STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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
E 000	Initial Comments An unnanounced recertification survey was conducted on 03/18/19 to 03/21/19. The facility was found in compliance with the requirement CFR.483.73, Emergency Preparedness. Event ID# 02EB11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted in conjunction with the annual recertification survey on 03/18/19 to 03/21/19. Event ID# 02EB11.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the	F 565		4/15/19

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

Electronically Signed | 04/07/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 565	Continued From page 1 facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to resolve and communicate the facility efforts to address resident requests and/or concerns voiced during 1 of 1 resident council meeting. Findings included: During a Resident Council Meeting group interview conducted on 03/19/19 at 3:30PM, residents present expressed an ongoing issue with the lack of resolutions of concerns and/or requests voiced during Resident Council meetings. The Resident Council minutes for February 2019 were reviewed and revealed the following: "Maintenance/Housekeeping/Laundry: 134 B hole next to bed in wall" There was no evidence of the facility's response to this request voiced during the meeting or discussed during the subsequent Resident Council Meeting on 03/15/19. During an observation in room 134 B on 03/21/19	F 565	F565 This alleged deficiency was caused by Administration's failure to consistently follow established procedures related to addressing requests/ concerns voiced during resident council meetings. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The hole in the wall next to the bed in Room 134 B was repaired by maintenance on 3/21/19. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: A review of resident council meeting minutes for 2019 year to date (January 2019- March 2019) will be performed by the Administrator on or before 4/5/19 and any requests/ concerns documented in the minutes will be forwarded to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 565	Continued From page 2 at 10:52AM with the Maintenance Director, a hole in the plywood overlay was seen next to the bed. The Maintenance Director stated he was typically informed of concerns in morning meeting, by word of mouth and through the TELS (automated electronic notification) system of any issues that needed to be addressed. The Maintenance Director further stated he had not been notified verbally, through a grievance form or through the TELS system that this was a concern in room 134 B. The Maintenance Director also stated he had not been made aware of any concerns from the Resident Council Meeting held in February 2019. During an interview with the Activity Director (AD) on 03/21/19 at 11:27AM, she indicated that she oversaw the Resident Council Meeting each month and would document any concerns that were brought up. The AD stated she did not write up a grievance form with concerns but would give a copy of the Resident Council Meeting minutes to the department head the next day in the morning meeting and if that person was not present she would put it in their mailbox. The AD also stated the department heads were supposed to fill out a form about what was done to resolve the issue and return it, so she could report off what had been done in the next Resident Council Meeting. The AD further stated she had received no forms from any of the department heads with issues expressed during the month of February 2019 and was unsure if any of the concerns brought up had been resolved when she had the March 2019 meeting. The AD stated she had given the Resident Council Meeting minutes to all the department heads with issues listed from the February meeting. During an interview with the Administrator on	F 565	appropriate department manager for follow up response(s) if not already completed and documented. Responses will be documented and returned to the Activities Director, with copies to the Administrator, on or before 4/11/19 using the established resident council meeting departmental response form. All responses will be reviewed with the residents at the April resident council meeting scheduled for 4/11/19. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Department managers will be educated by the Administrator on or before 4/8/19 on the procedure for addressing requests/ concerns voiced during resident council meetings and documenting responses. Responses will be due within seven (7) days of each monthly resident council meeting and documented and returned to the Activities Director, with copies to the Administrator, using the established resident council meeting departmental response form. All responses will be reviewed with the residents at the next resident council meeting. How the corrective actions 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 designee will perform	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 565	Continued From page 3 03/21/19 at 12:07PM, he stated all managers get a copy of the Resident Council Meeting minutes and he expects them to follow up if there are any concerns in their department within 7 days. The Administrator further stated he did not get the follow up forms from the managers for February and they needed to develop a better monitoring system to ensure concerns brought up in Resident Council were being followed up on and resolved.	