		ID HUMAN SERVICES			
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391 (X3) DATE SURVEY
	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED
		345393	B. WING		C 11/10/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PISGAH N	IANOR HEALTH CARE C	ENTER		04 HOLCOMBE COVE ROAD ANDLER, NC 28715	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 000	INITIAL COMMENTS		F 000		
F 278 SS=E	complaint investigatio 483.20(g) - (j) ASSES	cited as a result of the on. Event ID # OHNF11. SSMENT DINATION/CERTIFIED	F 278		12/9/16
	The assessment mus resident's status.	t accurately reflect the			
	A registered nurse me each assessment wit participation of health				
	A registered nurse massessment is compl	ust sign and certify that the eted.			
		completes a portion of the n and certify the accuracy of sessment.			
	willfully and knowingly false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingly to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money nan \$5,000 for each			
	Clinical disagreemen material and false sta	t does not constitute a tement.			
	This REQUIREMENT	is not met as evidenced			
		iew and staff interviews, the		 Corrective action was taken on 	
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E I	TITLE	(X6) DATE
Electroni	cally Signed				12/05/2016

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.

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 12/12/201 DRM APPROVE NO. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345393	B. WING			C 11/10/2016		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CIT				
				104 HOLCOMBE COVI	E ROAD			
PISGAH N	IANOR HEALTH CARE (CENTER		CANDLER, NC 287	15			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 278	Continued From page	o 1	F 27	o				
1 270								
		ately code the Minimum			Level II PASRR's that were			
	Data Set (MDS) to re				deficient practice on % audit was conducted on			
		ning and Resident Review on for 3 of 3 residents			% audit was conducted on RR's on 11/9/16. All			
		lent #67, and Resident #23)			or the remainder of Level II			
	· ·	II PASRR and failed to			nts were corrected on			
		dental status on 2 of 4		11/9/16.				
		#123 and Resident #106).		11/3/10.				
				Corrective acti	ion was taken in coding			
	Findings included:				vere identified as			
	i manigo moladoa.			edentulous on				
	1. Resident #22 was	readmitted to the facility on			vas done on those that			
		ses included depression.		wore dentures.	Corrective action was			
		al Minimum Data Set (MDS)		taken on 11/10/	/16 in correcting the coding			
	dated 10/28/16 indica	ated Resident #22 was not			ad dentures and those that			
		ate Level II Preadmission ent Review (PASRR)		were edentulou	IS.			
	process to have a se	rious mental illness and/or		All residents h	have the potential to be			
		The results of this screening		affected with in	accurate coding related to			
	and review are used			their care and r	needs. On 11/14/16 the			
		d, determination of an			ators reached out to RAI			
	appropriate care sett	-			nator for direction on the			
		r services to help develop an			person was able to give			
	individual's plan of ca			-	ecommend that a team			
		y's list of Level II PASRR			l one of next years			
	· ·	n entrance to the facility			isgah Manor will send a			
		nt #22 was included among			team (MDS coordinator) to			
	the residents named	on the list. Iducted with the MDS			conference available (Dates			
		/10/2016 at 8:15 AM who		have not yet be				
		annual MDS assessment on		•I Inon admissio	on to the facility the			
	Resident #22 dated 1				ector will verify all PASRR			
		d he had not verified that			e the resident may enter			
		etermined as Level II PASRR			admissions director will			
		annual MDS assessment		-	ASRR number to the face			
		r coding for Level II PASRR.			residents chart. A copy of			
		or #2 stated he submitted a			mber verification will then			
		S assessment on 11/09/16			ent's chart in the social			
		#22 was Level II PASRR.		-	With this system in place			

Facility ID: 923409

If continuation sheet Page 2 of 19

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	i î		COMPLETED	
					С	
		345393	B. WING		11/10/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PISGAH N	IANOR HEALTH CARE O	CENTER		104 HOLCOMBE COVE ROAD		
				CANDLER, NC 28715		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 278	Continued From page	e 2	F 278	3		
	conducted with the D who stated the social worked at the facility Resident #22's Level MDS Coordinator #2 dated 10/28/16. The Coordinator #2 had n PASRR Level II deter annual MDS Level II coding. The DON sta that the annual MDS been coded accurate was determined as L stated her expectatio #2 would correct Res reflect Level II PASRI On 11/10/2016 at 8:4 conducted with the A Resident #22 was de The Administrator sta assessment dated 10 coded to reflect Resid PASRR. The Adminis a turnover in the SW was responsible to pr II PASRR determinati #2 for coding. The Ad #22's annual MDS da	0 AM an interview was dministrator who stated termined as Level II PASRR. ited the annual MDS)/28/16 should have been		the MDS coordinators will then be all identify level II PASRR's and propert able to code them in the system. Corrective action was taken on 11/10 by the administrator informing the admissions director to add all PASRI the face sheet and put a copy of the verification in the residents chart. •The DON/Administrator will audit th various sections of the MDS for accu in coding. A 20% sample size will be from the monthly submitted MDS's. DON/Administrator will then report the results in our quarterly QAPI meeting until 100% compliance is met for a p of 6 months. The facilities QAPI tear monitor this throughout the year.	y be D/16 R's to e irracy taken The iose gs eriod	

