	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE		
			A. BUILDIN	NG				
		345411	B. WING _			C 02/27/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	UL.	2112010		
				51	16 WALL STREET			
BRIAN CE	ENTER HEALTH AND RE	HAB/WAYNESVILLE		W	AYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 242 SS=D		ERMINATION - RIGHT TO	F 2	242			3/27/15	
	schedules, and health her interests, assess interact with member inside and outside the	right to choose activities, in care consistent with his or ments, and plans of care; is of the community both e facility; and make choices or her life in the facility that resident.						
	by: Based on observatio interviews and record honor food preferenc reviewed for choices #115).	is not met as evidenced ns, staff and resident reviews the facility failed to es for 2 of 3 residents (Resident # 95 and Resident			F242 1. Corrective action has been accomplished for the alleged deficient practice for Resident #95 and Res#115 assessing the resident □ s likes and	-		
	The findings included				dislikes related to food preferences and updating the information in the facility	s		
	09/04/14 with diagnost deficiency, diabetes, depression. The mos (MDS) 30 day admiss 12/12/14 revealed res	admitted to the facility ses which included nutrition renal disease, dialysis and t recent Minimum Data Set sion assessment dated sident #95 was cognitively ke decisions of daily living.			 meal card system. Resident #95 s and Res #115 s food preferences are honored. 2. Facility residents have the potentia be affected by the same alleged deficie practice. Therefore, the Dietary Manage has conducted an audit of current 	l to nt er		
	12:29 PM revealed no tray card.	95's tray card on 02/23/15 at o dislikes recorded on the			residents ☐ food preferences to validate that tray cards reflect the residents ☐ current food likes/dislikes. 3. Measures put into place to ensure that the alleged deficient practice does	not		
	revealed he was invit conferences and was The weight loss and r 09/15/14 identified th	95's care conference notes ed and attended care involved in the plan of care. nutritional care plan dated e potential risk for weight c illness with approaches			recur include: The Director of Nursing o Administrator will provide in-service/re-education for nursing and dietary staff, including the Dietary Manager, regarding the resident⊡s righ to make choices related to areas of life	t		
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	?F		TITLE		(X6) DATE	

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

(X6) DATE 03/20/2015

PRINTED: 03/30/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

		MEDICAID SERVICES				IO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY	
			A. BUILDING	3		С	
		345411	B. WING		0,	02/27/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		2/2//2015	
				516 WALL STREET			
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	TO THE APPROPRIATE	COMPLETIO	
F 242	Continued From page	e 1	F 24	2			
	which included provid	le diet as ordered and		the facility that are impo	rtant to them;		
		nt's individual likes and		specifically, each reside			
	dislikes.			interviewed for their food			
				likes, and dislikes so that			
		list in the medical record of		can be entered into the t	•		
		09/05/14 noted Resident #95		tray system to ensure th does not receive items t			
		carbohydrate, no added salt ed liver, and cooked or raw		This education will also	•		
		reference list dated 02/26/15		a resident voices a like/			
		95 also indicated he disliked		should ensure that this i			
	carrots, corn and pea	IS.		provided to the Dietary	Manager in a		
				timely manner in order to			
		PM Resident #95's lunch		resident s preference.			
		re observed. The tray card		Information Manager or			
		and the lunch meal consisted		will review new admission	-		
		tatoes, peas and fruit 95 stated, "see here they		to identify that likes/disli documented and are tra			
		I hate peas and I have told		meal tray system. The D			
		#95 did not eat the peas		Unit Coordinator, or Soc			
	served with the lunch	-		Director will conduct ran			
				with at least three interv	iewable residents		
		PM Resident #95's lunch		weekly for four weeks, th			
		re observed. The tray card		interviewable residents			
		and the meal consisted of		three months to ensure			
		heese and peas. Resident you right now I won't eat		compliance with providir	-		
		them to me all the time and		compatible with the resident dislikes. The Administration			
	I don't like peas."			Resident Council Meetir			
				monthly to identify conce	•		
	On 02/26/15 at 12:28	PM Resident #95's lunch		preferences such as foo			
		re observed. The tray card		and ensure that concern			
		and the meal consisted of		4. The Administrator o			
	-	n bread, and a bowl of		Director will review data	-		
		ney beans and onions in a lent #95 stated, "I don't eat		the audits, interviews, and			
		and they know this. It was		Council Meetings, analy report patterns/trends to			
		admission when they filled		committee every other n			
	-	See this bowl of meat and		months. The QAPI com			
		onions in it, I will not eat this		evaluate the effectivene			

Facility ID: 923009

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		· · ·	TE SURVEY MPLETED
		345411	B. WING		0	C 2/27/2015
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH AND REI	HAB/WAYNESVILLE		516 WALL STREET WAYNESVILLE, NC 28786		
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	and they know I don't stated his food likes a	eat onions." Resident 95# and dislikes were reviewed	F 242	plan, and will add additional in based on outcomes identified		
	he kept receiving food Resident #95 reveale the dietary department told them then he did onions, and peas and	d and it was upsetting that d he disliked at his meals. d he spoke to someone in ht about a month ago and not like raw or cooked I carrots. Resident #95 ey would fix it so he would ods.		continued compliance.		
	Manager (DDM) confi not on Resident #95's and cooked onions w revealed that dislikes individual residents tr use to prepare meal t preferences for likes a	AM the District Dietary irmed peas and carrots were s preference list but that raw ere on the list. The DDM are not listed on each ay card that the dietary staff rays. The DDM stated and dislikes were listed in				
	explained tray cards of meal based on each of preferences with alter known dislikes. The of aware of a problem of food he did not like. The her expectation that a	nates substituted for any DDM stated she was not f Resident #95 receiving The DDM confirmed it was any time a preference or				
	system so residents f honored.	ed in the meal tracker ood preferences were				
	(DM) confirmed that r listed on the tray card prepare resident mea	PM the Dietary Manager residents dislikes are not ls which dietary staff use to I trays. The DM stated the was a new system put into				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
	CONNECTION	IDENTIFICATION NONIDER.	A. BUILDII	NG _			C
		345411	B. WING _				27/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REP	AB/WAYNESVILLE			16 WALL STREET VAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG			ID PREFI) TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 242	generate the tray card not aware Resident # not like. The DM expla- were reviewed at the admission, yearly and explained her expecta preferences were hord did not like were not so because Resident #99 communicated as a d honoring his food pref An interview was comp PM with the Director of stated she expected r were reviewed on adr as needed. The DON receive the foods they should ensure resider honored and the correct their meal tray. 2. Resident #115 was 01/22/15 with diagnost deficiency, renal disea depression. The most (MDS) 5 day admissio 02/02/15 revealed res- intact and able to mak Review of Resident # at 12:29 PM revealed tray card. Review of Resident #	sidents profile and used to d. The DM revealed she was 95 was served items he did ained that food preferences time of a residents 1 as needed. The DM further ation was that resident food ored and items residents served. The DM confirmed 5 received food he had islike, the facility was not ferences. ducted on 02/26/15 at 4:49 of Nursing (DON). The DON esidents food preferences mission, updated yearly and stated residents should v like and dietary staff at food preferences were exit foods were served on re-admitted to the facility on ses which included nutrition ase, diabetes, dialysis and recent Minimum Data Set on assessment dated sident #115 was cognitively ke decisions of daily living. 115's tray card on 02/23/15 no dislikes recorded on the 115's individual preferences b/15 identified his choice to	F	242			
	-	daily care decisions					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/30/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345411	B. WING		02/27/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET	
				WAYNESVILLE, NC 28786	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 242	Continued From page	e 4	F 24	2	
	interventions and spe	ecific preferences. The goal 5 to have his preferences		_	
	the review. The appro	ual consultation throughout baches listed revealed nents of interventions to			
	allow his individual pr to honor his individua	references and choices, and Il choices and preferences			
	weight loss and nutrit	eters of the facility. The ional care plan dated e potential risk for weight			
	loss related to chronic which included provide	c illness with approaches ling diet as ordered and			
	determining Resident dislikes.	t #115's individual likes and			
	medical record of Res	14 food preference list in the sident #115 revealed a pdated preference list dated			
	and dislikes was com	-			
	documented changes revealed Resident #1 carbohydrate renal di	15 was on a consistent			
	by the District Dietary	food item detail list provided / Manager (DDM) on 1 revealed macaroni and			
	cheese should not be	e served on a renal diet.			
		n on 02/23/15 at 12:29 PM bserved eating his lunch			
	which consisted of tu potatoes, stuffing and	rkey, mashed peas and carrots.Resident			
	#115 only ate the turk I don't like the carrots	key and potatoes and stated, and they know this.			
	Resident #115 was o	n on 02/26/15 at 12:48 PM bserved with his lunch tray e alternate menu item of			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED	
		345411	B. WING				C 27/2015	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
BRIAN CE	INTER HEALTH AND REI	HAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786					
(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 F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 242	chicken with peas/car spiced apple dessert. look at this again they it has carrots in it whi get frustrated by havin either don't eat or I or sandwiches." Reside only the spiced apple An interview was con PM with Resident #95 #115). Resident #95 lunch of ham and mar #95 stated, "you see My roommate will be because he hates mar right now he gets it or gets mad about it and because I heard him doesn't like it." An interview was con PM with Nurse #2 wh #115. Nurse #2 stated independent and was own choices and void revealed Resident #1 being given foods tha were communicated t Nurse #2 further reve frequently requested because he wasn't giv An interview was con PM with Resident #11 to the dietary staff wh facility and they came preference list. Resid	rots/biscuit dumpling and Resident #115 stated, "see give me this alternative but ch I told them I do not like. I ng to tell this all the time so I der grilled cheese nt #115 was observed to eat	F	242				