F 565	monthly audits using an audit tool for three (3) months to ensure that responses to requests/ concerns voiced during monthly resident council meetings are completed within seven (7) days, documented and returned to the Activities Director and Administrator. Any identified discrepancies will be corrected immediately with re-education provided as necessary. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Administrator is responsible for implementing the acceptable plan of correction.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, staff and Nurse Practitioner interviews, the facility failed to obtain a physician's order for oxygen therapy and did not follow a physician's order to change oxygen tubing (Resident #22)	F 695	F 695 This alleged deficiency was caused by Nursing's failure to consistently follow established policies & procedures related	4/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 695	Continued From page 4 and failed to follow a physician's order for oxygen setting (Resident #181) for 2 of 3 residents reviewed for oxygen therapy. The findings included: 1. a. A review of Resident #22's current care plan dated 01/01/19 revealed Resident #22 was to receive oxygen as ordered. A review of the admission Minimum Data Set (MDS) dated 01/15/19 revealed Resident #22 was cognitively intact and received oxygen therapy. Resident #22 was readmitted to the facility on 02/04/19 with diagnoses which included acute and chronic respiratory failure with hypoxia (low oxygen) and exacerbation of chronic obstructive pulmonary disease. A review of Resident #22's current physician's order dated 02/26/19 revealed no order for oxygen therapy. Observations of Resident #22's oxygen use were as follows: -03/18/19 at 2:18 PM Resident #22 was receiving oxygen via the concentrator at 5 LPM (liters per minute). -03/19/19 at 6:20 AM Resident #22 was receiving oxygen via the concentrator at 6 LPM. -03/19/19 at 2:10 PM Resident #22 was receiving oxygen via the concentrator at 6 LPM. -03/20/19 at 9:59 AM Resident #22 was receiving	F 695	to oxygen administration. How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: The oxygen tubing for resident # 22 was changed by the Director of Nursing on 3/20/19. A physician order for resident # 22 for the provision of oxygen was also received by the Director of Nursing on 3/20/19. On 3/21/19, the oxygen liter flow for resident # 181 and resident # 22 was corrected by the Director of Nursing in accordance with the physician’s orders. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Audits were initiated on 3/20/19 by the Director of Nursing and RN Unit Managers and will be completed on or before 4/10/19 to ensure that residents receiving oxygen have the appropriate physicians orders, that residents with oxygen are receiving the correct liter flow rate as per the physician’s order, and that oxygen tubing is changed according to policy. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: In-services for licensed nurses will be provided by the Director of Nursing or RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 695	Continued From page 5 oxygen via the concentrator at 5.5 LPM. -03/20/19 at 10:26 AM Resident #22 was receiving oxygen via the portable oxygen tank at 4 LPM. -03/20/19 at 12:38 PM Resident #22 was receiving oxygen via the concentrator at 5 LPM. On 03/20/19 5:04 PM an interview was conducted with the Director of Nursing (DON) who stated a physician's order was required for the delivery of oxygen and that the order should specify a specific liter(s) of oxygen to be delivered. The DON reviewed Resident #22's physician's orders and verified there was no order for oxygen therapy. On 03/20/19 at 5:30 PM an observation was made with the DON of Resident #22 receiving oxygen via the concentrator at 5 LPM. The DON stated it was her expectation for Resident #22 to have an order for oxygen therapy and a specific amount of liters of oxygen to be delivered. An interview was conducted on 03/21/19 at 11:05 AM with the Nurse Practitioner who stated she expected there to be a specific order for oxygen therapy for those residents who required oxygen. b. A review of Resident #22's current physician's order dated 02/26/19 revealed an order to change oxygen tubing every night shift on Sunday. On 03/20/19 at 10:26 AM an observation was made of Resident #22 receiving oxygen therapy from a portable oxygen tank via a nasal cannula dated 03/08/19 which indicated the date of the tubing change.	F 695	Unit Managers on or before 4/10/19 on the requirement that residents receiving oxygen have the appropriate physicians orders, that residents with oxygen are receiving the correct liter flow rate as per the physician's order, and that oxygen tubing is changed according to policy. Newly hired licensed nurses will receive education on this requirement as part of their new hire clinical orientation. How the corrective actions 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 Director of Nursing or RN Unit Managers will perform random audits beginning 4/11/19 of five (5) residents receiving oxygen weekly for twelve (12) weeks to determine if they have the appropriate physicians orders, that they are receiving the correct liter flow rate as per the physician's order, and that oxygen tubing is changed according to policy. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 695	Continued From page 6	F 695		