If continuation sheet Page 3 of 19

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/12/2016 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		345393	B. WING				C 11/10/2016
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				104	HOLCOMBE COVE ROAD		
PISGAH	IANOR HEALTH CARE C	ENTER		СА	NDLER, NC 28715		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	2. Resident #67 was 10/27/14 and diagnos s dementia, anxiety d A review of the admis indicated Resident #6 state Level II Preadm Resident Review (PA serious mental illness The results of this scr for formulating a deter determination of an a a set of recommenda develop an individual A review of the facility residents provided on revealed that Residen the residents named The MDS Coordinato 11/09/2016 at 4:06 PI Resident #67's annua annual MDS did not r determination for Res Coordinator #1 stated coded to reflect Residen PASRR and was miss Coordinator #1 stated require a correction to determined as Level On 11/09/2016 at 4:1 conducted with the D who stated the social worked at the facility Resident #67's Level MDS Coordinator #1 dated 12/31/15. The I Coordinator #1 had n PASRR Level II deter annual MDS Level II	readmitted to the facility on ses included non-Alzheimer ' lisorder, and depression. ssion MDS dated 12/31/15 67 was not considered by the hission Screening and SRR) process to have a s and/or intellectual disability. reening and review are used ermination of need, uppropriate care setting, and tions for services to help 's plan of care. y's list of Level II PASRR n entrance to the facility nt #67 was included among on the list. or #1 was interviewed on M regarding the accuracy of al MDS dated 12/31/15. The reflect the Level II PASRR sident #67 and the MDS d the MDS should have been dent #67 was Level II sed for coding. The MDS d the admission MDS would o reflect Resident #67 was	F	278			

If continuation sheet Page 4 of 19

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING	3		C
		345393	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PISGAH N	IANOR HEALTH CARE C	ENTER			104 HOLCOMBE COVE ROAD CANDLER, NC 28715		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)				(X5) COMPLETION DATE		
F 278	that the annual MDS been coded accurated was determined as Less stated her expectation #1 would correct Resi reflect Level II PASRF On 11/09/2016 at 4:3° conducted with the Ac Resident #67 was det The Administrator sta assessment dated 12 coded to reflect Resic PASRR. The Adminis a turnover in the SW was responsible to pr II PASRR determinati for coding. The Admir #67's annual MDS da coding for Level II PA stated it was his exper annual MDS would has to reflect Level II PAS Administrator stated f MDS Coordinator #1 #67's annual MDS to 3. Resident #23 was a 01/28/15 and diagnos manic depression. A review of the signifit Set (MDS) dated 02/0 was not considered b Preadmission Screen (PASRR) process to f and/or intellectual disc	dated 12/31/15 would have by to reflect Resident #67 evel II PASRR. The DON in was that MDS Coordinator ident #67's annual MDS to R. 1 PM an interview was dministrator who stated termined as Level II PASRR. ted the annual MDS /31/15 should have been lent #67 was Level II trator stated the facility had department and the SW ovide Resident #67's Level on to MDS Coordinator #1 histrator stated Resident ted 12/31/15 was missed for SRR. The Administrator ctation that Resident #67's ave been accurately coded RR determination. The his expectation was that would correct Resident reflect Level II PASRR. admitted to the facility on tes included depression and cant change Minimum Data 16/16 indicated Resident #23 y the state Level II ing and Resident Review have a serious mental illness ability. The results of this are used for formulating a	F	27	8		

