

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2017
NAME OF PROVIDER OR SUPPLIER BLUE RIDGE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 HEBRON STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	<p>HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2)</p> <p>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair a metal bracket with sharp edges on the lower half of the right side main dining room door that was sticking outward and was rough and sharp to touch. The facility also failed to repair wood edging at both sides of the entrance to the day room next to the main dining room which had broken and splintered wood on the lower edges on both sides of the doorway that were rough to touch and failed to repair resident room doors with broken and splintered laminate and wood on the lower edges of the doors for 7 of 68 resident room doors (#204, #225, #230, #231, #233, #112 and #119). In addition, the facility failed to repair 2 of 2 shower room doors with broken and splintered laminate and wood on the lower edges of the doors on 2 of 2 resident hallways (west hall and east hall), failed to repair broken and stained thresholds at resident doorways for 7 of 68 resident rooms on 1 of 2 resident hallways (room #101, #102, #103, #106, #107, #119 and #124) and failed to replace a missing threshold at the bathroom of resident room #117 on 1 of 2 resident hallways.</p> <p>Findings included:</p> <p>1. Observations on 10/31/17 at 12:25 PM revealed a metal bracket with sharp edges on the lower half of the right side main dining room door that was sticking outward and was rough and sharp to touch.</p>	F 253	<p>F253</p> <p>This deficiency was caused by an aging building combined with a failure to routinely assess and repair doors, doorways and thresholds.</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The metal bracket with the sharp edge on the main dining room door was removed by the Maintenance Director on 11/2/17. The wood trim on the entrance to the day room will be repaired to remove the broken and splintered wood by the Maintenance Director or contractor on or before 11/30/17. The broken and splintered laminate on the doors of rooms 204, 225, 230, 231, 233, 112, 119, the west shower room, and the east shower room will be repaired to remove the broken and splintered wood by the Maintenance Director or contractor on or before 11/30/17.</p> <p>The thresholds in the doorways of rooms 101, 102, 103, 106, 107, 119, 124, and 117 will be replaced or cleaned by the Environmental Services contractor,</p>	11/30/17

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

TITLE

(X6) DATE

Electronically Signed

11/21/2017

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.

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F 253	Continued From page 1 Observations on 11/01/17 at 8:15 AM revealed a metal bracket with sharp edges on the lower half of the right side main dining room door that was sticking outward and was rough and sharp to touch. Observations on 11/02/17 at 8:45 AM revealed a metal bracket with sharp edges on the lower half of the right side main dining room door that was sticking outward that s rough and sharp to touch. 2. Observation on 10/31/17 at 12:30 PM revealed wood edging at both sides of the entrance of the day room next to the main dining room with broken and splintered wood on lower edges on both sides of doorway that were rough to touch. Observation on 11/01/17 at 8:17 AM revealed wood edging at both sides of the entrance of the day room next to the main dining room with broken and splintered wood on lower edges on both sides of doorway that were rough to touch. Observation on 11/02/17 at 8:47 AM revealed wood edging at both sides of the entrance of the day room next to the main dining room with broken and splintered wood on lower edges on both sides of doorway that were rough to touch. 3. a. Observation on 10/31/17 at 12:32 PM of resident room door #204 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:19 AM of resident room door #204 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 8:49 AM of resident room door #204 revealed broken and splintered laminate and wood on the lower edges of the door.	F 253	Maintenance Director, or other contractor on or before 11/30/17. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An inspection of other resident rooms and common area rooms was completed by the Administrator on 11/18/17 to determine if there were other doors or doorways with broken or splintered wood or laminate, protruding metal brackets, or missing, cracked and/ or stained door thresholds. Those identified will be repaired, and thresholds replaced or cleaned, by the Environmental Services contractor, Maintenance Director, or other contractor on or before 11/30/17. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: To ensure that this deficient practice does not recur, facility staff and contracted staff will be educated by the Administrator on or before 11/30/17 on the process for reporting maintenance and housekeeping issues, including identifying damaged doors and doorways, and damaged or dirty thresholds. This education will include the designated staff members who participate in the Ambassador Program currently in effect at the facility, and the Ambassador Visit form will be amended to include a visual inspection of room doors and thresholds.		

