager (CDM) was

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 _____	05/12/2016

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F 371	Continued From page 13 present for this inspection. He stated dietary employees were responsible for stocking nourishment room refrigerators with drinks and snacks for residents, cleaning the interior of the refrigerators, and discarding old or improperly labeled items. He stated the items should have been discarded and would be discarded immediately. A typed and printed page was affixed to the front of each of the four (4) Nourishment Room refrigerators. The page read: "Any item placed in this refrigerator must have the date opened/placed. (This includes resident items.) Any item that is >7 days old will be discarded."	F 371		