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 03/30/20 ⁻ DRM APPROVE NO. 0938-039
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		NSTRUCTION		OATE SURVEY
		345411	B. WING			C 02/27/2015	
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE			VALL STREET NESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 242	cheese. Resident #11 assured him he would did not like on his me On 02/27/15 at 10:14 Resident #115 receiv Carbohydrate Diet (C explained the diet he liberalized diet for qui included some of the DDM confirmed that in preference list of Res and cheese was not of dislikes were not lister cards that the dietary trays. The DDM furth likes and dislikes were profile in the compute cards were generated each residents profile alternates substituted The DDM further stat Resident #115 receiv DDM confirmed it wa time a preference or should be documented tracker system so res were honored. On 02/27/15 at 1:35 I (DM) confirmed that in listed on the tray card prepare residents me meal tracker system of under each residents she was not aware R	15 revealed the dietary staff d not receive food items he al plates. AM the DDM stated ed a Consistent CD) renal diet. The DDM received was a more ality of life and that it renal diet restrictions. The	F	242			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345411	B. WING _			02/27/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH AND REP	HAB/WAYNESVILLE			16 WALL STREET /AYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG				(X5) COMPLETION DATE
F 242 F 252 SS=D	preferences were reviresidents admission, DM further explained resident food preferent items they did not like The DM further confir the fact that Resident foods that were on his not honoring his food On 02/26/15 at 4:49 F (DON) stated she exp were reviewed on admission receive food they like ensure all residents lif honored and the correct their trays. 483.15(h)(1) SAFE/CLEAN/COMF ENVIRONMENT The facility must provision comfortable and homost the resident to use his to the extent possible This REQUIREMENT by: Based on observation interviews the facility environment with sen	iewed at the time of a yearly and as needed. The her expectation was that nees were honored and were not served at meals. med that based on this and #115 was still receiving a dislike list, the facility was preferences. M the Director of Nursing bected residents preferences mission, updated yearly and stated residents should and dietary staff should kes and dislikes were ect foods were served on ORTABLE/HOMELIKE ide a safe, clean, elike environment, allowing s or her personal belongings ' is not met as evidenced ns, record reviews and staff failed to provide a homelike sory stimulation for 1 of 35 r homelike environment		242	F252 1. Corrective action for the alleged deficient practice with regarding to Resident #57 has been accomplished to providing a television for viewing, placin personal pictures in frames in his room and encouraging participation in activiti of interest.	ng ,	3/27/15

Event ID: WI4011

Facility ID: 923009

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		MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		COMPLETED	
					С	
		345411	B. WING		02/27/2015	
NAME OF P	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET WAYNESVILLE, NC 28786		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 252	Continued From page	e 8	F 25	2		
	-	lmitted to the facility on		 Facility residents have the potential 	ential to	
	10/13/10 with diagno			be affected by the same alleged de		
	-	weakness, difficulty walking,		practice; therefore, the Activities Di		
	Alzheimer's, delusior			has completed an audit of the curre		
	depression and senil	e dementia.		population to identify that the reside	ents	
				have items in their rooms, such as		
		recent quarterly Minimum		photos, framed pictures, televisions		
	Data Set (MDS) date			radios, that aid in making their room		
		ort term and long term		home-like and personalized. Respo		
		nd was severely impaired in cision making skills. The		parties will be contacted to assist in supplying personal items as needed		
		d Resident #57 required		3. Measures put in place to ensur		
		with activities of daily living		alleged deficient practice does not r		
	(ADLs) which include	, ,		include:	cour	
		personal hygiene. The MDS		The Administrator or Activities Direc	tor will	
		with behavior symptoms of		conduct in-service education for fac		
		zed thinking, and decreased		staff regarding the provision of a sa	-	
	-	MDs further coded Resident		clean, home-like environment, allow		
	#57 as not exhibiting	behaviors of rejected care.		the resident to use his/her personal		
				belongings when possible; specifica	ally, if a	
		an dated 07/08/14 last		resident is noted to have a need for	items	
		revealed Resident #57		that will enhance their environment		
		with ADLs related to his		as access to music, photos, etc., th		
		a. The goals indicated		should notify the Activities Director		
		have his daily needs met with		Administrator to contact the residen	IL_IS	
		n interventions to assist as The care plan for altered		Responsible Party for assistance. The facility s Ambassadors		
	communication relate	-		(Interdisciplinary Team) will conduct	t visits	
		erventions to provide a calm		at least weekly to assigned resident		
		note effective communication		identify concerns with the resident		
		the resident occupied in		environment. The concerns, as ide		
		lan for activities dated		will be brought to the morning stand		
	-	esident #57' s potential for		meeting for discussion and resolution	on.	
		on in activities related to his		The Activities Director will discuss		
		in his room. The goals		personalization of a resident s root		
		57 enjoyed TV, music and		the resident and/or responsible part	ty	
		interventions were designed		during care plan meetings at least		
		#57's strengths and provide		annually or when a concern is ident	ified.	
	1 on 1 activities as ne	eeded throughout the week.		4. The Administrator or Activities		

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES	· /	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
		345411	B. WING		C 02/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET	
				WAYNESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE
F 252	Continued From page	e 9	F 2	52	
	-	10/08/14 identified the		Director will review the re	esults of
		ntial for wandering related to		Ambassador visits, conce	erns, and care
		entions revealed offering		plan meetings, analyze th	
		ological support, provide and		patterns/trends and report	
		n activities directed at his ovide supervised walks, and		committee every other m months. The QAPI comr	
	to observe for increase	•		evaluate the effectivenes may amend the plan bas	s of the plan and
	A review of the physi	cian progress notes dated		outcomes to ensure cont	
		n exam of Resident #57 with		compliance	
		anxiety, depression and			
		ed a lot of help with ADLs.			
		vations further revealed no acute distress, sitting in			
		d in any interactions except			
	wanting to watch and	-			
		n on 02/23/15 at 11:56 AM			
		ting in his chair, beside the por. His wheelchair and			
	-	be on the opposite side of			
		al objects were noted in			
	room, on his tables o	r on the walls. There was no			
		om and no pictures on the			
		bird feeder or anything			
	outside the window b	beside his bed.			
	During an observatio	n on 02/25/15 at 11:54 AM			
		ting in his chair, beside his			
		notos on his side table			
		n where he was sitting. His			
		er remained on the opposite t to the table with the photos.			
		or TV in the room and no			
		. There was no bird feeder or			
		window beside his bed.			
		n on 02/26/15 of 0:42 AM			
	-				
ORM CMS-256	During an observatio	n on 02/26/15 at 9:43 AM ting in his chair, next to his	011	Facility ID: 923009	If continuation shoot

Facility ID: 923009

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPRON OMB NO. 0938-03	
TEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C 02/27/2015	
AME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				516 WALL STREET		
RIAN CE	NTER HEALTH AND R	EHAB/WAYNESVILLE		WAYNESVILLE, NC 28786		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETI THE APPROPRIATE DATE	
F 252	Continued From no.	ao 10				
F 202	Continued From page	•	F 25	52		
		floor. Resident #57 had a tray				
		with 2 wildlife bird magazines 007 and one dated Jan 2011.				
		eeder outside the window				
		wheelchair and walker were				
		opposite side of the room . No				
	personal objects we	ere noted in room, on his				
		lls. There was no radio or TV				
	in the room and no	pictures on the walls.				
	An interview was co	onducted on 02/25/15 at 2:51				
	PM with NA #1. NA	#1 stated Resident #57 stayed				
		iys but sometimes he would				
		into the halls. NA#1 further				
	stated Resident #5/	7 rarely attended any activities				
	An interview was co	onducted on 02/26/15 at 4:49				
	PM with the Directo	r of Nursing (DON). The DON				
		#57 rarely attended activities				
		e DON further stated the				
	-	mally visited with residents in				
		ON confirmed Resident #57				
		nelike environment and some . The DON stated it was her				
	•	sidents were provided in room				
		vities that met their interest.				
	An interview was co	onducted on 02/26/15 at 5:26				
		es Director (AD). The AD				
		t #57 enjoyed watching TV				
	-	sic. The AD further stated				
		ed listening and watching the				
	• .	nel on TV. The AD revealed				
		ttended music group activities				
		confirmed he was unaware ot have a TV or a radio in his				
	room.					
			1			

