PRINTED: 04/24/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345285	B. WING_			03/	03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND R	EUAD			TREET ADDRESS, CITY, STATE, ZIP CODE 00 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND R	CENAD		Н	ENDERSONVILLE, NC 28739			
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 242 SS=D	RIGHT TO MAKE CH (f)(1) The resident has schedules (including a health care and provice consistent with his or and plan of care and of this part. (f)(2) The resident has about aspects of his care significant to the resident has members of the community activities a facility. This REQUIREMENT by:	s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions a right to make choices or her life in the facility that	F	2242	What corrective action(s) will be		4/13/17	
	of 7 sampled resident demonstrate the ability (Residents #33 and # The Findings included The facility's smoking dated 2001 MED-PAS included the following 1. Prior to, or upon accomposition of the following designated the	ty to smoke independently. (59). d: policy referenced from and (SS, Inc. (Revised April 2012)) procedures: dmission, residents shall be mitations on smoking, smoking areas, and the cility can accommodate their ting preferences; for			accomplished for those residents found have been affected by the alleged deficient practice? Resident #33 was assessed by licensed nurse on April 5, 2017, utilizing the facil smoking assessment tool. The residen was also visually assessed by licensed nurse for demonstration of ability to smoke safely. Following the assessme the findings, which assessed the reside to be supervised, were reviewed by the interdisciplinary care plan team and the recommendations regarding smoking results were discussed. Nurse Practitioner was consulted by Director of Nursing regarding assessment results	d ity t nt nt		
	6. The staff shall cons	-			and was in agreement on April 6, 2017. Resident care plan was updated to refle	ect	(X6) DATE	

04/10/2017

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.

Electronically Signed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345285	B. WING _		0	3/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				200 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AN	D REHAB		HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 242	determine any res smoking privileges 7. Any smoking re and concerns (for monitoring) shall be all personnel carinalerted to these is 8. Residents with smoke during sup at the facility. 12. The staff will resmoking privileges needed with the Dethe Attending Physical Property of the Property of the Attending Physical Property of the Property of	Director of Nursing Services to trictions on a resident's s. lated privileges, restrictions, example, need for close or noted on the care plan, and or g for the resident shall be sues. smoking privileges may only ervised smoking breaks while eview the status of a resident's a quarterly, and consult as irector of Nursing Services and sician". with a typed list of designated designated smoking area	F2		sident was or of Nursing the 17. In the 17. In the 17. In the 18. In the 19. In the 1		
	on 09/16/13 agree smoking restriction Resident #33's me			utilizing the smoking asses visual observation. Their p be updated to reflect the as April 13, 2017. What measure will be put it systemic changes made to	esment and older of care will essessment by on place or ensure that		
	Review of Resider	nt #33's annual Minimum Data		the deficient practice will no	ot recur?	1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345285	B. WING		03	3/16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND F	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 242	readmitted to the faci current diagnoses that accident, hemiparesis revealed Resident #3 daily decision making with dressing, fed him tobacco. Review of Resident #4 dated 01/31/17 noted was at risk for injury. #33 to not sustain injinterventions such as procedure, see with a smoking, provide sup scheduled times and cart close to nursing Review of a Smoking dated 01/31/17 reveal assessed by the Soci paralysis, dementia a medications. The reconsistency assessment was for supervised smoking. Observations of Resi PM revealed he along breezeway smoking two hospitality aides. smoking protector and left hand to smoke. A cigarette, he handed took another cigarette for him. When Resides second cigarette, he	lity on 01/03/15 and had the at included cerebrovascular and anxiety. The MDS also as to be cognitively intact for any required limited assistance anself and currently used as Smoking care plan and the started to smoke and any from smoking using a providing the policy and as moking apron when be revision when smoking at the smoking materials in station. a Risk Assessment (SRA) alled Resident #33 was all Worker (SW) as having and receiving antianxiety ommendation of the Resident #33 to have	F 24	a. All current residents that smo assessed by a licensed nurse or Services Director utilizing the smassessment tool. Also, the resid be visually assessed by licensed Social Services Director for demof ability to smoke safely. The find the assessments will be discussed interdisciplinary care plan team a referred to the Physician or Nurse Practitioner for review and approximate Resident care plan will be updated reflect the recommendations from smoking assessment and will be discussed with the resident by the of Nursing or Assistant Director of by April 13, 2017. b. Any new admission to the fact be assessed by a licensed nursed Services Director utilizing the smassessment tool. Also, the resid be visually assessed by licensed Social Services Director for demof ability to smoke safely. The find the assessments will be discussed interdisciplinary care plan team a referred to the Physician or Nurse Practitioner for review and approximate Resident care plan will be implemented to the recommendations from the smoking assessments and will be discussed with the resident by the Services Director, Director of Nursing or Services Director of N	Social soking ents will I nurse or constration andings of ed by the and ed to m the enterprise or social soking ent will I nurse or constration andings of ed by the end ed by the end ed to m the enterprise or social soking ent will I nurse or constration andings of ed by the end ed to m the ed to m the ed to m the ed to m the ed to social raing, Staff	

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	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED			
		345285	B. WING _			03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND F	REHAB	•	STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) MPLETION DATE
F 242	On 03/14/17 at 9:10 other residents were smoking while being aides. Resident #33 of and held the cigarette After he finished with to a hospitality aide a cigarette from the aid he finished with his could then wheeled him on 03/15/17 at 9:05 of residents were observed breezeway while beirg hospitality aides. Resprotector and held that to smoke. After he firth handed it to a hospital another cigarette from him. When he was firth handed it to the aide building. Interview with Nurse revealed the resident were informed on adding required smokers to locally could not keep smok Nurse #1 also stated completed an initial sadmission and quarted desired to smoke. Interview with Reside AM stated he would I	AM Resident #33 along with observed in the breezeway supervised by two hospitality wore a smoking protector with his left hand to smoke. The cigarette, he handed it and then took another le and she lit it for him. After igarette, he handed it to the mself into the building. AM Resident #33 and other wed smoking in the ng supervised by two sident #33 wore a smoking e cigarette with his left hand hished with the cigarette, he ality aide and then took in the aide and she lit it for hished with the cigarette, he and wheeled himself into the who desired to smoke mission that the facility be supervised and they ing materials in their rooms. The Social Worker (SW) smoking assessment on early on the residents who sent #33 on 03/15/17 at 8:46 like to be able to smoke the had never been given the er been asked to	F	d. 100% of lici interdisciplinal in-serviced on visual observa 2017, by the S Coordinator, E Assistant Dire e. 100% of st smoking policy Staff Developing of Nursing or A f. An audit of completed motrigger from the schedule and Director of Nu Nursing, Staff MDS Coordinatensure smoking Interdisciplina Nurse practition resident review and Care Plar assessment. The monthly x 12 resident to ensure smoking corrected the Director of Nu Coordinator with the facility actions to ensure smoking corrected.	censed staff and ry care plan team will be a smoking assessment ar ation of smoking by April Staff Development Director of Nursing or actor of Nursing. aff will be in-serviced on y by April 13, 2017, by th ment Coordinator, Director Assistant Director of Nurs smoking residents will be antihly, for residents that the MDS assessment new admissions, by the arsing, Assistant Director Development Coordinate ator or Licensed nurse to ng assessment is comple ry team note is present, oner note is present, on of assessment is present in is current per the This will be completed	e por sing e of por, ete, ent	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	345285	B. WING				03/16/2017
NAME OF PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			20	00 HERITAGE DRIVE		
MOUNTAIN HOME HEALTH AND R	EHAB		Н	ENDERSONVILLE, NC 28739		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	DATE
revealed that the Smoto to the residents who do admission and were a explained the facility's residents to smoke un seven set smoking time as many cigarettes as minutes. She stated it complete a SRA which was completed quarter changes in the resident return demorand extinguishing a complete of the Administrator and (DON) revealed the Splace for at least nine a questionnaire. The not have the residents safe smoking because supervised smoking. Stated that no resident smoke independently thought they needed assessment. 2. Resident #59 was a 05/15/15 with diagnost failure, and asthma. A review of the quarter (MDS) dated 01/23/13 was cognitively intact thinking or inattention	on 03/16/17 at 3:35 PM oking Policy was explained desired to smoke on asked to sign a SC. The SW is Smoking Policy allowed the inder supervision at the ines and they could smoke is they wanted for fifteen it was her responsibility to in was a questionnaire that early and with significant int. The SW further stated is did not include having the instration of lighting, smoking igarette. PM an interview with both ithe Director of Nursing important and always been in expears and had always been	F	242	assessed for smoking in the month the MDS assessment schedule at new admissions. The results will reported to the Quality Assurance Performance Improvement Commonsisting of the Medical Director Administrator, Director of Nursing (Infecontrol Representative), Staff Development Coordinator, MDS Coordinator, Social Services Dire Admissions Director, Activity Dire Business Office Manager, Dietary Manager, Human Resources Mar Maintenance Director, Environme Services Supervisor, Restorative Medical Records, Charge nurse a Certified Nursing Assistant meetir monthly x 12 months for follow up recommendations.	nd all be nittee , , ection ctor, ctor, / nager, ental Nurse and a	2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345285	B. WING			3/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 242	indicated Resident # for injury. Intervention smoking policy and promoting smoking apron is available and smoking apron is available and revealed smoking scheduled smoking scheduled smoking scheduled smoking apron is available and revealed he was a cigarette was proved (HA) #1. The HA #1 safely smoked the cigarette was given the extinguished in a first no concerns noted done and revealed the standard standard show many cigarette was given the residents HA's used their own to the HA's that explain and how many cigared during each smoke the unsupervised smokes and how many cigared during an interview with the HA's that explain and how many cigared the would but had never been a smoking. He confirm was used when in hi oxygen tank attaches #59 revealed if he withen he must wait unsupervised smoking.	date was 01/23/17 and 59 was a smoker and at risk in included: provide with a procedures and ensure re available. Ensure a sailable and offer supervision toke breaks. pervised smoking with one on 03/14/17 at 9:14 AM is wearing a smoker's apronaided by the Hospitality Aide lithis cigarette. Resident #59 garette. When finished the one the HA #1 who is proof container. There were suring the observation of smoking. with HA #1 on 03/14/17 at and a smoking cart was used is smoking materials. The lighters. A list was provided ained smoking break times ettes the resident could have break. There was no are list provided.	F 24	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345285	B. WING _			3/16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND F	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	revealed that the Sm explained to the resident on admission and we SW explained the fact allowed the residents at the seven set smo smoke as many cigal fifteen minutes. She is responsibility to compuestionnaire that we with significant change further stated that the include having the re of lighting, smoking a On 03/16/17 at 6:30 lighting, smoking a On 03/16/17 at 6:30 lighting, smoking a questionnaire. The not have the resident safe smoking becaus supervised smoking. stated that no resider smoke independently	V on 03/16/17 at 3:35 PM oking Policy (SP) was dents who desired to smoke are asked to sign a SC. The cility's Smoking Policy to smoke under supervision king times and they could rettes as they wanted for	F 2	42		
F 253 SS=E	SERVICES (i)(2) Housekeeping a necessary to maintain comfortable interior;	REPING & MAINTENANCE and maintenance services n a sanitary, orderly, and r is not met as evidenced	F 2	53		5/16/17

