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 08/14/2018

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 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		9/23/18

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

Electronically Signed | 09/06/2018

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 08/14/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, and physician interviews the facility failed to notify the physician when a prescribed pain medication was unavailable for 1 of 1 residents (Resident #7) reviewed for physician notification. Resident #7 experienced increased nerve pain when staff failed to notify the physician that the prescribed dose of her nerve pain medication was not available and failed to obtain a physician's order to administer a reduced dose or alternate medication to relieve her pain. Findings include: 1. Resident #7 was admitted to the facility on 5/10/2016 with the diagnoses of chronic pain syndrome and peripheral neuropathy. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated for 7/3/18 revealed that Resident #7 was cognitively intact, required one person extensive to total assistance for all activities of daily living (ADLs). It also documented the resident was on a scheduled pain medication regimen for almost constant moderate pain and received opioids 7 of 7 days during that assessment period.	F 580	Ashton Health & Rehabilitation acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on August 12-14, 2018. Ashton Health and Rehabilitation response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Furthermore, Ashton Health & Rehabilitation reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures.	

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 08/14/2018

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 580	Continued From page 2 Review of the resident's August Physician Orders revealed the following medication orders: Original Order Date: 5/27/17 Lyrica 75 (milligrams) mg capsule (Nerve pain medication) - Take 1 tab by mouth (PO) two times (BID) daily 5/27/17 Lyrica 100mg capsule - Take 1 capsule PO at hour of sleep (HS) 5/27/17 Pain Assessment during every shift (6:00 AM/2:00 PM/10:00 PM) Review of the resident's June 2018 Medication Administration Record (MAR) revealed the Lyrica 75 mg dose had an "N" (Not Given) documented for the 6/24/18 8:00 AM and 5:00 PM doses and again on 6/25/18 for the 8:00 AM dose. In the note section of the MAR on 6/24/18 at 5:13 PM Med Aide #1 documented the medication was not available. On 6/25/18 at 2:16 PM it was also documented that the medication was not available. The Lyrica 100 mg ordered to be given at 8:00 PM was administered for all these dates. Review of Resident #7's June 2018 MAR revealed on 6/25/18 at 6:00 AM that the resident had a pain level of 0 out of 10 (the 0-10 pain scale) and there was no documentation for pain assessments for the 2:00 PM and 10:00 PM assessments for that date. On 6/26/18 the resident was documented to have a pain level of 0 at 6:00 AM, and for the 2:00 PM pain assessment the resident had reported a pain level of 10 out of 10 (worst pain level on the 0-10 pain scale) to Nurse #7. For the 10:00 PM assessment on 6/27/18 the resident reported a 7 out of 10 pain level.	F 580	F580 1. Facility failed to notify physician when a prescribed pain medication was unavailable for Resident #7. Facility failed to notify physician due to an oversight. Physician was notified by the Director of Nursing that the pain medication was not available on 8/15/18. 2. Audit of all residents on controlled substance(s) to ensure the medication and correct does is available. 3. Licensed staff will be educated to notify physician if correct dose and/or controlled substance(s) not available. Licensed staff and Medication Aides will be educated on the six rights of medication administration. Nurse Managers and/or Coordinator will audit the declining narcotic sheets for residents prescribed controlled substance(s). The Nurse Manager will be notified if a hard script is needed and ensure that the controlled substance(s) was ordered and delivered to the facility. Director of Nursing and/or designee will monitor all residents prescribed controlled substance(s) to ensure the medication and correct dose is available. This audit will occur weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends	

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 08/14/2018

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 580	Continued From page 3 Review of the resident's August 2018 MAR revealed that on 8/10/18 Med Aid #1 documented the resident had not received her 8:00 PM Lyrica 100mg dose due to the medication being unavailable. During an interview with Resident #7 on 8/12/18 at 3:55 PM she stated that she did not receive her Lyrica for approximately three days in June 2018. She stated that her neuropathy pain was horrible during that time, that she remembered reporting to the nurse that her pain level was a 10 out of 10. When the resident had asked about the medication, the staff just kept telling her they were out of the medication and were waiting on it to be dispensed from the pharmacy. When asked if she had received other pain medications, Resident #7 stated she had received her other scheduled pain medication. She also stated that her nerve pain was only relieved by Lyrica and that other pain medications didn't relieve that type of pain for her. She stated that she did not think she was getting the correct dose of Lyrica currently (as of 8/12/18), and that she had thought she was getting less than prescribed. She had asked staff (couldn't remember who) about her night time dose of 100 mg of Lyrica and was told that they were administering the 75 mg dose until the 100 mg dose arrived from pharmacy. She stated that she could tell a difference in the decreased dosage due to having more pain in her legs during the night. During an interview with Nurse #2 on 8/13/18 at 3:30 PM she stated that staff tried to avoid running out of medications, but that if it happened that they would check the back-up medication kit to see if the medication was available. If it wasn't, then the on-call provider would be contacted for	F 580	and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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 08/14/2018

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 580	Continued From page 4	F 580		

instructions and sometimes an order for an alternate medication would be placed until the medication was delivered from the pharmacy.

