STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 CLOVERDALE ROAD SYLVA, NC 28779

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 166		5/28/17

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

Electronically Signed | 05/26/2017

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BLUE RIDGE ON THE MOUNTAIN	**417 CLOVERDALE ROAD SYLVA, NC 28779**

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 166	Continued From page 2 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews the facility failed to resolve grievances regarding showers for 1 of 3 sampled residents reviewed for grievances (Resident #6). Findings included: Resident #6 was admitted on 01/09/17 with diagnoses that included Alzheimer's disease and muscle weakness. Review of Resident #6's care plans dated 01/27/17 revealed an active plan in place for activities of daily living (ADL). The ADL care plan indicated Resident #6 needed various amounts of assistance with ADL tasks due to Alzheimer's disease, diabetes, and chronic pain. Interventions included for staff to encourage him to do as much as possible for himself, assist with tasks he was unable to do independently and provide the level of care needed to complete ADL tasks. The most recent quarterly Minimum Data Set (MDS) dated 04/14/17 coded Resident #6 with severe, cognitive impairment for daily decision making skills. Further review of the MDS revealed he required total assistance of 1 staff person with bathing and extensive assistance of 1	F 166	Resident #5 grievance regarding showers was resolved 5/6/17 and Resident #6 received shower 5/6/17. An audit of Grievances was completed by Social Services Director 5/9/17 to insure the timey resolution of Grievances. IDT was In-serviced 5/26/17 by Administrator regarding the facility grievance policy which included resolution of grievances within 5 days. Per policy Social Services Director will receive and distribute grievances to the appropriate IDT member at the facilities□ morning meeting for resolution. The Medical Records Director will complete a weekly audit of grievances on the Weekly Grievance Audit sheet to ensure they are completed within 5 days per policy. The results of the weekly grievance Audit sheet will be reported to the QAPI committee for compliance for a minimum of 3 months by the Medical Records Director. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

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F 166	Continued From page 3 staff person for personal hygiene and dressing. Review of the facility's grievance logs for the period February 2017 through April 2017 revealed Resident #6's family member had filed grievances on 04/09/17, 04/12/17 and 04/17/17 related to showers. Review of the facility's Resident Concern/Grievance Response forms revealed the following: 04/09/17: multiple concerns voiced by the family member included Resident #6 reporting he had not received a shower. The summary of the concerns indicated Resident #6's shower days were Wednesday and Saturday between 3:00 PM to 11:00 PM. The steps take for resolution indicated Resident #6 was given a shower and his shower days were changed to Tuesday, Thursday and Saturday. 04/12/17: Resident #6's family member had met with the Director of Nursing (DON) to discuss previous concerns and informed the DON Resident #6 had not been shaved or received a shower since the previous weekend. The steps taken for resolution indicated Resident #6 was given a shower and shaved. 04/17/17: family member voiced concern that Resident #6 had not been getting showers. The step taken for resolution indicated "showers being completed on Tuesday, Thursday, and Saturday per family request and anytime requested." Review of Resident #6's computerized medical record revealed showers were scheduled for Tuesday, Thursday and Saturday between 3:00 PM and 11:00 PM. Review of the facility's Point of Care History report for bathing for the period February 2017 through April 2017 revealed that Resident #6	F 166		

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received 19 out of 29 scheduled showers (2 per week 02/01/17 through 04/09/17 and 3 per week 04/10/17 through 04/30/17). Further review of the bathing report revealed 3 of the days Resident #6 did not receive his scheduled shower were Saturday 04/22/17, Thursday 04/27/17 and Saturday 04/29/17 which was after the grievances had been filed by the family member.

Review of the nurses' notes for the period February 2017 through April 2017 revealed no documentation Resident #6 had refused showers.

Observations on 05/04/17 at 12:00 PM revealed Resident #6 was dressed in clean clothing but had a noticeable beard stubble and slight odor.

During a telephone interview on 05/04/17 at 12:18 PM, Resident #6's family member stated they visited him every other day and on numerous visits, he had appeared unbathed and had not been shaved. The family member added they had voiced their concerns on several occasions but nothing had improved and Resident #6 continued to not receive his showers as scheduled.

During an interview on 05/04/17 at 3:00 PM the Social Services Director (SSD) stated when a concern was voiced by a resident and/or family member, it was documented on a concern form and given to her for review. The SSD confirmed all concerns were investigated and resolution was communicated to the complainant. Once the concern had been investigated, it was given to the Administrator for review.