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345285	B. WING _			03	/16/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				20	00 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND F	REHAB		Н	ENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 253	Continued From page	e 7	F 2	253				
	facility failed to repair and splintered lamina doors on 2 of 2 wings #211, #217, #223, #2 The facility also failed splintered laminate of doors on 1 of 2 wings #223), replace overbe peeling vinyl in 3 roor room #217, #221, and and discolored caulki keep bathroom doors scratched bathroom vermove stains from a shared bathrooms on		dident doors with broken on 8 of 62 room entry esident room #207, #228, #231, and #308. repair broken and of 29 shared bathroom esident room #218 and ables with missing or on 2 of 2 wings (Resident 806), replace cracked at the base of toilets, e of scratches, paint s, repair dry wall, and chroom floor for 12 of 29 of 2 wings. In addition, abel and properly store		What corrective action(s) will be accomplished for those residents four have been affected by the alleged deficient practice? Overbed tables in rooms #217, #221 a #306a were replaced March 17, 2017 The wall in shared bathroom for #301 #303 was repaired and the caulking around the toilet was replaced on April 2017. The caulking around the toilet for shall bathroom for rooms #302 and #304 w replaced on April 4, 2017. Shared bathroom for rooms #309 and #311 paint scratched off was repaired April 4, 2017. Shared bathroom for rooms #309 and #311 caulking was replaced on April 4			
	Director on 03/16/17 Maintenance Director the facility for 5 years worked 30 hours a worked 30 hours a worked and painting. Quarter bedside tables, overthe caulking. The Maintenassistant was painting hall this week. In add hall had a complete at the list of repairs and February of 2017. Th further stated there wo	ducted with the Maintenance at 4:19 PM. The stated he had worked at and had one assistant who eek. The interview revealed monthly for needed repairs ly audits were conducted for			2017. The baseboard in room #309 was repaired on April 4, 2017. Shared bathroom #313 and #315 cau was replaced on April 4, 2017. Shared bathroom #210 and #212 the scratch on the wall will be repaired by 13, 2017. Shared bathroom #218 and #220 the scratch on the wall will be repaired by 13, 2017. Shared bathroom #221 and #223 the scratch on the wall will be repaired by 13, 2017. Shared bathroom #226 and #228 the scratch on the wall will be repaired by 13, 2017. Shared bathroom #229 and #231 the scratch on the wall will be repaired by 13, 2017.	April April April April		

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		345285	B. WING _			03/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE		
MOUNTAI	NUME HEALTH AND F	25114.5		200 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND F	KEHAB		HENDERSONVILLE, NC 28	3739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	RY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 253	Continued From page	e 8	F 2	53			
	communicate needed 1. a. Observations of rooms 301 and 303 n PM, 03/14/17 at 12:1 and 03/16/17 at 10:2 front of the toilet had almost the entire widing 12 inches from the flowase of the toilet was An interview was combirector on 03/16/17 observations of the s 301 and 303. The Mathe wall in the bathrooms of the second of t	the shared bathroom for made on 03/13/17 at 4:16 7 PM, 03/15/17 at 3:20 PM, 0 AM revealed the wall in the paint scratched off the of the wall approximately for and the caulking at the cracked and discolored. ducted with the Maintenance at 5:39 PM after hared bathroom for rooms aintenance Director stated om needed to be added to the caulking at the base of		Shared bathroom #31 to the right of the sink April 5, 2017. Shared bathroom #32 above the soap disper April 6, 2017. The resident room dod #217, #223, #227, #23 bathroom doors #218 patched to reduce the resident harm by April All resident personal it and bagged (if resider 13, 2017. Plunger in shared bath	was repaired on 3 and #325 drywall nser was repaired ors for #207, #211, 31, #308 and shared and #223 will be potential for 13, 2017. tems will be labeled nt choice) by April		
	b. Observations of the shared bathroom for rooms 302 and 304 made on 03/13/17 at 2:50 PM, 03/14/17 at 11:23 PM, and 03/15/17 at 3:54 PM revealed the caulking at the base of the toilet was cracked and discolored.			#312 was bagged on I Plunger in shared bath #212 was bagged on I How the facility will ide having the potential to same deficient practic	hroom #210 and March 16, 2017. entify other residents be affected by the	3	
	Director on 03/16/17 observations of share and 304. The Mainter caulking needed to be toilet and thought he to see if there was a c. Observations of the	ed bathroom for rooms 302 nance Director agreed the e replaced at the base of the may need take up the toilet		An audit of overbed ta by the Maintenance D 2017. Any overbed ta was replaced. An audit will be compl personal care items by Nursing, Assistant Din Ancillary Clerk or hosp	virector on April 4, while in need of repair leted for unlabeled by the Director of ector of Nursing,		
	PM, 03/15/17 at 3:50 AM revealed approximating from the edge of	PM, and 03/16/17 at 10:24 mately 7 inches of the vinyl f the overbed table was sed particle board which had		13, 2017. Items will b labeled properly. The resident room door	e bagged and		