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F 253	Continued From page 2 b. Observation on 10/31/17 at 12:34 PM of resident room door #225 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:22 AM of resident room door #225 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 8:51 AM of resident room door #225 revealed broken and splintered laminate and wood on the lower edges of the door. c. Observation on 10/31/17 at 12:37 PM of resident room door #230 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:25 AM of resident room door #230 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 8:53 AM of resident room door #230 revealed broken and splintered laminate and wood on the lower edges of the door. d. Observation on 10/31/17 at 12:39 PM of resident room door #231 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:28 AM of resident room door #231 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 8:55 AM of resident room door #231 revealed broken and splintered laminate and wood on the lower edges of the door.	F 253	How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator or Director of Nursing will audit ten (10) resident rooms and/ or common areas per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if any doors or doorways are damaged or have protruding metal objects attached. In addition, the Administrator or Director of Nursing will audit ten (10) resident rooms per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if any door thresholds are missing, cracked and/ or stained. Any concerns identified will be brought to the contracted Environmental Services Manager and Maintenance Director for corrective action to be taken. Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the Administrator or designee to maintain compliance when completing clinical system reviews. This plan of correction will be implemented by the facility Administrator.		

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F 253	Continued From page 3 e. Observation on 10/31/17 at 12:42 PM of resident room door #233 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:29 AM of resident room door #233 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 8:57 AM of resident room door #233 revealed broken and splintered laminate and wood on the lower edges of the door. f. Observation on 10/31/17 at 12:45 PM of resident room door #112 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:33 AM of resident room door #112 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 9:02 AM of resident room door #112 revealed broken and splintered laminate and wood on the lower edges of the door. g. Observation on 10/31/17 at 12:47 PM of resident room door #119 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:35 AM of resident room door #119 revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 9:04 AM of resident room door #119 revealed broken and splintered laminate and wood on the lower edges of the door.	F 253			

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F 253	<p>Continued From page 4</p> <p>4. a. Observation on 10/31/17 at 12:43 PM of the west shower room door revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:30 AM of the west shower room door revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 8:58 AM of the west shower room door revealed broken and splintered laminate and wood on the lower edges of the door.</p> <p>b. Observation on 10/31/17 at 12:50 PM of the east shower room door revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/01/17 at 8:40 AM of the east shower room door revealed broken and splintered laminate and wood on the lower edges of the door. Observation on 11/02/17 at 9:08 AM of the east shower room door revealed broken and splintered laminate and wood on the lower edges of the door.</p> <p>5. a. Observation on 10/31/17 at 12:52 PM of resident room #101 revealed the threshold at the resident's door was cracked with black stains. Observation on 11/01/17 at 8:42 AM of resident room #101 revealed the threshold at the resident's door was cracked with black stains. Observation on 11/02/17 at 9:10 AM of resident room #101 revealed the threshold at the resident's door was cracked with black stains.</p> <p>b. Observation on 10/31/17 at 12:54 PM of resident room #102 revealed the threshold at the resident's door had black stains.</p>	F 253			

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F 253	<p>Continued From page 5</p> <p>Observation on 11/01/17 at 8:44 AM of resident room #102 revealed the threshold at the resident's door had black stains.</p> <p>Observation on 11/02/17 at 9:12 AM of resident room #102 revealed the threshold at the resident's door had black stains.</p> <p>c. Observation on 10/31/17 at 12:57 PM of resident room #103 revealed the threshold at the resident's door was cracked with brown stains.</p> <p>Observation on 11/01/17 at 8:46 AM of resident room #103 revealed the threshold at the resident's door was cracked with brown stains.</p> <p>Observation on 11/02/17 at 9:15 AM of resident room #103 revealed the threshold at the resident's door was cracked with brown stains.</p> <p>d. Observation on 10/31/17 at 12:59 PM of resident room #106 revealed the threshold had been removed but the tile had brown stains.</p> <p>Observation on 11/01/17 at 8:49 AM of resident room #106 revealed the threshold had been removed but the tile had brown stains.</p> <p>Observation on 11/02/17 at 9:17 AM of resident room #106 revealed the threshold had been removed but the tile had brown stains.</p> <p>e. Observation on 10/31/17 at 1:00 PM of resident room #107 revealed the threshold at the resident's door had brown stains.</p> <p>Observation on 11/01/17 at 8:50 AM of resident room #107 revealed the threshold at the resident's door had brown stains.</p> <p>Observation on 11/02/17 at 9:19 AM of resident room #107 revealed the threshold at the resident's door had brown stains.</p> <p>f. Observation on 10/31/17 at 1:02 PM of resident room #119 revealed the threshold at the</p>	F 253			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	<p>Continued From page 6</p> <p>resident's door had brown stains. Observation on 11/01/17 at 8:52 AM of resident room #119 revealed the threshold at the resident's door had brown stains. Observation on 11/02/17 at 9:20 AM of resident room #119 revealed the threshold at the resident's door had brown stains.</p> <p>g. Observation on 10/31/17 at 1:03 PM of resident room #124 revealed the threshold at the resident's door had brown stains. Observation on 11/01/17 at 8:54 AM of resident room #124 revealed the threshold at the resident's door had brown stains. Observation on 11/02/17 at 9:23 AM of resident room #124 revealed the threshold at the resident's door had brown stains.</p> <p>6. Observation on 10/31/17 at 1:05 PM of resident room #117 revealed the threshold at the bathroom was missing and the floor had brown stains. Observation on 11/01/17 at 8:56 AM of resident room #117 revealed the threshold at the bathroom was missing and the floor had brown stains. Observation on 11/02/17 at 9:25 AM of resident room #117 revealed the threshold at the bathroom was missing and the floor had brown stains.</p> <p>During an interview and environmental tour on 11/02/17 at 5:08 PM the Maintenance Director explained the facility utilized a work order system. He stated he was the only employee in the maintenance department and he ran from one problem to the next on a daily basis. He explained he prioritized repairs and safety concerns were addressed first. He stated there</p>	F 253			