Facility ID: 923009

If continuation sheet Page 11 of 43

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345411	B. WING			C 02/27/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				5	16 WALL STREET			
BRIAN CE	INTER HEALTH AND REP	HAB/WAYNESVILLE		v	VAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION)				(X5) COMPLETION DATE			
F 253 SS=D	MAINTENANCE SER	VICES ide housekeeping and s necessary to maintain a	F	253				
	by: Based on observation interviews the facility resident's room for 1 of safe environment and (Resident #57). The findings included Resident #57 was add 10/13/10 with diagnos generalized muscle w Alzheimer's, delusion depression and senile A review of the most r Data Set (MDS) dated Resident #57 had sho memory problems and cognition for daily ded MDS further revealed extensive assistance (ADLs) which includer walking, toileting and coded Resident #57 v inattention, disorganiz level of activity. The N #57 as not exhibiting	mitted to the facility on sees which included veakness, difficulty walking, al disorder, anxiety, e dementia. recent quarterly Minimum d 12/09/14 revealed ort term and long term d was severely impaired in cision making skills. The Resident #57 required with activities of daily living d mobility, transfers, personal hygiene. The MDS with behavior symptoms of zed thinking, and decreased ADs further coded Resident behaviors of rejected care.			 F253 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #57 by completing repairs of the identified burn drawer handles and the veneer on the wardrobe closet. 2. Facility residents have the potentiative affected by the same alleged deficien practice; therefore, the Maintenance Director has completed an audit of resident rooms to identify repair needs. Repairs have been prioritized based or urgency and safety needs. 3. Measures put into place to ensure that the alleged deficient practice does recur include: the Administrator will conduct in-service education for the Maintenance Director, Ambassadors, a facility staff regarding the maintenance a sanitary, orderly, and comfortable environment; specifically, items that arr noted to be broken or in need of repair should be reported to the Maintenance Director via the Maintenance Request unless it is considered urgent for the safety of the resident. In this case, the repair is to be reported to the Maintenance Director or Administrator soon as possible so that repairs can be 	eau al to ent n not and e of e Log as		

Facility ID: 923009

If continuation sheet Page 12 of 43

TATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345411	B. WING		0	C 2/27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET		
				WAYNESVILLE, NC 28786		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From page	e 12	F 25	53		
	progressing dementia Resident #57 would f staff support and with needed with ADLs. T identified the problem wandering related to revealed offering emo support, provide and activities directed at f supervised walks, an safety risks. During an observation Resident #57 was sitt bed, looking at the flow walker were noted to the room. The drawe table and on the close hanging from one scr that was 6-8" from th peeling off the closet right hand side of the side of the base of th During an observation Resident #57 was sitt bed. His wheelchair a	dementia. The interventions botional and psychological involve the resident in his specific interests, provide d to observe for increased n on 02/23/15 at 11:56 AM ting in his chair, beside the bor. His wheelchair and be on the opposite side of r handle on the bedside et drawer was broken and rew on the bottom drawers he floor. The veneer was door at waist height on the door and on the right hand		accomplished timely. The Main Director will check the Mainter Request Log daily, Monday the Friday, and complete repairs to priority and equipment availab items that cannot be immediat will be denoted and arrangeme for repair in a timely manner. T Maintenance Director and Adm will conduct weekly facility rou (4) weeks to identify repair nee document the needs in the Ma Request Log. After four (4) we rounds will be conducted at lea The Administrator will review of related to Maintenance issues Monday through Friday during morning meeting and assure to resolution. The facility S Ambo will conduct rounds at least we include monitoring for issues r maintenance or repairs to ensi- continued compliance. 4. The Administrator or Main Director will review data obtair rounds, analyze the data and u patterns/trends to the QAPI co- every other month for four mon QAPI committee will evaluate	nance rough based on ility. Those ely repaired ents made The ninistrator nds for four eds and intenance beks, these ast monthly. concerns daily the imely assadors bekly to elated to ure tenance ned during report ommittee nths. The	
	broken and hanging f bottom drawers that we veneer was peeling of height on the right ha the right hand side of During an observation	d on the closet drawer was from one screw on the was 6-8" from the floor. The off the closet door at waist and side of the door and on the base of the closet unit. n on 02/26/15 at 9:43 AM ting in his chair, next to his		effectiveness of the above plan add additional interventions ba identified outcomes to ensure compliance.	ased on	

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	MENT OF HEALTH AN					RINTED: 03/30/201 FORM APPROVEI MB NO. 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 02/27/2015	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE	E, ZIP CODE		
BRIAN CE	ENTER HEALTH AND REP	AB/WAYNESVILLE		16 WALL STREET NAYNESVILLE, NC 28786	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 253	walker were noted to the room. The drawer table and on the close hanging from one scr that was 6-8" from the peeling off the closet right hand side of the side of the base of the side of the base of the An interview was com PM with the Director of DON verified the draw and needed to be rep verified the closet ver The DON stated it wa residents were provid safe and she expecte order to prevent injuri An interview was com PM with the Maintena MM explained that sta family members repor problems to him direct maintenance log that station. The MM furth the repair log daily an according to urgency he was unaware of th Resident #57's room the veneer on the close repair. The MM stated residents were provid	be on the opposite side of handle on the bedside et drawer was broken and ew on the bottom drawers e floor. The veneer was door at waist height on the door and on the right hand e closet unit. ducted on 02/26/15 at 4:49 of Nursing (DON). The wer handles were broken aired. The DON further ever was in need of repair. s her expectation that ed an environment that was d furniture in good working es. ducted on 02/26/15 at 4:21 nce Manager (MM). The aff and residents and their t any maintenance tly or they are written on a is kept at the nurse's er explained he reviewed d prioritized the jobs and safety. The MM stated e repairs needed in to the drawer handles and set. The MM verified the broken and needed to be et veneer was in need of d it was his expectation that ed an environment that was to be notified of needed	F 253				

Facility ID: 923009

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/30/201 1 APPROVE 0. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345411	B. WING				_ 27/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	2172010
				51	6 WALL STREET		
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE		w	AYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	e 14	F	312			
F 312 SS=D	483.25(a)(3) ADL CA DEPENDENT RESID	RE PROVIDED FOR	F	312			3/27/15
	daily living receives th	able to carry out activities of he necessary services to on, grooming, and personal					
	by: Based on observatio interviews the facility	is not met as evidenced ins, record reviews and staff failed to provide nail care for idents reviewed for activities ent #57).			F312 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident # 57 b	ο γ	
	10/13/10 with diagnos	mitted to the facility on ses which included veakness, difficulty walking, al disorder, anxiety,			providing nail care and trimming the resident □s finger nails. The Resident □ grooming/personal hygiene needs are provided for during routine care by assigned nursing staff and as needed based on the plan of care. 2. Facility residents who are unable carry out activities of daily living have to potential to be affected by this alleged	to	
	Data Set (MDS) date Resident #57 had sho memory problems an cognition for daily der MDS further revealed extensive assistance (ADLs) which include walking, toileting and coded Resident #57 symptoms of inattent and decreased level	ort term and long term d was severely impaired in cision making skills. The I Resident #57 required with activities of daily living d mobility, transfers, personal hygiene. The MDS			deficient practice. The Director of Nurs and Unit Coordinators have completed audit of current residents ☐ nail care needs. Any concerns regarding nail ca needs were resolved upon identificatio 3. Measures put into place to ensure that the alleged deficient practice does recur include: The Director of Nursing Unit Coordinator will conduct In-service for Nursing Staff regarding provision of ADL care for dependent residents; specifically, that nail care is to be durin the resident ☐s shower and as needed including checking for jagged edges an	l an re n. s not or e f	

Event ID: WI4011

Facility ID: 923009

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · /	IPLETED
					С	
		345411	B. WING		02/27/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI			516 WALL STREET		
BRIAN OF				WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 312	Continued From page	e 15	F 31	2		
	revised 12/09/14 rever assistance with ADLs dementia. The goals would have his daily r and with interventions Resident #57 with AD dated 07/08/14 identii #57 eating with his ha interventions for staff and after meals. A review of an ADL st the daily care guide for provide resident care required assistance w instructions section of indicate that Resident On 02/23/15 at 11:56 2/24/15 at 2:53 PM R seated in a chair, in h fingernails were noted edges. The fingernai 1⁄4 inch at the end of e whitish/brown debrist hands.	PLs. The behavior care plan fied the problem of Resident ands and addressed to wash his hands before neet (which was identified as or Nurse Aides (NAs) to) indicated Resident #57 with grooming. The special in the ADL sheet did not t #57 had refused nail care. AM, 2/23/15 at 4:04 PM and esident #57 was observed is room, and all ten d to be long with ragged Is extended approximately		 clipping finger nails to reduce the for injury. Nail care and grooming will be provided during routine da and as needed by assigned Resi Care Specialists and/or Licensed Nail care needs will be evaluated Licensed Nurse at least weekly at the Weekly Skin Checks. Care robe conducted by the Director of N or Unit Coordinators at least 3 tim week for four (4) weeks, then at I weekly thereafter to monitor for meeds. 4. The Director of Nursing or U Coordinator will review the result rounds, analyze the results, and patterns/trends to the QAPI commetvery other month for four month QAPI committee will evaluate the effectiveness of the plan and ma the plan based on patterns/trend ensure continued compliance. 	g needs aily care dent I Nurses. I by the as part of bunds will Nursing nes per east hail care nit s of care report mittee us. The y amend	
	and oatmeal. Reside his fingers to eat the of on both hands were lo resident's fingernails inch at the end of eac whitish/brown debris	isted of eggs, ground meat nt #57 was observed using oatmeal and the fingernails ong with ragged edges. The extended approximately ¼ ch finger and had under the nails on both ere was oatmeal observed				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/30/2015 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/27/2015	
		345411	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	ENTER HEALTH AND RE	HAB/WAYNESVILLE		-	16 WALL STREET		
				V	VAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 312	Continued From page	e 16	F	312			
		ex finger of his right hand.	•	012			
	observed seated in a lunch. The lunch me- soft meal which inclue Resident #57 was ob his right hand and pu spoon with his left ha of Resident #57's har edges. The resident' approximately ¼ inch and had whitish/brow both hands. An interview was con PM with Nurse Aide (had taken care of Re- was familiar with his r were expected to che and to clean and trim shower but on a daily confirmed Resident # care but she had not shift on 02/26/15. NA were provided a daily residents and their ne that Resident #57 rec ADLs, but that he ate needed only tray set- Resident #57 ate usin An interview was con PM with Nurse # 2 wi required for Resident Resident #57 require but was able to feed I Nurse #2 revealed na	 PM Resident #57 was chair, in his room, eating al consisted of a mechanical ded ground cabbage. served holding a spoon in shed the food onto the nd. The fingernails on both nds were long with ragged s fingernails extended at the end of each finger in debris under the nails on ducted on 02/26/15 at 2:51 NA) #1. NA #1 stated she sident #57 in the past and needs. NA #1 stated NAs eck residents' nails every day them not only during their e basis as needed. NA #1 557 was cooperative with his trimmed his nails during her A # 1 further explained they eded care. NA # 1 revealed quired total care for most e well without assistance and up. NA # 1 further revealed ng his hands at times. ducted on 02/25/15 at 3:37 ho was familiar with the care #57. Nurse # 2 confirmed d total care for most ADLs himself with tray set up. ail care was provided for power days, and as needed 					

