PRINTED: 03/18/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345270	B. WING _			l	05/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			8 LAUREL CREEK COURT		
				SI	PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039 SS=F	EP Testing Requiremed CFR(s): 483.73(d)(2) *[For RNCHI at §403. HHAs at §484.102, C "Organizations" under §485.920, RHC/FQH0 Facilities at §494.62]: (2) Testing. The [facilities at §494.62]: (2) Testing. The [facilities at §494.62]: (2) Testing. The [facilities at §494.62]: (3) Testing. The [facilities at §494.62]: (4) When a community-based every (a) When a community-based every 2 (B) If the [facilities	ents 748, ASCs at §416.54, ORFs at §485.68, OPO, r §485.727, CMHC at C at §491.12, ESRD ty] must conduct exercises r plan annually. The [facility] owing: a full-scale exercise that is ery 2 years; or community-based exercise is act a facility-based functional years; or cility] experiences an actual emergency that requires gency plan, the [facility] ing in its next required individual, facility-based dercise following the onset of dditional exercise at least te the year the full-scale or ider paragraph (d)(2)(i) of ted, that may include, but is wing: d full-scale exercise that is individual, facility-based		039		.TE	DATE
	(C) A tableto is led by a facilitator a discussion using a na clinically-relevant	p exercise or workshop that and includes a group					
ABOBATORY	DIPECTOR'S OP PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1		TITI F		(X6) DATE

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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E 039	maintain documentate exercises, and emergate revise the [facility's] of the secretary states of the exercises to test the exercises in community based events (A) When a not accessible, conducts and the emergency plate exempt from engaging scale community-based facility-based of the emergency plate exempt from engaging scale community-based of the emergency plate exempt from engaging scale community-based of the emergency plate exercise until this section is conducted in the follow (A) A second community-based or exercise; or (B) A mock (C) A tablet is led by a facilitator and discussion using a national exercise and clinically-relevanted.	the [facility's] response to and ion of all drills, tabletop gency events, and emergency plan, as needed. 8.113(d):] ces that provide care in the hospice must conduct emergency plan at least ce must do the following: a full-scale exercise that is ery 2 years; or community based exercise is uct an individual facility roise every 2 years; or spice experiences a natural ency that requires activation in, the hospital is gin its next required full sed exercise or individual functional exercise following regency event. additional exercise every 2 ear the full-scale or inder paragraph (d) (2)(i) of cted, that may include, but is owing: and full-scale exercise that is a facility based functional disaster drill; or cop exercise or workshop that and includes a group	EO	39		

	ATEMENT OF DEFICIENCIES DEPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(3) ca ex ye that no factor of ex full fur of the follows em star que em ex the *[F	re directly. The hose ercises to test the elear. The hospice muticipate in at is community-base (A) When a control of the accessible, conductive based function (B) If the hose man-made emerge the emergency planempt from engaging l-scale community benctional the emergency evenctional (A) A second munity-based or a facilitator that including a narrated, hergency scenario, atements, directed restions desinergency plan. (iii) Analyze the leantain documentatic ercises, and emergency energer energency emergency emerger energency emerger.	es that provide inpatient spice must conduct emergency plan twice per ust do the following: an annual full-scale exercise sed; or community-based exercise is ct an annual individual all exercise; or spice experiences a natural ncy that requires activation in, the hospice is go in its next required based or facility-based exercise following the onset int. In the diditional annual exercise is not limited to the individual and a set of problem messages, or prepared signed to challenge an incospice's response to and on of all drills, tabletop ency events and revise incy plan, as needed.	E	039			

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E 039	(2) Testing. The [PRT conduct exercises to twice per year. The [do the following:	rest the emergency plan PRTF, Hospital, CAH] must an annual full-scale exercise sed; or community-based exercise is act an annual individual, all exercise; or RTF, Hospital, CAH] all natural or man-made res activation of the [facility] is exempt from equired full-scale community individual, facility-based Illowing the onset of the additional] annual exercise or but is not limited to the difull-scale exercise that is individual, a facility-based r disaster drill; or op exercise or workshop that and includes a group arrated, t emergency scenario, and a ments, directed messages, or designed to challenge an facility's] response to and ion of all drills, tabletop gency events and revise ncy plan, as needed.	E 03	39	

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E 039	including unannounce emergency procedur ICF/IID] must do the (i) Participate in that is community-based (A) When a not accessible, conditation (B) If the [L] an actual natural or requires activation of the LTC facility is extrequired a full-scale.	colan at least twice per year, seed staff drills using the res. The [LTC facility, following: In an annual full-scale exercise ased; or In community-based exercise is suct an annual individual, unal exercise. TC facility] facility experiences man-made emergency that find the emergency plan, empt from engaging its next community-based or	E 03	39		
	following the onset of (ii) Conduct an that may include, but following: (A) A seconormal community-based or functional exercise; (B) A mock (C) A table is led by a facilitator using a narrated, emergency scenario statements, directed questions defended and the community of the	and full-scale exercise that is an individual, facility based for a disaster drill; or top exercise or workshop that includes a group discussion, clinically-relevant, and a set of problem messages, or prepared esigned to challenge an esigned to challenge an estate [LTC facility] facility's intain documentation of all ises, and emergency ne [LTC facility] facility's needed.				
		33.475(d)]: /IID must conduct exercises				

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E 039	The ICF/IID must do (i) Participate in that is community-base (A) When a not accessible, conduction (B) If the ICI natural or man-made activation of the emeris exempt from engage full-scale community-based functional of the emergency ever (ii) Conduct an amay include, but is not (A) A second community-based or functional exercise; of (B) A mock (C) A tableto is led by a facilitator adiscussion, using a noclinically-relevant set of problem statem prepared questions emergency plan. (iii) Analyze the Imaintain documentate exercises, and emergency exercises are exercises and exercises and exercises are exercised as a constant exercises and exercises are exerc	the following: an annual full-scale exercise sed; or community-based exercise is act an annual individual, hal exercise; or. F/IID experiences an actual emergency that requires rgency plan, the ICF/IID ging in its next required based or individual, facility- exercise following the onset ent. dditional annual exercise that bot limited to the following: d full-scale exercise that is an individual, facility-based or disaster drill; or op exercise or workshop that and includes a group arrated, t emergency scenario, and a hents, directed messages, or designed to challenge an CF/IID's response to and ion of all drills, tabletop gency events, and revise hcy plan, as needed.	E 03	39		
	to test the emergency following: (i) Conduct a par	y plan. The OPO must do the per-based, tabletop exercise annually. A tabletop exercise				

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BRIAN CTR HEALTH & REHAB/SPRUC	DRESS, CITY, STATE, ZIP CODE L CREEK COURT PINE, NC 28777
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE
E 039 Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to test their Emergency Preparedness (EP) plan in 2019 by either participating in a full-scale, community-based exercise or by conducting an individual facility-based functional exercise. The facility's failure to test their EP plan had the potential to affect all residents and staff. Findings included: The facility's EP manual was reviewed on 03/05/20. The review revealed there was no information available to show the facility tested their EP plan by participating in either a full-scale community-based exercise or by conducting an individual facility-based functional exercise during 2019. An interview on 3/5/20 at 11:03 AM with the Administrator revealed the facility did not participate in a community-based full-scale	