During an interview with Pharmacy Director/Owner on 8/13/18 at 3:44 PM he stated that Resident #7's prescriptions for Lyrica 75mg (28 pills) and 100 mg (14 pills) were dispensed in 14-day supply due to insurance reasons. The last date that the Lyrica 100 mg was dispensed from the pharmacy was on 7/25/18. There were no pending refills placed for the dose of 100 mg Lyrica for Resident #7 at the time of this interview.

During an interview with Nurse #1 on 8/14/18 at 2:54 PM she stated that she had instructed Med Aide #1 to administer the 75 mg of Lyrica in place of the ordered 100 mg dose. When asked if she had called the physician or the on-call provider to obtain an order to use the 75 mg Lyrica as an alternate dose for the prescribed 100 mg dose she stated that she did not. She also stated that she had not notified the pharmacy to refill the prescription.

During an interview with the Physician on 8/14/18 at 3:15 PM he stated that medications should not run out if staff are ordering them correctly, but if it did happen that they were expected to call the on-call provider immediately if the medication is not available in the facility's back-up medication kit. Depending on the medication, an alternate could be ordered and in Resident #7's case an order to substitute the 100 mg dose of Lyrica with the 75 mg could have been a possibility. He stated that no one other than another physician or other licensed provider should change prescribed medication doses ordered by the physician.

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 08/14/2018

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 580	Continued From page 5 During an interview with the Director of Nursing on 8/14/18 at 3:35 PM she stated that it was her expectation that all medications are administered per the physician's order and only to be altered by the physician or on-call provider.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		9/23/18

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 08/14/2018

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 585	Continued From page 6	F 585		

facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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 08/14/2018

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 585	Continued From page 7 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review, the facility failed to thoroughly investigate a grievance filed by a resident and a resident representative and failed to follow their grievance policy to inform the resident and resident representative both verbally and in writing of the findings of the investigation for 2 of 3 residents (Resident #1 and Resident #7) reviewed for grievances. Findings included: 1. The facility policy titled "Grievances/Complaints, Filing," revised April 2017 was reviewed. The policy stated, in part, "The Administrator and staff will make prompt	F 585	F585 1. The facility failed to thoroughly investigate a grievance filed by Resident #1 and #7. Social Worker failed to follow facility grievance process. Administrator has been in contact with Resident #1 Responsible Party. Administrator provided Responsible Party with his personal phone number to be contacted if any further issues arise. No issues surrounding the original grievance have been noted by Responsible Party. Facility is attempting to reasonable	

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 08/14/2018

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 585	Continued From page 8	F 585		

efforts to resolve grievances to the satisfaction of the resident and/or representative. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five working days of receiving the grievance and/or complaint. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. A written summary of the investigation will also be provided to the resident."

Resident #1 was admitted to the facility on 2/22/17 with diagnoses that included, in part, heart failure and diabetes mellitus.
A review of a significant change Minimum Data Set (MDS) assessment dated 11/23/17 revealed Resident #1 was cognitively intact. He required extensive assistance with toileting.

A review of a grievance form dated 7/19/18 and filed by Family Member #1 revealed on 7/15/18, "Staff not responding to call button, nurse duty phone called, no answer, went to voice mail. Main number at facility called, no answer."

A review of the facility's investigation and findings revealed the following information: "Weekend reception hours given. If no answer then the nurse supervisor can be paged. Administrator and Director of Nursing can be contacted." Further review of the grievance form revealed there was no documentation of who completed the investigation, and the investigation resolution and family member follow up was not completed.

On 8/12/18 at 4:38 PM an interview was

accommodate Resident #7 daily care routine. Administrator and Director of Nursing are in frequent contact with Resident #7 to ensure her needs are being met.

Social Worker no longer is employed at the facility.

2. Facility will hold resident and family meetings to give the opportunity to voice grievances or concerns. These will be held in the form of a family night and increased frequency of resident council meetings.

3. All staff will be reeducated on the grievance process.

Administrator will audit the grievance log weekly to ensure that grievances and concerns are being brought to resolution.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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 08/14/2018

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 585	Continued From page 9	F 585		

completed with Resident #1. He stated on 7/15/18 he was in his bed and turned his call light on at 6:00 AM because he needed assistance to the bathroom. Resident #1 said the call light stayed on until 9:30 AM and that nobody responded to the call light during that time. Resident #1 further stated that because nobody answered his call light for 3 ½ hours he urinated on the floor. Resident #1 said he called Family Member #1 and she tried to call the weekend supervisor and main facility number but there was no answer on either line. He stated Family Member #1 filed a grievance but could not remember if the facility investigated or followed up with him about the incident.

On 8/13/18 at 10:50 AM an interview was completed with Family Member #1. She reported on 7/15/18 Resident #1 called her at 9:30 AM and informed her he had put the call light on at 6:00 AM and nobody had responded to the call light. Family Member #1 said she called the main number to the facility but there was no answer. She then called the nurse supervisor's number at the facility with no answer. Family Member #1 said she completed a grievance form on 7/16/18 and faxed it to the facility and received a confirmation that the fax was successful. She stated nobody from the facility followed up with her about her grievance, either over the phone, in person or in writing.