Facility ID: 923009

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345411	B. WING		02/27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE		516 WALL STREET WAYNESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 312	before and after meal		F 31	2	
F 332 SS=E	PM with the Director of revealed Resident #5 for most ADLs but he with tray set-up only. she was aware that R his hands. The DON that nail care was pro shower days and as r stated that Resident # and hands cleaned bo due to his eating with 483.25(m)(1) FREE OF RATES OF 5% OR M	of Nursing (DON). The DON 7 required total assistance was able to feed himself The DON further revealed Resident #57 often ate with stated it was her expectation vided for residents on their needed. The DON further #57 should have his nails efore and after each meal his hands. DF MEDICATION ERROR ORE	F 33	2	3/27/15
	by: Based on observatio interview the facility n greater than 5 percent medication errors out which resulted in a m 15.38% for 2 of 9 resi medication administra sliding scale insulin w orders (Residents # 3 The findings include: 1. Resident # 31 was	is not met as evidenced ns, record review and staff nedication error rate was t (%) as evidenced by 4 of 26 opportunities for error edication error rate of dents observed during ation who were administered rithout current physician's 1 and # 125).		F332 1. Corrective action has been accomplished for the alleged deficient practice with regard to Resident #31 b obtaining a clarification of the physicia order for capillary glucose testing and sliding scale insulin administration. Testing results and administration of insulin is documented by the licensed nurse on the Medication Administration Record. Resident #125's order for capillary blood glucose testing and slid scale insulin has been clarified to inclu the administration scale. testing result	y n's n ling ide

Event ID: WI4011

Facility ID: 923009

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						0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY PLETED
			A. BUILDING	;	C 02/27/2015	
		345411	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02	./2//2015
				516 WALL STREET		
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE		WAYNESVILLE, NC 28786		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 332	Continued From page	- 1 9	Гаа	2		
F 332	10		F 33			
		ve heart failure. His most		and administration of insulin is	o on the	
	-	d 12/26/14 addressed his		documented by the licensed nurs Medication Administration Record		
		of blood glucose levels with glucose (CBG)) tests and		Medications are delivered per the		
	sliding scale insulin a			physician's order for the identified		
				residents.	4	
	Review of Resident #	31's medical record				
	revealed a document	titled "Blood Glucose		2. Facility residents have the	potential	
	Tracking/Sliding Scal	e Insulin Administration		to be affected by the same allege		
	Record" dated Febru	ary 2015 which indicated		deficient practice; therefore, the	Director	
	Resident # 31 receive	ed daily CBG tests before		of Nursing and Unit Coordinators		
		e and sliding scale insulin		completed an audit of current res		
	-	s were written at the top of		who require capillary blood gluce	se	
		inister sliding scale Novolog		testing and sliding scale insulin		
		and at bedtime with the		administration to determine accu		
		: "0 - 150 = 0 units, 151 -		transcription. Any discrepancies	were	
		250 = 4 units, $251 - 300 = 6$		corrected upon identification.		
		units and $351 - 400 = 10$		2 Macauraa put in place to	000110	
		entation on the record 31 had received sliding scale		3. Measures put in place to the alleged deficient practice doe		
		times every day in February		recur include:	5 1101	
		place designated on the		The Director of Nursing will cond	uct	
		cian signature to indicate the		in-service re-education for Licens		
		vere reviewed and approved		Nurses and Health Information M		
	by the physician.			regarding the residents right to b	0	
				from medication errors, specifica		
	Review of Resident #	31's January and February		an order for capillary blood gluco		
		ysician's orders, which were		and sliding scale insulin are rece	•	
		by the physician, revealed		Licensed Nurses are transcribe		
		for CBG tests or sliding		physician's orders accurately and	d validate	
	scale insulin before n	neals and at bedtime.		the accuracy of the information p	rovided	
		medical record did not		on the Medication Administration		
	-	the current chart for CBG		The Health Information Manager		
		insulin before meals and at		enter physician's orders for capil		
	bedtime.			glucose testing and sliding scale		
				parameters accurately and timely		
		ved on 02/26/15 at 11:41 AM		facilitate licensed nurses review		
	-	st on Resident # 31 and		medication recapitulations on a r	nonthly	
	obtained a result of 2	46. Nurse # 1 was observed		basis.		

Facility ID: 923009

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TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	
		345411	B. WING		C 02/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
				516 WALL STREET	
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE		WAYNESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETIO O THE APPROPRIATE DATE
F 332	Continued From page	<u>-</u> 19	F 33	2	
F 332	checking the dosage Scale Insulin Adminis administering Novolog # 31 and documenting administration on the An interview with Unit 02/26/15 at 3:01 PM of locate a signed physic 31's chart for CBG tes UC # 1 stated the par insulin were listed on Tracking/Sliding Scale Record. When asked the document and ap parameters, UC # 1 s review or sign the doo dosage parameters. An interview with the coordinator on 02/26/ located a telephone of CBG's and sliding scalarchived records, whi physician. When asked and sliding scale insu January or February 2 physician orders, she including the CBG an on the monthly summ months ago. When as for the physician revie orders, she acknowle system in place for th orders.	parameters on the Sliding tration Record, then g insulin 4 units to Resident g the CBG and insulin record. t Coordinator (UC) # 1 on revealed she was unable to cian's order on Resident # sts or sliding scale insulin. rameters for the sliding scale the Blood Glucose e Insulin Administration if the physician reviewed proved the dosage stated the physician didn't cument to approve the Medical Records (15 at 3:20 PM revealed she order dated 05/22/14 for ale insulin in Resident # 31's ich was signed by the ed why the order for CBG's lin was not included in the 2015 summary of current e stated the facility stopped d sliding scale insulin orders hary of orders about 6 sked what the system was ewing and approving those rdged there was not a le physician to review the	F 33	 The Director of Nursing a Coordinator will review morders during the morning and validate that the order correctly transcribed to the monthly basis, The Direct Unit Coordinators, and at Nurses will review the more recapitulation of physicia reviewed by the Director Unit Coordinators during meeting to validate accur transcription. The Director of Nursing at Development Manager w total of at least two Medic Observations weekly for and Certified Medication have been observed. The Director of Nursing and A Development Manager w of two observations per raccuracy of medication data the results of audits, meeting to the plan based on identified monthly for four months a findings to the QAPI compliant. 	ew physician's g clinical meeting er has been he MAR. On a tor of Nursing, ssigned Licensed onthly n's orders will be of Nursing and the morning racy of and Area Staff <i>v</i> ill complete a cation Pass Licensed Nurses Aides until all ereafter, the Area Staff <i>v</i> ill conduct a total month to ensure lelivery. rsing will review dication pass ly recapitulations, ify patterns/trends and report mittee. The luate the and may amend ied outcomes to
	on 02/27/15 at 2:45 P	Director of Nursing (DON) PM revealed the monthly n's orders was considered			

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039 FE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	MPLETED
						С
		345411	B. WING		0	2/27/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE		516 WALL STREET		
				WAYNESVILLE, NC 28786		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 332	Continued From page	e 20	F 33	2		
		d orders after they were	1 00	2		
	2 11	an and should include all				
	• • • •	dication and treatment. The				
	DON stated the nurse	es were not instructed to				
	omit orders for CBG's	and sliding scale insulin				
		mary of physician's orders				
		uld have been included on				
	the January and Febr	uary 2015 orders.				
	2 Resident # 125 wa	as admitted to the facility on				
		ses including diabetes				
		schemic heart disease. His				
		dated 12/31/14 addressed				
	•	ng of blood glucose levels				
	with daily capillary blo	ood glucose (CBG)) tests				
	and sliding scale insu	llin as ordered.				
	Review of Resident #	125's medical record				
	revealed a document					
		e Insulin Administration				
		ary 2015 which indicated				
	Resident # 125 receiv	ved daily CBG tests before				
	meals and at bedtime	e and sliding scale insulin				
	-	s were written at the top of				
		inister sliding scale Novolog				
		and at bedtime with the $150 = 0$ units 151				
		: "0 - 150 = 0 units, 151 - 50 = 4 units, 251 - 300 = 6				
		50 = 4 units, $251 - 300 = 6units and 351 - 400 = 10$				
		entation on the record				
	-	125 had received sliding				
		s usually three times every				
	day in February 2015					
	-	cument for a physician				
	-	the dosage parameters were				
	reviewed and approve	ed by the physician.				
	Poviow of Posidont #	125's January and February				
	REVIEW OF RESIDENT #					1