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NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN CT	D UEAITU & DEUAD/SD	BUC		21	18 LAUREL CREEK COURT		
BRIAN CI	R HEALTH & REHAB/SP	RUC		S	PRUCE PINE, NC 28777		
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E 039	September 2018. The tried repeatedly in 20 participation in a full-sexercise but was told person that the full-sexercise to be done of the Administrator stated to plan on 10/23/19 when	n one of these exercises in e Administrator stated she 19 to schedule the facility's scale community-based by their local EP resource sale exercise was only	E	039			
F 000	INITIAL COMMENTS		F	000			
F 561 SS=D			F	561			
	promote and facilitate through support of res	right to and the facility must resident self-determination sident choice, including but s specified in paragraphs (f)					
	activities, schedules (waking times), health						
		ident has a right to make s of his or her life in the cant to the resident.					
	§483.10(f)(3) The res	ident has a right to interact					

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F 561	community activities it facility. §483.10(f)(8) The resparticipate in other acreligious, and communinterfere with the right facility. This REQUIREMENT by: Based on record revisinterviews, the facility showers for 2 of 4 respectively. The findings included 1. Resident #44) review living. The findings included 1. Resident #3 was acredited as a second record revision and contractures to be the findings included 1. Resident #3 was acredited as a second record revision. The quarterly Minimulassessment dated 2/8 had intact cognition, who one-person physical acredited impairment to both up Resident #3's Treatme (TAR) for February 20	community and participate in both inside and outside the dident has a right to stivities, including social, nity activities that do not at sof other residents in the dident is not met as evidenced as ew, resident and staff failed to provide scheduled addents (Resident #3 and ed for activities of daily didents included hereditary europathy, muscle weakness oth hands. In Data Set (MDS) 5/20 indicated Resident and had	F	561	DEFICIENCY)		
	#3 revealed he had n showers for the past 3	2/29/20. , an interview with Resident ot received his scheduled 3 Saturdays. Resident #3 lled to receive a shower on					

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F 561	the past 3 weeks. Refacility had one nurse hall on the weekends said the NA who wor stayed past the time order to give him a serceived a shower for the shared that they missed Saturday should not want to take 2 days. On 3/4/20 at 4:03 PM #5 revealed she worl 2/15/20 and 2/29/20 not have time to give NA #5 stated she comminutes to give any rehad been assigned to no 2/15/20 and 2/29/ take care of. NA #5 3/1/20 past the time Resident #3 his schemot received one for further stated the factor at least a month.	turdays but had only a week on Wednesday for esident #3 further stated the e aide (NA) assigned to his a for the past 3 weeks. He ked this past weekend her shift ended on 3/1/20 in hower since he had not r 3 consecutive Saturdays. did offer to make up his other lowers on Tuesdays, but he 2 showers on back-to-back 1, a phone interview with NA ked with Resident #3 on during the day shift and did him his scheduled shower. uld not leave the hall for 45 resident a shower. NA #5 resident a shower. NA #5 resident sto shared she stayed over on her shift ended to give duled shower since he had the past 3 Saturdays. NA #5 illity had been understaffed	F 50	,	
	revealed she worked and worked on 2/15/2 Nurse #3 stated she #3 had missed his so dates (2/15/20, 2/22/ stated Nurse #1 shou could have made up shower on the next day	A, an interview with Nurse #3 as the weekend supervisor 20, 2/22/20 and 2/29/20. was unaware that Resident cheduled showers on those 20 and 2/29/20). Nurse #3 uld have notified her so they Resident #3's scheduled ay. Nurse #3 further stated A per hall and a floater NA on			

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F 561	on 3/4/20 at 4:42 PN conducted with Nurswith NA #5 on 2/29/2 worked as the only N Nurse #1 also worke that Resident #3 did shower on 2/22/20 at there was another NA halls and helped with care, but this NA did showers. Nurse #1 chad notified the week Resident #3 had mis on the past 3 Saturda #3 would let staff me his showers. On 3/4/20 at 5:34 PN with NA #7 revealed on 2/15/20 and 2/29/and was unaware that received his schedul NA #7 stated she did shower because she receive them during Resident #3 never reshowers. On 3/5/20 at 9:23 AN #4 revealed she worl and was assigned to stated she had to help	In not know that showers not having enough staff. If, a phone interview e #1 revealed she worked 0 and verified that NA #5 IA on the 300 hall on 2/29/20. Id on 2/22/20 and confirmed not get his scheduled nd 2/29/20. Nurse #1 stated A who floated among the meals and incontinence not have time to do resident could not remember if she kend supervisor that sed his scheduled showers ays but shared that Resident mbers know if he did miss If, an interview conducted she worked with Resident #3 20 during the evening shift at Resident #3 had not ed shower for those days. not give Resident #3 his did not know he did not the day shift. NA #7 shared	F 5	61		
	care, passing meal tr	n 300 hall with incontinence rays, feeding assistance and red she did not provide any				

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F 561	have enough time. It worked on Saturdays have 2 NAs per hall weeks, they have hat hall and a floater NA. On 3/5/20 at 9:30 AM with NA #6 revealed on 2/22/20 on day shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 300 hall be time to do all the shocked on 3/5/20 at 3:46 PM Director of Nursing (I should have received. The DON was unsur offered a make-up should have received situation obtain staff to provide. On 3/5/20 at 4:40 PM Administrator revealer receive at least 2 shocked was unaware that his scheduled showed Saturdays, but the new or a shower should and on the day it was a shower should and on the day it was a shower should and on the day it was a start of the shower should and the day it was a shower should an and the day it was a shower should an	th NA #5 because they did not NA #4 shared she only is and they were supposed to but during the last 3 to 4 did to work with only 1 NA per M, an interview conducted she worked with Resident #3 hift and did not provide his in that day. NA #6 stated she by herself and did not have owers that were scheduled for ead she had meant to offer tup shower on 2/23/20 but he is that day and she did not to ask him. M, an interview with the DON) revealed Resident #3 did his showers as scheduled. The interview with the action of the showers he that the facility had staffing due to callouts and its but have been trying to be care for the residents. M, an interview with the ed all residents should be were a week. She stated that Resident #3 had missed at Resident #3 had missed the staffing the past 3 ext shift should have made it lid have been offered the next the time to get his shower.	F 56			

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F 561	weakness. The quarterly Minimulassessment dated 1/had intact cognition a from one person in per	es that included egeneration and muscle sum Data Set (MDS) (3/20 indicated Resident #44 and required physical help art of bathing activity. ment Administration Record 020 was not initialed for eate that he received a	F 56	51			