An attempt to interview the nurse aide (3rd shift) who worked with Resident #1 on 7/15/18 was unsuccessful.

On 8/13/18 at 1:13 PM an interview was completed with Nurse Aide (NA) #3. She said she worked first shift on 7/15/18 and 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 _____	C 08/14/2018

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 585	Continued From page 10	F 585		

assigned to Resident #1. She stated she thought she was late to work that day and could not remember if Resident #1's call light was on.

On 8/13/18 at 1:46 PM an interview was completed with the Administrator. He stated the Social Services Director (SSD) was assigned to investigate the grievance but did not know if the grievance was investigated and further stated that nobody had followed up with the family about the grievance. The Administrator said the facility had issues with how grievances were managed which included the process that was supposed to be followed when a grievance was received. He said typically the grievance process went through the social services office but because there had been issues on how grievances were managed the process had been switched to the Administrator's office.

On 8/14/18 at 10:08 AM an interview was completed with the SSD. She said she remembered finding the grievance under her office door. She stated she showed the grievance to the Administrator who acknowledged that he also received the same grievance. The SSD said she was not told by the Administrator to investigate the grievance filed by Family Member #1 and therefore, had not investigated the concern. She further stated she did not know who investigated the grievance.

On 8/14/18 at 2:45 PM a follow up interview was completed with the Administrator. He stated Resident #1's grievance was not investigated because, "Our grievance process wasn't followed like it was supposed to be; our grievance process needs work." The Administrator further stated he expected grievances be investigated timely and

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 08/14/2018

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 585	Continued From page 11	F 585		

that follow up be completed with whomever filed the grievance.
2. Resident #7 was admitted to the facility on 5/10/2016 with the diagnoses of chronic pain syndrome, heart failure, and peripheral neuropathy.

Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated for 7/3/18 revealed that Resident #7 was cognitively intact, required one person extensive to total assistance for all activities of daily living (ADLs).

During an interview with Resident #7 on 8/12/18 at 3:55 PM she stated that she had a meeting with the Ombudsman regarding her daily routine not being carried out the way she wanted it to be on 8/9/18. They had discussed that Resident #7 wanted to have incontinence care provided at 2:00 PM and 6:00 PM. She stated that she wanted her dinner around 7:00 PM, and to have coffee served at 8:00 PM. She then stated that she wanted her medications at 9:20 PM, then to be set up after dinner to brush her teeth, do her daily devotions, put her night clothes on, and then to go to bed at 9:30 PM. She stated that staff was then to come in and check on her at 2:00 AM and at 6:00 AM. The Ombudsman had told resident #7 that she was going to speak with the Director of Nursing (DON) about the daily schedule the resident preferred. Resident #7 stated that the DON and the Assistant Director of Nursing (ADON) came to her room on 8/10/18 to discuss the matter. They had planned for the resident to have a care plan meeting on 8/16/18 to establish the best schedule for the resident and were going to add it to her care plan.

During an interview with the Ombudsman on

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 08/14/2018

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 585	Continued From page 12 8/13/18 at 10:30 AM she verified that the resident had verbally shared her concerns regarding her daily routine. She stated that she had discussed the concerns the resident had shared with her with the DON on 8/9/18. The DON stated she would follow-up with the resident to resolve the issues. Review of the Grievance Log from January 2018 through 8/14/18 revealed that no grievances had been filed or documented for Resident #7. During an interview with the DON on 8/14/18 at 3:35 PM she stated that her and the ADON had a meeting with Resident #7 on 8/10/18 after speaking with the Ombudsman. The resident had verbally informed the DON and ADON of several concerns she had about her daily care. When asked if she had any documentation about the meeting and/or plan to resolve the resident's concerns, she stated that she did not have any documentation. She stated that it was her expectation that the grievance policy be followed and that the Quality Assurance Committee had already identified problems regarding the grievance process and was developing a plan to address the issue.	F 585		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		9/23/18

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 08/14/2018

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 684	Continued From page 13 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review staff and family interviews the facility failed to provide skin treatment for one of one sampled residents for dermatitis of the face. Resident #5 The findings included: Resident #5 was admitted to the facility on 12/29/16 with diagnoses that included diabetes type 2 and seborrhea dermatitis. Review of a physician's progress note dated 12/2017 indicated Resida residenent #5 had seborrhea dermatitis and was ordered a medicated cream to be applied twice a day to his face and eye brows. The Minimum Data Set (MDS) dated 7/18/18 indicated Resident #5 had moderate impairment with short and long term memory and required extensive assistance of one staff with bathing and dressing. Review of the August 2018 signed physician orders included the use of a medicated cream for dermatitis on his face and eye brows. The order instructed nursing to apply the cream twice a day. Review of the Treatment Administration Record (TAR) for August 1st to the 14th, 2018 revealed the cream was to be applied at 2:00 PM and 10:00 PM. Review of the nurses' initial revealed documentation was present indicating the cream had been applied 2 of the 14 days on day shift at 2:00 PM and 4 of the 14 days on evening shift at 10:00 PM.	F 684	F684 1. Facility failed to provide skin treatment for Resident #5 for dermatitis of the face. The skin treatment was discontinued for the face on 8/24/18. The order was clarified and the skin treatment is for buttocks and abdominal folds. 2. Audit of all residents with topical treatment will be conducted to ensure they are being administered as ordered. 3. Licensed staff and Medication Aides will be educated on applying topical treatments as ordered. Nurse Managers will conduct audits to ensure that topical treatments are applied as ordered. This audit will occur weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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 08/14/2018

