PRINTED: 08/05/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
345548		B. WING		C 06/18/2015			
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COL 5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301		10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	F 0	00			
F 225 SS=D	compliant investiga Event ID # OCWN1	(c)(2) - (4) PORT	F 2	25		7/10/15	
	been found guilty or mistreating resident had a finding entered registry concerning of residents or mistand report any known court of law against indicate unfitness for	of employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a transpection and an employee, which would or service as a nurse aide or the State nurse aide registry ties.					
	involving mistreatm including injuries of misappropriation of immediately to the to other officials in	isure that all alleged violations tent, neglect, or abuse, is unknown source and is resident property are reported administrator of the facility and accordance with State law disprocedures (including to the pertification agency).					
	violations are thoro	ave evidence that all alleged ughly investigated, and must ential abuse while the rogress.					
	to the administrator representative and	vestigations must be reported or his designated to other officials in accordance uding to the State survey and					
_ABORATOR\	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	

Electronically Signed

07/02/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345548		B. WING) 18/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	10/2010
				5533 BURLINGTON ROAD		
ASHTON	PLACE HEALTH AN	D REHAB	r	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			(X5) COMPLETION DATE
F 225	incident, and if the	age 1 /) within 5 working days of the alleged violation is verified tive action must be taken.	F 225			
	by: Based on record r facility failed to sub day report to The N Personnel Registry (Resident # 26). Finding include: Resident #26 was	NT is not met as evidenced eview and staff interview, the mit a 24 hour and 5 working North Carolina Health Care for 1 of 3 sampled residents admitted to the facility on		Based on record review and staff interview, the facility failed to subm hour and 5 working day report to T North Carolina Health Care Persor Registry for 1 of 3 sampled resider (Resident # 26). Finding included:	the nnel nts	
	Lack of Coordinatic Weakness-General (joint disease), and A review of the quation 5/10/2015 revealed deficit; was able to no behavior during and she was extendination and transfer services.	II, Hypertension, Arthropathy I Hyperlipemia. Interly Minimum Data Set dated I Resident #26 had no hearing communicate her needs; had the 7 day look back period; sive assistance for bed er. Resident #26 had a Brief		Resident #26 was admitted to the on 5/1/2015 with the active diagno which included Lack of Coordination Muscle Weakness-General, Hypertension, Arthropathy (joint diagnoth Hyperlipemia. A review of the quarterly Minimum Set dated 5/10/2015 revealed Res #26 had no hearing deficit; was abcommunicate her needs; had no between the state of the s	ses on, sease), Data ident le to ehavior	
	A review of the fact 6/1/2015 for Resident NA (nurse assistant to a roommate whe Resident #26 indicher the night before when turning her.	al Status (BIMS) score of 15 cognitively intact. Ility grievance report dated ent #26 revealed on 5/28/2015 at 1 refused to provide snack en requested. On 5/29/2015 ated that NA #1 was rough with e and " jerked her around " Resident #26 stated that NA #1 NA #1 stated to Resident #26		during the 7 day look back period; she was extensive assistance for the mobility and transfer. Resident # 2 Brief Interview for Mental Status (Escore of 15 revealing she was cognitact. A review of the facility grievance redated 6/1/2015 for Resident #26 red on 5/28/2015 NA (nurse assistant) refused to provide snack to roomn	ped 6 had a BIMS) nitively eport evealed #1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345		345548	B. WING			C 06/18/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	06/	10/2015
INAIVIE OF I	-ROVIDER OR SUPPLIER						
ASHTON	PLACE HEALTH AN	D REHAB			533 BURLINGTON ROAD		
				M	ICLEANSVILLE, NC 27301		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225			F 2	25	when requested On 5/00/2045 De	aid a sat	
	concern saying " v and tell staff?" On	embers told her about her why you running your mouth 5/28/2015 an email was sent			when requested. On 5/29/2015 Res #26 indicated that NA #1 was rough her the night before and " jerked h	n with er	
		or to discuss Resident #26 's Resident #26 told 3 staff			around " when turning her. Reside stated that NA#1 was " nasty " are		
	members the same	e story as above. In addition			#1 stated to Resident #26 that fello	w staff	
		the Social Worker that NA #1 (26) that NA #1 would fix you			members told her about her concersaying "why you running your mou		
		d NA #1 will wake you every			tell staff? " On 5/28/2015 an Email		
		Resident #26 was very specific			sent to the unit supervisor to discus		
		Occumentation was received at care was provide for			Resident #26 's concern with staff. Resident #26 told 3 staff members		
	Resident #26 without	out any problems. On 6/1/2015			same story as above. In addition R	esident	
		sing (DON) and Assistant			#26 told the Social Worker that NA		
		met with NA #1 to discuss the potential for abuse. NA#1			her (resident #26) that NA #1 would you tomorrow night and NA #1 will		
	denied any allegati	on of abuse (being rough or			you every hour on the hour. Reside		
	jerked Resident #2	6 bad arm).			was very specific that it was NA#1. Documentation was received from	hoth	
	Interview with the [OON on 6/16/2015 at 3:30pm			NA's that care was provide for Re		