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F 561	and worked on 2/15/2 Nurse #3 was unawa missed his scheduled (2/15/20, 2/22/20 and Nurse #1 should have have made up his she #3 further stated they and a floater NA on th know that showers we having enough staff. On 3/4/20 at 4:42 PM conducted with Nurse with NA #5 on 2/29/20 worked as the only N. Nurse #1 also worked that Resident #44 did shower on 2/22/20 ar there was another NA halls and helped with care, but they did not Nurse #1 could not re the weekend supervis missed his showers of On 3/4/20 at 5:34 PM with NA #7 revealed s #44 on 2/15/20 and 2 was unaware that Re his scheduled shower stated she did not giv because she did not giv	as the weekend supervisor 20, 2/22/20 and 2/29/20. re that Resident #44 had a showers on those dates 1 2/29/20). Nurse #3 stated the notified her so they could lower on the next day. Nurse you usually had 1 NA per hall the weekends but did not the ere missed due to not	F	561			

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	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	'	00/00/2020
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F 561	helped NA #5 on 300 passing meal trays, charting. NA #4 state resident showers with have enough time. I worked on Saturday have 2 NAs per hall weeks, they have hahall and a floater NA On 3/5/20 at 9:30 Al with NA #6 revealed #44 on 2/22/20 durin provide his scheduled stated she worked on thave time to do a scheduled for the da provided Resident #2/23/20. On 3/5/20 at 3:46 Pl Director of Nursing (should have receive The DON was unsur offered a make-up s missed. The DON schallenges with the sunexpected situation	She further stated she had D hall with incontinence care, feeding assistance and ed she did not provide any the NA #5 because they did not NA #4 shared she only and they were supposed to but during the last 3 to 4 and to work with only 1 NA per supposed. M, an interview conducted she worked with Residenting the day shift and did not ed shower on that day. NA #6 in 300 hall by herself and did all the showers that were y. NA #6 shared she 44 a make-up shower on M, an interview with the DON) revealed Resident #44 dhis showers as scheduled. The if Resident #44 had been shower for the showers he	F5			
	Administrator reveal receive at least 2 sh she was unaware th his scheduled showed Saturdays, but the nup or a shower show	M, an interview with the ed all residents should owers a week. She stated at Resident #44 had missed ers during the past 3 ext shift should have made it ld have been offered the next ave time to get his shower				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345270	B. WING			03/	05/2020
	ROVIDER OR SUPPLIER R HEALTH & REHAB/SP	RUC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 18 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561 F 641 SS=E	resident's status. This REQUIREMENT by: Based on observatio resident and staff inte accurately code Minir assessments in the a (Residents #16 and #	of Assessments. t accurately reflect the is not met as evidenced ns, record review and erviews, the facility failed to num Data Set (MDS) reas of behaviors 17), oxygen use (Resident		561 641			
	(Residents #16 and #17), oxygen use (Resident #16), influenza immunization (Residents #50, #56, #22, #42 and #33) and prognosis (Resident #88) for 8 of 24 sample residents reviewed for MDS accuracy. The findings included: 1. Resident #16 was admitted to the facility on 2/5/18 and readmitted on 5/14/19 with diagnosis						
	which included respiratory failure. Resident #16's Treatment Administration Record (TAR) dated February 2020 revealed she refused her continuous positive airway pressure (CPAP) treatments on the following dates: 2/4/20, 2/5/20, 2/6/20, 2/7/20, 2/11/20, 2/17/20, 2/19/20, 2/21/20, 2/25/20, 2/26/20 and 2/27/20. Resident #16's quarterly Minimum Data Set (MDS) assessment dated 2/21/20 coded the resident as being cognitively intact. Resident #16 was coded under behaviors for no rejection of care.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			, ,	(X3) DATE SURVEY COMPLETED	
					C 03/05/2020		
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP COI 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	•	3103/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From pag		F 6	41			
	with Resident #16. S continuous positive (refusing it for the pas mask bothering her. had attempted to chaher face however she her and had continued. An interview was corwith Nurse #4. Nurse refused to wear her (stated a staff member had came in the wee solution to the mask had continued to refuse the MDS Coordinaterview, the MDS Coordinaterview as sessment along with the Coordinater the MDS as residents in the faciliary the faciliary that the showed a revision was Resident #16's rejection of the MDS as accurate and corresponded to what she will be a coordinated the MDS as accurate and corresponded or what she will be continued to the MDS as accurate and corresponded or what she will be continued to the MDS as accurate and corresponded or what she will be continued to the MDS as accurate and corresponded or what she will be continued to the MDS as accurate and corresponded or what she will be continued to the MDS as accurate and corresponded to the MDS as accurate	nducted on 3/03/20 at 4:35 nator #1. During the coordinator reviewed 20 quarterly MDS ith her February 2020 TAR. on of care was marked no on t. MDS Coordinator #1 coded inaccurately based on e stated he answered ssessment questions for ty and mistakes happen. erly MDS assessment as made on 3/03/20 to reflect					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345270	B. WING		03/05/2020
	NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SPRUC			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	1 33/05/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 641	12/5/17 with diagnos depression, cerebrown hyperlipidemia. Resident #17's care on 1/10/20, revealed he was resistive to conften refused to let sith his nightstand drawer Resident #17 to coop cleaning through the Interventions listed in education to the resident to make his plan did not include it resident's refusal of sith services.	readmitted to the facility on is which included hemiplegia, vascular accident and plan, most recently reviewed a focus area which stated are such as therapy and taff clean out old food from rs. The goal was for perate with care and room next review date. Included occupational therapy, dent and allowing the own decisions. The care information regarding the	F 64 ²	,	
	revealed he had refu following dates: 2/1/2 2/22/20 and 2/29/20. his 9 scheduled show February 2020. Resident #17's quart (MDS) assessment or resident as being cog was coded under belicare. An observation was a AM of Resident #17. observation Resident Urinals were observed black debris around to the following the followi	sed a shower on the 20, 2/5/20, 2/15/20, 2/19/20, Resident #17 refused 6 of ver days for the month of erly Minimum Data Set lated 2/23/20 coded the gnitively intact. Resident #17 naviors for no rejection of conducted on 3/2/20 at 10:12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 03/05/2020	
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CO 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	•	3/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	AM with Resident #1 his showers due to n bed. The interview rechoice to often refuse encouragement from An interview was corwith Nurse #4. Nurse refused all care inclumatter how many timeresident he still would An interview was corpm with MDS Coordinatoriew, the MDS Coerdinatoriew, the MDS Coerdinatoriem, the confirmed reno. MDS Coordinatoriem, the corresponded in the care phave been coded for the corresponded of the MDS as accurate and corresponded or what he was she also understood error not by intention	aducted on 3/2/20 at 10:12 7. He stated he often refused of wanting to get out of the evealed it was the resident's a shower despite staff. Inducted on 3/3/20 at 4:52 PM at 4:52 PM at 4:54 stated Resident #17 had ding showers. She stated no resonursing staff asked the direfuse to take a shower. Inducted on 3/03/20 at 4:20 mater #1. During the coordinator reviewed 20 quarterly MDS at his February 2020 shower rejection of care was marked at #1 stated the MDS was assed on the shower log and the care plan reflected are further review of the care as stated refusal of showers cluded. Since it was not blan then the MDS should rejection of care. Inducted with the Director of 05/20 at 3:46 pm who assessment should be bond with the residents is doing. The DON stated it was missed out of human	F 6	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345270	B. WING		C 03/05/2020
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	1 00/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 641	Continued From page	e 19 d on 5/14/19 with diagnosis	F 64	1	