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		345285	B. WING _				3/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		07.1072011	
				200 HERI	ITAGE DRIVE			
MOUNTAI	N HOME HEALTH AN	D REHAB		HENDE	RSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ID NCY MUST BE PRECEDED BY FULL PREFIX DR LSC IDENTIFYING INFORMATION) TAG		(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		(X5) COMPLETION DATE	
F 253	Continued From page	200 0).E2				
1 255	-	age 9	F 2	253	_ ,, ,,			
	a rough surface.			I	7, #223, #227, #231, #308 and			
	A :				nroom doors #218 and #223 wi			
		conducted with the Maintenance			ched to reduce the potential for	•		
		17 at 5:31 PM after		resid	dent harm by April 13, 2017.			
		e overbed table in room 306 A. Director stated the overbed		And	audit of 100% of all doors was			
		e replaced because the rough		I	upleted on April 7, 2017, by the			
		e a skin tear or a cut. The			ntenance Director. It was note			
	Maintenance Direct		I	doors needed to be replaced.				
		drobes, night stands, and		l l	nber, 42 doors were noted to ha			
		did not recall if he noticed this		l l	st significant need for repair.			
	particular overbed				e eigenmeent meet a epenme			
	•			Wha	at measure will be put in place	or		
	d. Observations of	the entry door for room 308			emic changes made to ensure			
	made on 03/13/17	at 4:39 PM, 03/14/17 at 12:23		the	deficient practice will not recur	?		
	PM, and 03/15/17	at 3:47 PM revealed broken						
	and splintered lam	inate and wood on the lower		In-se	ervicing of properly labeling pe	ersonal		
	half of the hinge si	de of the door.			e items will be conducted with 1			
					staff by April 13, 2017, by the S			
		ucted with the Maintenance		l l	elopment Coordinator, Director			
		17 at 5:30 PM after		Nurs	sing, or Assistant Director of N	ursing.		
		e entry door for room 308. The						
		ctor agreed the splintered wood			ervicing for proper storage and			
		to the residents and they would			ging of plungers will be conduc			
		plintered edges of the door with			% of the staff by April 13, 2017			
		nd until a decision was made		l l	f Development Coordinator, Di			
		e doors or a better solution was		I	lursing, Assistant Director of No	ursing		
		nance Director stated during an 4:41 PM that 90% of the doors		Oriv	Maintenance Director.			
				In ea	ervicing of completion of a wor	k order		
	had splintered wood from being hit by wheelchairs and lifts.			l l	be conducted with 100% of the			
	Wilcolonalis and III			l l	April 13, 2017, by the Staff	Juli		
	e. Observations of	the shared bathroom for		1 -	relopment Coordinator, Director	r of		
		1 made on 03/13/17 at 3:22		I	sing, Assistant Director of Nurs			
		1:30 AM, and 03/15/17 at 3:33		l l	ntenance Director.	J,		
		vall in front of the toilet had the						
		almost the entire width of the		Mair	ntenance Director and Assistar	nt		
	·	12 inches from the floor and			ntenance Director will be in-ser			
		oor at the base of the toilet was		l l	completion of work orders and t			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345285	B. WING_			03/	16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N HOME HEALTH AND F	REHAB		20	00 HERITAGE DRIVE		
MOONIA	N HOME HEALTHAID I	(LIAB		Н	ENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 253	baseboard approxima	There was also a piece of ately 8 inches long missing	F:	253	completed work orders and facility physical plant repairs by April 13, 2017	, by	
	An interview was conditioned by the missing baseboar replaced. f. Observations of the missing baseboar replaced. An interview was conditioned by missing baseboar replaced by missing baseboar replaced. An interview was conditioned by missing baseboar replaced by missing baseboar replaced by missing baseboar replaced. An interview was conditioned by missing baseboar replaced by missing baseboar replaced. An interview was conditioned by missing baseboar replaced by missing baseboar replaced. An interview was conditioned by missing baseboar replaced by missing baseboar replaced. An interview was conditioned by missing baseboar replaced. An interview was conditioned by missing baseboar replaced. An interview was conditioned by missing baseboar replaced. Director on 03/16/17 observations of the same replaced by missing baseboar replaced.	room door in room 309. Inducted with the Maintenance ations in room 309 and the room 309 and 311. The restated the bathroom wall to the touch up list and he tech work on the bathroom ce Director explained a floor 016 and the most recent at two weeks ago. In addition, and in room 309 needed to be reshared bathroom for rooms in 03/14/17 at 9:07 AM, and 03/16/17 at 10:28 AM at the base of the toilet was eed and a 2 inch piece of the away from the toilet.			the Administrator. A personal item audit which includes labeling or bagging personal items will completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Central Sup Clerk, Environmental Services Supervisor Administrator. On April 11, 2017, 42 doors will be ordered by the Maintenance Director, anticipated date for installation is May 2017. The remaining doors will be replaced by replacing 30 doors per quarter until all doors in need of repair replaced. A physical plan audit which includes, be not limited to, walls, baseboards, toilets doors, trim and sinks will be completed weekly x 2 months, bi-weekly x 2 month and monthly x 6 months. The audit will completed by the Administrator, Director of Nursing, or Environmental Services Supervisor. How the facility will monitor its corrective actions to ensure the deficient practice being corrected and will not recur. A personal item audit which includes labeling or bagging personal items will conducted weekly x 4 weeks, bi-weekly	be ply sor The 16, are ut is 5, hs l be or	
	potential for injury an	e splintered doors were a d there needed to be a ntil a decision was made.			2 months and monthly x 3 months. The audit will be completed by the Director Nursing, Assistant Director of Nursing of States.	of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345285	B. WING		,	3/16/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		071072017	
				200 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND	REHAB		HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 253	made on 03/15/17 at AM, and 03/16/17 at with the Director of Nunlabeled comb on the faucet. b. Observations of the on 03/13/17 at 2:49 revealed an unlabeled periwash on the back. Observations on 03/0bservations with the PM revealed an unlabeled an unlabeled on 03/13/17 at uncovered and unlabeled tube of too sink. Subsequent observations observations of the made on 03/15/17 at 3:51 PM during observations on 03/15/17 at 3:51 PM during observations of the made on 03/15/17 at 3:51 PM during observation	f the shared sink in room 301 to 3:20 PM, 03/16/17 at 10:20 3:09 PM during observations dursing (DON) revealed an he back of the sink behind the shared sink in room 302 PM and 03/14/17 at 11:24 AM and be	F 25	Staff Development Coordinator Supply Clerk, Environmental Se Supervisor or Administrator. The of the audit findings will be presented the Director of Nursing to the magnetic Consisting of the Medical Direct Administrator, Director of Nursing (in Control Representative), Staff Development Coordinator, MDS Coordinator, Social Services Di Admissions Director, Activity Di Business Office Manager, Dieta Manager, Human Resources Maintenance Director, Environm Services Supervisor, Restoration Medical Records, Charge Nurs Certified Nursing Assistant mee monthly for 6 months for further and/or recommendations. A physical plant audit which income is not limited to, walls, baseboardoors, trim and sinks will be conveekly x 2 months, bi-weekly x and monthly x 6 months. The activities of the supervisor of	ervices the results sented by nonthly e ng tor, ng, nfection S irector, irector, ary flanager, mental ve Nurse, e and a ting r follow-up sludes, but ards, toilets, mpleted 2 months audit will be		
	bottle of shampoo/bolabeled. d. Observations of the made on 03/13/17 at 12:23 PM revealed a bottle of lotion, and points.	ne shared sink in room 308 to 4:37 PM and 03/14/17 at an unlabeled brush, comb, periwash on the back of the		completed by the Administrator Environmental Services Supervices of Nursing. The results audit findings will be presented Environmental Services Supervices Supervices Administrator to the Quality Assistent Poirector, Administrator, Director Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Assistant Director Supervices S	visor or s of the by the visor or surance mmittee cal r of		
	Subsequent observa	itions on 03/15/17 at 3:49 PM		(Infection Control Representative	ve), Staff		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION	(X3) DATE S COMPL		
		345285	B. WING		03/	16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 253	e. Observations of the rooms 309 and 311 r. PM, 03/14/17 at 11:3 and during observations of the graduated cylinder of an unlabeled urine coresting on top of a battoilet. f. Observations of the 310 and 312 made of 03/14/17 at 12:26 PM during observations 3:19 PM revealed a graduated personal care equipmost and the toilet. During an interview of Nurse #3 stated personal care equipmost and 2:31 PM revealed personal care products with Nurse #3 stated personal care products with the resident's napersonal care equipmost at 2:31 PM revealed personal care products with Nurse #3 stated personal care products with Nurse #3 personal care equipmost at 2:31 PM revealed personal care products with Nurse #3 personal c	ons with the DON on revealed an unlabeled brush ck of the sink. The shared bathroom for made on 03/13/17 at 3:24 at 30 AM, 03/15/17 at 3:33 PM, ons with the DON on revealed an unlabeled on the back of the toilet and collection hat and a plunger ag both on the floor near the se shared bathroom for rooms on 03/13/17 at 2:43 PM, and with the DON on 03/16/17 at plunger on the floor next to the solution of the floor next to the shared bathroom for rooms on 03/16/17 at 2:27 PM and with the DON on 03/16/17 at plunger on the floor next to the shared bathroom for rooms on 03/16/17 at 2:27 PM and with the DON on 03/16/17 at 2:27 PM and hygiene and personal kept in zip top bag labeled ame. Nurse #3 indicated ment should be labeled and are should be labeled and ag. NA #3 stated graduated abeled and placed on the e interview further revealed e personal care equipment	F 25	Development Coordinator, M Coordinator, Social Services Admissions Director, Activity Business Office Manager, D Manager, Human Resource Maintenance Director, Envir Services Supervisor, Restor Medical Records, Charge N certified nursing assistant m monthly for 10 months for fu follow-up and/or recommend	s Director, y Director, y Director, bietary s Manager, conmental rative Nurse, urse, and a leeting urther	
	An interview was cor the observations of r	nducted with the DON during esidents' rooms and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345285	B. WING _		0	3/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 253	The DON stated per should be labeled if of the sink but she p labeled with the residuip top bag. The DO should never be stor further stated urine of discarded once the s graduated cylinders in a bag on the back	stred on 03/16/17 at 3:01 PM. sonal hygiene products they were stored on the back referred personal items to be dent's name and stored in a N indicated toothbrushes red uncovered. The DON collection hats should be specimen was collected and should be labeled and stored of the toilet. In addition, ored in bathroom but should	F 2	53			
	rooms 210 and 212 revealed the inside of the wall in front of the subsequent observations of the subsequent observations observat	f the shared bathroom in on 03/15/17 at 10:42 AM of both bathroom doors and e toilet were scratched. The tions were on 03/16/17 at M in which the conditions d. The bedroom in room 217 on revealed the vinyl on the was peeled back which left absequent observations were AM and 03/16/17 at 4:55 PM ns remained unchanged. The shared bathroom in rooms 13/17 at 1:36 PM revealed the om doors and the wall in the scratched. The subsequent in 03/14/17 at 8:17 AM and in which the conditions					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER	REHAB	:	STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 253	remained unchanged. d. Observations of the 221 and 223 on 03/2 inside of both bathrofront of the toilet were observations of room the overbed table ender the end of	the shared bathroom in rooms /13/17 at 1:52 PM revealed the oom doors and the wall in ere scratched. In addition, m 221 revealed the vinyl on dge was peeled back which he subsequent observations t 8:19 AM and 03/16/17 at he conditions remained Dedroom 223 on 03/13/17 at he bedroom door had gouged the hinge side of the door. The ations were on 03/14/17 at /17 at 5:06 PM in which the d unchanged. The shared bathroom in rooms /14/17 at 11:49 AM revealed athroom doors were on, observations of the entry revealed the hinge side of the gouged out wood areas on it. servations were on 03/16/17 16/17 at 5:11 PM in which the	F 253			