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 684	Continued From page 14 Observations of Resident #5 on 8/13/18 at 10:06 AM revealed the resident had red, scaly skin on his face. Interview on 8/13/18 at 1:30 PM with a family member revealed she visited often, and his face was usually dry, red and scaly. The family member explained the nursing staff was supposed to apply a cream to his face for this condition. Interview with nursing assistant (NA) #1 on 8/13/18 at 10:10 AM revealed he providing care for Resident #5 that day. NA #1 was not aware of any cream that was to be applied to Resident #5's face. Interview on 8/14/18 at 10:41 AM with Nurse #1, responsible for Resident #5's care, revealed she was not aware of any cream for Resident #5's face. She explained the treatment nurse would apply any creams for residents. Interview on 8/14/18 at 11:30 AM with the treatment nurse revealed the floor nurses applied physician ordered creams for residents. She explained she did the major wound care and would write orders for the floor nurses to apply creams and would indicate the shift that was responsible for the treatment on the TAR. Interview with the Director of Nursing on 8/14/18 at 3:25 PM revealed the floor nurses were to apply creams that were ordered by the physician. The treatment nurse provided care for the major wounds in the facility.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k)	F 697		9/23/18

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 08/14/2018

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 697	Continued From page 15 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, resident, and physician interviews the facility: 1) Failed to follow physician orders for prescribed pain medication doses and failed to reorder pain medications from the pharmacy to prevent delay in administering prescribed pain medications for 1 of 2 residents (Resident #7) reviewed for pain management. Resident #7 experienced increased nerve pain when staff failed to administer her routine pain medication as ordered and when she received a decreased dosage of her prescribed pain medication; and, 2) Failed to initiate a new physician ' s order for a transdermal (through the skin) fentanyl patch (an opioid pain medication) for a period of 3 days; and, failed to apply and remove a fentanyl patch in accordance with the physician ' s orders for 1 of 2 residents (Resident #8) reviewed for pain management. Findings include: 1. Resident #7 was admitted to the facility on 5/10/2016 with the diagnoses of chronic pain syndrome and peripheral neuropathy. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated for 7/3/18 revealed that Resident #7 was cognitively intact, required one person extensive to total assistance for all activities of daily living (ADLs). It also	F 697	F697 1. Facility failed to follow physician orders for a prescribed pain medication doses and failed to reorder pain medications from the pharmacy to prevent delay in administering prescribed pain medications for Resident #7. This was due to an oversight. Facility reordered Resident #7 pain medication. Facility failed to initiate a new physician□s order for a transdermal fentanyl patch for a period of 3 days; and, failed to apply and remove a fentanyl patch in accordance with the physician□s orders for Resident #8. This was due to an oversight. Medication error report completed for missed doses on 8/2 & 8/8 2. Audit of all residents on controlled substance(s) to ensure the medication and correct dose is available. Audit all residents with fentanyl patches to ensure they are applied and removed as ordered. 3. Licensed staff educated to notify physician if correct dose and/or controlled substance(s) not available.	

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 08/14/2018

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 697	Continued From page 16 documented the resident was on a scheduled pain medication regimen for almost constant moderate pain and received opioids 7 of 7 days during that assessment period. Review of the resident's August Physician Orders revealed the following medication orders: Original Order Date: 5/27/17 Lyrica 75 (milligrams) mg capsule (Nerve pain medication) - Take 1 tab by mouth (PO) two times (BID) daily 5/27/17 Lyrica 100mg capsule - Take 1 capsule PO at hour of sleep (HS) 5/27/17 Pain Assessment during every shift (6:00 AM/2:00 PM/10:00 PM) Review of the resident's June 2018 Medication Administration Record (MAR) revealed the Lyrica 75 mg dose had an "N" (Not Given) documented for the 6/24/18 8:00 AM and 5:00 PM doses and again on 6/25/18 for the 8:00 AM dose. In the note section of the MAR on 6/24/18 at 5:13 PM Med Aide #1 documented the medication was not available. On 6/25/18 at 2:16 PM it was also documented that the medication was not available. The Lyrica 100 mg ordered to be given at 8:00 PM was administered for all these dates. Review of the Declining Inventory Log for Lyrica 75 mg dated to start on 6/8/18 revealed that the last dose of this medication supply from the pharmacy was administered on 6/22/18. Review of the resident #7's June 2018 MAR revealed the Lyrica 75 mg dose documented to be administered on 6/25/18 for the 5:00 PM dose, however the next Declining Inventory Log for Lyrica 75 mg was dated to start on 6/26/18 at	F 697	Licensed staff will be educated on the six rights of medication administration. Nurse Managers and/or Coordinator will audit the declining narcotic sheets for residents prescribed controlled substance(s). The Nurse Manager will be notified if a hard script is needed and ensure that controlled substance(s) was ordered and delivered to the facility. Nurse Managers and/or Coordinator will audit to ensure that residents with fentanyl patch to ensure they are applied and removed as ordered. Director of Nursing and/or designee will monitor all residents prescribed controlled substance(s) to ensure the medication and correct dose is available. This audit will occur weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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 08/14/2018

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 697	Continued From page 17	F 697		

10:00 AM.