	which included respir	ratory failure.			
		order for oxygen therapy a 2 la as needed to keep oxygen			
	(MDS) assessment d	erly Minimum Data Set lated 2/21/20 coded the gnitively intact. Resident #16 /gen therapy use.			
	wore oxygen at 2 lite	21/20 stated Resident #16 rs especially at night with a irway pressure (CPAP).			
	with Resident #16. S continuous positive a night but had been rebecause of the mask revealed staff had att mask to better fit her was suffocating her atthe machine. She sta	ducted on 3/2/20 at 8:24 AM he stated she wore a irway pressure (CPAP) at efusing it for the past month bothering her. The interview tempted to changer her face however she felt like it and had continued to refuse the instead of wearing the len via a nasal cannula at 2			
	AM with MDS Coordi interview, the MDS C Resident #16's 2/21/2 assessment. He conf marked no. The MDS	coordinator reviewed 20 quarterly MDS irmed oxygen therapy was 3 Coordinator #1 stated the ccurately because he knew			
	An interview was con	ducted with the Director of			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345270	B. WING		C 03/05/2020		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	03/03/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 641	indicated the MDS accurate and corres needs or what she she also understooderror not by intention 4. Resident #50 was 3/20/15 with diagnor heart failure and not The resident vaccin Resident #50 received in the facility on the Resident #50's qual (MDS) assessment resident as being so Resident #50 was confluenza vaccination. An interview was confluenzed when the resident was to look in the residents stated from now on vaccination log. An interview was conversed to the MDS of	B/05/20 at 3:46 pm who assessment should be spond with the residents was doing. The DON stated dit was missed out of human in. Is admitted to the facility on sis which included cancer, in-Alzheimer's dementia. Ination log for 2019 revealed yed her influenza vaccination date of 11/5/19. Interly Minimum Data Set dated 1/8/20 coded the everely cognitively impaired. Ecoded as receiving her	F 64				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345270	B. WING		03/05/2020
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	03/03/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 641	and incorrect dates. Coordinator had tho system was automa however that was not revealed the facility prior to the survey a error. She stated MI in the dates for all reaudit. 5. Resident #56 was 12/24/18 with diagnomellitus and depress. The resident vaccina Resident #56 receiv in the facility on the Resident #56's quar (MDS) assessment resident as being cowas coded as not el vaccination. An interview was cop M with MDS Coordinaterview, the MDS Resident #56's 1/15 assessment and the confirmed the informinaccurate. MDS Conot been provided word log and was having to verify the date of the vaccination. He ask to see the vaccination.	the MDS vaccination issue She stated the MDS ught the point click care tically pulling the dates over of the case. The interview had not identified the issue and this was a facility wide OS was going to manually put esidents and complete an sadmitted to the facility on osis which included diabetes sion. ation log for 2019 revealed ed her influenza vaccination date of 11/6/19. terly Minimum Data Set dated 1/15/20 coded the agnitively intact. Resident #56 igible to receive the influenza anducted on 3/04/20 at 1:10 dinator #1. During the Coordinator reviewed /20 quarterly MDS a vaccination record. He anation coded on the MDS was a vaccination record. He anation coded on the MDS was coordinator #1 stated he had with the resident vaccination to look in the residents received stated from now on he would	F 64		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345270	B. WING			C 03/05/2020	
	ROVIDER OR SUPPLIER	RUC	<u>.l</u>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	1 03/	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	needs and immunizate they had discussed the and incorrect dates. See Coordinator had thou system was automatic however that was not revealed the facility higher to the survey an error. She stated MDS in the dates for all resaudit. 6. Resident #22 was an	25/20 at 8:57 AM who assessment should be ond with the residents and record. The DON stated the MDS vaccination issue of the stated the MDS ght the point click care cally pulling the dates over the case. The interview ad not identified the issue of this was a facility wide. So was going to manually put sidents and complete an an areadmitted to the facility on the included anemia, but the influenza vaccination in the of 11/5/19. The provided the influence of th	F	641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345270	B. WING		C 03/05/2020		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	•	3/03/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	An interview was con Nursing (DON) on 3/ indicated the MDS as accurate and corresponeeds and immunizately had discussed they have that was not revealed the facility in prior to the survey are error. She stated MD in the dates for all results. 7. Resident #42 was 3/1/18 with diagnosis Alzheimer's dementional diabetes mellitus. The resident vaccinates Resident #42 receives in the facility on the control of the facility on the control of the facility on the control of the facility on the facility on 10/23/2018. An interview was correctly was cordinaterview, the MDS Coordinaterview, the MDS Coordinaterview.	stated from now on he would hation log. Inducted with the Director of 05/20 at 8:57 AM who is sessment should be bond with the residents atton record. The DON stated the MDS vaccination issue is she stated the MDS ught the point click care it in the case. The interview had not identified the issue and this was a facility wide as was going to manually put is idents and complete an admitted to the facility on which included nonary. Parkinson's disease and atton log for 2019 revealed and her influenza vaccination date of 11/6/19. In Minimum Data Set (MDS) 12/20 coded the resident as tively impaired. Resident #42 ing her influenza vaccination and action 1. During the	F 6	41			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345270	B. WING _			C 03/05/2020	
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		05.05.2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	Continued From pag	e 24	F 6	41			
	Coordinator #1 stated with the resident vacto look in the resident when the residents re	DS was inaccurate. MDS d he had not been provided cination log and was having t charts to verify the date of eceived the vaccination. He se would ask to see the					
	Nursing (DON) on 3/indicated the MDS as accurate and corresponeeds and immunizathey had discussed the and incorrect dates. Coordinator had thousystem was automathowever that was no revealed the facility higher to the survey are error. She stated MD	aducted with the Director of 05/20 at 8:57 AM who assessment should be bond with the residents tion record. The DON stated the MDS vaccination issue She stated the MDS aght the point click care ically pulling the dates over the case. The interview and not identified the issue and this was a facility wide S was going to manually put sidents and complete an					
	9/10/19 with diagnos	readmitted to the facility on is which included non- a, anemia, seizure and					
		tion log for 2019 revealed ed her influenza vaccination late of 11/5/19.					
	(MDS) assessment d						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345270	B. WING			C 3/05/2020	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		3/03/2020	
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	PM with MDS Coord interview, the MDS Cordinterview, the MDS Cordinterview, the MDS Cordinater and the confirmed the date of inaccurate. MDS Cordinater and was having to verify the date of the vaccination. He sask to see the vaccination. He sask to see the vaccination and interview was concluded the MDS are accurate and corresponded and immunization that they had discussed	inducted on 3/04/20 at 1:10 inator #1. During the Coordinator reviewed 4/20 quarterly MDS vaccination record. He coded on the MDS was ordinator #1 stated he had ith the resident vaccination to look in the resident charts when the residents received stated from now on he would nation log. Inducted with the Director of 105/20 at 8:57 AM who ssessment should be pond with the residents ation record. The DON stated the MDS vaccination issue	F 64	,			
	9. Resident #88 was 11/03/19 with diagnor vascular accident (C disease and dement in her health over the Resident #88 was ac 11/27/19 and had a last 11/27/19, with a doctor	admitted to the facility on oses which included cerebral eVA), diabetes, Alzheimer's ia with a noted rapid decline e past six months. Idmitted to Hospice on Hospice Certificate dated umented life expectancy of gned by the Hospice Medical					