If continuation sheet Page 5 of 19

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/12/2016 MAPPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		IPLE CONSTRUCTION		SURVEY PLETED	
		345393	B. WING			C 11/10/2016		
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
	IANOR HEALTH CARE O	*ENTED		10	4 HOLCOMBE COVE ROAD			
FIGGATIN				C	ANDLER, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 278	individual's plan of ca A review of the facility residents provided or revealed that Resident the residents named An interview was con Coordinator #1 on 11 stated she coded the assessment on Resid The MDS Coordinato verified that Resident Level II PASRR befor change MDS assess coding Level II PASR stated she submitted change MDS assess Resident #23 was Le On 11/10/2016 at 9:0 conducted with the D who stated the social worked at the facility Resident #23's Level MDS Coordinator #1 change MDS dated 0 because MDS Coord Resident #23's Level from the SW the sign PASRR was missed f it was her expectation MDS dated 02/06/16 accurately to reflect F determined as Level her expectation was f	 Ing, and a set of services to help develop an are. y's list of Level II PASRR in entrance to the facility in #23 was included among on the list. ducted with MDS /10/2016 at 8:57 AM who significant change MDS dent #23 dated 02/06/16. r #1 stated she had not #23 was determined as the she coded the significant ment and it was missed for R. The MDS Coordinator #1 a corrected significant ment on 11/09/16 to indicate vel II PASRR. 5 AM an interview was irector of Nursing (DON) worker (SW) who no longer was responsible to provide II PASRR determination to for coding the significant 2/06/16. The DON stated inator #1 had not received II PASRR determination to for coding. The DON stated in that the significant change would have been coded Resident #23 was II PASRR. The DON stated that MDS Coordinator #1 nt #23's significant change 	F	278				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/12/2016 MAPPROVED D: 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE		
		345393	B. WING				C 10/2016	
NAME OF P	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				1	104 HOLCOMBE COVE ROAD			
PISGAH N	IANOR HEALTH CARE C	ENTER		c	CANDLER, NC 28715			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
F 278	On 11/10/2016 at 9:10 conducted with the Ac Resident #23 was det The Administrator sta MDS assessment dat been coded to reflect PASRR. The Adminis a turnover in the SW was responsible to pr II PASRR determinati for coding. The Admir #23's annual MDS da coding for Level II PA stated it was his expe significant change ME accurately coded to re determination. The Ac expectation was that correct Resident #23' reflect Level II PASRF 4. Resident #123 was The annual Minimum 3/15/16 coded Reside cognitively impaired fo skills. The MDS oral/ indicated there were re An interview was com Coordinator #1 on 11/ Coordinator #1 stated code the oral/dental s MDS, she did not alw the resident but did re assessments, nursing and dietary notes to s	0 AM an interview was dministrator who stated termined as Level II PASRR. ted the significant change ted 02/06/16 should have Resident #23 was Level II trator stated the facility had department and the SW ovide Resident #23's Level on to MDS Coordinator #1 histrator stated Resident ted 10/28/16 was missed for SRR. The Administrator ectation that Resident #23's DS would have been effect Level II PASRR dministrator stated his MDS Coordinator #1 would s significant change MDS to R. bata Set (MDS) dated ent #123 as severely or daily decision making dental status section ho problems present. ducted with the MDS (9/16 at 4:30 PM. The MDS i when determining how to status section of the annual ays make an observation of	F	278				

If continuation sheet Page 7 of 19

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/12/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345393	B. WING				C 10/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	IANOR HEALTH CARE C	ENTED		1	104 HOLCOMBE COVE ROAD		
FISGARIN	IANOR HEALTH CARE C	ENTER		0	CANDLER, NC 28715		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278	MDS Coordinator #1 of was edentulous during the annual MDS date acknowledged the MD inaccurately coded fo MDS Coordinator #1 a would require a correc #123 was edentulous An interview was cond Nursing (DON) on 11/ it was her expectation to be accurately code MDS Coordinator #1 1 annual MDS assessm Resident #123 to accurately code MDS Coordinator #1 1 annual MDS assessm Resident #123 to accurately code 5. Resident #106 was The annual MDS date #106 as moderately, of decision making skills status section indicate present. Review of Resident # revealed a dental note indicated "patient is e An interview was cond Coordinator #1 on 11/ Coordinator #1 stated	confirmed Resident #123 g the assessment period for d 3/15/16 and DS assessment had been r oral/dental status. The stated the annual MDS ction to indicate Resident ducted with the Director of '9/16 at 5:50 PM who stated n for the MDS assessments d. The DON confirmed the had submitted a corrected hent dated 11/9/16 for urately reflect her oral ducted with the 0/16 at 8:33 AM who stated for the MDS assessments d. admitted on 7/24/15. ed 8/2/16 coded Resident cognitively impaired for daily the MDS oral/dental ed there were no problems 106's medical record e dated 5/6/16 which dentulous."	F	278	3		

If continuation sheet Page 8 of 19

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/12/2016 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		345393	B. WING _				C 10/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PISGAH N	IANOR HEALTH CARE C	ENTER					
					CANDLER, NC 28715		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 278 F 312 SS=D	MDS, she did not alw, the resident but did re assessments, nursing and dietary notes to s oral issues during the MDS Coordinator #11 was edentulous during the annual MDS asses acknowledged the MD inaccurately coded fo MDS Coordinator #11 would require a correct #106 was edentulous An interview was contone Nursing (DON) on 11/ it was her expectation to be accurately code MDS Coordinator #11 annual MDS assessm Resident #106 to accurately status. An interview was contone Administrator on 11/1 it was his expectation to be accurately code 483.25(a)(3) ADL CAU DEPENDENT RESID A resident who is una daily living receives th	ays make an observation of eview the nursing in otes, Physician notes, ee if the resident had any assessment period. The confirmed Resident #106 g the assessment period for ssment dated 8/2/16 and DS assessment had been r oral/dental status. The stated the annual MDS ction to indicate Resident ducted with the Director of 9/16 at 5:50 PM who stated i for the MDS assessments d. The DON confirmed the had submitted a corrected tent dated 11/9/16 for urately reflect her oral ducted with the D/16 at 8:33 AM who stated for the MDS assessments d. RE PROVIDED FOR		278			12/9/16
	This REQUIREMENT	is not met as evidenced					