NAME OF PROVIDER OR SUPPLIER MOUNTAIN HOME HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (PALID REGULATORY OR LSC IDENTIFYING INFORMATION) F 253 Continued From page 15 remained unchanged. h. Observations of the shared bathroom in rooms 229 and 231 on 03/13/17 at 8:48 AM revealed the inside of both of the bathroom doors and the wall in front of the toilet were scratched. In addition, observations of the entry door for room 231 revealed both edges of the door had gouged out wood areas on it. The subsequent observations were on 03/14/17 at 8:57 AM and 03/16/17 at 5:14 PM in which the conditions remained unchanged. An interview conducted with the Maintenance Director on 03/16/17 at 4:19 PM in which he revealed the performed routine weekly audits on call lights, monthly audits on hand rails, lifts and (Resident) rooms, and the side rails were checked twice a month. The Maintenance Director stated that repair requisitions were left on clip boards that were kept on both sides of the building and were checked several times a day. The Maintenance Director stated that repair requisitions were left on the building and were checked several times a day. The Maintenance Director stated that repair requisitions were but the building and were checked several times a day. The Maintenance Director stated that he would have to putly the gouged out areas in the doors, paint the bathroom walls and he agreed that the sharp edges on the over bed tables could cause skin tears.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
MOUNTAIN HOME HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739			345285	B. WING		0	3/16/2017	
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 253 Continued From page 15 remained unchanged. h. Observations of the shared bathroom in rooms 229 and 231 on 03/13/17 at 8:48 AM revealed the inside of both of the bathroom doors and the wall in front of the tollet were scratched. In addition, observations of the entry door for room 231 revealed both edges of the door had gouged out wood areas on it. The subsequent observations were on 03/14/17 at 8:57 AM and 03/16/17 at 5:14 PM in which the conditions remained unchanged. An interview conducted with the Maintenance Director on 03/16/17 at 4:19 PM in which he revealed he performed routine weekly audits on call lights, monthly audits on hand rails, lifts and (Resident) rooms, and the side rails were checked twice a month. The Maintenance Director stated that repair requisitions were left on clip boards that were kept on both sides of the building and were checked several times a day. The Maintenance Director stated that he would have to putty the gouged out areas in the doors, paint the bathroom walls and he agreed that the sharp edges on the over bed tables could cause			REHAB	:	200 HERITAGE DRIVE	·		
remained unchanged. h. Observations of the shared bathroom in rooms 229 and 231 on 03/13/17 at 8:48 AM revealed the inside of both of the bathroom doors and the wall in front of the toilet were scratched. In addition, observations of the entry door for room 231 revealed both edges of the door had gouged out wood areas on it. The subsequent observations were on 03/14/17 at 8:57 AM and 03/16/17 at 5:14 PM in which the conditions remained unchanged. An interview conducted with the Maintenance Director on 03/16/17 at 4:19 PM in which he revealed he performed routine weekly audits on call lights, monthly audits on hand rails, lifts and (Resident) rooms, and the side rails were checked twice a month. The Maintenance Director stated that repair requisitions were left on clip boards that were kept on both sides of the building and were checked several times a day. The Maintenance Director stated that he would have to putty the gouged out areas in the doors, paint the bathroom walls and he agreed that the sharp edges on the over bed tables could cause	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION	
4. a. Observations of the shared bathroom in rooms 210 and 212 on 03/15/17 at 10:42 AM revealed an uncovered black plunger on the floor next to the toilet as well as an unlabeled and uncovered graduated cylinder on the back of the toilet. The subsequent observations were on 03/16/17 at 8:11 AM and at 3:02 PM in which the conditions remained unchanged. An interview was conducted with the Director of	F 253	remained unchanger h. Observations of the 229 and 231 on 03/1 inside of both of the in front of the toilet wobservations of the revealed both edges wood areas on it. The were on 03/14/17 at 5:14 PM in which the unchanged. An interview conduct Director on 03/16/17 revealed he perform call lights, monthly a (Resident) rooms, at checked twice a morn Director stated that reclip boards that were building and were chart to putty the gorn paint the bathroom wisharp edges on the oskin tears. 4. a. Observations or rooms 210 and 212 revealed an uncovernext to the toilet as we uncovered graduate toilet. The subseque 03/16/17 at 8:11 AM conditions remained	d. ne shared bathroom in rooms 13/17 at 8:48 AM revealed the bathroom doors and the wall were scratched. In addition, entry door for room 231 of the door had gouged out the subsequent observations 8:57 AM and 03/16/17 at the conditions remained ted with the Maintenance of at 4:19 PM in which he ded routine weekly audits on udits on hand rails, lifts and and the side rails were eight. The Maintenance of the expair requisitions were left on the kept on both sides of the elecked several times a day, rector stated that he would auged out areas in the doors, walls and he agreed that the over bed tables could cause of the shared bathroom in 100 03/15/17 at 10:42 AM are black plunger on the floor evel as an unlabeled and decylinder on the back of the int observations were on and at 3:02 PM in which the unchanged.	F 253				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HERITAGE DRIVE IENDERSONVILLE, NC 28739		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 253	and the graduated c in a bag on the back 5. a. Observations on 03/13/17 at 4:34 and 03/16/17 at 3:01 and un-bagged: toot bottle of mouthwash b. Observations of a 03/14/17 at 8:42 AM 03/16/17 at 3:04 PM un-bagged tooth bru of shampoo. c. Observations of a 03/14/17 at 9:50 AM 03/16/17 at 3:30 PM un-bagged denture of and shampoo. Interview with the Di 03/16/17 at 3:20 PM items should not be unlabeled. The DON personal care items and for tooth brushe	er should be in a tied bag ylinder should be labeled and of the toilet. of a shared sink for room 208 PM, 03/15/17 at 4:21 PM, PM revealed an unlabeled hbrush, tube of toothpaste, and bottle of shampoo. shared sink for room 223 on 03/15/17 at 5:05 PM, and revealed an unlabeled and sh, tooth paste, and a bottle shared sink for room 218 on 03/15/17 at 4:59 PM, and revealed an unlabeled and sh, tooth paste, and a bottle shared sink for room 218 on 03/15/17 at 4:59 PM, and revealed an unlabeled and cup, bottle of perineal care, rector of Nursing (DON) on revealed personal care stored on the back of the sink I stated she preferred be in a labeled zip top bag s not to be uncovered.	F 253			
	207 on 03/15/17 at 4 PM revealed broken	f the entrance door for room 1:30 PM and 03/16/17 at 4:30 and splintered laminate and of the bottom half of the				
	211 on 03/13/17 3:2 and 03/16/17 at 4:41	he entrance door for room 7 PM, 03/15/17 at 4:54 PM, I PM revealed broken and and wood on both edges of e door.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 HERITAGE DRIVE HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 253	Continued From pag	ge 17	F 253			
	217 on 03/15/17 at ² PM revealed broken wood on both edges door.	ne entrance door for room 4:52 PM and 03/16/17 at 4:52 and splintered laminate and of the bottom half of the				
d. Observations of a shared bathroom door for room 218 on 03/14/17 at 9:50 AM, 03/15/17 at 4:59 PM, and 03/16/17/at 4:59 PM revealed splintered wood along the lower portion of the door.	17 at 9:50 AM, 03/15/17 at /17/at 4:59 PM revealed					
	e. Observations of a shared bathroom door for room 223 on 03/14/17 at 8:42 AM, 03/15/17 at 5:05 PM, and 03/16/17 at 5:06 PM revealed splintered wood along the lower portion of the door. An interview conducted with the Maintenance Director on 03/16/17 at 5:30 PM revealed the splintered wood could cause injury to the residents and they would need to fill in the splintered edges of the door with wood putty and sanded until a decision was made about replacing the doors or a better solution was found.					
	5:52 PM in which sh trying to decide whe replace the doors. S	e Administrator on 03/16/17 at e revealed the facility was ther to use coverings or he agreed the splintered al for injury and there needed				
	rooms 314 and 316	f the shared bathroom for made on 03/13/17 at 2:30 04 PM, 03/15/17 at 9:38 AM,				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345285	B. WING		03/16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	,
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 253	03/16/17 at 8:24 AM revealed an area me inches wide by 12 in of drywall missing lo of the sink. b. Observations of the	and 03/16/17 at 5:19 PM easuring approximately 4 ches long with the top layer cated above and to the right the shared bathroom for made on 03/13/17 at 4:23	F 25	3	
	pm, 03/14/17 at 11:5 03/16/17 at 8:23 AM 03/16/17 at 5:36 PM approximately 5 inch	66 AM, 03/15/17 at 9:40 AM, , 03/16/17 at 2:53 PM and revealed an area measuring nes wide by 5 inches long with all missing located above the			
	03/16/17 at 5:36 PM assistant completed January 2017 and he February 2017. The	e Maintenance Director on revealed he and his a full audit of the 300 hall in ad just finished the list in Maintenance Director was ese 2 bathrooms were on the			
	rooms 314 and 316 PM, 03/14/17 at 12:0 03/16/17 at 8:24 AM	ne shared bathroom for made on 03/13/17 at 2:30 04 PM, 03/15/17 at 9:38 AM, and 03/16/17 at 5:19 PM ed and unbagged tube of athroom sink.			
F 272	on 03/16/17 at 3:20 personal care items back of the sink unla preferred for personal labeled zip top bag.	e Director of Nursing (DON) PM revealed residents' should not be stored on the abeled. The DON stated she al items to be stored in a	F 27	72	4/13/17
F 272 SS=D	483.20(b)(1) COMPI ASSESSMENTS	REHENSIVE	F 27	72	4/13/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 272	Continued From pa	ge 19	F 27	2		
	(b) Comprehensive	Assessments				
	must make a compresident's needs, stropreferences, using treatment (RAI) speasessment must in (i) Identification are (ii) Customary rout (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and behave (vii) Psychological volii) Physical fur problems. (ix) Continence. (x) Disease diagnot (xi) Dental and nutrof (xii) Skin Conditions (xiii) Activity pur (xiv) Medication (xv) Special treatment (xvi) Discharge (xvii) Documentare garding the addition the care areas of the Minimum Dataressessment. The a include direct observation	rns. Avior patterns. Evell-being. Inctioning and structural Asis and health conditions. Ititional status. Is. Is. Is. Is. Is. Is. Is.				