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		' '	IPLE CONSTRUCTION IG	(>	(X3) DATE SURVEY COMPLETED	
		345270	B. WING			C 03/05/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	I	03/03/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656 SS=D	Set (MDS) dated 12/0 was coded for the archaving a condition or result in a life expecta. The resident was coded Hospice Care while a comparison of the resident was compared to the resident was compared to the resident #88's 12/07 assessment and her 11/27/19. He confirm inaccurately on the 12 based on the Hospice stated he answered to assessment question and mistakes happen. The resident's Significant assessment showed 3/03/20 to reflect Resident was connursing (DON) on 3/0 indicated the MDS as accurate and corresp prognosis and programals ounderstood it was not by intention. Develop/Implement CCFR(s): 483.21(b)(1)	cant Change Minimum Data 17/19 revealed the resident ea of Prognosis as not chronic disease that may ancy of less than 6 months. Ited as having received resident. ducted on 3/03/20 at 4:35 mator #1. During the coordinator reviewed 1/19 Significant Change MDS Hospice Certificate dated led Prognosis was coded 12/07/19 MDS assessment to Certificate provided. He chousands of MDS is for residents in the facility in cant Change MDS are revision was made on sident #88's Prognosis. ducted with the Director of 15/20 at 3:46 pm who is sessment should be ond with the residents' ms. The DON stated she is missed out of human error comprehensive Care Plan	Fé			
	§483.21(b) Comprehe §483.21(b)(1) The fac	ensive Care Plans cility must develop and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	\ , ,	(X3) DATE SURVEY COMPLETED	
		345270	B. WING _			C 3/05/2020	
	ROVIDER OR SUPPLIER	RUC		STREET ADDRESS, CITY, STATE, ZIP COD 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		3/03/2020	
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 656	care plan for each reserved resident rights set for §483.10(c)(3), that in objectives and timefrom medical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, include treatment under §483 (iii) Any specialized sere and in the reside (ivi) Any specialized sere and in the reside (ivi) In consultation with resident's representa (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident' community was asselocal contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate,	nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ided in the comprehensive inprehensive care plan must greater to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse gravity and in the nursing facility will passed at the nursing facility will passed in the resident and the tive(s)-als for admission and reference and potential for illities must document as desire to return to the seed and any referrals to se and/or other appropriate	F 6	56			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		COMPLETED	
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	ROVIDER OR SUPPLIER	SPRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		00/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 656	by: Based on record reinterviews, the facil plan with intervention who rejected treath reviewed for behave. The finding include Resident #16 was resident #17 was resident #18 w	eview, and resident and staff ity failed to develop a care ons and goals for a resident nents for 1 of 2 residents iors. (Resident #16) d: readmitted to the facility on osis which included respiratory ian order dated 5/14/19 #16 was to wear her CPAP at e settings at bedtime related to	F 65	56			
	(TAR) dated Februarefused her continu (CPAP) treatments 2/5/20, 2/6/20, 2/7/2 2/21/20, 2/25/20, 2/2 Resident #16's qua (MDS) assessment resident as being c	atment Administration Record ary 2020 revealed she had lous positive airway pressure on the following dates: 2/4/20, 20, 2/11/20, 2/17/20, 2/19/20, /26/20 and 2/27/20. Interly Minimum Data Set adated 2/21/20 coded the ognitively intact. Resident #16 ehaviors for no rejection of					
		onducted on 3/2/20 at 8:24 AM She stated she wore a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345270	B. WING _				O5/2020	
	ROVIDER OR SUPPLIER	PRUC		21	REET ADDRESS, CITY, STATE, ZIP CODE 8 LAUREL CREEK COURT PRUCE PINE, NC 28777	1 03/	03/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	night but had been rebecause of the mask revealed staff had at mask to better fit her was suffocating her at the machine. An interview was conwith Nurse #4. Nurse refused to wear her estated a staff member had came in the wees solution to the mask had continued to refuse the machine of the mask had continued to refuse the mask	airway pressure (CPAP) at efusing it for the past month to bothering her. The interview tempted to changer her face however she felt like it and had continued to refuse and ducted on 3/3/20 at 4:42 PM et 44 stated Resident #16 had CPAP on a nightly basis. She er from the CPAP company et prior to assist in finding a fitting however the resident use the machine. Inducted on 3/03/20 at 4:35 mator #1. During the Coordinator reviewed	F	556				
	correspond with the was doing. The DON	an should be accurate and residents needs or what she I stated she also understood human error not by intention.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	20//050 00 01/00/150	343270	D. WING		TREET ADDRESS SITV STATE ZID SODE	03/	05/2020
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			18 LAUREL CREEK COURT		
				5	PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	≥ 30	F	657			
F 657	Care Plan Timing and			657			
SS=D	CFR(s): 483.21(b)(2)(007			
	§483.21(b) Comprehe §483.21(b)(2) A complete §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the rangement of the resident of the resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determing or as requested by the (iii)Reviewed and reviteam after each assessments. This REQUIREMENT by: Based on record reviteresident and staff interevise a care plan with a resident who rejected.	ensive Care Plans prehensive care plan must I days after completion of essessment. terdisciplinary team, that hited to visician. I with responsibility for the I and nutrition services staff. Eticable, the participation of resident's representative(s). The included in a resident's participation of the resident resentative is determined to development of the staff or professionals in fined by the resident's needs the resident. The including both the fluarterly review The is not met as evidenced T					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED	
		345270	B. WING		١,	C 03/05/2020	
	ROVIDER OR SUPPLIER	SPRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	<u>'</u>	30,00,2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	Continued From page	-	F 65	77			
	Resident #17 was ro	eadmitted to the facility on sis which included hemiplegia side), depression, and					
	on 1/10/20, revealed was resistive to care refused to let staff or nightstand drawers, with care and room review date. Interve occupational therap and allowing the residecisions. The care	e plan, most recently reviewed d a focus area indicating he e such as therapy and often elean out old food from his. The goal was to cooperate cleaning through the next intions listed included by, education to the resident sident to make his own plan did not include and the refusal of showers.					
	revealed he had ref	wer log dated February 2020 used 6 of his 9 scheduled month of February.					
	(MDS) assessment	rterly Minimum Data Set dated 2/23/20 indicated he ct. No rejection of care was					
	AM of Resident #17 observation Reside	conducted on 3/2/20 at 10:12 7. At the time of the nt #17 smelled of a foul odor, d had tan debris on his shirt					
	AM with Resident #	onducted on 3/2/20 at 10:12 17. He stated he often refused not wanting to get out of the					