If continuation sheet Page 9 of 19

		ND HUMAN SERVICES MEDICAID SERVICES				12/12/2016 APPROVED 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE S COMPLE	JRVEY		
		345393	B. WING		C 11/10/2016		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				104 HOLCOMBE COVE ROAD			
PISGAH N	IANOR HEALTH CARE C	ENTER		CANDLER, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 312	Continued From page	e 9	F 31	12			
	and staff interviews, f nail care for 3 of 4 resproviding activities of dependent residents The findings included 1. Resident # 7 was a 01/19/16 with diagnos urinary tract infection history of stroke, and A review of the most Data Set (MDS) date Resident # 7 had sho deficits and was mod for daily decision mal revealed Resident # assistance with activit which included mobilit toileting and persona Resident # 7 showed with no behaviors cool A review of a care pla revealed Resident # extensive assistance living (ADL) related to interventions indicate	 daily living (ADL) care for (Resident # ' s 7, 110, 67). admitted to the facility on ses which included history of s, depression, weakness, dementia without behaviors. recent quarterly Minimum d 08/22/16 revealed ort and long term memory derately impaired cognitively king skills. The MDS further 7 required extensive ties of daily living (ADLs) ity, transfers, walking, I hygiene. The MDS coded little interest in activities, ded or rejection of care. 		 Corrective action was put 11/10/16. The residents that be affected had their nails cleaned by the CNA's. CNA's were in serviced by 11/16/16 on nail care protoco be trimmed by the CNA on day of the week, and check cleanliness on 7-3 and 3-1 daily basis. Diabetic resider be trimmed by the treatme weekly basis. Any resident in nail spa will have nails of chips in nail polish are note edges CNA's will remove prails. Activity department work for resident to attend the noresident refuses nail care to nurse will be notified. Chart then visit resident and encompliance and assist in protocol. The DON will review the name provided by the charge nurse will be notified. 	at were found to trimmed and y the DON on cool. Nails are to the 1st shower ked for 1 shifts on a ent's nails are to nt nurse on a as participating hecked daily. If ed or rough colish and file will be notified ext nail spa. If a he charge rege nurse will ourage roviding nail to refuse their he charge residents erviced by the nail care		
	(NAs) to provide resid # 7 required assistan	care guide for Nurse Aides dent care indicated Resident ce with grooming. The		supervisors on a weekly ba months. Then on a monthl throughout the year. The D her findings from her week quarterly QAPI meeting. If	y basis DON will report Ily reports in the problematic		
		daily care for Resident #7 non-shower days including		areas occur, they will be an time of the findings and bro			

Facility ID: 923409

If continuation sheet Page 10 of 19

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/12/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345393	B. WING	_			C 10/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	04 HOLCOMBE COVE ROAD		
PISGAH	IANOR HEALTH CARE C	ENTER		c	CANDLER, NC 28715		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	SHOULD BE COMPL	
F 312	hand care, showers o	n day shift Monday and	F	312	attention of the QAPI committee.		
	Thursday with nail can A review on the show Resident # 7 ' s show and Thursday on the On 11/07/16 at 12:27 observed with all fingu approximately ¼ to ½ edges that were not the white substance under On 11/07/16 at 3:46 F observed with all fingu unchanged from the p On 11/08/16 at 9:16 A observed with all fingu	re. er schedules revealed er days were on Monday day shift. PM Resident # 7 was ernails of both hands " long nails with rough rimmed with a yellowish er the nails. PM Resident # 7 was ernails of both hands previous observation. AM Resident # 7 was ernails of both hands previous observations. PM Resident # 7 was			attention of the QAPI committee.		
	On 11/09/16 at 12:10 observed with all finge unchanged from the p On 01/09/16 at 4:42 F observed with all finge	ernails of both hands previous observations. PM Resident # 7 was ernails of both hands previous observations. PM Resident # 7 was					
	On 11/09/16 at 1:55 F observed in the dining	PM Resident # 7 was g room eating her lunch					