STATEMENT OF DEFICIENCIES (X* AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		345285	B. WING		03	3/16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH ANI) REHAB	•	STREET ADDRESS, CITY, STATE, ZIP CO 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		· · · · · · · · · · · · · · · · · · ·		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 272	on all shifts. The assessment probservation and coas well as commur non-licensed direct shifts. This REQUIREME by: Based on record refacility failed to conthat addressed the factors for 1 of 3 savision (Resident #8 The findings included Review of the med #81 was admitted including dementian Review of the annual dated 02/15/17 review moderately impaired large print but not rebooks. The annual did not use correction Review of the Care Vision completed werevealed Resident.	rocess must include direct immunication with the resident, inication with licensed and incare staff members on all NT is not met as evidenced eviews and staff interviews the implete Care Area Assessments contributing factors and risk impled residents reviewed for initial. ed: ical record revealed Resident ion 03/24/15 with diagnoses . ual Minimum Data Set (MDS) ealed Resident #81 had indication on one of the contribution and could see egular print in newspapers and implementation on one of the contribution of the contribution and could see egular print in newspapers and implementation of the contribution of the cont	F 2	What corrective action(s) will accomplished for those reside have been affected by the all deficient practice? Care Area Assessment for rewas updated to reflect her detect the problem, possible cause contributing factors and risk related to Visual function on How the facility will identify chaving the potential to be affected to visual function on the problem of	ill be dents found to dents found to dents found to desident #81 description of s and factors april 5, 2017. Dether residents fected by the desident seed ar by April 13,	
	last update. The C need to be seen by 07/2017. The CAA findings did not inc	were no real changes from AA noted Resident #81 did not the eye clinic again until summary and analysis of lude her strengths and v the triggered area impacted		systemic changes made to e the deficient practice will not The Director of Social Servic in-serviced on completion of Area Assessment by the MD	recur? ces was the Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345285	B. WING _			03/	16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND R	ЕНАВ		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 HERITAGE DRIVE ENDERSONVILLE, NC 28739		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	her day to day life. The the vision loss affected social activities, or seen an interview was consumed with the vision section. Worker (SW) on 03/1 stated she had been assessments for a veresponsible for several vision section. Reside Vision was reviewed a SW indicated she usucher progress note in the SW further stated the resident specific infortriggered area affected life. The SW was not	dere was no mention of how dere her safety, participation in lf-care activities. ducted with the Social 5/17 at 4:46 PM. The SW completing MDS	F 2	272	Coordinator on March 28, 2017. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or MDS Coordinator will at Care Area Assessments for Vision with weekly x 4 weeks, then 1 weekly x 4 weeks, then 2 monthly x 6 months. How the facility will monitor its corrective actions to ensure the deficient practice being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or MDS Coordinator will at Care Area Assessments for Vision with weekly x 4 weeks, ten 1 weekly x 4 weeks, then 2 monthly x 6 months. The Director of Nursing will report the finding to the Quality Assurance Performance Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Control Representative), State Development Coordinator, MDS Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medica Records, Charge Nurse and a certified nursing assistant meeting monthly x 8 months for follow up and/or	udit 2 ve is udit 2 e gs	
F 281 SS=D	483.21(b)(3)(i) SERV PROFESSIONAL STA	ICES PROVIDED MEET ANDARDS	F 2	81	recommendations.		4/13/17

* 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED
		345285	B. WING		03/	16/2017
	ROVIDER OR SUPPLIER	D REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739		
(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 COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 22	F 2	281		
	(b)(3) Comprehens	ive Care Plans				
		ded or arranged by the facility, comprehensive care plan,				
		al standards of quality. NT is not met as evidenced				
	Based on observations, record reviews, and staff interviews the facility failed to rinse a resident's mouth with water after administering an inhaler to reduce the chance of a fungal infection for 1 of 5 residents observed during medication			What corrective action(s) will to accomplished for those resider have been affected by the alleg deficient practice?	nts found to	
	administration (Res	sident #53).		The Medication Administration resident #53 was updated to in instructions to rinse and spit af Symbicort inhaler use on Marc	clude ter	
		admitted on 08/08/13 with				
	pulmonary disease			How the facility will identify oth having potential to be affected same deficient practice.		
	#53 was prescribed steroid and bronch	n's orders revealed Resident d Symbicort inhaler (contains a odilator) 160-4.5 mcg e 2 puffs orally twice a day for		Any resident receiving a steroic will be audited by a licensed not ensure their orders include rins spitting after inhaler use by Apr	urse and sing and	
	03/14/17 at 4:18 P Resident #53's me inhaler 160-4.5 mc	edication administration on M revealed Nurse #2 prepared dications including a Symbicort g. Nurse #2 entered Resident		What measure will be put in pla systemic changes made to ens the deficient practice will not re	sure that ecur?	
	administered oral r Symbicort inhaler v between inhalation	oximately 4:20 PM and nedications and then the vaiting several minutes s. Nurse #2 exited Resident oximately 4:35 PM.		100% of licensed nurses (inclunurse who did not provide a rinin-serviced about rinsing mouth spitting out after any steroid inlimarch 17, 2017, by the Director Nursing or the Staff Development	nse) were n and naler use by or of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345285	B. WING _			03/1	16/2017
NAME OF P	ROVIDER OR SUPPLIER		· I	STREET ADDRESS, 0	CITY, STATE, ZIP CODE		
MOUNTAI	N HOME HEALTH AND	REHAB		200 HERITAGE DRI	VE		
				HENDERSONVILI	LE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From pag	ge 23	F 2	81			
		on 03/14/17 at 4:47 PM		Coordinator.			
	after administering a resident. Nurse #2 s supposed to have the with water to prevent confirmed she did in her mouth with water Symbicort inhaler. An interview with the 3:06 PM revealed stresidents rinse their after administering a contains a steroid at fungal infection (thruth An interview with the on 03/16/17 at 8:41 expected to have rewater and spit after contained a steroid confirmed Resident	d if there was anything she did a Symbicort inhaler to a stated she thought she was he resident rinse their mouth at a yeast infection. Nurse #2 of have Resident #53 rinse or after administering the expected nurses to have mouth with water and spit a Symbicort inhaler because it and to reduce the chance of a rish). Director of Nursing (DON) AM revealed nurses were sidents rinse their mouth with administering an inhaler that such as Symbicort. The DON #53 would be able to rinse or and spit without any		Director of N Coordinator v medication p observations 4 weeks, the observations 4 weeks, the observation t months. New in-serviced d How the facil actions to en being correct The Director Director of N Coordinator v random med licensed nurs Quality Assul Improvement consisting of Administrator Services Direct Manager, Die	of Nursing, Assistant lursing or Staff Development will complete five random passes of licensed nurse at to include all shifts weekly an 3 random licensed nurse at to include all shifts weekly an 1 random licensed nurse at include all shifts weekly are 1 random licensed nurse at include all shifts weekly are 1 random licensed nurse at include all shifts weekly are 1 random licensed nurse at luring their orientation period lity will monitor its corrective issure the deficient practice and will not recur. Tof Nursing, Assistant lursing or Staff Development will present findings of lication observations with sees during the monthly rance Performance at Committee meeting at the Medical Director, are MDS Coordinator, Social ector, Admissions Director, ctor, Business Office etary Manager, Human manager, Maintenance	/ x / x x 6 od. e is	
F 282 SS=D	483.21(b)(3)(ii) SER PERSONS/PER CA	EVICES BY QUALIFIED RE PLAN	F 2	Supervisor, F Records, Chanursing assistand/or record	vironmental Services Restorative Nurse, Medical arge Nurse and certified stant monthly for follow-up nmendations x 8 months.		4/13/17