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	ROVIDER OR SUPPLIER R HEALTH & REHAB/SF	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	'	35/35/2020
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F 657	choice to often refuse encouragement from An interview was conwith Nurse #4. Nurse refused all care inclumatter how many timesident he still would an interview was compared with MDS Coordinaterview, the MDS Coordinate showers. He furthe shower log provious have reflected Reside take showers. An interview was converse of the MDS as should be accurate as should should should be accurate as should shou	vealed it was the resident's a shower despite staff. ducted on 3/3/20 at 4:52 PM #4 stated Resident #17 had ding showers. She stated no es nursing staff asked the direfuse to take a shower. ducted on 3/03/20 at 4:20 mator #1. During the coordinator reviewed	F6	557		
F 690 SS=D	CFR(s): 483.25(e)(1) §483.25(e) Incontine §483.25(e)(1) The far- resident who is continuadmission receives somaintain continence	tinence, Catheter, UTI -(3) nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical nes such that continence is ain.	F6	90		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 690	ensure that- (i) A resident who entindwelling catheter is resident's clinical concatheterization was noted in the catheterization was possible unless the demonstrates that catheterization as possible unless the demonstrates that catheterization in the catheterization in	ters the facility without an not catheterized unless the addition demonstrates that accessary; atters the facility with an rubsequently receives one val of the catheter as soon e resident's clinical condition at the terization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. The sident with fecal on the resident's assment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as This not met as evidenced a from touching the shower residents (Resident #3) catheters. The initted to the facility on es that included obstructive	F 69	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l \	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345270	B. WING			C 3/05/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	•	3/03/2020	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 690	last revised on 3/26/a urinary catheter rel uropathy. The goals to be/remain free froi and for Resident #3 to symptoms of urinary interventions were list and tubing below the handwashing before anchor catheter to probserve/record/reporsymptoms of UTI (uring perineal care as indicent of the quarterly Minimulassessment dated 2/2 was cognitively intacturinary catheter. A review of a Physicic indicated Meropenen (intravenously) every On 3/2/20 at 3:32 PM/3 revealed him sittir fluid running through observation, an intervevealed he was currifor UTI. Resident #3 him to get UTI because on 3/4/20 at 10:35 A Resident #3 in the shower in the first shower states the curtain, our states of the curtain of the curtain, our states of the curtain of the c	an initiated on 5/24/18 and 19 indicated Resident #3 had ated to obstructive and reflux listed were for Resident #3 m catheter-related trauma o show no signs and infection. The following sted: position catheter bag level of the bladder, and after delivery of care, event excess tension, to the doctor signs and nary tract infection) and cated. Im Data Set (MDS) 5/20 indicated Resident #3 to and had an indwelling and Order dated 2/24/20 m 500 mg (milligrams) IV 8 hours x 7 days for UTI. If, an observation of Resident mg inside his room with an IV his right arm. During this view with Resident #3 rently receiving IV antibiotics stated it was common for se he had a urinary catheter.	F 6'	90			

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(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 690	Continued From pag	e 35	F 6	90			
	urinary catheter bag the shower room floor assisting Resident #3 NA #1 and Nurse #2 shower room. On 3/4/20 at 10:51 A revealed this was he #3 a shower and he his urinary catheter the corner under the sind his shower. NA #2 supset Resident #3 if NA #2 further stated a request to place his floor, she would have	s right next to where the was observed laying flat on or. Nurse aide (NA) #2 was 3 with his shower and both were also present in the MM, an interview with NA #2 r first time to give Resident had requested her to place oag on the floor around the k so it won't get wet during stated she did not want to she did not do as he asked. If Resident #3 had not made is urinary catheter bag on the e hung it on the shower chair so that it did not touch the					
	#2 revealed she did urinary catheter bag floor. Nurse #2 state urinary catheter inse attention to where hi Nurse #2 stated that Resident #3's urinary the shower room floo after the interview. On 3/4/20 at 11:07 A revealed she had give before and she usual bag on the shower of the floor. NA #1 state his urinary catheter by	M, an interview with Nurse not notice Resident #3's being on the shower room ed she was focused on his rtion site and had not paid is catheter bag was placed. It was unacceptable for y catheter bag to be laying on or and would change it right. M, an interview with NA #1 ren Resident #3 a shower lly hung his urinary catheter hair so that it did not touch ed Resident #3 did not want to get wet during showers set for it not to, but she never shower room floor.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	,		
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F 690	Resident #3 revealed hung his urinary cath gets a shower. Resident NA #2 to place the camorning and admitted do so before someting getting on the bag. On 3/5/20 at 3:46 PM with the Director of N #2 had placed Resident on the floor because let her hang it on the unacceptable to place stated she could have	I, a follow-up interview with I the nurse aides usually eter bag on the side while he dent #3 stated he had asked atheter bag on the floor this I he had requested them to hes to keep water from I, an interview conducted ursing (DON) revealed NA ent #3's urinary catheter bag he was upset and would not shower chair but it was e it on the floor. The DON e placed it on a wash basin to prevent it from touching	F 69				
F 693 SS=D	Administrator revealer followed the standard regarding urinary cat Administrator stated what Resident #3 was found another solution #3's choice and main practice. Tube Feeding Mgmt/ CFR(s): 483.25(g)(4)-(5) Enter (Includes naso-gastria both percutaneous endoscenteral fluids). Based	heter care. The she understood NA #2 did nted but she could have n to accommodate Resident tain the standards of clinical Restore Eating Skills (5) reral Nutrition c and gastrostomy tubes, indoscopic gastrostomy and copic jejunostomy, and	F 69	3			