If continuation sheet Page 11 of 19

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/12/2016 // APPROVED). 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345393	B. WING				C 10/2016	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
PISGAH N	IANOR HEALTH CARE C	ENTER	104 HOLCOMBE COVE ROAD CANDLER, NC 28715					
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 312	which consisted of me dumplings. Resident a using a fork in her rigl onto the fork with her her fingers and picked fingers to eat. Reside hands were unchange observation with long were not trimmed with substance under the f On 11/10/16 at 8:17 A observed with all finge unchanged from the p On 11/10/16 at 8:18 A #2 who was familiar w was interviewed. NA a #7 received showers NA #2 further explaine normally provided dur also as needed, and o stated he provided ca yesterday and today a morning (Thursday). I nails needed cleaning further verified he did Resident # 7 yesterda shower. An interview was atte provided care for Res 3 was unable to be in On 11/10/16 at 10:00 (AD) was interviewed days for residents we and was one of the m	echanical soft turkey and # 7 was further observed ht hand pushing the food left hand. She then licked d up a buttered roll with her nt # 7 's fingernails of both ed from the previous nails with rough edges that n a yellowish white nails. M Resident # 7 was ernails of both hands previous observations. M Nursing Assistant (NA) with the care for Resident # 7 #2 explained that Resident on Mondays and Thursday. ed that nail care was ring Monday showers but on nail spa days. NA # 2 re for Resident # 7 and provided a shower this NA #2 verified Resident # 7 g and trimming. NA #2 not provide nail care for ay, or today during her mpted with NA #3 who ident # 7 on Monday. NA #	F	312				

Facility ID: 923409

If continuation sheet Page 12 of 19

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
34539		345393	B. WING			C 11/10/2016		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
PISGAH N	IANOR HEALTH CARE C	ENTER			104 HOLCOMBE COVE ROAD CANDLER, NC 28715			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 312	rooms unless a reside of appointments then manicure. The AD rev a hand massage on C her attending the nail On 11/10/16 at 9:29 A (DON) was interview. # 7 's fingernails wer The DON stated that completed the first da care which is Monday needed. The DON ex provides nail spa mar residents and sometin their rooms. The DON expectation that Resi cleaned and trimmed days and as needed. 2. Resident # 110 wa 06/20/13 with diagnos depression, anxiety, g weakness, lack of coo dementia. A review of the most the Data Set (MDS) dated Resident # 110 had w cognitively for daily do MDS further revealed extensive assistance (ADLs) which include walking, toileting and indicated Resident # activities, with no beh care.	ent missed spa day because they would do an in room vealed Resident #7 received 09/28/16 but could not recall spa day. AM the Director of Nursing The DON verified Resident e not clean and trimmed. nail care should be by of the week during shower v for these ladies, and as plained the activity director nicures each week for some mes provides nail care in N further stated it was her dents ' nails would be in the shower on showers s admitted to the facility on ses which included generalized muscle ordination, and Alzheimer ' s recent quarterly Minimum d 08/31/16 revealed vas moderately impaired ecision making skills. The I Resident # 110 required with activities of daily living	F	312	2			

If continuation sheet Page 13 of 19

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/12/2016 MAPPROVED D. 0938-0391				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED					
		345393	B. WING				C 10/2016				
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE						
PISGAH N	IANOR HEALTH CARE C	ENTER		104 HOLCOMBE COVE ROAD CANDLER, NC 28715							
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	N SHOULD BE COMPLETIC					
F 312	Resident # 110 requir with grooming and perinterventions indicates encourage and praises personal hygiene task accomplished in small dated 01/01/16 for Re activities would be en- her care and with faci- interventions included such as nail spa, and attendance provide ro- as nail care. A review of the daily of (NAs) to provide resid # 110 required assistata approaches revealed 110 included bed batti- including hand care, si Monday and Thursda nails were trimmed. A review on the show Resident # 110 ' s show and Thursday on the On 11/07/16 at 3:52 F observed with all finge brown substance und approximately 1/2" or edges and red chipper On 11/08/16 at 10:01 observed with all finge unchanged from the p	ed assistance from staff rsonal hygiene. The d Resident # 110 would be ed for participation in ks, tasks were to be ler steps. The care plan esident # 110 to attend group couraged to participate with lity activities. The d engage in group activities if declining group boom visits for activities such care guide for Nurse Aides lent care indicated Resident ance with grooming. The daily care for Resident # n on non-shower days showers on day shift y with nail care, and ensure er schedules revealed ower days were on Monday day shift. PM Resident # 110 was ernails on both hands with a er all ten digits and more in length with rough ed polish. AM Resident # 110 was ernails of both hands previous observation.	F	312	2						