Review of Resident #7's June 2018 MAR revealed on 6/25/18 at 6:00 AM that the resident had a pain level of 0 out of 10 (the 0-10 pain scale) and there was no documentation for pain assessments for the 2:00 PM and 10:00 PM assessments for that date. On 6/26/18 the resident was documented to have a pain level of 0 at 6:00 AM, and for the 2:00 PM pain assessment the resident had reported a pain level of 10 out of 10 (worst pain level on the 0-10 pain scale) to Nurse #7. For the 10:00 PM assessment on 6/27/18 the resident reported a 7 out of 10 pain level.

Review of the resident's August 2018 MAR revealed that on 8/10/18 Med Aid #1 documented the resident had not received her 8:00 PM Lyrica 100mg dose due to the medication being unavailable.

Review of the Declining Inventory Logs for Lyrica 100 mg revealed that the last dose of the medication was administered on 8/9/18 at 9:00 PM.

During an interview with Resident #7 on 8/12/18 at 3:55 PM she stated that she did not receive her Lyrica for approximately three days in June 2018. She stated that her neuropathy pain was horrible during that time, that she remembered reporting to the nurse that her pain level was a 10 out of 10. When the resident had asked about the medication, the staff just kept telling her they were out of the medication and were waiting on it to be dispensed from the pharmacy. When asked if she had received other pain medications, Resident #7 stated she had received her other

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 08/14/2018

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 697	Continued From page 18	F 697		

scheduled pain medication. She also stated that her nerve pain was only relieved by Lyrica and that other pain medications didn't relieve that type of pain for her. She stated that she did not think she was getting the correct dose of Lyrica currently (as of 8/12/18), and that she had thought she was getting less than prescribed. She had asked staff (couldn't remember who) about her night time dose of 100 mg of Lyrica and was told that they were administering the 75 mg dose until the 100 mg dose arrived from pharmacy. She stated that she could tell a difference in the decreased dosage due to having more pain in her legs during the night.

An observation and review on 8/12/18 at 4:15 PM of the current Declining Inventory Logs being used by staff to administer medications revealed that there was no log for the Lyrica 100 mg dose.

An interview with Nurse #7 was unable to be completed during the investigation.

During an interview with Nurse #2 on 8/13/18 at 3:30 PM she stated that staff tried to avoid running out of medications, but that if it happened that they would check the back-up medication kit to see if the medication was available. If it wasn't, then the on-call provider would be contacted for instructions and sometimes an order for an alternate medication would be placed until the medication was delivered from the pharmacy.

During an interview with Pharmacy Director/Owner on 8/13/18 at 3:44 PM he stated that Resident #7's prescriptions for Lyrica 75mg (28 pills) and 100 mg (14 pills) were dispensed in 14-day supply due to insurance reasons. The last date that the Lyrica 100 mg was dispensed from

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 08/14/2018

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 697	Continued From page 19	F 697		

the pharmacy was on 7/25/18. There were no pending refills placed for the dose of 100 mg Lyrica for Resident #7 at the time of this interview.

During an interview on 8/14/18 at 2:45 PM with Med Aide #1 she stated that on 8/10/18 she had notified Nurse #1 that the 100 mg Lyrica medication had ran out. Nurse #1 told her to administer the 75 mg Lyrica dose instead until the 100 mg dose was ordered and delivered from the pharmacy. She stated that she administered the 75 mg dose in place of the 100 mg dose of Lyrica and signed it out in the Declining Inventory Logs for Lyrica 75 mg. When asked if she had noticed an increase in Resident #7's pain level she stated that the resident had chronic pain and she could not determine if there was a difference.

Review of the Declining Inventory Logs for Lyrica 75 mg revealed that on 8/10/18, 8/11/18, and 8/12/18 the medication was administered three times per day confirming the 75 mg dose of Lyrica was being administered in place of the ordered 100 mg dose of Lyrica.

During an interview with Nurse #1 on 8/14/18 at 2:54 PM she stated that she had instructed Med Aide #1 to administer the 75 mg of Lyrica in place of the ordered 100 mg dose. When asked if she had called the physician or the on-call provider to obtain an order to use the 75 mg Lyrica as an alternate dose for the prescribed 100 mg dose she stated that she did not. She also stated that she had not notified the pharmacy to refill the prescription.

During an interview with the Physician on 8/14/18 at 3:15 PM he stated that medications should not run out if staff are ordering them correctly, but if it

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 08/14/2018

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 697	Continued From page 20	F 697		

did happen that they were expected to call the on-call provider immediately if the medication is not available in the facility's back-up medication kit. Depending on the medication, an alternate could be ordered and in Resident #7's case an order to substitute the 100 mg dose of Lyrica with the 75 mg could have been a possibility. He stated that no one other than another physician or other licensed provider should change prescribed medication doses ordered by the physician.