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BRIAN CTR HEALTH & REHAB/SPRUC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		03/03/2020
DEFICIENCY MUST BE PRECEDI	ED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
a resident- (4) A resident who has bee alone or with assistance is hods unless the resident's emonstrates that enteral fedicated and consented to be dicated and consented to be sives the appropriate treatment of the complications of enters at not limited to aspiration omiting, dehydration, metales, and nasal-pharyngeal element of the facility failed to follow Fedicated to follow Fedicated for tube feeding for 1 of 1 same feeding feed	s not fed by clinical seding was by the seding was by the seding was by the seding was all feeding pneumonia, bolic seding skills all feeding pneumonia, bolic seding sedi	F 69	3		
FII (Integrated / Logical Control of the Control of	From page 37 t a resident- (4) A resident who has been alone or with assistance in thods unless the resident's emonstrates that enteral fedicated and consented to be alone or with appropriate treatment of the dicated and consented to be alone or with assistance in thods unless the resident's emonstrates that enteral fedicated and consented to be alone or with a propriate treatment of the dicated and consented to be alone or with a propriate treatment or the propriate treatment of the propriate treatment of the propriate treatment of the facility failed to appropriate treatment of the facility failed to follow for the facility failed to the facility failed for the facility failed for the facility failed for the facility failed to the facility failed to the facility failed for the facility failed for the facility failed for decisions including anoxic brain the quarterly Minimum Data failed for decisions and fa	From page 37 t a resident- (4) A resident who has been able to alone or with assistance is not fed by thods unless the resident's clinical emonstrates that enteral feeding was dicated and consented to by the nd (5) A resident who is fed by enteral elives the appropriate treatment and restore, if possible, oral eating skills went complications of enteral feeding ut not limited to aspiration pneumonia, omiting, dehydration, metabolic lies, and nasal-pharyngeal ulcers. JIREMENT is not met as evidenced observations, record review, and staff the facility failed to follow Physician's administering the correct ordered fube feeding for 1 of 1 sampled viewed for tube feeding (Resident	From page 37 t a resident- (4) A resident who has been able to a lance or with assistance is not fed by thods unless the resident's clinical emonstrates that enteral feeding was dicated and consented to by the not limited to aspiration pneumonia, orniting, dehydration, metabolic ies, and nasal-pharyngeal ulcers. JIREMENT is not met as evidenced observations, record review, and staff the facility failed to follow Physician's administering the correct ordered for tube feeding (Resident Cluded: 69 was admitted to the facility 09/11/18 basis including anoxic brain injury. the quarterly Minimum Data Set (MDS) 2/20 revealed Resident #69 was agnitively impaired for decision making. also stated Resident #69 had a feeding	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) From page 37 t a resident- (4) A resident who has been able to a lone or with assistance is not fed by thods unless the resident's clinical emonstrates that enteral feeding was dicated and consented to by the not (5) A resident who is fed by enteral eives the appropriate treatment and restore, if possible, oral eating skills vent complications of enteral feeding ut not limited to aspiration pneumonia, omiting, dehydration, metabolic les, and nasal-pharyngeal ulcers. JIREMENT is not met as evidenced observations, record review, and staff the facility failed to follow Physician's administering the correct ordered it tube feeding (Resident viewed for tube feeding (Resident cluded: 69 was admitted to the facility 09/11/18 biss including anoxic brain injury. the quarterly Minimum Data Set (MDS) 2/2/10 revealed Resident #69 was applitively impaired for decision making, also stated Resident #69 had a feeding label.	SUMMARY STATEMENT OF DEFICIENCIES HOREITH TO SET DEFICIENCY MUST BE PRECEDED BY FULL TAGY OR LSC IDENTIFYING INFORMATION) From page 37 t a resident- (4) A resident who has been able to alone or with assistance is not fed by thods unless the resident's clinical emonstrates that enteral feeding was dicated and consented to by the nd (5) A resident who is fed by enteral eives the appropriate treatment and restore, if possible, oral eating skills rent complications of enteral feeding ut not not limited to aspiration pneumonia, omiting, dehydration, metabolic es, and nasal-pharyngeal ulcers. JIREMENT is not met as evidenced observations, record review, and staff the facility failed to follow Physician's administering the correct ordered fube feeding for 1 of 1 sampled viewed for tube feeding (Resident delives) the quarterly Minimum Data Set (MDS) 2/20 revealed Resident #69 was opinitively impaired for decision making, also stated Resident #69 had a feeding laboratory and the properties of

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F 693	was for Resident #69 through the next revi included observation fever, shortness of b malfunction. Review of Resident a 10/10/19 revealed sh feeding of Osmolite (ml/hr) via feeding pu 175 ml every 4 hours calories in a 24-hour Review of the Medic for March 2020 reve- for Resident #69 to r ml/hr via feeding pur ml every 4 hours for 24-hour period. The	deeding as ordered. The goal of to remain free of aspiration ew date. Interventions of any signs of aspiration, reath, tube dysfunction or 469's Physician orders dated he was to receive a tube 1.2 at 50 milliliters an hour cump with water flushes of so for a total of 1200 total	F 693				
	revealed Resident #I no weight loss noted An observation of Re 3:50 PM revealed he at 60 milliliters an ho every 4 hours. An observation of Re 2:00 PM revealed he at 60 milliliters an ho every 4 hours. An interview with Nu PM revealed Reside	09/06/19 through 03/05/20 69's weights were stable with esident #69 on 03/04/20 at er tube feeding was infusing ur with flushes of 350 ml esident #69 on 03/05/20 at er tube feeding was infusing ur with flushes of 175 ml erse #6 on 03/05/20 at 2:10 erse #69's tube feeding was ers an hour with flushes of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 693	Physician's order staregarding her tube for order read for the resinfusing at 50 millilited 175 ml every 4 hours conducted of Nurse; room to change the spump from 60 ml/hr. Physician orders. Nu Osmolite bottle read and administered on Resident #69 to recent Nurse #6 stated she #69's tube feeding so with the Physician's with the Physician's with the Physician's and 11:0 stated Resident #69' at 60ml/hr with flush on the date of 03/04/recall the flush running interview with Nurse reviewed the Physiciand stated she had recorrect on 03/04/20 and stated Resident #69' and stated she had recorrect on 03/04/20 an	When asked what the ted for Resident #69 reding Nurse #6 stated the sident to receive tube feeding rs an hour with flushes of a An observation was #6 entering Resident #68's rettings on the Kangaroo to infuse at 50 ml/hr per rse #6 stated the label on the that Nurse #7 had written 03/05/20 at 12:00 AM for rive tube feeding at 60 ml/hr. Thad not checked Resident rettings or compared them proders during her shift. The se #4 on 03/05/20 at 2:16 of cared for Resident #69 of PM on 03/04/20. Nurse #4 is tube feeding was infusing res of 175 ml/hr every 4 hours 20. She stated she did not ring at 350 ml. A follow up #4 revealed she had an orders for Resident #69 not verified the settings were and had made a mistake. The interview revealed she reviewing the Physician's Resident #69's room to restated she hadn't reported reeding pump prior to	F 69	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
		345270	B. WING_				C (05/2020
NAME OF PR	ROVIDER OR SUPPLIER	0.02.0		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2020
					AUREL CREEK COURT		
BRIAN CT	R HEALTH & REHAB/S	PRUC		SPRU	JCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 693	Continued From pag	e 40	F6	693			
	PM revealed she had during third shift on to 03/05/20. She stated bottle of Osmolite 1.2 #69 every night at m had accidently put the and infused Resident rate of 60ml/hr instead could not recall what flushes at or if it was stated this happened who received tube fesame hall and she had confused. She stated to a nurse calling outwasn't paying attenti Nurse #7 did not know the feeding pump. An interview with the on 03/05/20 at 3:04 Physician orders to be #69's tube feeding a feeding was not on the resident received the as ordered by the Physician orders to the incident, notified family of Resident #6 facility was handling error by Nurse #4 and the state of the	rse #7 on 03/05/20 at 5:39 d cared for Resident #69 he dates of 03/04/20 and I she administered a new 2 tube feeding for Resident idnight. Nurse #7 stated she we wrong setting on the label t #69's tube feeding at the ad of 50ml/hr. She stated she she had set Resident #69's set to 350 ml/hr. Nurse #7 I because another resident edings had been on the ad gotten the two residents d she had been in a rush due t on the date of 03/05/20 and on. The interview revealed ow of any malfunctions with PM revealed she expected be followed for Resident and she wasn't sure why the he correct setting so the c correct amount of feeding hysician. The interview mpleted an assessment of the Physician, Dietitian and 69. The DON stated the the situation as a medication and had replaced the feeding alfunction with the pump					
F 725 SS=D			F7	'25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	<u>'</u>	00/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 725	the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each reresident assessment and considering the diagnoses of the faci accordance with the at §483.70(e). §483.35(a)(1) The faby sufficient numbers types of personnel or nursing care to all reresident care plans: (i) Except when waive this section, licensed (ii) Other nursing per limited to nurse aides §483.35(a)(2) Excep paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on record reversidating failed to provide scheduled sharesidents (Resident and The findings included This tag was cross-residents and residents and residents are sidents.	e sufficient nursing staff with petencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and lity's resident population in facility assessment required cility must provide services a of each of the following in a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not is. It when waived under section, the facility must nurse to serve as a charge of duty. It is not met as evidenced the sufficient nursing staff to nowers for 2 of 4 sampled its and Resident #44).	F 7	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345270	B. WING _			C 03/05/2020	
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777	•		
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F 725	scheduled showers 1 #3 and Resident #44 daily living. A review of the Daily revealed: 1. 2/15/20 - 1 nurs floater on day shift 2. 2/22/20 - 1 NA p shift 3. 2/29/20 - 1 NA p shift 4. 3/1/20 - 1 NA p	acility failed to provide for 2 of 4 residents (Resident e) reviewed for activities of Staffing Assignment Sheets e aide (NA) per hall plus 1 per hall plus 1 floater on day per hall plus 1 floater on day er hall plus 1 floater on day	F 7.	25			
	with NA #3 revealed from 7 AM to 12 PM #3 stated she couldr done that were sche stated she tried to go she did not have timhave to wait until the On 3/4/20 at 5:28 PM with NA #8 revealed for 3 months on the she had worked by hweekend but she couldr done but she had off residents who were shower. NA #8 shar asked to make up a completed on day she						
		/I, an interview with Nurse #5 rrked with just 1 NA on an					