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F 253	Continued From page 7 were no major projects planned for the facility but a new company had taken over the facility earlier this year and he expected there would be projects planned for the coming year. He further stated he expected for staff to report repairs that needed to be made and if there was a safety issue he expected for staff to report it to him right away. He confirmed he was not aware of the metal bracket on the dining room with the sharp edges and stated it needed to be removed and the doors with broken and splintered edges needed to be smoothed and the thresholds needed to be replaced. During an interview on 11/02/17 at 5:25 PM the Administrator stated he expected for staff to report repairs that needed to be made to the Maintenance Director and he expected the Maintenance Director to fix the repairs that needed to be made. He explained they made regular rounds and if they found repairs that needed to be made they should be reported so they could be fixed.	F 253			
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or	F 323		11/30/17	

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F 323	<p>Continued From page 8</p> <p>bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to transfer a resident with a mechanical lift who was at risk for falls for 1 of 2 residents sampled for supervision to prevent accidents (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was readmitted to the facility on 07/28/17 after a brief hospitalization with diagnoses that included a non-surgical left hip fracture (07/18/17) and pneumonia.</p> <p>Review of Resident #2's quarterly Minimum Data Set (MDS) dated 10/28/17 revealed Resident #2 had moderately impaired decision making skills and could usually make himself understood. The MDS also indicated Resident #2 was totally dependent on staff for activities of daily living (ADLs) which included transfers and he had impairment on one side of his lower body.</p> <p>Review of Resident #2's care plan with revision</p>	F 323	<p>F323</p> <p>The reason this alleged deficient practice occurred was that the Resident Care Specialists(RCS#1 and RCS#2)did not follow the care plan for transfers for Resident #2.</p> <p>How will corrective action be accomplished for those residents found to have been affected by the deficient practice:</p> <p>A therapy referral was completed for Resident #2 for transfer screening on 11/2/17 by the Unit Coordinator. RCS#1 and RCS#2 will be given a teachable moment by the Director of Nursing on using a total body lift for those residents evaluated and indicated for a total body lift for transfers with two person assist by 11/28/17.</p>		

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F 323	<p>Continued From page 9</p> <p>date of 05/04/17 revealed he had an activity in daily living (ADL) self-care performance deficit related to a decline in cognition and physical performance. The revised goal dated 08/31/17 noted that Resident #2 would improve his current level of function in his adl self-performance. Interventions noted on his care plan indicated a total body mechanical lift with 2 person assistance to be used at all times.</p> <p>Review of a transfer evaluation dated 10/20/17 revealed Resident #2 scored a 27 on the evaluation which indicated the caregiver would perform 100% of the task. The transfer evaluation also indicated a total body mechanical lift be used for transfers.</p> <p>Review of a Resident Care Guide (RCG) updated 11/02/17 revealed Resident #2 required a total body mechanical lift with 2 person assistance for transfers.</p> <p>An observation on 11/02/17 at 9:20 AM revealed Resident #2 was heard hollering for help to go to the bathroom. Resident Care Specialist (RCS) #2 entered Resident #2's room and stated she was going to take Resident #2 to the shower so she would let him use the bathroom when she got him up. RCS #2 further stated she needed to have help with the resident so she left and came back into the room with RCS #1. RCS #1 identified Resident #2 was incontinent of bowel and asked the resident if he still needed to have a bowel movement and the resident said yes. RCS #1 explained to the resident they were going to clean him up and let him sit on the commode. As soon as RCS #1 touched Resident #2 he began to holler that his leg was broken and not to touch them. RCS #1 stated he always said that when</p>	F 323	<p>How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice:</p> <p>An audit of active residents requiring 2 person total mechanical lift will be completed by 11/28/17 by the MDS Coordinator, Director of Nursing, and /or Unit Managers to ensure orders, care plans, Resident Care Specialists Assignment sheets and/or the Kardex's are correct. Any identified issues will be corrected immediately by the Unit Managers and/or MDS Coordinator.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <p>Current licensed nurses and Resident Care Specialists will be educated by the Director of Nursing, Assistant Director of Nursing and/or Unit Managers on or before 11/30/17 regarding the requirements for compliance with F323 with emphases on transferring resident with a mechanical lift who are at risk for falls and who have been evaluated for the need of total body lift with 2 person assist.</p> <p>How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>To ensure ongoing compliance, the Director of Nursing, Assistant Director of Nursing and/or Unit Managers will</p>		