On 03/20/19 at 5:04 PM during an interview with the Director of Nursing (DON) she stated the oxygen tubing should be changed every week on Sunday for all residents who receive oxygen. The DON confirmed that
Resident #22 had a order effective 02/26/19 for the oxygen tubing to be changed every night shift on Sunday.

At 5:30 PM on 03/20/19 an observation was made along with the DON of Resident #22's oxygen tubing connected to the portable oxygen tank with a date of the last change of 03/08/19.

An interview was conducted with the Nurse Practitioner (NP) on 03/21/19 at 11:05 AM. The NP stated that her expectation was that the staff follow the orders for specific oxygen tubing changes.

2. Resident #181 was admitted to the facility on 03/14/19 with multiple diagnoses that included obstructive sleep apnea (repetitive episodes of shallow or paused breathing during sleep).

Review of Resident #181's electronic medical record revealed the following physician's orders:
03/04/19: Oxygen via nasal cannula at 4 LPM (Liters per Minute).
03/04/19: CPAP (Continuous Positive Airway Pressure - device used primarily for the treatment of sleep apnea) at HS (bedtime).

Review of Resident #181's care plans, initiated on 03/07/19, included a plan that addressed the following problem area:
Resident #181 has chronic obstructive pulmonary disease (difficulty breathing). Interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 695	Continued From page 7	F 695		

included for staff to administer oxygen as ordered at 4 LPM via nasal cannula.

Review of the admission Minimum Data Set (MDS) dated 03/11/19 indicated Resident #181 had intact cognition. Further review of the MDS revealed Resident #181 received oxygen and used a CPAP.

An observation and interview were conducted on 03/19/19 at 9:05 AM with Resident #181. She was observed lying in bed wearing her CPAP. The oxygen concentrator connected to her CPAP device was sitting to the left of her bedside table out of her reach and was set to deliver oxygen at 4.5 LPM. Resident #181 confirmed she was unable to adjust the oxygen setting on the concentrator and it should be set at 4 LPM.

An interview was conducted on 03/20/19 at 12:40 PM with the Director of Nursing (DON). The DON stated all residents receiving oxygen should have a physician's order that specified the liters per minute and if the oxygen setting could be adjusted when needed.

Observations of Resident #181 on 03/20/19 at 6:00 PM and 03/21/19 at 10:40 AM revealed she was lying in bed wearing her CPAP with the oxygen concentrator set at 4.5 LPM.