Facility ID: 923409

If continuation sheet Page 14 of 19

		ID HUMAN SERVICES				FORM	M APPROVED			
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			PLETED			
		345393	B. WING			C 11/10/2016				
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>				
PISGAH N	IANOR HEALTH CARE C	ENTER			104 HOLCOMBE COVE ROAD					
					CANDLER, NC 28715					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	(EACH CORRECTIVE ACTION SHOULD B	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 312		e 14 previous observations.	F	312	2					
	On 11/09/16 at 9:41 A observed with all fing	AM Resident # 110 was								
		previous observations.								
	On 11/09/16 at 12:10	PM Resident # 110 was								
	observed with all fing									
	unchanged from the p	previous observations.								
	11/09/2016 1:29:28 P	M Resident # 110 was								
		g room eating her lunch								
		rkey and dumplings, mixed h jelly and butter. Resident #								
	110 was further obser	rved eating her roll with her								
	hands. Resident # 11 hands were unchange	0 's fingernails of both								
		own substance under all ten								
		tely 1/2" or more in length								
	with rough edges and	I red chipped polish.								
	On 11/09/16 at 4:42 F	PM Resident # 110 was								
	observed with all fing									
		previous observations.								
		AM Resident # 110 was								
	observed with all fing	ernails of both hands previous observations.								
		AM Resident # 110 was								
	-	akfast with toast with butter her hands. Resident #110								
	was further observed	with all fingernails of both								
		m the previous observations ce under all ten digits and								
		more in length with rough								
	edges and red chippe									
	On 11/10/16 at 10:22	AM Nursing Assistant (NA)								