During an interview on 05/04/17 at 4:55 PM the DON confirmed Resident #6's family member had voiced concerns related to showers but was

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F 166	Continued From page 5 unaware that Resident #6 was still not receiving all of his showers after his concerns had been addressed. The DON stated it was his expectation for "staff to provide showers when scheduled or requested, regardless" and accurately document the type of bathing activity in the resident's medical record to reflect any refusals, partial bed baths or complete bed baths. During an interview on 05/04/17 at 5:44 PM the Administrator stated the family member's concerns had been addressed and resolved at the time the concern had been voiced. The Administrator was unaware that Resident #6 was still not receiving all of his showers after his concerns had been addressed and confirmed it was his expectation for showers to be provided as scheduled or requested.	F 166		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, and staff interviews the facility failed to provide assistance with showers for 2 of 5 sampled residents who required extensive to total assistance with activities of daily living (Resident #5 and #6). Findings included: 1. Resident #5 was admitted on 01/20/16 with diagnoses that included chronic pain, low back	F 312	Resident #5 received shower on 5/6/17 and resident #6 received shower on 5/6/17. An Audit was completed of documentation or patient interviews 5/12/17 by DON/Unit Manager of residents to insure residents are receiving showers as scheduled and/or requested. Nursing staff in-serviced completed	5/28/17

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F 312	Continued From page 6 pain and weakness. The annual Minimum Data Set (MDS) dated 01/05/17 coded Resident #5 as cognitively intact and displayed no rejection of care. The MDS indicated Resident #5 required physical assistance of 1 staff person with part of the bathing activity and limited to extensive assistance of 1-2 staff persons for personal hygiene and dressing. Review of Resident #5's care plans revealed an active plan in place for activities of daily living (ADL) dated 01/19/17. The ADL care plan indicated Resident #5 needed assistance with ADL due to chronic pain and his desire to have staff assistance. Interventions included for staff to encourage him to do as much as possible for himself, assist with tasks he was unable to do independently and provide the level of care needed to complete ADL tasks, monitor for fatigue, and have 2 female staff when providing care. Review of the Resident #5's computerized medical record revealed his showers were scheduled on Wednesday and Saturday between 7:00 AM and 3:00 PM. Review of the facility's Point of Care History report for bathing for the period February 2017 through April 2017 revealed Resident #5 only received 10 out of 26 scheduled showers. Further review of the bathing report revealed 5 of the days that Resident #5 did not receive a shower were Saturday 04/01/17, Wednesday 04/05/17, Wednesday 04/12/17, Saturday 04/15/17, and Saturday 04/22/17.	F 312	5/27/17 by DON regarding residents receiving showers on scheduled days and/or requested as well as, appropriate reporting/documentation of same. DON/Unit Manager will complete daily audits for 3 months of Daily shower sheet and weekly ongoing to insure that residents are receiving showers as scheduled and/or requested and this includes documentation as well as resident interviews. The results of the Daily Shower sheet will be reported by the DON/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for a minimum of 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

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Review of the nurses' notes for the period February 2017 through April 2017 revealed no documentation that Resident #5 had refused showers.

During an interview and observation on 05/03/17 at 9:40 AM Resident #5 was dressed in a wrinkled and slightly stained t-shirt with noticeable beard stubble and uncombed hair but no odors. Resident #5 stated he was scheduled to receive showers on Wednesday and Saturday of each week but "quite often only gets 1 per week." Resident #5 confirmed his preference was to receive at least 2 showers per week.

2. Resident #6 was admitted on 1/9/17 with diagnoses that included Alzheimer's disease and muscle weakness.

Review of Resident #6's care plans dated 1/27/17 revealed an active plan in place for activities of daily living (ADL). The ADL care plan indicated Resident #6 needed various amounts of assistance with ADL tasks due to Alzheimer's, diabetes, and chronic pain. Interventions included for staff to encourage him to do as much as possible for himself, assist with tasks he was unable to do independently and provide the level of care needed to complete ADL tasks.

The most recent quarterly Minimum Data Set (MDS) dated 04/14/17 coded Resident #6 with severe, cognitive impairment for daily decision making skills. Further review of the MDS revealed he required total assistance of 1 staff person with bathing and extensive assistance of 1 staff person for personal hygiene and dressing.