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F 323	<p>Continued From page 10</p> <p>you touched him but his leg was broken several months ago. RCS #1 and #2 continued to clean the resident up and rolled him onto the lift pad. During this procedure the resident hollered intermittently that his legs were broke. The RCSs hooked the sling up to the mechanical lift and guided the resident onto the shower chair then rolled the resident into his bathroom and positioned the shower chair over the commode. RCS #1 told the resident to use the bathroom while he stood outside the bathroom door. Resident #2 hollered intermittently to get him up from there and put him in the bed. RCS #1 and #2 then put a brief and pants on the resident by lifting him up under his shoulders one on each side while he was still in the bathroom. RCS #1 pulled the shower chair into the resident's room and positioned it by his wheelchair and the two RCSs then transferred the resident into his wheel chair by lifting him at his shoulders and one on each side.</p> <p>An interview with RCS #2 on 11/02/17 at 9:56 AM, immediately after Resident #2 was transferred into the wheelchair with RCS #2 revealed when asked how she knew how to transfer Resident #2, she provided a resident care guide with Resident #2's name on it dated 11/02/17 and pointed to the section under transfer which stated to use the total body mechanical lift with two person assistance. When asked her why she and RCS #1 transferred Resident #2 to his wheel chair without using the mechanical lift she stated they should have used the lift. She further stated she did not know why they did not use the lift to transfer Resident #2 back into the wheelchair.</p> <p>An observation and interview on 11/02/17 at 10:00 AM revealed RCS #1 was still in the room</p>	F 323	<p>randomly observe three (3) different transfers to ensure transfers are occurring per evaluation and care plan three (3) times per week for four (4) weeks, then monthly for two (2) months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing clinical system reviews.</p> <p>The Director of Nursing is responsible for implementing the acceptable plan of correction.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/02/2017
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F 323	<p>Continued From page 11</p> <p>dressing Resident #2 and when asked how he knew what Resident #2's transfer status was he stated because he worked with the resident all the time. When asked why he and RCS #1 transferred Resident #2 from the commode into a wheelchair without a lift he stated it was easier to transfer him by using two people because of his contractures. When asked if he had reported that to administration that it would be easier to transfer Resident #2 by two persons instead of using a lift he stated he had reported it to the Unit Coordinator (UC) about two months ago but they hadn't done anything about it yet. When asked how he would know if Resident #2's transfer status had changed since he had worked with him last and RCS #1 pulled two sheets of resident care guides out of his pocket and pointed to the section of transfer status. He then stated he had to go to the green notebook at the nurses' station to get Resident #2's care guide because he was not assigned to Resident #2's hall today. RCS #1 went to the nurses' station and pulled Resident #2's care guide and confirmed Resident #2's transfer status was to use a total body mechanical lift with two person assistance. RCS #1 then stated they should have used the lift to transfer Resident #2 from the commode into his wheelchair.</p> <p>An interview on 11/02/17 at 10:10 AM with the UC explained the RCSs were allowed to suggest that a resident's transfer status be reassessed. When asked had anyone reported to her in the past few months that Resident #2's transfer status needed to be reassessed she said no. The UC then demonstrated at the computer the last time Resident #2's transfer status had been reviewed was on 10/20/17 for his quarterly assessment and before that 07/20/17 because of his readmission</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 12</p> <p>and both assessments revealed a total body mechanical lift be used for transfers.</p> <p>During an interview on 11/02/17 at 5:30 PM with the UC with the Director of Nurses present the UC stated the RCSs were expected to go by the resident care guides which were updated immediately when there was a change in the resident' plan of care. She then explained Resident #2's care plan indicated to use a total body mechanical lift with two assist for all transfers dated 08/03/17. She stated RCS #1 reported to her that Resident #2 was hollering in pain while he was on the commode and while up in the lift and he made the decision to transfer him by the two person lift because of it.</p> <p>During an interview with the DON on 11/02/17 at 6:10 PM the Director of Nursing (DON) stated she expected the care plan to be correct and the resident care guide should correctly identify the transfer method for the resident. The DON further indicated she expected the resident to be transferred safely as stated on Resident #2's current care plan.</p>	F 323			