		ition was not reported to the			#26 without any problems. On 6/1/2	2015	
		completed her investigation daccording to staff this			the Director of Nursing (DON) and Assistant Director of Nursing met w	/ith NA	
		place. The DON also			#1 to discuss the concerns and the		
		vestigation was done and			potential for abuse. NA#1 denied a		
		d from the care and treatment he DON indicated Resident			allegation of abuse (being rough or Resident #26 bad arm).	jerkea	
	#26 had a history of	of telling wrong things and			ŕ		
		appen. The DON indicated that			Interview with the DON on 6/16/20		
		sident #26 's family about the agreed to a care plan to			3:30pm revealed the allegation was reported to the state because she	s not	
	address Resident				completed her investigation within 2	24hrs	
	Intonious with the - N	JA #1 on 6/17/2015 of 11:00			and according to staff this incident		
		NA #1 on 6/17/2015 at 11:00am er care rounds at the start of			took place. The DON also indicated an investigation was done and this		
		ncerns and at 5am she got			was removed from the care and tre		
		ber, NA# 2 to help her with			of Resident #26. The DON indicate		
		use she required two person			Resident #26 had a history of telling		
		activity of daily living care. NA			wrong things and things that never	,	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345548	B. WING			C 06/18/2015	
NAME OF I	PROVIDER OR SUPPLIER	040040	3		TREET ADDRESS, CITY, STATE, ZIP CODE	06/	18/2015
NAIVIE OF I	PROVIDER OR SUPPLIER						
ASHTON	PLACE HEALTH AND	O REHAB			533 BURLINGTON ROAD		
				N	ICLEANSVILLE, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225			F 2	25	TI DON' II 4 14 4 1		
	hold her left arm [basheet to put Reside provided peri-care.	ne always got Resident #26 to ad arm] and she used a draw ant #26 closer to her and she NA#1 indicated that she never cive to Resident #26 during her			happen. The DON indicated that she spoke with Resident #26 's family the concern and family agreed to a plan to address Resident #26 's be	about care	
	am care. She repor to any of her reside	ted she would never talk ugly nts. NA#1 reported she was o go into Resident #26 ' s			Interview with the NA #1 on 6/17/20 11:00am revealed she did her roun the start of her shift with no concer at 5am she got another staff members to help her with Resident #26 bed	ds at ns and per NA#	
	6/17/2015 at 3pm s was very rough with arm during care. Re not had any contact Resident #26 indica	with Resident #26 on he revealed she report NA #1 her and she jerked her bad esident #26 reported she had t with NA#1 since that night. her care since that night.			she required two person assistance activity of daily living care. NA #1 in that she always got Resident #26 to her left arm and she used a draw s put Resident #26 closer to her and provided peri-care. NA#1 indicated she never said anything negative to	e for idicated o hold heet to she that	
	An interview with th revealed that the D	e Administrator on 6/18/2015 ON did not submit the 24 hour completed the investigation			Resident #26 during her am care. S reported she would never talk ugly of her residents. NA#1 reported she no longer allowed to go into Reside 's room to provide care.	She to any e was	
					During an interview with Resident # 6/17/2015 at 3pm she revealed she NA #1 was very rough with her and jerked her bad arm during care. Re #26 reported she had not had any with NA#1 since that night. Resider indicated that she had not had any problems with her care since that n	e report she esident contact nt #26 other	
					During an interview with the Adminion 6/18/2015 revealed that the DO not submit the 24hr report because completed the investigation within a timeframes.	N did she	
					Per Facility		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548			` ,	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		B. WING		С		
		343546	B. WING _		06/	18/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHTON	I PLACE HEALTH AN	D REHAB		5533 BURLINGTON ROAD		
7.0111.01.				MCLEANSVILLE, NC 27301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4		F 22	All allegations of mistreatement, ror abuse, including injuries of unk source and misappropriation of reproperty will be reported accordin State law within 24 hours. Investi of such situations will include intered record review and the circum surrounding the alleged incident. results will be communicated to the appropriate State agencey within Instances of such situations will be included as part of the QAA meet three times a month and then qual and discussed as approropriate. All staff will be inserviced on paties and the proper procedures by 07/ Updated plan of correction All employees hired by Ashton Plascreened for prior history of abuse addition to other licensing and background checks prior to employent of all new hires include extensive education related to Ab Neglect as well as the Elder Justie All employees receive annual re-education/updates on Abuse and Neglect during our annual educat If necessary, additional education provided as needed. In relationsh deficiency, all staff have been rein-serviced and was completed 7/10/15. All employees are experienced incidents of immediately and ensure that the results and the state of the property and the property and the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and ensure that the results are supported to the property and the pro	nown esident g to gations rviews, estances. The estances of the estances of the estance of the e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` ,	E SURVEY IPLETED
		345548 B. WING			C 06/18/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI		10/2013