Review of Resident #6's computerized medical

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record revealed showers were scheduled for Tuesday, Thursday and Saturday between 3:00 PM and 11:00 PM.

Review of the facility's Point of Care History report for bathing for the period February 2017 through April 2017 revealed that Resident #6 only received 19 out of 29 scheduled showers. Further review of the bathing report revealed 3 of the days that Resident #6 did not receive a shower were Saturday 04/22/17, Thursday 04/27/17 and Saturday 04/29/17.

Review of the nurses' notes for the period February 2017 through April 2017 revealed no documentation Resident #6 had refused showers.

Observations on 05/04/17 at 12:00 PM revealed Resident #6 was dressed in clean clothing but had a noticeable beard stubble and slight odor.

During a telephone interview on 05/04/17 at 12:18 PM, Resident #6's family member stated they visited him every other day and on numerous visits, he had appeared unbathed and not been shaved. The family member added they had voiced their concerns on several occasions but nothing had improved and Resident #6 continued to not receive his showers as scheduled.

On 05/04/17 at 3:48 PM an interview was conducted with Nurse Aide (NA) #1. NA #1 confirmed there had been a staffing challenge due to recent terminations. NA #1 added when there was only one NA assigned to the hall, showers might not get done in order to ensure residents received other needed care, such as turning and repositioning, assistance with meals and incontinence care.

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F 312	Continued From page 9 During an interview on 05/04/17 at 4:55 PM the DON was unaware Resident #5 and Resident #6 had not received all showers as scheduled. He stated it was his expectation for "staff to provide showers when scheduled or requested, regardless" and accurately document the type of bathing activity in the resident's medical record to reflect any refusals, partial bed baths or complete bed baths. During an interview on 05/04/17 at 5:44 PM the Administrator was unaware Resident #5 and Resident #6 had not received all showers as scheduled. He confirmed it was his expectation for showers to be provided as scheduled or requested.	F 312		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353		5/28/17

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F 353	Continued From page 10 (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interview, family interview and staff interviews, the facility failed to provide sufficient nursing staffing, resulting in showers not being provided as scheduled and preferred for 2 of 5 sampled residents who required extensive to total assistance with activities of daily living (Resident #5 and #6). The findings included:	F 353	Resident #5 received shower on 5/6/17 and resident #6 received shower on 5/6/17. Staffing is audited/reviewed daily to insure sufficient nursing staff to provide assistance with ADL. Admin provided in-service 5/26/17 to DON/Staff scheduler related to scheduling	

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F 353	Continued From page 11 1. Cross refer to tag F-312. Based on observations, record review, family and staff interviews the facility failed to provide assistance with showers for 2 of 5 sampled residents who required extensive to total assistance with activities of daily living (Resident #5 and #6). Telephone interview on 05/03/17 at 3:36 PM with Staff #1 revealed showers often did not get done. The complainant stated that normal total facility staffing for Nurse Aides (NAs) was 6 on day shifts, 5 on evenings and 4 on nights. The complainant stated when the facility census dropped below 70 then total facility staffing for NAs changed to 5 on day shifts, 5 on evenings and 3 or 4 on night shifts. The complainant stated that when the staffing was decreased, staff were told to stay home, they did not get their scheduled hours and some began to quit their jobs. Telephone interview on 05/03/17 at 5:00 PM with Staff #2 revealed that several times they had been forced to be the only NA on a hall and had to choose between performing incontinence care and doing showers. The second complainant stated that on a particular Saturday there was only one NA on the 100 hallway and they were the only NA on 200 hallway and some of the showers they were supposed to do were not done as they only had time to change residents. The second complainant stated the facility was only allowed to have so many NAs in the building based on the number of residents and the care acuity did not matter. Review of Facility Daily Assignment Sheets from 02/01/17 through 05/04/17 revealed NA staff	F 353	a sufficient staff to provide assistance with residents ADL. DON will review/audit daily staffing sheet, which is an on-going process, to insure sufficient staff is scheduled to provide assistance with residents ADL. Daily staffing sheets are posted and reviewed per state regulation. Call outs, termination and vacations are reviewed and shifts filled in with PRN, Agency and staffing pool availability. Use of Agency, job fairs, local newspaper job listing, use of recruiting websites, local outreach to colleges used to recruit. The staffing needs of the facility are reviewed during morning meeting by Administrator and results of these reviews brought to QAPI committee for a minimum of 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