Facility ID: 923009

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/30/2015 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ´	E CONSTRUCTION		
		345411	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET NAYNESVILLE, NC 28786		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 332	signed as approved to there were no orders scale insulin before in Further review of the admission order date "Insulin Aspart sliding bedtime" but did not if dosage parameters for Nurse # 3 was obsern performing a CBG test obtained a result of 2 checking the dosage Scale Insulin Administ administering Novolo # 125 and documentif administration on the Nurse # 2 was obsern performing a CBG test obtained a result of 2 checking the dosage Scale Insulin Administ administering Novolo # 125 and documentif administering Novolo # 125 and documentif administering Novolo # 125 and documentif administering Novolo # 125 and documentif administering Novolo # 125 and documentif administration on the An interview with Uni 02/26/15 at 3:01 PM locate a signed physi 125's chart that listed sliding scale insulin. If parameters for the slid on the Blood Glucose Insulin Administration physician reviewed th the dosage parameter physician didn't revier	by the physician, revealed for CBG tests or sliding neals and at bedtime. medical record revealed an d 12/19/14 which listed y scale before meals and at nclude the type of insulin or for the sliding scale insulin. wed on 02/25/15 at 4:28 PM st on Resident # 125 and 96. Nurse # 3 was observed parameters on the Sliding stration Record, then g insulin 6 units to Resident ng the CBG and insulin record. wed on 02/26/15 at 12:00 PM st on Resident # 125 and 84. Nurse # 2 was observed parameters on the Sliding stration Record, then g insulin 6 units to Resident ng the CBG and insulin record. to Resident # 125 and 84. Nurse # 2 was observed parameters on the Sliding stration Record, then g insulin 6 units to Resident ng the CBG and insulin record. t Coordinator (UC) # 1 on revealed she was unable to cian's order on Resident # l specific parameters for JC # 1 stated the ding scale insulin were listed a Tracking/Sliding Scale a Record. When asked if the ne document and approved	F 332			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE 10. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/27/2015	
		345411	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO		
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE		516 WALL STREET		
				WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 332	Continued From page	22	F 332			
	the specific dosage parameters for the sliding scale insulin should have been included on the admission orders.					
	located a hospital dis Resident # 125 with a dated 12/19/14 which scale insulin. She wa physician's order for a scale insulin that inclu When asked why the scale insulin was not February 2015 summ orders, she stated the the CBG and sliding s monthly summary of When asked what the physician reviewing a she acknowledged th place for the physician	15 at 3:20 PM revealed she charge summary for a discharge medication list included CBG's and sliding s unable to locate a signed administration of sliding uded dosage parameters. order for CBG's and sliding included in the January or eary of current physician e facility stopped including scale insulin orders on the orders about 6 months ago. e system was for the and approving those orders, ere was not a system in n to review the orders.				
F 333 SS=E	on 02/27/15 at 2:45 F summary of physician the currently approve signed by the physicia current orders for me DON stated the nurse omit orders for CBG's from the monthly sum	ENTS FREE OF	F 333	3		3/27/15
00-L	The facility must ensu					

Facility ID: 923009

If continuation sheet Page 23 of 43

NUMBER: A. BUI 411 B. WIN	LDING	E CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED C				
			(•				
E			02/27/201	5			
E		STREET ADDRESS, CITY, STATE, ZIP CODE					
D BY FULL PR	EFIX		D.41	ETION			
	F 333	3					
and staff r transcribe of 6 age of 130). acility d anxiety, last g problem meprazole) nt regime. ea order. cal record medication een r on 0/14 noted ues with een on ding scent dation to econdary		 clarifying the physician □s order for Omeprazole. Resident #130 □s order for Pepcid has been corrected to include the ordered administration times. Resident #80 receives Tramadol as ordered by the physician. Medication Variances were completed for each identified resident. 2. Facility residents have the potentiate be affected by the same alleged deficiene practice; therefore, the Director of Nurse and Unit Coordinators have completed audit of current physician □s orders and Medication Administration Records to determine accuracy of transcription. And discrepancies were corrected upon identification. 3. Measures put in place to ensure the alleged deficient practice does not recution. include: The Director of Nursing will conduct in-service re-education for Licensed Nurses, Certified Medication Aides, and Health Information Manager regarding or resident □s right to be free from significane dication errors, specifically, Licenser Nurses are to transcribe physician □s orders accurately and validate the accuracy of the information provided or the Medication Administration Record 	or le ne I to nt ing an Y e r				
	D BY FULL PR ORMATION) T	E ID NCIES ID D BY FULL PREFIX TAG F 333 videnced v v and staff y y transcribe of 6 age of 130). acility ed anxiety, H last anxiety, weeprazole) ent regime. rea order. ical record medication ween on ding y on 20/14 noted uss with been on ding ecent dation to secondary	WAYNESVILLE, NC 28786 NCIES DB Y FULL ORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) //denced F 333 //denced F 303 //denced F 303 //denced F 303 //denced F 303 //denced F 304 <td>E WAYNESVILLE, NC 28786 NCIES D BY FULL DEVICUL DEVICUE DEVICUE SRMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERCED TO THE APPROPRIATE DEFICIENCY) COMP COMP DEFICIENCY) ridenced F 333 F333 Corrective action has been accomplished for the alleged deficient practice with regard to Resident #24 by clarifying the physician⊡s order for Omeprazole. Resident #130⊡s order for Pepcid has been corrected to include the ordered administration times. Resident #30). Corrective action Variances were completed for each identified resident. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current physician⊡s orders and Medication Administration Records to determine accuracy of transcription. Any discrepancies were corrected upon identification. van staff y on 3. Measures put in place to ensure the alleged deficient practice does not recur include: y on 3. Measures put in place to ensure the alleged deficient practice does not recur include: y order.</td>	E WAYNESVILLE, NC 28786 NCIES D BY FULL DEVICUL DEVICUE DEVICUE SRMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERCED TO THE APPROPRIATE DEFICIENCY) COMP COMP DEFICIENCY) ridenced F 333 F333 Corrective action has been accomplished for the alleged deficient practice with regard to Resident #24 by clarifying the physician⊡s order for Omeprazole. Resident #130⊡s order for Pepcid has been corrected to include the ordered administration times. Resident #30). Corrective action Variances were completed for each identified resident. 2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Director of Nursing and Unit Coordinators have completed an audit of current physician⊡s orders and Medication Administration Records to determine accuracy of transcription. Any discrepancies were corrected upon identification. van staff y on 3. Measures put in place to ensure the alleged deficient practice does not recur include: y on 3. Measures put in place to ensure the alleged deficient practice does not recur include: y order.			

Facility ID: 923009

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	0. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			1 Y	PLETED
							С
		345411	B. WING			02/	27/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE			6 WALL STREET AYNESVILLE, NC 28786		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETIC
F 333	Continued From page	e 24	F 33	33			
		20/14 for Omeprazole 20			bring to the nurse⊡s attention any		
	mg, twice a day.				discrepancies identified during medical	tion	
					administration passes so that the Five		
		Administration Records			Rights of Medication Administration are		
		2014-November 2014 noted			followed. The Health Information Mana	-	
	-	administered to Resident			is to enter physician □s orders accurate	ely	
		dered. On 12/09/14 a the December 2014 MAR for			and timely to facilitate licensed nurse		
		change in the Omeprazole			review of medication recapitulations or monthly basis.	la	
		nce a day. There was not a			The Director of Nursing and Unit		
	-	order in the medical record			Coordinator will review new physician	S	
		rrespond with the decrease			orders daily during the morning clinical		
	in the Omeprazole.				meeting and validate that the order has been correctly transcribed to the MAR.		
	On 02/27/15 at 10:30	AM Unit Coordinator #2			a monthly basis, the Director of Nursing	g,	
		record of Resident #24 and			Unit Coordinators, and assigned Licens	sed	
		onsultation Report dated			Nurses will review the monthly		
		nmendation to decrease the			recapitulation of physician □s orders to		
		mg twice a day to 20 mg /ritten response by the			validate accuracy of transcription. Discrepancies will be corrected at the t	imo	
	•	itioner (GNP) for Resident			of discovery. Newly admitted residents		
	#24 dated 12/05/14 n				physician s orders will be reviewed by		
		ng the resident "has severe			Director of Nursing and Unit Coordinate		
		lux disease and needs this			during the morning clinical meeting to		
		ement." Unit Coordinator #2			validate accuracy of transcription.		
		noted this recommendation			The Director of Nursing and Area Staff		
		Nurse #2 mistakenly read			Development Manager will complete a		
		pproval and changed the m twice a day.			total of at least two Medication Pass Observations at least twice weekly for		
		tated the Omeprazole order			Licensed Nurses and Certified Medical	ion	
		changed, that it was a			Aides until all have been observed.		
		would be reported to the			Thereafter, the Director of Nursing and		
		mpts were made to contact			Area Staff Development Manager will		
		interview but the attempts			conduct two observations per month to		
	were unsuccessful.				ensure accuracy of medication delivery		
	0-00/07/45 -+ 40 50				4. The Director of Nursing will review	v	
		PM the GNP for Resident			the results of audits, medication pass		
	#24 stated she had d	azole when requested by the			observations, and monthly recapitulation analyze the data to identify patterns/tree		