If continuation sheet Page 15 of 19

SIATURAN 0F DENCEMENS AND PLAN 0F CORRECTION (M) PROVIDERSUMPLIES DENTIFICATION NUMBER (M) NUMER ABUINNE		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
J46393 D. WHIG Intro2018 INAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE If HOLCOME COVE ROAD CANDER, N.C. 28775 IMPLID SUMMANY STATEMENT OF DEFICIENCIES (PREINK) DEFICIENCY DEFICIENCY IMPLID SUMMANY STATEMENT OF DEFICIENCIES (PREINK) DEFICIENCY DEFICIENCY IMPLID SUMMANY STATEMENT OF DEFICIENCIES (PREINK) DEFICIENCY DEFICIENCY DEFICIENCY IMPLID SUMMANY STATEMENT OF DEFICIENCIES (PREINK) DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY IMPLID SUMMANY STATEMENT OF DEFICIENCIES (PREINK) DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY IMPLID SUMMANY STATEMENT OF DEFICIENCIES (PREINK) F312 F312 DEFICIENCY DEFICIENCY DEFICIENCY IF 312 Continued From page 15 #4 who was familiar with the care for Resident # 110 was interviewed. N # 4 & thrther explained that Resident #110 conceived showers on Mondays. F312 F312 Implies three preint of the preint and three preint and three preint and three preint of the preint and three preint and three preint preint and preint preint preint preint preint preint preint preint preint	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	, <i>'</i>					
184 HOLCOMEE COVE ROAD CANDER, N. 28715 (291)0 PREMA TAG SUMMARY STATEMENT OF DEFICIENCIES INTEGENT OF CORLECTION INCL. STATEMENT OF DEFICIENCIES INTEGENT OF CORLECTION INCL. DESTITUTION INFORMATION Integent OF CORRECTION (EACH CORRECTIVE CORLECTION INFORMATION) F 312 Continued From page 15 # 4 who was familiar with the care for Resident # 110 was interlivewed. NA # 4 explained that Resident #110 received showers on Mondays and Thursday. NA # 4 further explained that also as needed, and on all aga days. NA # 4 verified he provided during Monday, showers but also as needed, and on all aga days. NA # 4 verified he provided during Monday, showers but also as needed. NA # 6 explained that Resident #110 complained when trying to provide nall care. NA # 4 further stated he did not report her refusal of nall care on Mondays and Thursday. NA # 4 further explained that Resident #110 complained when trying to provide nall care. NA # 4 further stated he did not report her refusal of nall care on Mondays and Thursday. NA # 5 further explained that Resident #110 complained that all care was normally provided during Monday, showers but also as needed. NA # 6 stated he did not report her refusal of nall care on Mondays and Thursday. NA # 5 further explained that Resident #110 cecieved showers on Mondays and Thursday. NA # 5 turther explained that all care was normally provided description of Monday showers but also as needed. NA # 6 explained that all care was normally provided description and activities she held. The AD stated the dath Wednesday and was no of the most attended activities she held. The AD stated they try not to do nall care in noming. Thursday but did not do her nall care. NA #5 stated the was in a hurry and did not pay attention to providing nall care. NA # 5 who was neorties are existent misset aga days back bec			345393	B. WING				-	
PRSGAM MANOR HEALTH CARE CENTER CANDLER, NC 28715 (p4) ID PRETIX TWC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RENCED BY FULL RECULATORY OR LSC LEMITETING INFORMATION) ID PRETIX NC PRETIX PRETIX Reculation of the pretix to constrain the pretix Reculation of the pretix Reculati	NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
Prefry TAG CEACH DEFICIENCY MOST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ON THE APPROPRIATE COMMETING DEFICIENCY F 312 Continued From page 15 #4 who was familiar with the care for Resident # 110 was interviewed. NA # 4 explained that Resident #110 received showers on Mondays and Thursday. NA # 4 further explained that nail care was normally provided during Monday showers but also as needed, and on nail spa days. NA # 4 verified he provided care for Resident # 110 during Monday, but did not provide nail care. NA # 4 stated Resident # 100 complianed when trying to provide nail care. NA # 4 further stated he did not report her refusal of nail care on Mondays and Thursday. NA # 5 further explained that 100 was interviewed. NA # 5 explained that Resident #110 received showers on Mondays and Thursday. NA # 5 further explained that Resident #110 concluded during Monday showers but also as needed, and on nail spa days. NA # 5 verified she provided during Monday showers but also as needed, and on nail spa days. NA # 5 verified she provided during Monday showers but also as needed, and on nail spa days. NA # 5 verified she provided during Monday showers but also as needed, and on nail age days. NA # 5 verified she provided Resident # 110 her shower this moming (Thursday) but did not do her nail care. NA #5 stated she was in a hurry and did not pay attention to providing nail care. On 11/10/16 at 10:00 AM the Activity Director (AD) was interviewed. The AD revealed Resident # 110 attended nail spa and received a maincure of appointments then they will do an in room manicure. The AD revealed Resident # 110 attended nails pa and received a maincure of appointments then they will do an in room manicure. The AD verified she did not offer in room mail care. Imathet that that that that tha	PISGAH M	IANOR HEALTH CARE C	ENTER						
 # 4 who was familiar with the care for Resident # 110 was interviewed. NA # 4 explained that Resident #110 received showers on Mondays and Thursday. NA # 4 further explained that nail care was normally provided during Monday showers but also as needed, and on nail spa days. NA# 4 verified he provided care for Resident # 110 during Monday, but did not provide nail care. NA # 4 stated Resident # 110 complained when trying to provide nail care. NA # 4 further stated he did not report her related of nail care on Monday. On 11/10/16 at 9.52 AM Nursing Assistant (NA) # 5 who was familiar with the care for Resident # 110 was interviewed. NA # 5 explained that Resident #110 received showers on Mondays and Thursday. NA # 5 further explained that nail care was normally provided during Monday showers but also as needed, and on nail spa days. NA# 5 verified she provided Resident # 110 her shower this morning (Thursday) but did not to her nail care. NA #5 stated she was in a hurry and did not pay attention to providing nail care. On 11/10/16 at 10:00 AM the Activity Director (AD) was interviewed. The AD revealed nail spa days for residents were held each Wednesday and was one of the most attended activities she held. The AD stated they try not to do nail care in rooms unless a resident missed spa day because of appointments then they will do an in room manicure. The AD revealed Resident # 110 attended nail spa and received a manicure on 00/14/16 and 10/26/16, but did not anile spa this week. The AD verified she did not offer in room nail care. 	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
(DON) was interview. The DON verified Resident	F 312	# 4 who was familiar y 110 was interviewed. Resident #110 receive Thursday. NA # 4 furt was normally provide but also as needed, a verified he provided c during Monday, but d # 4 stated Resident # to provide nail care. N not report her refusal On 11/10/16 at 9:52 A 5 who was familiar wi 110 was interviewed. Resident #110 receive Thursday. NA # 5 furt was normally provide but also as needed, a verified she provided this morning (Thursda care. NA #5 stated sh pay attention to provide days for residents we and was one of the m held. The AD stated th rooms unless a reside of appointments then manicure. The AD rev attended nail spa and 09/14/16 at 10/26/1 this week. The AD ve room nail care.	with the care for Resident # NA # 4 explained that ed showers on Mondays and her explained that nail care d during Monday showers and on nail spa days. NA # 4 are for Resident # 110 id not provide nail care. NA 110 complained when trying VA # 4 further stated he did of nail care on Monday. AM Nursing Assistant (NA) # th the care for Resident # NA # 5 explained that ed showers on Mondays and her explained that nail care d during Monday showers and on nail spa days. NA # 5 Resident # 110 her shower ay) but did not do her nail ne was in a hurry and did not ding nail care. AM the Activity Director . The AD revealed nail spa re held each Wednesday tost attended activities she hey try not to do nail care in ent missed spa day because they will do an in room vealed Resident # 110 I received a manicure on 6, but did not attend nail spa rified she did not offer in	F	312				