PRINTED: 04/24/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N HOME HEALTH AND I	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5475	
F 282	Continued From pag	e 24	F 28	2		
		e Care Plans d or arranged by the facility, mprehensive care plan,				
	care. This REQUIREMEN by: Based on record rev facility failed to imple intervention for routin	h resident's written plan of I is not met as evidenced riew and staff interviews the ment a care planned he dental services for 1 of 3 eviewed for dental status and		What corrective action(s) will be accomplished for those residents found have been affected by the alleged deficient practice?		
	The findings included: Review of the medical record revealed Resident #110 was admitted on 06/24/16 with diagnoses including Alzheimer's disease. Review of the admission Minimum Data Set (MDS) dated 07/03/16 revealed Resident #110 had severely impaired cognition and had obvious			 a. Dental appointment is scheduled for resident #110 on the earliest available appointment. The Nurse Practitioner is aware and is agreement with the appointment schedule. How the facility will identify other resident having the potential to be affected by the same deficient practice. 	ents	
	or likely cavity or bro Review of the Care A Summary for Dental admission MDS reve risk for mouth pain a broken and missing t noted Resident #110 her regular diet and o of pain or problems of Review of a care plan	ken natural teeth. Area Assessment (CAA) Care completed with the aled Resident #110 was at not problems chewing due to eeth. The CAA Summary consumed 68% to 83% of did not have any complaints		All resident charts were audited for last dental appointment. The audit was completed on April 5, 2017 by a Licens Nurse. The audit was to ensure all residents dental appointments have not been missed and follow up occurred. Those residents found to have missed dental appointments will have appointments made by the Social Services Director. What measure will be put in place or systemic changes made to ensure that	sed	

PRINTED: 04/24/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345285	B. WING)		03/16/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				200 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND	REHAB		HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pag	ne 25	F 28	32			
		ng due to missing and broken		the deficient practice will not re	ecur?		
		to ensure dental health by		the denoted produce will her h			
		through next review on		100% of staff will be in-service	ed on dental		
		17. Interventions included:		referrals or need of referral of	any dental		
	extractions as ordered by the dentist, report oral pain or difficulty chewing food, obtain a dental			concerns to licensed nurse. A	•		
				included is referral of dental no	eeds in		
		rough, ensure complete		writing to Social Services Dire			
	T	th, and in house dentist per		Physician. The in-servicing w			
	facility protocol.			completed by April 13, 2017, b			
	A . (20.11 //4 20./40./47 /		Development Coordinator, Dir			
An interview with MDS Nurse #1 on 03/16/17 at 8:56 AM revealed when she completed an MDS			Nursing or Assistant Director of				
				All new hires will be in-service	a upon nire.		
		ermined a resident required a rpically communicated this		Director of Nursing, Assistant	Director of		
		ocial Worker (SW) verbally		Nursing or Staff Development			
		disciplinary Team (IDT)		will randomly audit 2 MDS (Se			
		e #1 reviewed Resident		one week for a month, 1 MDS			
	_	DS assessment dated		x one week for one month and	•		
	07/03/16 and noted i	it had been completed by		random MDS (Section L) x mo	onth for nine		
	MDS Nurse #2.			months.			
	During an interview of	on 03/16/17 at 9:02 AM MDS		How the facility will monitor its	corrective		
	Nurse #2 confirmed	she completed Resident		actions to ensure the deficient	practice is		
	#110's admission MD	DS assessment dated		being corrected and will not re	cur.		
	_	ne Oral/Dental Status section.					
		d Resident #110 had broken		The Director of Nursing, Assis			
		ıt denied pain. MDS Nurse #2		Director of Nursing or Staff De	•		
	•	determined a resident		Coordinator will present the re			
	required a dental cor			MDS (Section L) audit to the n	•		
		nformation to the Social		Quality Assurance Performance			
		y during the daily IDT ner office. MDS Nurse #2		Improvement Committee mee consisting of the Medical Direct	•		
		ad told the SW Resident #110		Administrator, Director of Nurs			
		by the Dentist but was not		Assistant Director of Nursing (-		
	certain when because			Control Representative), Staff			
		nen the request was made.		Development Coordinator, ME			
				Coordinator, Social Services I			
	An interview was cor	nducted with the SW on		Admissions Director, Activity [
		. The SW stated MDS Nurse		Business Office Manager, Die			

F 282 Continued From page 26 #1 and MDS Nurse #2 would come by her office and tell her if a resident needed to be seen by the Dentist. The SW explained if the resident was not set up with the dental plan she filled out and submitted the paper work. The SW further stated F 282 F 282 Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge nurse and a certified nursing assistant meeting	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TRUCTION	(X3) DATE SURVEY COMPLETED		
MOUNTAIN HOME HEALTH AND REHAB (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 26 #1 and MDS Nurse #2 would come by her office and tell her if a resident needed to be seen by the Dentist. The SW explained if the resident was not set up with the dental plan she filled out and submitted the paper work. The SW further stated 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SH			345285	B. WING _	B. WING		03	/16/2017
F 282 Continued From page 26 #1 and MDS Nurse #2 would come by her office and tell her if a resident needed to be seen by the Dentist. The SW explained if the resident was not set up with the dental plan she filled out and submitted the paper work. The SW further stated F 282 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge nurse and a certified nursing assistant meeting			REHAB	•	200 HER	RITAGE DRIVE	•	
#1 and MDS Nurse #2 would come by her office and tell her if a resident needed to be seen by the Dentist. The SW explained if the resident was not set up with the dental plan she filled out and submitted the paper work. The SW further stated Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Restorative Nurse, Medical Records, Charge nurse and a certified nursing assistant meeting	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	((EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
last visit was on 01/23/17 and the next scheduled visit was on 03/29/17. The SW reviewed her lists of who had been seen by the Dentist on 01/23/17 and which residents were scheduled to be seen on 03/29/17 and confirmed Resident #110 was not on either list. The SW indicated she had not been informed Resident #110 needed to be seen by the Dentist and she was not aware of any dental problems. During an interview on 03/16/17 at 1:27 PM the Director of Nursing (DON) stated the SW took care of referrals to the Dentist and she expected the MDS Nurses to communicate any dental concerns that were identified during the MDS assessment to the SW. The DON explained this information was usually communicated verbally during the daily morning stand up meeting. The DON could not explain why Resident #110 was not referred to the Dentist and stated the facility needed to change their process to ensure residents were referred to Dentist when they had dental issues. F 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT Free acility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323	#1 and MDS Nurse # and tell her if a reside Dentist. The SW expl set up with the dental submitted the paper of the Dentist came to the Dentist came to the Dentist came to the Dentist was on 03/29/17 of who had been see and which residents on 03/29/17 and confinot on either list. The been informed Reside by the Dentist and ship dental problems. During an interview of Director of Nursing (Coare of referrals to the MDS Nurses to concerns that were in assessment to the Ship information was usual during the daily morn DON could not explain not referred to the Deneeded to change the residents were referred dental issues. 483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVIOLATION (d) Accidents. The facility must ensident environments of the property of the p	2 would come by her office ent needed to be seen by the lained if the resident was not a plan she filled out and work. The SW further stated he facility quarterly and the 3/17 and the next scheduled. The SW reviewed her lists in by the Dentist on 01/23/17 were scheduled to be seen firmed Resident #110 was SW indicated she had not ent #110 needed to be seen in was not aware of any on 03/16/17 at 1:27 PM the DON) stated the SW took in the DON explained this allentified during the MDS W. The DON explained this ally communicated verbally ing stand up meeting. The fin why Resident #110 was entist and stated the facility eir process to ensure end to Dentist when they had on (3) FREE OF ACCIDENT SION/DEVICES		Mar Mai Ser Med cert mor recc abe inte acti	ntenance Director, Environmental vices Supervisor, Restorative Nurdical Records, Charge nurse and diffied nursing assistant meeting on the properties of the properties of the properties will be addressed, recently to developed and corrections.	il rse, a or	4/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND F	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323		Continued From page 27 (2) Each resident receives adequate supervision		23		
	(n) - Bed Rails. The appropriate alternative bed rail. If a bed or somust ensure correct in maintenance of bed into the following element (1) Assess the reside from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or the reside	rails, including but not limited ents. ent for risk of entrapment or installation. and benefits of bed rails with ent representative and obtain or to installation. ed's dimensions are sident's size and weight. I is not met as evidenced				
	interviews the facility were secured safely	ons, record reviews, and staff failed to ensure bed rails for 4 of 4 residents reviewed ents #32, #44, #97, and		What corrective action(s) will accomplished for those resid have been affected by the all deficient practice? The Maintenance Director tig	ents found to eged	
	Findings Included:	lical records revealed		rails for residents #32, #44, # on March 16, 2017.		
		mitted to the facility on				
		ses including anxiety,		How the facility will identify of having the potential to be affer same deficient practice.		
	dated 02/06/17 revea moderately impaired MDS implied Resider	Minimum Data Set (MDS) Iled Resident #32 had cognition. The quarterly nt #32 needed extensive ity and transfers and walking		All residents with rails have the to be affected. The residents rails will have their beds audit adjustments will be made to the same to t	s with side ted and	