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F 725	couldn't get a shower required 2-person as was impossible for the extra showers that dibecause they had at each evening. On 3/4/20 at 8:33 AM Scheduler revealed topen NA positions we full-time and 1 part-time full-time positions for positions for night shipposed to have at day and evening shifts. The facility has not having enough stand unexpected situated and called the staffing continued to utilize at 250-300 hours per we open positions online offered a sign-on bor advertised in every noneded at least 2 NA incomplete to the continued to utilize at 250-300 hours per we open positions online offered a sign-on bor advertised in every noneded at least 2 NA incomplete to the continued to utilize at 250-300 hours per we open positions online offered a sign-on bor advertised in every noneded at least 2 NA incomplete the continued to utilize at 250-300 hours per we open positions online offered a sign-on bor advertised in every noneded at least 2 NA incomplete the continued to utilize at 250-300 hours per we open positions online offered a sign-on bor advertised in every noneded at least 2 NA incomplete the continued to utilize at 250-300 hours per we open positions online offered a sign-on bor advertised in every noneded at least 2 NA incomplete the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per we open positions on the continued to utilize at 250-300 hours per w	20 but she couldn't A she worked with. The NA r done because the resident sistance. Nurse #5 shared it le evening shift to pick up d not get done on day shift least five showers to do 1, an interview with the he facility currently had 14 which consisted of 2 12-hour me position for day shift, 5 evening shift, 2 full-time iff and 4 prn (as needed) duler stated the facility was least 2 NA per hall on night is had some challenges with haff to work due to callouts ations affecting the bers. The Scheduler stated or staff members to come in g agency for help. She gency staffing who worked heek. They had posted their hand on social media, had hous for new hires and had hewspaper. 1, an interview with the DON) revealed the staffing in the census but the facility	F 7				
	keep good help. The other staff members	ause it was hard for them to supervisors tried to call to come in when there were ered a shift bonus for staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '			(X3) DATE COMP	SURVEY
		345270	B. WING				05/2020
	ROVIDER OR SUPPLIER	L		2	STREET ADDRESS, CITY, STATE, ZIP CODE 18 LAUREL CREEK COURT SPRUCE PINE, NC 28777	1 03/	03/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	shared the facility relistaffing which current positions. On 3/5/20 at 4:40 PM Administrator reveale callouts, but they cove could and tried to get come in. The Administrator disconducted job fares especial media, advertisand offered sign-on balso improved their or increase new employ	d an extra shift. The DON ed heavily on agency ly filled 10 to 11 open NA , an interview with the d they could not control the ered them as quickly as they other staff members to strator stated they every quarter, shared on sed on papers, put up signs onuses for new hires. They rientation process to ee retention. The she also went to the local	F	725			
F 761 SS=D	Label/Store Drugs an CFR(s): 483.45(g)(h)(s) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessorinstructions, and the capplicable. §483.45(h) Storage of §483.45(h)(1) In accordance professional principle appropriate accessorinstructions, and the capplicable.	d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized	F	761			

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345270	B. WING				05/ 2020
	ROVIDER OR SUPPLIER R HEALTH & REHAB/SP	RUC	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
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F 761	the Comprehensive E Control Act of 1976 a abuse, except when to package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to dispossion to the findings included medication cart). The findings included During an observation cart on 03/03/20 at 4: medication was found use: Sodium Chloride table count with 57 tablets an expired date of 01 An interview with the 03/03/20 at 4:45 PM expired and should has 300 Hall medication of the medication carts of the medication carts of the checked for expired in nurses. According to	drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ation systems in which the imal and a missing dose can is not met as evidenced and staff interviews, the se of an expired medication carts (300 Hall in the cart and available for ets, 1 gram tablets 100 remaining in the bottle with 1/2020. Nurse #2 on the 300 Hall on revealed the medication was ave been removed from the cart. Director of Nursing (DON) I'M revealed the medication moved from the 300 Hall cart macy. She went on to say, were supposed to be medications by all the the DON, the pharmacy cently gone through the	F	761			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	ULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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F 761	5:24 PM revealed she	s well. Administrator on 03/05/20 at expected expired expected expired anoved from the medication	F 7	61				