If continuation sheet Page 16 of 19

		ID HUMAN SERVICES				FORM	D: 12/12/2016 APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	` '			COMPLETED		
		345393	B. WING				C	
	ROVIDER OR SUPPLIER	343333	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	10/2016	
NAME OF P	ROVIDER OR SUPPLIER				104 HOLCOMBE COVE ROAD			
PISGAH N	IANOR HEALTH CARE C	ENTER			CANDLER, NC 28715			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 312	 # 110 's fingernails w The DON stated that completed the first da care which is Monday needed. The DON ex provides nail spa mar residents and sometin their rooms. The DON expectation that Resid cleaned and trimmed days and as needed. 3. Resident # 67 was 10/02/14 with diagnos coordination, essentia osteoporosis, abnorm generalized muscle w A review of the most n Data Set (MDS) dated Resident # 67 was m cognitively for daily de MDS further revealed extensive assistance (ADLs) which includer walking, toileting and coded Resident # 67 activities, with no beh care. A review of a care pla revealed Resident # 67 activities, assisted participation in persor 	rere not clean and trimmed. nail care should be by of the week during shower of these ladies, and as plained the activity director nicures each week for some mes provides nail care in A further stated it was her dents ' nails would be in the shower on showers admitted to the facility on ses which included lack of al tremors, history of stroke, nal gait and mobility, veakness, and depression. recent quarterly Minimum d 09/27/16 revealed noderately impaired ecision making skills. The Resident # 67 required with activities of daily living d mobility, transfers, personal hygiene. The MDS showed little interest in aviors coded or rejection of an last updated 09/27/16 b7 required assistance from nd personal hygiene. The d Resident # 67 would be and praised for nal hygiene tasks, tasks hed in smaller steps. The l/16 for Resident # 67	F	31:				

Facility ID: 923409

If continuation sheet Page 17 of 19

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	MAPPROVED 0. 0938-0391	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE	E CONSTRUCTION	(X3) DATE	X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		345393	B. WING			C 11/10/2016		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
PISGAH N	IANOR HEALTH CARE C	ENTER			104 HOLCOMBE COVE ROAD CANDLER, NC 28715			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE COMPLETION		
F 312	activities. The interver group activities such a group attendance pro activities. A review of the daily of (NAs) to provide resid # 67 required assistant approaches revealed included bed bath on hand care, showers of Thursday with nail can trimmed. A review on the show Resident # 67 's show and Thursday on the On 11/08/16 at 9:52 A observed with all finge approximately 1/2 " of chipped edges. Resid particularly like them them off. On 11/08/16 at 4:29 F observed with all finge unchanged from the p On 11/09/2016 at 12:: observed with all finge unchanged from the p On 11/09/2016 at 12:: observed with all finge unchanged from the p	ntions included engage in as nail spa, and if declining vide room visits for care guide for Nurse Aides lent care indicated Resident nee with grooming. The daily care for Resident # 67 non-shower days including n day shift Monday and re and ensure nails were er schedules revealed wer days were on Monday day shift. M Resident # 67 was emails on both hands or more in length with rough lent # 67 stated she did not long, and could not bite PM Resident # 67 was ernails of both hands orevious observation. M Resident # 67 was ernails of both hands orevious observations.	F	312				
	them off. On 11/08/16 at 4:29 F observed with all fingu unchanged from the p On 11/09/16 at 9:35 A observed with all fingu unchanged from the p On 11/09/2016 at 12:: observed with all fingu unchanged from the p	2M Resident # 67 was ernails of both hands previous observation. M Resident # 67 was ernails of both hands previous observations. 105 PM Resident # 67 was ernails of both hands previous observations.						

If continuation sheet Page 18 of 19

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI					FORM	2: 12/12/2016 1 APPROVED 2: 0938-0391	
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	345393	B. WING			(11/*	C 10/2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE			
PISGAH MANOR HEALTH CARE CEI		104 HOLCOMBE COVE ROAD	0				
PISGAN MANOR NEALTH CARE CEI	NIEK		CANDLER, NC 28715				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 312 Continued From page 1 unchanged from the pro- On 11/10/16 at 9:48 AW 6 who was familiar with was interviewed. NA # # 67 received showers of Thursday. NA # 6 further was normally provided of but also as needed, and stated she provided car (Thursday), but did not On 11/10/16 at 10:00 A (AD) was interviewed. T days for residents were and was one of the most held. The AD stated the rooms unless a residen of appointments then th manicure. The AD revea attends group activities, spa days. The AD was a was provided on an in r On 11/10/16 at 9:29 AW (DON) was interviewed Resident # 67 's fingen trimmed. The DON stat completed the first day care which is Monday fo needed. The DON expla provides nail spa manic residents and sometime their rooms. The DON f	evious observations. A Nursing Assistant (NA) # the care for Resident # 67 6 explained that Resident on Mondays and er explained that nail care during Monday showers d on nail spa days. NA # 6 re for Resident # 67 today provide nail care for her. M the Activity Director The AD revealed nail spa held each Wednesday st attended activities she ey try not to do nail care in t misses spa day because hey will do an in room aled Resident # 67 rarely , and did not attend nail unable to verify nail care oom visit. A the Director of Nursing . The DON verified nails were not clean and ed that nail care should be of the week during shower or these ladies, and as ained the activity director cures each week for some es provides nail care in further stated it was her	F 31		FICIENCY)			

Facility ID: 923409

If continuation sheet Page 19 of 19