During an interview with the Director of Nursing on 8/14/18 at 3:35 PM she stated that it was her expectation that all medications are administered per the physician's order and only to be altered by the physician or on-call provider.

2. Resident #8 was admitted to the facility on 7/27/18 from a hospital. His cumulative diagnoses included a compression fracture of the 7th and 8th thoracic vertebrae. Thoracic vertebrae comprise the middle segment of the backbone.

A review of Resident #8 ' s medical record included a physician ' s progress note dated 8/2/18 which read, in part, "Please note that pain control is necessary for continual participation with rehab."

A review of the resident ' s Physician ' s Orders included an order dated 8/2/18 for a 12 micrograms (mg) / hour (hr) fentanyl patch to be applied to the skin once every 72 hours. Fentanyl is a potent, long-acting opioid medication which may be administered transdermally (through the

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 08/14/2018

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 697	Continued From page 21	F 697		

skin) by the application of a patch. According to the product manufacturer, a fentanyl patch should be changed every 72 hours. The old fentanyl patch should be removed before the new patch is applied.

A review of the Resident #8 ' s admission Minimum Data Set (MDS) assessment dated 8/3/18 revealed the resident had intact cognitive skills for daily decision making. The resident required extensive assistance from staff for bed mobility, transfers, locomotion on the unit, dressing, toileting and personal hygiene. He was independent for eating. Section J of the MDS revealed the resident received scheduled and as needed (PRN) medications for frequent pain rated as a 5 out of 10 (on a scale of 0 to 10, with "0" indicative of no pain and "10" as the worst pain imaginable).

A review of Resident #8 ' s care plan included an area of focus related to his potential for pain (dated 8/5/18). The interventions for this care area included, in part, to administer pain medications as ordered.

Further review of the resident ' s Physician Orders revealed a new order was received on 8/8/18 to initiate tramadol (an opioid pain medication) to be given as 25 mg three times daily for pain. An order was also written to discontinue the 325 mg acetaminophen (an over-the-counter pain medication) previously prescribed as 2 tablets by mouth every 4 hours as needed for mild/moderate pain; and, to initiate a scheduled dose of 500 mg acetaminophen to be given as 2 tablets by mouth three times daily.

An observation was conducted on 8/14/18 at 8:32

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 08/14/2018

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 697	Continued From page 22	F 697		

AM as Nurse #4 prepared medications to be administered to Resident #8. Prior to applying a new fentanyl patch to the resident ' s skin, the nurse was observed as he found one fentanyl patch on the resident ' s right side of his back and another one on the left side of his back. One of the fentanyl patches was dated 8/5/18 and the other one was dated 8/11/18. The nurse removed both of the patches prior to applying a new 12 mcg/hr fentanyl patch to the resident ' s skin.

An interview was conducted on 8/14/18 at 8:45 AM with Resident #8. During the interview, the resident was asked whether his level of pain had changed during his stay at the facility. The resident reported it had not. The resident stated his level of pain primarily changed based on positioning. He reported having more pain when sitting up versus when he was lying down in bed.

A review of Resident #8 ' s August 2018 Medication Administration Record (MAR) revealed one - 12 mcg/hr fentanyl patch was applied to the resident on each of the following dates: 8/5/18, 8/11/18, and 8/14/18. No fentanyl patch was documented as having been applied prior to 8/5/18. The fentanyl patch scheduled to be applied on 8/8/18 at 9:00 AM was not documented as done. The MAR included documentation of varying levels of pain reported by the resident, ranging from "0" to "6" (with no significant trends noted between 8/2/18 and 8/14/18).

A review of the resident ' s Controlled Substance declining inventory sheet (also known as a Narcotic Log) revealed 10 fentanyl patches were dispensed from the pharmacy for Resident #8 on

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 08/14/2018

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 697	Continued From page 23	F 697		

8/2/18. One fentanyl patch was removed from the inventory on each of the following dates: 8/5/18, 8/11/18, and 8/14/18. Seven fentanyl patches remained in the inventory stored on the medication cart for this resident.

An interview was conducted with the facility ' s Director of Nursing (DON) in the presence of the Administrator on 8/14/18 at 10:38 AM. During the interview, the DON stated she would expect the nurses to check for the placement / removal of a fentanyl patch every day and to change the fentanyl patch in accordance with the physician orders.

An interview was conducted on 8/14/18 at 11:52 AM with Nurse #5. Nurse #5 was identified by her initials on the MAR as the nurse who was assigned to Resident #8 ' s hall on the 1st shift of 8/8/18. Upon review of the resident ' s August MAR, the nurse reported it would have been the Med Aide ' s responsibility to apply the fentanyl patch on that date.

An interview was conducted on 8/14/18 at 11:55 AM with Med Aide #2. Med Aide #2 was identified by her initials on the MAR as the Med Aide who was assigned to Resident #8 ' s hall on the 1st shift of 8/8/18. Upon review of the resident ' s MAR, the Med Aide stated she was, "Not sure if I just didn ' t see it (the fentanyl patch needing to be applied) or if I overlooked it."