				5533 BURLINGTON ROAD	_,	
ASHTON	PLACE HEALTH AN	D REHAB		MCLEANSVILLE, NC 273	01	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 225	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 2	is protected. All allegations of mistrabuse including injuries source and misappropayill be reported per strategies that may he issues. All allegations of mistrabuse including injuries source and misappropayill be reported per strategies that may he issues. The investigation of all include resident/staff is record review and the surrounding the allegent as notification to the record review and the surrounding the investigation of all include resident/staff in record review and the surrounding the allegent as notification to the record review and the surrounding the investigation of all include resident/staff in record review and the surrounding the investigation of all include resident/staff in record review and the surrounding the investigation of all include resident/staff in record review and the surrounding the investigation of all include residents as a proprieta in record review and the surrounding the investigation of all include residents are also monitor and the include residents are a	es of unknown priation of property ate law within the se. Staff involved in one will be removed investigative ement will also be es. Inappropriate se, family/visitors or pred for potential secircumstances ed incident as well esponsible party. Estigation will be appropriate state and days. Situations I will result in the ployee and siticensing boards with residents and/or larly to help identify cern and devlop elp resolve these efforts to ensure tion will be ory staff will intervene behaviors.	

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345548	B. WING			C / 18/2015	
	PROVIDER OR SUPPLIE I PLACE HEALTH A			STREET ADDRESS, CITY, STATE, ZIP C 5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 225	Continued From p	page 6	F 2	Director of Nursing or her dimeet with the resident at leadiscuss any issues the residence perceived concerning her caddress as appropriate. Allegations that have been will be reported monthly in the Assurance/Quality Improve x3 and discussed as appropriate and discussed and was composed as needed. In reladed deficiency, all staff have be rein-serviced and was composed and was composed and was composed and discussed and discussed incides immediately and ensure that is protected. All allegations of mistreatm abuse including injuries of usource and misappropriation will be reported per state latestablished quidelines. Staff	investigated the Quality ement Meeting priate. orted quarterly to Abuse and the Abuse at the resident the Abuse abuse abuse at the resident the Abuse		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345548	B. WING			
		343546	B. WING _		06/18/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHTON	PLACE HEALTH AN	D REHAB		5533 BURLINGTON ROAD		
7.0111.01.				MCLEANSVILLE, NC 27301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	
F 225	Continued From pa	nge 7	F 22	such potential situations will be rer from work during the investigative process. Law enforcement will also notified as appropriate, Inappropriate behaviors of resident, family/vistor others are also monitored for pote abuse. The investigation of allegations will include resident/staff interviews, mercord review and the circumstand surrounding the alleged incident as as notification to the responsible p. The results of the investigation will communicated to the appropriate agency within 5 working days. Situ that are substantiated will result in termination of the employee and appropriate agencies/licensing boanotified. Care plan meetings with resident a families are held regularly to help i potential areas of concern and devistrategies that may help resolve the issues. At all time, efforts to ensurresident safety/protection will be supported. Supervisory staff will in for any staff or visitor behaviors. The resident (#26) was seen by Popsychological Services (aka NCEF a psychological Services (aka NCEF a psychological work-up and has be diagnosed with anxiety reaction and dementia with behaviors. A care planeting was conducted with the redaughter who confirmed history of exaggerating behaviors. Social Se staff have met with the resident at weekly, as well as the Director of Nursing, to help reassure resident at weekly, as well as the Director of Nursing, to help reassure resident acconcerns are important and taken	o be ate s or intial ledical es s well arty. be state ations the ards and /or dentify relop ese e tervene CP PS) for seen d an esident's rvice least	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345548	B. WING			06/	C 1 8/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB				5 5 N	1 00/	10/2010	
(X4) ID PREFIX TAG			ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 225	Continued From pa	nge 8	F 2	225	seriously. A 24 hour and 5 day reposince been sent to the State. While the original incident was writ as a grievance and investigated the not any other similar incidents which not reported as potential abuse. Subsequent issues have all sent to state per the established guidelines. The employee who was identified the resident (#26) has since resigned. The Director of Nursing, or her des will continue to meet with the resideleast weekly to discuss any issues resident may have perceived concentre care and address as appropriate. Allegations that have been investigned will be reported monthly in the Qual Assurance /Quality Improvement to X 3 and discussed as appropriate. Allegations will then be reported quality or nine additional months.	ten up ere was th was been by the ignee, ent at the erning te. ated lity leeting	