PRINTED: 04/24/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE	1 00.10.2011	
MOUNTAI	N HOME HEALTH AND I	REHAB		HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 323	Continued From pag	e 28	F 32	3		
	did not occur.			necessary for safety by April 13, 2	2017.	
	revised date of 02/20 for falls due to poor some non-ambulatory statuinterventions were to reach and use a meet to keep the bed in low. An observation of Remade on 03/13/17 at PM, and 03/16/17 at quarter rail at the heathe ability to move from approximately 3 inchemattress. There was bed. The Maintenance Direction observe the side rails were loose and not a tightened or replaced.	esident #32 side rail was 2:14 PM, 03/16/17 at 3:16 4:34 PM revealed the right ad of the bed to be loose with		What measure will be put in place systemic changes made to ensure deficient practice will not recur? Maintenance Director, Assistant Maintenance Director, Environmen Services Supervisor, Director of N Assistant Director of Nursing or Administrator will audit rails for proattachment to the bed and will tight needed. This will be completed by 13, 2017. 100% of staff will be educated on safety. The in-service includes ch for loose rails, completion of work if repair or adjustment is needed. hours, then replacement of reside until adjustment/repair can be madin-service will be completed by the Development Coordinator by April 2017.	e the Intal lursing, Interpretation as a second as a	
	revealed Resident #3 side rail, but was uns roll while in the bed. staff used a mechani #32. An interview with the 5:55 PM confirmed to be addressed and im 2. Review of the median reveals and resident processes are resident processes and resident processes and resident processes are resident processes and resident processes are resident processes and resident processes are resident processes.	#1 on 03/16/17 at 5:07 PM 32 possibly could grab the sure of the ability to turn or NA #1 revealed direct care cal lift to transfer Resident Administrator on 03/16/17 at the loose side rails needed to amediately fixed. dical records revealed limitted to the facility on		The Maintenance Director, Mainte Assistant, Environmental Services Supervisor, Director of Nursing, As Director of Nursing or Administrate audit all beds with rails weekly for month, bi-weekly for a month and x 3 months. How the facility will monitor its cor actions to ensure the deficient prabeing corrected and will not recur.	ssistant or will a monthly rective ctice is	

PRINTED: 04/24/2017 FORM APPROVED OMB NO. 0938-0391

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		345285	B. WING _			03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB	•	STREET ADDRESS, CITY, STATE, ZIP C 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	cerebral infarction. Review of the quart dated 02/15/17 reve cognitively intact an with bed mobility and An observation of R made on 03/14/17 a AM, and 03/16/17 a quarter rails at the h with the ability to ma approximately 3 inc. An interview with Nawas able to use the #1 indicated Reside getting better and refered to be and not tightened or replace confirmed side rails. An interview with th 5:55 PM confirmed needed to be addressed to the addressed of cerebral palsy. There was no Minin comprehensive care.	erly Minimum Data Set (MDS) saled Resident #44 was d needed extensive assist d transfers. esident #44 side rails was at 10:05 AM, 03/15/17 at 8:43 at 4:18 PM revealed two head of the bed to be loose ove from side to side hes from mattress. A #1 confirmed Resident #44 grab bars for bed mobility. NA nt #44 had been sick, but is regaining his strength. irrector was accompanied to n on 03/16/17 at 4:59 PM to ls and confirmed the rails acceptable and needed to be d. The Maintenance Director were checked twice a month. e Administrator on 03/16/17 at the beds with loose side rails ssed and immediately fixed. dical records revealed admitted on 03/01/17 with dx	F3	The Maintenance Director results of the bed rail audit Assurance Performance Im Committee meeting consist Medical Director, Administr of Nursing, Assistant Direct (Infection Control Represer development Coordinator, I Coordinator, Social Service Admissions Director, Activit Business Office Manager, I Manager, Human Resource Maintenance Director, Envi Services Supervisor, Restor Medical Records, Charge N certified nursing assistant remonths for further follow-up recommendations.	at the Quality approvement ting of the rator, Director for of Nursing antative), Staff MDS as Director, by Director, Dietary as Manager, fronmental prative Nurse, Nurse and a monthly x 5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER N HOME HEALTH AND) REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 323	of the bed moved from matter an interview with N had the ability to us mobility. The Maintenance I Resident #126's roobserve the side rawere loose and not tightened or replace confirmed side rails. An interview with the 5:55 PM confirmed.	d two quarter rails at the head rom side to side approximately	F 323			
	Resident #97 was a diagnoses including infarction affecting dementia. Review of a care pl Resident #97 had t unsteady gait and I Interventions including reach and answer i assist with transfer.	edical record revealed admitted on 10/01/15 with g hemiplegia following cerebral dominant side and vascular an dated 02/15/16 revealed he potential for falls due to an eft sided weakness. led: keep call bell in easy n a timely manner, 1 to 2, and encourage and remind k for assistance with transfer.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345285	B. WING _			03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND	REHAB	'	STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	-	pdated on 06/23/16 to	F 3	23			
		e bed side rail to the right side e plan was due to be 6/23/16.					
	dated 01/29/17 reve moderately impaired	al Minimum Data Set (MDS) aled Resident #97 had I cognition and required e with bed mobility and					
	noted Resident #97 awareness due to co demonstrated poor b moving into a sitting bed. The assessme was currently using	assessment dated 02/09/17 had alterations in safety ognitive decline and had bed mobility or difficulty position on the side of the int concluded Resident #97 the the side rail for positioning ated it served as an enabler dence.					
	on her bed on 03/14 9:47 AM, and 03/16/ right side 1/2 rail wa grasped it moved up inches and could be frame leaving approx	sident #97's right side 1/2 rail 1/17 at 11:31 AM, 03/15/17 at 17 at 2:51 PM revealed the s loose and when the rail was and down approximately 2 pulled away from the bed ximately 2 to 3 inches of mattress and the side rail.					
	8:50 AM revealed shad for turning and righting out of bed. F	esident #97 on 03/16/17 at ne used the side rail on her repositioning in bed and Resident #97 indicated she side rail on her bed was					
		on 03/16/17 at 4:09 PM stated Resident #97 used the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		345285	B. WING		03	3/16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND I	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	side rail on her bed for The interview further noticed loose side railighten them down. An interview with the 03/16/17 at 4:19 PM order forms on a clip stations for staff to whis assistant checked times a day. The Mastated side rails were On 03/16/17 at 5:34 was accompanied to observe the right side loose side rail was not Maintenance Directo was missing a space and if this did not wore replaced. During an interview of Administrator stated side rails and they with immediately. 483.55(a)(1)(2)(4) RODENTAL SERVICES (a) Skilled Nursing For A facility- (a)(1) Must provide of resource, in accordant	or bed mobility and transfers. revealed when NA #2 ills he turned the knob to Maintenance Director on revealed there were work board at both nurse's rite down repairs and he and if the clip boards several intenance Director further e checked twice a month. PM the Maintenance Director Resident #97's room to be 1/2 rail and stated the of acceptable. The refurther stated the side rail or that would make it tighter risk the side rail would be an 03/16/17 at 5:55 PM the she did not approve of loose build need to be fixed DUTINE/EMERGENCY IN SNFS	F 32			4/13/17