A follow-up interview was conducted on 8/14/18 at 2:30 PM with Nurse #5. During the interview, Nurse #5 reported the order for Resident #8 ' s fentanyl patch was put into the computer at 2:09 PM on 8/2/18 and it was initially scheduled to be applied at 9:00 AM on 8/2/18. She explained 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 08/14/2018

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 697	Continued From page 24 since the time of the initial scheduled dose was already past when the order was put into the computer, the system automatically scheduled the next dose for 72 hours later (which would have been 8/5/18 at 9:00 AM). Nurse #5 stated, "It ' s an education issue." A follow-up interview was conducted on 8/14/18 at 2:50 PM with the DON. During the interview, the DON reported her expectation would have been for the fentanyl patch to start the day after the physician ' s order was written (8/3/18). A telephone interview was conducted on 8/14/18 at 3:02 PM with the resident ' s physician. During the interview, the physician was asked when he would have expected Resident #8 ' s fentanyl patch to be applied if it was ordered on 8/2/18. The physician responded by saying, "Immediately." The physician was then asked for his thoughts on the delay in initiation of the fentanyl patch until 8/5/18, the missed fentanyl patch placement on 8/8/18, and the missed fentanyl patch removal (of the patch applied on 8/5/18) when a new patch was applied on 8/11/18. The physician stated that in view of the fact that the order was written and they had the medication, he would have expected the resident to receive the medication as ordered.	F 697		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		9/23/18

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 08/14/2018

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 755	Continued From page 25 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observations and Physician, resident, pharmacy and staff interviews, the facility failed to acquire and administer pain medication as ordered by the physician for 1 of 1 sampled residents (Resident #7) reviewed for medication administration. Resident #7 experienced increased nerve pain when staff failed to notify the pharmacy regarding the required refill of her nerve pain medication, which delayed the dispense of the medication, as well as the ordered treatment for her nerve pain management.	F 755	F755 1. Facility failed to acquire and administer pain medication as ordered by the physician for Resident #7. Facility obtained correct dose of medication on 8/17/18. 2. Audit of all residents on controlled substance(s) conducted to ensure the medication and correct dose is available.	

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 08/14/2018

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 755	Continued From page 26 Findings include: 1. Resident #7 was admitted to the facility on 5/10/2016 with the diagnoses of chronic pain syndrome and peripheral neuropathy. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated for 7/3/18 revealed that Resident #7 was cognitively intact, required one person extensive to total assistance for all activities of daily living (ADLs). It also documented the resident was on a scheduled pain medication regimen for almost constant moderate pain and received opioids 7 of 7 days during that assessment period. Review of the resident's August Physician Orders revealed the following medication orders: Original Order Date: 5/27/17 Lyrica 75 (milligrams) mg capsule (Nerve pain medication) - Take 1 tab by mouth (PO) two times (BID) daily 5/27/17 Lyrica 100mg capsule - Take 1 capsule PO at hour of sleep (HS) 5/27/17 Pain Assessment during every shift (6:00 AM/2:00 PM/10:00 PM) Review of the resident's June 2018 Medication Administration Record (MAR) revealed the Lyrica 75 mg dose had an "N" (Not Given) documented for the 6/24/18 8:00 AM and 5:00 PM doses and again on 6/25/18 for the 8:00 AM dose. In the note section of the MAR on 6/24/18 at 5:13 PM Med Aide #1 documented the medication was not available. On 6/25/18 at 2:16 PM it was also documented that the medication was not available.	F 755	3. Licensed staff educated to notify physician if correct dose and/or controlled substance(s) not available. Licensed staff will be educated on the six rights of medication administration. Nurse Managers and/or Coordinator will audit the declining narcotic sheets for residents prescribed a controlled substance(s). The Nurse Manager will be notified if a hard script is needed and ensure that controlled substance(s) was ordered and delivered to the facility. Director of Nursing and/or designee will monitor all residents prescribed controlled substance(s) to ensure the medication and correct does is available. This audit will occur weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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 08/14/2018

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 755	Continued From page 27	F 755		

Review of Resident #7's June 2018 MAR revealed on 6/26/18 the resident had reported a pain level of 10 out of 10 (worst pain level on the 0-10 pain scale) to Nurse #7.

Review of the resident's August 2018 MAR revealed that on 8/10/18 Med Aid #1 documented the resident had not received her 8:00 PM Lyrica 100mg dose due to the medication being unavailable.

During an interview with Resident #7 on 8/12/18 at 3:55 PM she stated that she did not receive her Lyrica for approximately three days in June 2018. She stated that her neuropathy pain was horrible during that time, that she remembered reporting to the nurse that her pain level was a 10 out of 10. When the resident had asked about the medication, the staff just kept telling her they were out of the medication and were waiting on it to be dispensed from the pharmacy. When asked if she had received other pain medications, Resident #7 stated she had received her other scheduled pain medication. She also stated that her nerve pain was only relieved by Lyrica and that other pain medications didn't relieve that type of pain for her. She stated that she did not think she was getting the correct dose of Lyrica currently (as of 8/12/18), and that she had thought she was getting less than prescribed. She had asked staff (couldn't remember who) about her night time dose of 100 mg of Lyrica and was told that they were administering the 75 mg dose until the 100 mg dose arrived from pharmacy. She stated that she could tell a difference in the decreased dosage due to having more pain in her legs during the night.