An observation of Resident #181 and follow-up interview was conducted on 03/21/19 at 10:45 AM with the DON. Resident #181 was observed lying in bed wearing her CPAP. The DON confirmed the oxygen setting on the concentrator that was connected to Resident #181's CPAP device was set at 4.5 LPM and stated it should have been set at 4 LPM as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 695	Continued From page 8 An interview with the Nurse Practitioner (NP) on 03/21/19 at 11:08 AM revealed it was her expectation staff would follow the orders for specific oxygen settings.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to discard 2 of 9 multi-dose influenza vaccine vials that were	F 761	F 761 This alleged deficiency was caused by	4/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 761	Continued From page 9 opened and expired and were available for resident use in 1 of 1 medication storage refrigerator. Findings included: A review of the manufacturer's recommendation for multi-dose afluria Quadrivalent Influenza Vaccine for the 2018-2019 season indicated that once the product stopper of the multi-dose vial had been pierced then the vial had to be discarded within 28 days. On 03/18/19 at 2:50 PM one multi-dose afluria Quadrivalent Influenza Vaccine for the 2018-2019 season with lot # 03044621A was observed dated 11/12/18 when opened and the stopper of the multi-dose vial was pierced and was available for resident use in the medication storage refrigerator. The multi-dose influenza vaccine had been expired for 99 days. One multi-dose afluria Quadrivalent Influenza Vaccine for the 2018-2019 season with lot # 03044621A was observed dated 11/29/18 when opened and the stopper of the multi-dose vial was pierced and was available for resident use in the medication storage refrigerator. The multi-dose influenza vaccine had been expired for 82 days. Nurse #1 verified both multi-dose vials of afluria Quadrivalent Influenza Vaccine were expired and the stopper had been pierced on both vials and they were available for resident use in the medication storage refrigerator. Nurse #1 verified the manufacturer's recommendation indicated the multi-dose influenza vaccine was good for 28 days once the stopper of the vial had been pierced. Nurse #1 verified that one multi-dose influenza vaccine vial had been dated 11/12/18 when opened and verified that one multi-dose influenza vaccine vial	F 761	Nursing's failure to identify expired medication located in the medication storage room. How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: The two expired influenza vaccine vials that were identified were immediately removed from the medication storage refrigerator and discarded by the Director of Nursing on 3/18/19. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An audit of the medication storage room was conducted on 3/18/19 by the Director of Nursing or RN Unit Managers to ensure no other influenza vials were noted with an expired date. No others were identified. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: In-services for licensed nurses will be provided by the Director of Nursing or RN Unit Managers on or before 4/10/19 on the facility policy on storage of medications, including the proper disposal of expired medications. How the corrective actions will be monitored to ensure the practice will not recur, i.e. what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 761	Continued From page 10 had been dated 11/28/19 when opened. On 03/18/19 at 2:59 PM an interview was conducted with the Director of Nursing (DON) who verified one multi-dose afluria Quadrivalent Influenza Vaccine for the 2018-2019 season with lot # 03044621A was dated 11/12/18 when opened and the stopper of the multi-dose vial was pierced and was available for resident use in the medication storage refrigerator and verified one multi-dose afluria Quadrivalent Influenza Vaccine for the 2018-2019 season with lot # 03044621A was dated 11/29/18 when opened and the stopper of the multi-dose vial was pierced and was available for resident use in the medication storage refrigerator. The DON verified by reviewing the manufacturer's recommendations that the multi-dose afluria Quadrivalent Influenza Vaccine had to be discarded within 28 days once the stopper had been pierced. The DON stated her expectation was that staff were to date multi-dose influenza vaccine vials when opened and used. The DON indicated she was not aware that once opened and the stopper of the vial was pierced that the manufacturer's recommendation was that the multi-dose influenza vaccine expired in 28 days. The DON verified that the multi-dose vials of influenza vaccine that were dated 11/12/18 and 11/28/18 when opened were expired and should have been removed from the medication storage refrigerator. On 03/18/19 at 3:08 PM an interview was conducted with the Administrator who stated his expectation was that the multi-dose vials of influenza vaccine that were dated 11/12/18 and 11/29/18 when opened and the stopper of the vials had been pierced should have been discarded at 28 days per manufacturer's	F 761	Quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing or RN Unit Managers will audit the medication storage room weekly for twelve (12) weeks to ensure there are no expired medications present. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 761	Continued From page 11 recommendations.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of	F 791		4/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 791	Continued From page 12 dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to make a dental referral in a timely manner for 1 of 2 residents reviewed for dental (Resident #39). The findings included: Resident #39 was admitted to the facility on 08/08/14 with multiple diagnoses that included diabetes and dementia. Review of Resident #39's medical record revealed a dental consult note dated 12/06/18 that read in part, "patient has severe decay and will need sedation dentistry. The patient needs restorative treatment for fillings and has dry mouth causing decay." There was a handwritten note at the bottom of the page dated 12/08/18 that read, "copy to transport scheduler." Review of the social service and nurse notes for the period December 2018 to March 2019 revealed no entries indicating attempts made to schedule a dental referral for Resident #39. Review of the quarterly Minimum Data Set (MDS) dated 01/25/19 indicated Resident #39 had moderate impairment in cognition, clear comprehension of what was being said and was able to express her needs.	F 791	F 791 This alleged deficiency was caused by the interdisciplinary team's failure to follow through on a dental consultation request. How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: A dental appointment, as per the dental consult, was scheduled for 5/27/19 for Resident #39 by the facility appointment scheduler on 3/20/19. