**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ___________________________
B. WING ___________________________

(X3) DATE SURVEY COMPLETED
C 04/28/2016

NAME OF PROVIDER OR SUPPLIER
ASHTON PLACE HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
5533 BURLINGTON ROAD
MCLEANVILLE, NC 27301

(X4) ID PREFIX TAG
F 000 INITIAL COMMENTS

No deficiencies were cited as a result of this complaint investigation conducted on 4/28/16 exit dated ED# V1B111

F 000

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

04/29/2016

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: V1B111
Facility ID: 061196
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