Facility ID: 923009

	S FOR MEDICARE &			LE CONSTRUCTION		NO. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>′</i>	G		ATE SURVEY OMPLETED
						С
		345411	B. WING			02/27/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	= 333 Continued From page 25 F 333 consultant pharmacist 12/01/14. The GNP stated monthly for four months and re findings to the QAPI committee		•			
		he Omeprazole dose back to		QAPI committee will evaluate effectiveness of the plan and the plan based on identified o	the may amend	
	On 02/27/15 at 1:30 PM the Director of Nursing (DON) stated the Omeprazole should not have been decreased for Resident #24 on 12/09/14. The DON stated that it was most likely not identified by staff when the January 2015 MAR/physician orders were reconciled. The DON stated she suspected the staff member that typed the January 2015 physician orders and January 2015 MAR for Resident #24 used the December MAR as a guide and did not verify if there was a physician's order to decrease the Omeprazole on 12/09/14.		ensure continued compliance			
	02/11/15 with diagnost non-Hodgkin's lymph gastroesophageal ref most recent care plar her need for a proton of GERD. The interver medication per order	as admitted to the facility on ses which included relapsed oma, hypertension and flux disease (GERD). Her n dated 02/24/15 addressed pump inhibitor for treatment entions included: administer and monitor for abdominal miting, diarrhea, increased che.				
	dated 02/11/15 includ inhibitor) 20 milligram	s orders for Resident # 130 ded Pepcid (a proton pump ns (mg) one tablet twice a ebruary 2015 Medication				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			LETED
		345411	B. WING				C 27/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH AND REI	HAB/WAYNESVILLE			516 WALL STREET		
					WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	Administration Record revealed Pepcid 20 m was listed on the MAR was listed for once a documentation on the was administered ond through 02/26/15, wh Coordinator # 1 when Visual inspection of th Pepcid 20 mg for Res labeled as dispensed 02/11/15 and the pac medication was to be An interview on 02/26 Coordinator (UC) # 1 transcribing physiciar charge nurse transcri MAR. When asked if verifying accuracy of UC # 1 stated the fac system for double che transcription of physic she checked the trans requested by the char the accuracy of transcri During an interview o the Geriatric Nurse P was asked if there wa Resident # 130 from 1 dosage of Pepcid for admission to the facili didn't think Resident # she expected the med as prescribed.	e 26 d (MAR) for Resident # 130 ng one tablet twice a day R but the administration time day at 5:00 PM. Nursing MAR indicated the Pepcid ce a day from 02/11/15 ich was verified by Unit brought to her attention. The medication package of sident # 130 revealed it was from the pharmacy on kage label indicated the administered twice a day. 3/15 at 4:07 PM with Unit about the process for ns orders revealed the bed new orders onto the the facility had a system for the transcription of orders, ility did not have a formal ecking the accuracy of cians orders. UC # 1 stated scription of orders when rge nurse but didn't verify cription on a routine basis. n 02/27/15 at 1:33 PM with ractitioner (GNP), the GNP as any adverse effect on receiving half the prescribed the first 15 days of her ity. The GNP stated she # 130 suffered any harm but dication to be administered	F	333			

Facility ID: 923009

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 03/30/2015 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) [DATE SURVEY OMPLETED
		345411	B. WING				C 02/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE			WALL STREET AYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 333	Director of Nursing (E process for verifying for of medication orders revealed a chart audi after a resident was a the error on Resident 3. Resident # 80 was 11/05/12 with diagnost depression, dementia hypertension and chr quarterly Minimum Da dated 11/07/14 indica impaired cognitive sk and impaired short te Her most recent care addressed the reside for administration of T to treat pain, on an as Review of Resident # summary of physiciar as reviewed by Unit O 09/30/14, revealed the included Tramadol 50 every 6 hours PRN p of 11/05/12. Review of Resident # Medication Administra revealed the following tablet by mouth every documentation on the Tramadol had been g October 2014 and was	200N) about the facility's the accuracy of transcription for newly admitted residents t was completed the day admitted but failed to identify admitted but failed to identify at 130's MAR. a admitted to the facility on ses which included a, chronic lumbago, onic pain syndrome. A ata Set (MDS) assessment ited she had moderately ills for daily decision making rm and long term memory. plan dated 11/12/14 nt's chronic pain with need framadol, a medication used s needed (PRN) basis. 880's October 2014 n's orders, which was signed Coordinator (UC) # 1 on e list of medications 0 milligrams (mg) by mouth ain with an origination date 880's October 2014 ation Record (MAR) g entry: Tramadol 50 mg one y 6 hours PRN pain. Nursing e MAR indicated the	F	333			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345411	B. WING	-			C /27/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	2112010
				5	516 WALL STREET		
BRIAN CE	INTER HEALTH AND REP	HAB/WAYNESVILLE		١	WAYNESVILLE, NC 28786		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	as reviewed by UC # Tramadol was not inc listed. The summary of physician on 11/06/14 Review of Resident # revealed Tramadol was Review of Resident # summary of physician as reviewed by UC # Tramadol was not inc listed. The summary of physician on 12/08/14 Review of Resident # revealed the following tablet by mouth every documentation on the Tramadol had been g December 2014 and y and 12/28/14. Review of Resident # summary of physician as reviewed by UC # Tramadol was not inc listed. The summary of physician on 01/11/15 Review of Resident # revealed the following tablet by mouth every documentation on the Tramadol was not inc listed. The summary of physician on 01/11/15 Review of Resident # revealed the following tablet by mouth every documentation on the Tramadol had been g January 2015 and wa and 01/07/15.	 1 on 10/31/14, revealed luded with the medications of orders was signed by the 80's November 2014 MAR as not listed on the MAR. 80's December 2014 I's orders, which was signed 1 on 11/30/14, revealed luded with the medications of orders was signed by the 80's December 2014 MAR entry: Tramadol 50 mg one 6 hours PRN pain. Nursing MAR indicated the iven all but 3 days in was given twice on 12/19/14 80's January 2015 I's orders, which was signed 1 on 12/31/14, revealed luded with the medications of orders was signed by the 80's January 2015 I's orders, which was signed 1 on 12/31/14, revealed luded with the medications of orders was signed by the 80's January 2015 MAR entry: Tramadol 50 mg one 6 hours PRN pain. Nursing MAR indicated the 	F	333			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345411	B. WING				C 27/2015
NAME OF P	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH AND REI	HAB/WAYNESVILLE			516 WALL STREET WAYNESVILLE, NC 28786		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	orders revealed a tele for Tramadol 50 mg o hours as needed for the Review of Resident # summary of physician as reviewed by UC # Tramadol was not incl listed. Review of Resident # revealed the following tablet by mouth every documentation on the Tramadol had been g February 2015 beginn Further review of Res revealed there was not discontinue the Trama 11/05/12. There was the Tramadol after it w November 2014 summand the November 2010 December 2014 and physician's orders un 01/28/15. Review of tt of physician orders re one tablet by mouth es An interview with the on 02/17/15 at 2:45 P an explanation for the from November 2014 MAR physician signed the following the tablet of the following tablet by mouth the tablet of the following tablet by mouth the tablet of the following tablet of the	ephone order dated 01/28/15 one tablet by mouth every 6 back pain. 8 80's February 2015 n's orders, which was signed 1 on 01/31/15, revealed duded with the medications 8 80's February 2015 MAR g entry: Tramadol 50 mg one of hours PRN pain. Nursing e MAR indicated the tiven all but 3 days in hing 02/01/15. Sident #80's medical record of a physician's order to adol after it was ordered on also not an order to resume was omitted from the mary of physician's orders 014 MAR as well as the lanuary 2015 summary of til the order obtained on he February 2015 summary evealed the Tramadol 50 mg every 6 hours PRN pain was ummary. Director of Nursing (DON) M revealed she did not have e Tramadol being omitted through February 2015 n's orders and from the 8. The DON stated once the	F	333	3		

Facility ID: 923009

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/30/ FORM APPRO OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 02/27/2015
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COD	E
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		WALL STREET (NESVILLE, NC 28786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET
F 333	current orders unless after that date. The D Records coordinator into the computer pro- generate the monthly orders and MARs and the Tramadol. 483.65 INFECTION O SPREAD, LINENS The facility must esta Infection Control Pro- safe, sanitary and con to help prevent the de of disease and infection (a) Infection Control F The facility must esta Program under which (1) Investigates, cont in the facility; (2) Decides what pro- should be applied to a (3) Maintains a record actions related to infer (b) Preventing Spread (1) When the Infection determines that a res prevent the spread of isolate the resident. (2) The facility must p communicable disease from direct contact will direct contact will trar (3) The facility must p	another order was written ON stated the Medical entered physician's orders ogram that was used to summary of physician's d she must have overlooked CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control in t - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection in Control Program ident needs isolation to f infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if nsmit the disease. equire staff to wash their ot resident contact for which	F 333		3/27/15