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345285	B. WING		03/16/2017	
	ROVIDER OR SUPPLIER N HOME HEALTH AND I	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	,	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 411	Continued From pag (a)(2) May charge a additional amount for dental services; (a)(4) Must if necess resident; (i) In making appoint (ii) By arranging for the dental services located This REQUIREMENT by: Based on record revifacility failed to provide 1 of 3 sampled resides status and services (The findings included Review of the medical #110 was admitted of including Alzheimer's	e 33 Medicare resident an routine and emergency ary or if requested, assist the ments; and ransportation to and from the ion; I is not met as evidenced riew and staff interviews the de routine dental services for ents reviewed for dental Resident #110). d: all record revealed Resident in 06/24/16 with diagnoses	F 41	DEFICIENCY)	or e is in ed	
	(MDS) dated 07/03/1 had severely impaire or likely cavity or bro Review of the Care A Summary for Dental admission MDS reversk for mouth pain a broken and missing to noted Resident #110 her regular diet and of pain or problems of	6 revealed Resident #110 d cognition and had obvious ken natural teeth. Area Assessment (CAA) Care completed with the aled Resident #110 was at nd problems chewing due to eeth. The CAA Summary consumed 68% to 83% of did not have any complaints		having the potential to be affected by same deficient practice. All resident charts were audited for late dental appointment. The audit was completed on April 5, 2017, by a licen nurse. The audit was to ensure all residents dental appointments have no been missed and follow up occurred. Those residents found to have missed dental appointments will have appointments made by the Social Services Director.	st sed ot	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345285	B. WING			03/16/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		0/10/2017	
				200 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND F	REHAB		HENDERSONVILLE, NC 28739	e		
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F 411	Continued From page	e 34	F 4	11			
	Resident #110 had th	ne potential for mouth pain		What measure will be put	t in place or		
		ng due to missing and broken		systemic changes made			
		o ensure dental health by		the deficient practice will	not recur?		
	means of the dentist	through next review on					
		7. Interventions included:		100% of staff will be in-se			
extractions as ordered by the dentist, report oral pain or difficulty chewing food, obtain a dental consult and follow through, ensure complete			referrals or need of referr				
			concerns to licensed nurs				
				included is referral of der			
	· •	h, and in house dentist per		writing to Social Services			
	facility protocol.			Physician. The in-servici			
	An interview with MD	S Nurse #1 on 03/16/17 at		completed by April 13, 20 Development Coordinato			
	An interview with MDS Nurse #1 on 03/16/17 at 8:56 AM revealed when she completed an MDS			Nursing or Assistant Dire			
		ermined a resident required a		All new hires will also be	-		
		pically communicated this		hire.	iii ooi viood apoii		
		cial Worker (SW) verbally		1			
		disciplinary Team (IDT)		Director of Nursing, Assis	stant Director of		
		#1 reviewed Resident		Nursing or Staff Develop			
	#110's admission MD	S assessment dated		will randomly audit 2 MD3	S (Section L) x		
	07/03/16 and noted it	t had been completed by		one week for a month, 1	MDS (Section L)		
	MDS Nurse #2.			x one week for one mont			
				random MDS (Section L)	x month for nine		
		on 03/16/17 at 9:02 AM MDS		months.			
		she completed Resident			,		
	#110's admission MD			How the facility will monit			
	_	e Oral/Dental Status section.		actions to ensure the def	•		
		d Resident #110 had broken		being corrected and will r	not recur.		
		t denied pain. MDS Nurse #2 determined a resident		The Director of Nursing, A	Accietant		
	required a dental con			Director of Nursing or Sta			
	•	formation to the Social		Coordinator will present t		 	
	Worker (SW) verbally			MDS (Section L) audit to		 	
		er office. MDS Nurse #2		Quality Assurance Perfor		 	
		d told the SW Resident #110		Improvement Committee		 	
		y the Dentist but was not		consisting of the Medical	_	 	
	certain when because			Administrator, Director of		 	
	documentation of wh	en the request was made.		Assistant Director of Nurs		 	
				Control Representative),	Staff	 	
	An interview was con	ducted with the SW on		Development Coordinato	r, MDS		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345285	B. WING _	B. WING		03/16/2017
	ROVIDER OR SUPPLIER N HOME HEALTH AND F	REHAB	•	STREET ADDRESS, CITY, STATE, ZIP COI 200 HERITAGE DRIVE HENDERSONVILLE, NC 28739	DE .	
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F 411	#1 and MDS Nurse # and tell her if a reside Dentist. The SW expl set up with the dental submitted the paper of the Dentist came to the Dentist came to the Dentist was on 03/29/17 of who had been see and which residents on 03/29/17 and confinct on either list. The been informed Reside by the Dentist and ship dental problems.	The SW stated MDS Nurse 2 would come by her office ent needed to be seen by the ained if the resident was not plan she filled out and work. The SW further stated he facility quarterly and the 3/17 and the next scheduled. The SW reviewed her lists in by the Dentist on 01/23/17 were scheduled to be seen irmed Resident #110 was SW indicated she had not ent #110 needed to be seen ie was not aware of any	F 4	Coordinator, Social Services Admissions Director, Activity Business Office Manager, Di Manager, Human Resources Maintenance Director, Enviro Services Supervisor, Restora Medical Records, Charge nu certified nursing assistant me monthly to for further follow recommendations x 9 month aberrancies will be addresse interventions developed and actions taken.	Director, ietary s Manager, conmental ative Nurse, arse and a eeting up and/or s. Any	
F 520 SS=E	During an interview on 03/16/17 at 1:27 PM the Director of Nursing (DON) stated the SW took care of referrals to the Dentist and she expected the MDS Nurses to communicate any dental concerns that were identified during the MDS assessment to the SW. The DON explained this information was usually communicated verbally during the daily morning stand up meeting. The DON could not explain how Resident #110 was not referred to the Dentist and stated the facility needed to change their process to ensure residents were referred to Dentist when they had dental issues. 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a		F 5	20		4/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 520	(iii) At least three oth staff, at least one of administrator, owner individual in a leader (g)(2) The quality assommittee must: (i) Meet at least quar coordinate and evalute identifying issues with assessment and assomecessary; and (ii) Develop and implication to correct identifying increases in the correct identifying issues with assessment and assomecessary; and	rsing services; ctor or his/her designee; er members of the facility's who must be the , a board member or other ship role; and sessment and assurance terly and as needed to late activities such as h respect to which quality urance activities are ement appropriate plans of stified quality deficiencies; rmation. A State or the equire disclosure of the mittee except in so far as lated to the compliance of the requirements of this	F 520			
	sanctions. This REQUIREMEN' by: Based on observation resident interviews the	oe used as a basis for T is not met as evidenced ons, record reviews, staff and the Quality Assessment and the of the facility failed to		What corrective action(s) will be accomplished for those residents found have been affected by the alleged	d to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				200 HERITAGE DRIVE			
MOUNTAI	N HOME HEALTH AND	REHAB		HENDERSONVILLE, NC 28739			
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F 520	Continued From pa	ige 37 and monitor the inventions	F 5	20 deficient practice?			
	This was for 2 defice December 2015 and recertification surved deficiencies were in housekeeping and failure of the facility record show a patter sustain an effective Findings Included: This tag is cross refeatly: The right to recember 2015. Be review, and resider facility failed to allo regarding wake times.	make choices was cited in ased on medical record at and staff interviews, the w residents to make choices es and bath/shower		The Vice President of Clin will in-service the Quality A Committee members inclu Administrator, Director of I Business Office Manager, Director, Human Resource Medical Records, Minimur Coordinator, Restorative N Admissions Director, Dieta Activity Director, Environm Supervisor, Maintenance I 13, 2017, on the Quality A Assurance Committee Pol How the facility will identify having the potential to be same deficient practice.	Assurance iding: Nursing, Social Service Director, In Data Set Nurse, In Manager, Inental Service Director by A ssessment a icy.	es pril nd	
	for 2 of 3 residents (Resident #50 and During the recertific the facility was cite smoking residents the ability to independent observations, recommercies the ability to safely #59). F 253: Housekeepi was cited in Decemposervations, medi interviews with resifialed to address m	ere significant to the resident reviewed for choices Resident #132). cation survey of March 2017 d for F242 for failing to provide the opportunity to demonstrate endently smoke. Based on d reviews, staff and resident ty failed to provide 2 of 7 the opportunity to demonstrate smoke (Residents #33 and and Maintenance Services aber 2015. Based on cal record review and dents and staff the facility aintenance concerns in 6 2 of 2 halls in the facility		a. All residents have the paffected. b. The Vice President of Cowill in-service the Quality And Assurance Committee scheduled telephone training 2017. The team will be inpresenting information regulated that are related the follow the facility policy an identified, action plans will implemented to prevent decrecurring. What measure will be put systemic changes made to deficient practice will not resident to the province of the part o	Clinical Service Assurance Assessment e policy during ing by April 1 -serviced on larding any when issues a to failure to d/or trends a be efficiencies from the place or to ensure the	g a 3, are	

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F 520	(Residents #117, #13 #27). During the recertificat the facility was cited fand maintenance corrobservations and staft to repair resident doos splintered laminate or on 2 of 2 wings (Resimulate of 2 wings (Resimulate of 2 wings (Resident replace over-bed tablowinyl in 3 rooms on 2 maintenance over-bed tablowing and the facility also failed personal hygiene proequipment, and plung An interview with Adm 7:01 PM revealed her of correction for Deceaddressed and correction for the choice identified for the choice of the facility with Adm 7:01 PM revealed her of correction for Deceaddressed and correction for the choice identified for the choice of the facility with Adm 7:01 PM revealed her of correction for Deceaddressed and correction for the choice identified for the choice identified for the choice identified for the choice of the facility was a facility with a facility was a facility with a facility was a facility with a facility was a fa	2, #105, #30, #122 and fion survey of March 2017 for failing to address repair forms. Based on if interviews the facility failed from with broken and for 8 of 62 room entry doors dent room #207, #211, forms broken and splintered for shared bathroom doors on 1 froom #218 and #223), forms with missing or peeling for 2 wings (Resident room forms, replace cracked and forms the base of toilets, keep for scratches, paint forms floor for 12 of 29 forms of 2 wings. In addition, forms and properly store forms of 2 wings. In a dition, forms of 2 wings.	F 52	a. The Vice President of Clinical Serwill in-service the Quality Assurance Committee on the Quality Assessmer and Assurance Committee Policy dur scheduled telephone training by April 2017. The team will be in-serviced or presenting information regarding any systems breakdown and when issues identified that are related to failure to follow the facility policy and/or trends identified, action plans will be implemented to prevent deficiencies for recurring. b. The facility Quality Assurance Committee will hold its regularly scheduled monthly meeting on April 2017. Included in this meeting will be review of audits and in-services pertate to the recent survey. All monitoring to and documentation for all tags cited where the reviewed during the meeting. c. A new stand up morning meeting for is being utilized and filled out by the Administrator or Director of Nursing to discuss monitoring tools for compliant. The form is comprehensive in nature includes survey tag monitoring for compliance, ensuring current monitor tools completed for survey compliance policies under review, admissions and resident concerns, How the facility will monitor its correct actions to ensure the deficient practic being corrected and will not recur.	at ing a 13, an 13, an sare are from 25, a a ining pols will form occ. and ing e, d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 520	Continued From pag	e 39	F 5	The Regional Vice Presid President of Clinical Serv the Quality Assurance Pe Improvement Meeting mir three months to ensure al are included and that the Assurance Committee ha issues that were identified implementation of policies procedures, in-servicing, improvement plans and many many many many many many many many	ices will review rformance nutes monthly for Il required items Quality s addressed d with s and performance		