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Audits were initiated on 3/21/19 by the Director of Nursing and RN Unit Managers and will be completed on or before 4/10/19 to ensure that recommendations for dental consultations for the previous 30 days have been scheduled or completed. Dental appointments will be made by the facility appointment scheduler or social worker as necessary for any missed recommendations identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 791	Continued From page 13 During an interview on 03/19/19 at 10:02 AM, Resident #39 indicated she requested to see a dentist for a routine check-up but had not received an appointment. Resident #39 stated she had all her natural teeth and it was important to her that she receive routine dental services because she did not want to lose her teeth. During an interview on 03/20/19 at 4:04 PM, the Scheduler revealed she had been in the current position for approximately 2 months. She stated when an order for a dental referral was received, staff would place it in her box to schedule an appointment. The Scheduler reviewed the dental consult note for Resident #39 dated 12/06/18 and stated at that time, the Social Worker (SW) was scheduling referral appointments for the residents. During an interview on 03/20/19 at 4:16 PM, the SW recalled attempting to schedule a referral for Resident #39 but stated she had difficulty finding a dentist that would accept her insurance. She stated the only dentist she found who would perform the dental sedation for Resident #39 required a down payment of $200 for the services and when it was explained to Resident #39 she stated she could not afford to pay. The SW explained she contacted several local dental offices as well as ones in another county but did not document the names of the dental offices, dates or times they were contacted. She confirmed there was no follow-up or further attempts to schedule an appointment since receiving the initial referral on 12/08/18. During an interview on 03/20/19 at 5:02 PM, the Director of Nursing (DON) recalled talking to	F 791	What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Dental consultations will be reviewed by the Director of Nursing or RN Unit Managers following future dental appointments to ensure that follow up appointments are scheduled. The facility appointment scheduler or social worker will be responsible for making any necessary dental appointments. In-services for licensed nurses, the licensed social worker, and facility scheduler will be provided by the Director of Nursing or RN Unit Managers on or before 4/10/19 on the requirement that recommendations for dental services be followed up on. Newly hired licensed nurses, schedulers, or social workers will receive education on this requirement as part of their new hire orientation. How the corrective actions 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 Director of Nursing or RN Unit Managers will perform random audits of resident records beginning 4/11/19 to ensure that recommendations for dental consultations are acted on per the consult. Five (5) resident records will be audited weekly for twelve (12) weeks to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 791	Continued From page 14 Resident #39 prior to her going to the dentist on 12/06/18 and stated Resident #39 told her she didn't want to lose her natural teeth. The DON was unaware Resident #39 had a referral dated 12/06/18 for restorative dental services that had not been scheduled. The DON stated had the SW explained she was unable to schedule the appointment, she would have assisted the SW with locating a dentist that would accept Resident #39's insurance. The DON stated she would have expected to have been notified when staff were unable to schedule the dental appointment and further attempts made until one was arranged.	F 791	is achieved and maintained. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		4/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 842	Continued From page 15	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 842	Continued From page 16 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document notification of the responsible party regarding a medication change for 1 of 1 resident reviewed for notification of change (Resident #28). Findings included: Resident #28 was admitted to the facility on 11/28/17 with diagnoses which included chronic lung disease and an unspecified mood disorder among others. The annual Minimum Data Set (MDS) dated 12/17/18 revealed Resident #28 had significant short and long-term memory problems and required assistance with activities of daily living. Review of the care plan revealed Resident #28 used smokeless tobacco. Review of physician's orders revealed an order dated for 03/11/19 for a smoking cessation patch to be applied to the skin daily each morning for 7 days. Review of the Medication Administration Record (MAR) for March 2019 revealed the patch had been applied daily per MD order. Review of nurse's notes and physician's progress notes for March 2019 revealed no documentation that the Responsible Party (RP) for Resident #28 had been notified of the addition of a smoking	F 842	F842 This alleged deficiency was caused by Nursing's failure to consistently follow established policies & procedures related to resident and/ or responsible party notification. How will corrective action be accomplished for those residents having the potential to be affected by the deficient practice: The responsible party for Resident #28 was notified by the Director of Nursing on 3/20/19 of the nicotine patch as prescribed by the physician. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Audits were initiated on 3/20/19 by the Director of Nursing and RN Unit Managers and will be completed on or before 4/10/19 to ensure that residents and/ or responsible parties have been notified of medication changes for the previous 30 days. Notifications will be made for any omissions identified. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: On 3/22/19, an in-service for licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	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 842	Continued From page 17 cessation patch to Resident #28's medication regimen. During an interview with Resident #28's RP on 03/18/19 at 3:16 PM, she stated she had not been notified that the facility had changed him to a nicotine patch when he was moved to the locked unit. The RP further stated it bothered her that she was not notified because the staff is usually very good about contacting her with any changes. During an interview with the Director of Nursing (DON) on 03/20/19 at 3:31 PM, she stated residents were not allowed to have smoking products on the locked unit. The DON further stated there was a Family Nurse Practitioner (FNP) that had been working with the family of Resident #28 and she was sure the FNP had discussed it with his RP. The DON proceeded to look through the nurses notes and notes from the FNP but could not find documentation of notification to the RP. During an interview with the FNP on 03/20/19 at 4:04 PM, she stated she only contacted the RP when there was a change in condition. She further stated that the nurses call the RP when there was a medication or treatment change. During an interview with Nurse #3 on 03/20/19 at 5:37 PM, he stated he had called the RP to let her know Resident #28 was starting a new medication. Nurse #3 stated if he had not documented it in nurses notes he must have forgotten to do so. During a 2nd interview with the DON on 03/21/19 at 12:28 PM, she stated her expectation was for	F 842	nurses was conducted by the Director of Nursing and RN Unit Managers on administration documentation related to notification of the resident and/ or responsible party of physician order changes. Additional in-services on this requirement will be provided for licensed nurses by the Director of Nursing or RN Unit Managers on or before 4/10/19. Newly hired licensed nurses will receive education on this requirement as part of their new hire clinical orientation. How the corrective actions 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 Director of Nursing or RN Unit Managers will perform random audits of documentation beginning 4/11/19 to ensure that the resident and/ or responsible party has been notified of new physician orders using an audit tool. Five (5) resident records will be audited twice weekly for four (4) weeks and then weekly for eight (8) weeks to ensure compliance is achieved and maintained. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	**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 842	Continued From page 18 the nurses to notify the RP for any changes of events or medication for a resident and to document that as well.	F 842		