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		ND HUMAN SERVICES			PRINTED: 03/30/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345411	B. WING		02/27/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02202010
BRIAN CE	ENTER HEALTH AND RE	HAB/WAYNESVILLE		16 WALL STREET VAYNESVILLE, NC 28786	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 441	Continued From page		F 441		
		lle, store, process and s to prevent the spread of			
	by: Based on observation facility failed to saniti supplies before placing	Γ is not met as evidenced on and staff interviews the ze contaminated wound care ng them in a common 1 residents. (Resident #70) t:		F441 1. Corrective action has been accomplished for the alleged deficie practice with regard to Resident # 7 providing wound care using clean technique. Nurse #4 has been provi	0 by
	Nurse #4 on Resider PM. Nurse #4 cleans saline and applied m bed with gloved hand medicated cream and without changing glov Nurse #4 did not san cream or container of of medicated cream a saline were handled	erved being performed by at #70 on 02/25/2015 at 3:57 ed the wound with normal edicated cream to the wound is then handled the tube of d container of normal saline ves or washing hands. itize the tube of medicated f normal saline after the tube and container of normal by Nurse #4's gloved hands		 with one-to-one education regarding infection control practices related to to change gloves, wash hands, and to store treatment creams and other to reduce the potential for the sprear infection. Treatment carts were clear and treatment items, such as tubes medication and bottles, are stored appropriately. 2. Facility residents who receive w treatments have the potential to be 	y when how ritems d of ined of
	medicated cream on dressing resident's w wound care supply ca had been in contact w #70's wound which w pressure ulcer in the bed was beefy red. If	ming wound care, applying resident's wound and yound prior to replacement in art. Nurse #4's gloved hands with the bed of Resident vas described as a stage 3 medical record. The wound No drainage, bleeding or ent #70's wound was		affected by the same alleged deficie practice; therefore, the Director of N has audited the facility s treatment to ensure that items are separated appropriately and infection control practices are in place. 3. Measures put in place to ensur the alleged deficient practice does r recur include: The Director of Nursing and Area St Development Manager will conduct	lursing carts e that not caff

Facility ID: 923009

		ND HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 03/30/2015 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345411	B. WING		0	C 2/27/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	=	
				516 WALL STREET		
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE		WAYNESVILLE, NC 28786		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	wound care supplies the wound care supp interview immediately procedure. On 02/25/2015 at 4:1 observed placing the had just been used to wound care cart draw other residents. Nurs the tube of contamina cream into an unlabe the medicated cream placing the contamin saline into a drawer w intended for use trea #4 had not labeled th with the resident's na normal saline after st preparation to perform A staff interview was Nurses and Unit Coo approximately 5:00 F and Unit Coordinator facilities in-service ar instruct staff to sanitiz equipment prior to pla wound care cart and supplies and equipm	that she does not sanitize prior to placing them back in ly cart during a staff y following wound care 19 PM Nurse #4 was wound care supplies which to treat Resident #70 in a ver with supplies for use with e #4 was observed placing ated, unlabeled medicated eled box with other tubes of the Nurse #4 was observed ated container of normal with wound care supplies ting other residents. Nurse the container of normal saline ame or dated the container of the had opened it in	F 44	 in-service education for licens regarding infection control prareduce the potential for the sp disease or infection; specifical care supplies are to be handle gloves/hands and if treatment are touched with soiled hands then the vessel must be wiped an appropriate disinfecting ag labeled prior to returning the it central treatment cart. In addit treatment medications that are an individual are to be kept in plastic bags and housed in the cart away from common suppl gauze pads, saline bottles, or care supplies. The Director of Nursing and A Development Manager will co observations for clean dressin for three licensed nurses per v nurses have been observed. The Director of Nursing and Ar Development Manager will co of two wound care observation month for four months to valid proper infection control technib being employed. The Director and Unit Coordinator will audit contents of the treatment items appropriately to reduce the poinfection. The Director of Nursing with reatment items appropriately to reduce the poinfection. The Director of Nursing with reatment items appropriately to reduce the poinfection. 	ctices that read of Ily, wound ed with clean supplies /gloves, d down with ent and tem to the tion, e specific to separate e treatment lies such as other wound rea Staff mplete skill g changes week until all Thereafter, ea Staff nduct a total ns per ate that ques are of Nursing t the s weekly for our months a re stored ttential for will review rvations, he QAPI	

Event ID: WI4011

Facility ID: 923009

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 03/30/201 RM APPROVE O. 0938-039
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		02	C 2/27/2015
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441 F 514	Continued From page	e 33	F 441	committee will evaluate the effectiv of the plan and may amend the pla based on identified outcomes to en continued compliance.	n	3/27/15
SS=E	RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately document systematically organi The clinical record m information to identify resident's assessment services provided; the	ust contain sufficient y the resident; a record of the nts; the plan of care and				
	by: Based on medical re- interview the facility f orders and Medicatio (MARs) were comple residents reviewed for (Residents # 31, 53, The findings includer 1. Resident # 31 was 11/26/13 with diagnor mellitus and congesti recent care plan date			F514 1. Corrective action has been accomplished for the alleged defici practice with regard to Resident #3 obtaining a signed clarification orde Capillary Blood Glucose testing and Sliding Scale Insulin administration placing the orders on the Medication Administration Record (MAR). Res #53 s order for Artificial Tears was clarified on 2/26/15 and the MAR w updated to reflect the change. Resi #80 s order for Tramadol has been reviewed for accuracy and the MAR	1 by er for d and on ident r/as ident n	

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						NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	. ,	ATE SURVEY OMPLETED
						С
		345411	B. WING			02/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE		516 WALL STREET		
	1			WAYNESVILLE, NC 2	8786	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 514	Continued From page	e 34	F 51	4		
	daily capillary blood g	plucose (CBG) tests and			correct administration	
	sliding scale insulin a	s ordered.			#130□s order for Pepcid	
	Boviow of Booldart #	21's January and Eshruary		has been correct administration tin	ed to include the ordered	
		31's January and February sician's orders, which were			lents have the potential to	
		by the physician, revealed			e same alleged deficient	
		for CBG tests or sliding			e, the Director of Nursing	
	scale insulin before m	-			ators have completed an	
		medical record did not			hysician⊡s orders and	
	-	the current chart for CBG			nistration Records to	
	-	insulin before meals and at			acy of transcription. Any	
	bedtime.			identification.	ere corrected upon	
	Nurse # 1 was observ	ved on 02/26/15 at 11:41 AM			ut in place to ensure the	
		st on Resident # 31 and			practice does not recur	
		46. Nurse # 1 was observed		include:		
	checking the dosage	parameters on the Sliding		The Director of N	lursing amd Area Staff	
	Scale Insulin Adminis				nager will conduct	
		g insulin 4 units to Resident			cation for Licensed	
		g the CBG and insulin			Medication Aides, and	
	administration on the	record.			on Manager regarding	
	An interview with Unit	t Coordinator (UC) # 1 on			clinical record to include scription of physician⊡s	
		revealed she was unable to			Five Rights of Medication	
		cian's order on Resident #		•	pecifically, a review of the	
		sts or sliding scale insulin.		facility s practice	· ·	
		rameters for the sliding scale			orders and how to	
	insulin were listed on				sician ☐s order. Licensed	
		e Insulin Administration			nscribe physician s	
		if the physician reviewed			γ, physician⊡s orders are y the licensed nurse to	
	the document and ap	stated the physician didn't			sary components of a	
		cument to approve the			, and Licensed Nurses	
	dosage parameters.				e accuracy of the	
					ded on the Medication	
	An interview with the				ecord (MAR). Certified	
		15 at 3:20 PM revealed the			are to bring to the	
		ling the CBG and sliding			n any discrepancies	
	scale insulin orders o	n the monthly summary of		identified during	medication administration	

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		3		MPLETED
						С
		345411	B. WING		c	2/27/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
BRIAN CE	INTER HEALTH AND RE	HAB/WAYNESVILLE		516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 514	Continued From page	e 35	F 51	4		
	orders about 6 month	ns ago. When asked what		passes so that the Five F	Rights of	
	the system was for th	e physician reviewing and		Medication Administratio	n are followed.	
		rs, she acknowledged there		The Health Information N		
		place for the physician to		enter physician □s orders		
	review the orders.			timely to facilitate license medication recapitulation		
	An interview with the	Director of Nursing (DON)		basis.	is on a monuny	
		PM revealed the monthly		The Director of Nursing a	and Unit	
		n's orders was considered		Coordinator will review n		
	the currently approve	d orders after they were		orders daily, Monday thre	ough Friday,	
		an and should include all		during the morning clinic		
		dication and treatment. The		validate that the order ha		
		es were not instructed to s and sliding scale insulin		transcribed to the MAR. scale insulin will be inclu	•	
		mary of physician's orders		physician s order summ		
		uld have been included on		MAR. On a monthly basi	•	
	the January and Febr	ruary 2015 orders.		Nursing, Unit Coordinato Licensed Nurses will rev	rs, and assigned	
		originally admitted to the		recapitulation of physicia		
	-	nd readmitted on 02/03/15		validate accuracy of tran	-	
	-	ling congestive heart failure,		Discrepancies will be cor		
	hypertension and dia	betes mellitus.		of discovery. Newly adm physician s orders will b		
	Review of Resident #	53's readmission orders		Director of Nursing durin	2	
		aled an order for "artificial		clinical meeting to valida		
		nes a day" and did not		transcription.	, -	
	specify the eye(s) to	which they were to be		4. The Director of Nurs	-	
	administered.			results of audits and mor		
		Ella Fabruary 2015		recapitulations, analyze		
	Review of Resident # Medication Administra	-		identify patterns/trends n months and report finding	-	
		ich read: "artificial tears 1		committee. The QAPI co		
		y" and did not specify the		evaluate the effectivenes		
		were to be administered.		may amend the plan bas outcomes to ensure conf	ed on identified	
	#53's medication on (compliance.		
		Aide (CMA) # 1 removed a				
	bottle of artificial tear	s labeled for Resident # 53				