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 08/14/2018

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 755	Continued From page 28	F 755		

During an interview with Nurse #2 on 8/13/18 at 3:30 PM she stated that staff tried to avoid running out of medications, but that if it happened that they would check the back-up medication kit to see if the medication was available. If it wasn't, then the on-call provider would be contacted for instructions and sometimes an order for an alternate medication would be placed until the medication was delivered from the pharmacy.

During an interview with Pharmacy Director/Owner on 8/13/18 at 3:44 PM he stated that Resident #7's prescriptions for Lyrica 75mg (28 pills) and 100 mg (14 pills) were dispensed in 14-day supply due to insurance reasons. The last date that the Lyrica 100 mg was dispensed from the pharmacy was on 7/25/18. There were no pending refills placed for the dose of 100 mg Lyrica for Resident #7 at the time of this interview.

During an interview with Nurse #1 on 8/14/18 at 2:54 PM she stated that she had instructed Med Aide #1 to administer the 75 mg of Lyrica in place of the ordered 100 mg dose. When asked if she had called the physician or the on-call provider to obtain an order to use the 75 mg Lyrica as an alternate dose for the prescribed 100 mg dose she stated that she did not. She also stated that she had not notified the pharmacy to refill the prescription.

During an interview with the Physician on 8/14/18 at 3:15 PM he stated that medications should not run out if staff are ordering them correctly, but if it did happen that they were expected to call the on-call provider immediately if the medication is not available in the facility's back-up medication kit. Depending on the medication, an alternate could be ordered and in Resident #7's case an

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 08/14/2018

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 755	Continued From page 29 order to substitute the 100 mg dose of Lyrica with the 75 mg could have been a possibility. During an interview with the Director of Nursing on 8/14/18 at 3:35 PM she stated that it was her expectation that all medications are administered per the physician's order.	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		9/23/18

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 08/14/2018

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 880	Continued From page 30 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to disinfect a shared glucometer	F 880	F880	

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 08/14/2018

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 880	Continued From page 31 (device used to measure a resident ' s blood glucose or blood sugar level) after the glucometer was used on one resident and prior to staff intending to use it on another for 1 of 5 residents (Resident #8) observed to have blood glucose monitoring. The findings included: A review of the facility ' s policy entitled, "Blood Sampling Capillary (Finger Sticks)" and revised on September 2014 was conducted. The policy included procedures to guide the safe handling of capillary-blood sampling devices to prevent the transmission of bloodborne diseases to residents and employees. The General Guidelines of this policy read, in part: 1) "Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses ...." On 8/14/18 at 8:25 AM, Nurse #4 was observed as he used a glucometer to obtain a blood glucose reading for Resident #9. After checking the resident ' s blood glucose, a continuous observation was made as the nurse set the glucometer used for Resident #9 on top of the medication cart. The glucometer was not disinfected. Nurse #4 then prepared medications to be administered to Resident #8. On 8/14/18 at 8:32 AM, the nurse gathered the medications, along with the equipment and supplies to do a blood glucose check for Resident #8 (including the same glucometer used for Resident #9), and entered the resident ' s room. Nurse #4 set the blood glucose supplies and the shared glucometer next to Resident #8 and picked up an alcohol wipe to initiate the blood glucose check. At that point, the nurse was asked to stop the	F 880	1. Facility failed to disinfect a shared glucometer after the glucometer was used on one resident and prior to staff intending to use it on another for Resident #8 observed to have blood glucose monitoring. Nurse was re-educated on 8/14/18 by SDC on the proper glucometer cleaning methods. 2. Licensed Staff and Certified Medication Aides were educated by the DON and/or SDC on the proper glucometer cleaning process. 3. Glucometer skill checks will be conducted weekly by the SDC, DON and Unit Managers, on all shifts with licensed staff to ensure the proper glucometer cleaning methods. Weekly audits will continue for 12 weeks by the Nurse Managers. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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 08/14/2018

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 880	Continued From page 32	F 880		

procedures and a request was made for him to step out into the hallway. While in the hallway, Nurse #4 was asked when he would need to disinfect the glucometer previously used for Resident #9. The nurse responded by saying, "I should have grabbed his (Resident #8 ' s) meter." The nurse then retrieved a different glucometer from the medication cart for Resident #8 ' s use, re-entered the resident ' s room, and completed the blood glucose check. After returning to the medication cart, Nurse #4 was observed as he disinfected the glucometers used for Resident #9 and Resident #8.

An interview was conducted on 8/14/18 at 8:40 AM with Nurse #4. During the interview, the nurse confirmed each resident who required blood glucose testing had his/her own glucometer. He was unable to explain why he had opted to use another resident ' s glucometer for Resident #8.

An interview was conducted on 8/14/18 at 10:38 AM with the facility ' s Director of Nursing (DON) in the presence of the Administrator. During the interview, the DON was asked what her expectation was in regards to the use of a shared glucose meter. The DON stated if one was used, she would expect it to be disinfected between each resident.