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initials next to printed names for specific rooms and halls. Averages each month by shifts (days, evenings and nights), and rounded to the nearest whole tenth, of number of NAs assigned to direct resident care were as follows:
February 2017 (full month) - day shift was 5.6, evenings was 4.9 and nights was 3.6
March 2017 (full month) - day shift was 5.8, evenings was 5.1 and nights was 3.5
April 2017 (full month) - day shift was 4.7, evenings was 4.5 and nights was 2.9
May 2017 (first four days) - day shift was 4.1, evenings was 4.1 and nights was 2.8.

Facility census on 05/03/17 was 65.

Interview on 05/04/17 at 4:53 PM with the Director of Nursing revealed the facility recently had 3 or 4 Nurse Aide (NA) terminations and there had been more but he was unsure how many as he was recently a unit manager. He stated he was not aware that showers were not being done and the expectation was that they were to be done when scheduled or requested. At a minimum he expected staff to do a bed bath and dress residents with clean clothes. He stated that sometimes showers were moved to the next shift and he even had helped staff in completing them. He stated the previous Sunday he came in to work as an aide and also as a nurse. He named three administrative staff who were trained NAs that could also assist with resident care and had worked over weekends. He stated the facility offered staff overtime and some would work double shifts. He stated there were some NAs currently going through the hiring process.

Interview on 05/04/17 at 5:44 PM with the Administrator revealed NA staffing had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 CLOVERDALE ROAD SYLVA, NC 28779

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 13 recently affected by some terminations and the tight local market from which to hire from but he stated the facility had staffing up to their full Patients per Day (PPD) as determined by the corporate office. He stated department heads had filled staffing gaps and he had worked the weekend passing meal trays. He stated the facility had experienced about 8 terminations and he called the local community college for recruiting of new NAs. He stated he was very frustrated to hear that some showers had not been done and did not think that staffing had been a factor in this, but stated it could be perceived by some as such.	F 353		
F 520 SS=D	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 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520		5/28/17

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F 520	Continued From page 14 identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2016. This was for a recited deficiency which was originally cited in May of 2016 on a recertification survey and on the current complaint investigation. The deficiency was in the area of Activities of Daily Living (ADL) Care Provided for Dependent Residents. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to:	F 520	Residents #5 and #6 receive assistance & ADLs (i.e. Showers). Reviewed QAPI minutes from May 2016 to present to identify potential improvements in F312 related to ADLs Ad-hoc review of active QAPI 5/26/17 to insure appropriate outcomes in regards to ADLs. During the Ad-hoc review the QAPI process was reviewed with the members of the QAPI Committee 5/26/17 to insure that we continue to monitor citations as to avoid repeat citations. Once the QAPI committee determines compliance random audits within each quarter throughout the year to insure continued compliance related to F312 ADLs and documented on the QA Committee	

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F 520	Continued From page 15 F312 ADL Care Provided for Dependent Residents: Based on observations, record review, family, and staff interviews the facility failed to provide assistance with showers for 2 of 5 sampled residents who required extensive to total assistance with activities of daily living (Resident #5 and #6). The facility was recited for F312 for failing to provide showers as scheduled or requested by residents. F312 ADL Care was originally cited during the May 5, 2016 recertification survey for failing to remove a resident's chin hair. During an interview on 05/04/17 at 4:53 PM the Director of Nursing stated he was not made aware that showers were not being done but his expectation of staff was that they be done when scheduled and as requested. He stated that at a minimum, staff should a bed bath and put clean clothes on residents. He stated that sometimes showers would be moved to the next shift and he had even helped in completing them. He stated ADL care would be reported out in the next quality assurance (QA) meeting. During an interview on 05/04/17 at 5:44 PM the Administrator stated he was frustrated to hear that showers were not being done and although he did not think that staffing had an impact on showers, he stated it could be perceived as such. He stated staffing would be on his agenda for the next QA meeting. He stated ADL care was monitored through a monthly compliance report and although showers were not focused on, he can make them a focus.	F 520	minutes form. The results of the Quality Improvement monitoring will be reported by the Director of Nursing/Administrator to the Quality Assurance Performance Improvement Committee monthly for 3 months and ongoing compliance related to F312 ongoing throughout the year each quarter for 1 year. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	