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	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES	(X2) MU		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· <i>`</i>			COMPLETED		
						(C	
		345411	B. WING			02/27/2015		
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE								
				V	VAYNESVILLE, NC 28786			
(X4) ID PREFIX				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG				6	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 514	Continued From page	36	E	514				
		cart. CMA # 1 read the MAR		514				
		ays gotten drops in both						
		t it on the MAR. CMA then						
		rdinator (UC) # 2 to ask for						
	clarification.							
	UC # 2 checked the r	eadmission orders for						
		02/03/15 and confirmed the						
		the eye(s) to which the drops						
		red. UC # 2 then checked						
		nedications on the hospital vhich indicated 1 drop was						
		each eye. UC # 2 stated						
		ssion orders for Resident #						
		verlooked including on the						
		vere to be administered to						
	and added the instruct	en wrote a clarification order						
		s admitted to the facility on						
		ses including depression,						
		nbago, hypertension and ie. A quarterly Minimum						
		ssment dated 11/07/14						
		derately impaired cognitive						
	-	n making and impaired short						
	-	emory. Her most recent						
	care plan dated 11/12 resident's chronic pai							
	•	nadol, a medication used to						
	treat pain, on an as n							
		00la Ostabar 2011						
	Review of Resident #	'80's October 2014 n's orders revealed the list of						
		Tramadol 50 milligrams						
		6 hours PRN pain with an						
	origination date of 11	/05/12.						
	Review of Resident #	80's October 2014						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345411	B. WING			02/27/2015		
NAME OF P	ROVIDER OR SUPPLIER		1	S				
BRIAN CE	RIAN CENTER HEALTH AND REHAB/WAYNESVILLE				516 WALL STREET WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 514	Medication Administra revealed the following tablet by mouth every documentation on the Tramadol had been g October 2014 and wa Review of Resident # summary of physician was not included with summary of orders wa on 11/06/14. Review of Resident # revealed Tramadol wa Review of Resident # January and February physician's orders rev included with the med Review of Resident # revealed the following tablet by mouth every documentation on the Tramadol had been g December 2014 and va and 12/28/14. Review of Resident # revealed the following tablet by mouth every documentation on the Tramadol had been g January 2015 and wa and 01/07/15. Further review of Resident	ation Record (MAR) g entry: Tramadol 50 mg one '6 hours PRN pain. Nursing MAR indicated the iven all but 5 days in as given twice on 10/01/14. '8 80's November 2014 h's orders revealed Tramadol the medications listed. The as signed by the physician '8 80's November 2014 MAR as not listed on the MAR. '8 80's December 2014, y 2015 summary of vealed Tramadol was not dications listed. '8 80's December 2014 MAR g entry: Tramadol 50 mg one '6 hours PRN pain. Nursing MAR indicated the iven all but 3 days in was given twice on 12/19/14 '8 80's January 2015 MAR g entry: Tramadol 50 mg one '6 hours PRN pain. Nursing MAR indicated the iven all but 3 days in was given twice on 12/19/14	F	514				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 03/30/2015 // APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING					SURVEY LETED		
345411		345411	B. WING			-	C 02/27/2015		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-		
				5	16 WALL STREET				
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				v	VAYNESVILLE, NC 2878	36			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 514	Continued From page	• 38	F	514					
	for Tramadol 50 mg o hours as needed for b	ne tablet by mouth every 6 back pain.							
		80's February 2015 MAR entry: Tramadol 50 mg one							
	tablet by mouth every documentation on the	6 hours PRN pain. Nursing MAR indicated the							
	Tramadol had been g February 2015 beginr	5							
		ident #80's medical record ot a physician's order to							
		adol after it was ordered on							
		also not an order to resume							
	the Tramadol after it v								
		nary of physician's orders 14 MAR as well as the							
		uary 2015 and February							
	2015 summary of phy								
		Director of Nursing (DON) M revealed she did not have							
		Tramadol being omitted							
		through February 2015							
		's orders and from the . The DON stated once the							
	physician signed the								
		y were considered the							
	current orders unless	another order was written							
		ON stated there should							
		o discontinue the Tramadol							
		from the November 2014 I's orders and MAR. She							
	stated there should ha								
		before it was added to the							
	December 2014 MAR	. The DON stated she							
		n's orders to correspond							
		isted on the MAR and for complete and accurate.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		345411	B. WING			C 02/27/2015		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	2//2015	
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				5	16 WALL STREET			
	CENTER HEALTH AND REHAB/WAYNESVILLE			v	VAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 514	Continued From page	e 39	F	514				
	4. Resident # 125 wat 12/19/14 with diagnos mellitus and chronic is most recent care plan his need for monitorin with daily capillary blo and sliding scale insu Review of Resident # 2015 summary of phy signed as approved b there were no orders scale insulin before m Further review of the admission order date "Insulin Aspart sliding bedtime" but did not in dosage parameters for Nurse # 3 was observ performing a CBG tes obtained a result of 29 checking the dosage Scale Insulin Adminis administering Novolog # 125 and documentin administration on the Nurse # 2 was observ performing a CBG tes obtained a result of 20 checking the dosage Scale Insulin Adminis administration on the Nurse # 2 was observ performing a CBG tes obtained a result of 20 checking the dosage Scale Insulin Adminis administering Novolog	s admitted to the facility on ses including diabetes schemic heart disease. His in dated 12/31/14 addressed ag of blood glucose levels bod glucose (CBG)) tests din as ordered. 125's January and February visician's orders, which were by the physician, revealed for CBG tests or sliding heals and at bedtime. medical record revealed an d 12/19/14 which listed scale before meals and at nclude the type of insulin or or the sliding scale insulin. ved on 02/25/15 at 4:28 PM st on Resident # 125 and 96. Nurse # 3 was observed parameters on the Sliding tration Record, then g insulin 6 units to Resident ng the CBG and insulin record. ved on 02/26/15 at 12:00 PM st on Resident # 125 and 84. Nurse # 2 was observed parameters on the Sliding tration Record, then g insulin 6 units to Resident ng the CBG and insulin record.						
	An interview with Unit	t Coordinator (UC) # 1 on						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/30/2015 M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345411		B. WING			C 02/27/2015		
NAME OF PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CENTER HEALTH AND REHAR/WAYNESVILLE				51	16 WALL STREET			
BRIAN OF				W	AYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	NTER HEALTH AND REHAB/WAYNESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 02/26/15 at 3:01 PM revealed she was unable to locate a signed physician's order on Resident # 125's chart that listed specific parameters for sliding scale insulin. UC # 1 stated the parameters for the sliding scale insulin were listed on the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. When asked if the physician reviewed the document and approved the dosage parameters. UC # 1 stated the physician didn't review or sign the document to approve the dosage parameters. UC # 1 stated the specific dosage parameters for the sliding scale insulin should have been included on the admission orders. An interview with the Medical Records coordinator on 02/26/15 at 3:20 PM revealed the facility stopped including the CBG and sliding scale insulin orders on the monthly summary of orders about 6 months ago. When asked what the system was for the physician reviewing and approving those orders, she acknowledged there was not a system in place for the physician to review the orders. An interview with the Director of Nursing (DON) on 02/27/15 at 2:45 PM revealed the monthly summary of physician's orders was considered the currently approved orders after they were signed by the physician and should include all current orders for CBG's and sliding scale insulin from the monthly summary of physician's orders and those orders should have been included on the January and February 2015 orders. 5. Resident # 130 was admitted to the facility on 02/11/15 with diagnoses which included relapsed		F	514				
	5. Resident # 130 wa	s admitted to the facility on						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C					
		345411	B. WING			02/27/2015				
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>				
BRIAN CE	AN CENTER HEALTH AND REHAB/WAYNESVILLE				516 WALL STREET WAYNESVILLE, NC 28786					
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 514	non-Hodgkin's lympho gastroesophageal ref most recent care plan her need for a proton of GERD. The interver medication per order pain, nausea and von flatulence and headad Her admission physic included Pepcid (a pr milligrams (mg) one to the February 2015 Me Record (MAR) reveal twice a day was listed administration time w 5:00 PM. Nursing doo indicated the Pepcid of day from 02/11/15 thr surveyor brought the attention. Visual inspection of th Pepcid 20 mg revealed dispensed from the pl the package label ind be administered twice An interview on 02/26 Coordinator (UC) # 1 transcribing physiciar charge nurse transcri MAR. When asked if verifying accuracy of UC # 1 stated the fac system for double che transcription of physic	oma, hypertension and lux disease (GERD). Her a dated 02/24/15 addressed pump inhibitor for treatment entions included: administer and monitor for abdominal niting, diarrhea, increased che. iian's orders dated 02/11/15 oton pump inhibitor) 20 ablet twice a day. Review of edication Administration ed Pepcid 20 mg one tablet d on the MAR but the as listed for once a day at cumentation on the MAR was administered once a ough 02/26/15 when the medication package for ed it was labeled as harmacy on 02/11/15 and icated the medication was to e a day.	F	514						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/30/2015 / APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED			
		345411	B. WING			-	C 02/27/2015		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE					516 WALL STREET WAYNESVILLE, NC 2878	36			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
TAG F 514	Continued From page verify the accuracy of basis. During an interview o the Geriatric Nurse P was asked if there wa Resident # 130 from 1 dosage of Pepcid for admission to the facili didn't think Resident # she expected the mer as prescribed. An interview on 02/27 Director of Nursing (D process for verifying t of medication orders f revealed the facility p chart audit the day aff	e 42 transcription on a routine n 02/27/15 at 1:33 PM with ractitioner (GNP), the GNP as any adverse effect on receiving half the prescribed the first 15 days of her ity. The GNP stated she # 130 suffered any harm but dication to be administered 7/15 at 3:18 PM with the DON) about the facility's the accuracy of transcription for newly admitted residents rotocol was to complete a ter a resident was admitted id the audit failed to identify		514	D				

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