PRINTED: 05/02/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345411	B. WING	B. WING		C 03/24/2016	
NAME OF P	ROVIDER OR SUPPLIER	0.0		_	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2016
TO THE OT THE	TO VIDER OR OUT FEET						
BRIAN CE	BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	1. 483.10 (F157) at J	ı					
	, , ,	began on 02/26/16 when					
		se #1 she was raped by					
		and neither the physician nor					
		e notified. Immediate					
		2/28/16 for Resident #4					
	when she told Nurse	#1 and Nurse #2 she was					
		NA #1 and neither the					
		ponsible party were notified.					
		was removed on 03/24/16 at					
	8:12 PM when the fac	• •					
	compliance. The faci	eptable credible allegation of					
		r scope and severity of D					
		al harm with potential for					
	,	arm, that is not immediate					
		e education and ensure					
	monitoring systems p	ut into place are effective					
	related to notification	of a significant change.					
	2. 483.13 (F223) at J						
		began on 02/25/16 when					
	Resident #3 was rape	ed by Nurse Aide (NA) #1.					
		began for Resident #4 on					
	02/28/16 when she to						
	sexually assaulted by						
		ed on 03/24/16 at 8:12 PM					
		ided and implemented an					
		llegation of compliance.					
		ut of compliance at a lower D (isolated with no actual					
		or more than minimal harm,					
		jeopardy) to complete					
		e monitoring systems put into					
		lated to resident rights to be					
	free from abuse.	and to room ingrito to bo					
ADODATODY	DIDECTOR'S OF PROVIDERS	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITI F		(X6) DATE

Electronically Signed

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.

04/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411 B. WIN				C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786		3/24/2016	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 000	after Resident #3 all neither Nurse #1 no Administrator of the police. The DON di report to the HCPR Jeopardy began on when she told Nurse sexually abused by Nurse #2 called the the Director of Nursi Administrator. Immon 03/24/16 at 8:12 and implemented ar allegation of complia of compliance at a le (isolated with no act more than minimal higopardy) to comple monitoring systems related to informing allegations of abuse of the suspicion of a the HCPR within 24 abuse. 4. 483.13 (F226) at Immediate Jeopardy Resident #3 told Nu Nurse Aide (NA) #1 (DON) allowed the puilding without sup Neither Nurse #1 no Administrator of the police, or sought me	began on 02/26/16 when eged rape to Nurse #1, reference the abuse allegation or called the donot fax the 24 hour initial until 02/29/16. Immediate 02/28/16 for Resident #4 eff and Nurse #2 she was NA #1, neither Nurse #1 nor police and neither nurse nor ng (DON) called the ediate Jeopardy was removed PM when the facility provided in acceptable credible ance. The facility remains out ower scope and severity of Doual harm with potential for narm, that is not immediate the education and ensure put into place are effective the Administrator of informing law enforcement crime and making reports to hours of an allegation of	FO				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	345411	B. WING _			C 03/24/2016	
	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	'	00/24/2010	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
Nurse #1 nor Nurse medically assessed nurse or the Director Administrator. Immon 03/24/16 at 8:12 and implemented at allegation of compliance at a language (isolated with no act more than minimal ipopardy) to complemonitoring systems related to protecting and following the at 15. 483.75 (F490) at Immediate Jeopard Resident #3 was sea Aide (NA) #1. Resident #3 was sea Aide (NA) #1. Resident raped by NA# (DON) allowed the building without sup Neither Nurse #1 not Administrator of the police, called the rephysician. In additional was not faxed to the hours. Immediate of rapidities and faxed to the hours. Immediate of rapidities and faxed to the hours. Immediate of the police, the admires ponsible party, of Immediate Jeopard 8:12 PM when the fimplemented an accompliance. The faxed immediate Jeopard 8:12 PM when the fimplemented an accompliance. The faxed immediate Jeopard 15 pm.	Resident #4, and neither or of Nursing (DON) called the ediate Jeopardy was removed PM when the facility provided in acceptable credible ance. The facility remains out ower scope and severity of D tual harm with potential for tharm, that is not immediate be education and ensure put into place are effective gresidents from being abused buse policy. Jy began on 02/25/16 when exually assaulted by Nurse dent #3 told Nurse #1 she had #1 and the Director of Nursing perpetrator to remain in the pervision for 3 additional hours. For the DON informed the abuse allegation, called the sponsible party, or called the sponsible party, or called the son, the 24 hour initial report the HCPR within the required 24 deopardy began on 02/28/16 for she told Nurse #1 and sexually abused by NA #1, and urse #2, or the DON called nistrator immediately, the or called the physician. It is acceptable credible allegation of incility remains out of	FC				
	Continued From pa Nurse #1 nor Nurse medically assessed nurse or the Directo Administrator. Imm on 03/24/16 at 8:12 and implemented at allegation of compli of compliance at a I (isolated with no ac more than minimal I jeopardy) to comple monitoring systems related to protecting and following the at 5. 483.75 (F490) at Immediate Jeopard Resident #3 was se Aide (NA) #1. Resi been raped by NA # (DON) allowed the building without sup Neither Nurse #1 no Administrator of the police, called the re physician. In additio was not faxed to the hours. Immediate of resident #4 who Nurse #2 she was s neither Nurse #1, N the police, the admi responsible party, of Immediate Jeopard 8:12 PM when the f implemented an ac compliance. The fa compliance at a low	ROVIDER OR SUPPLIER ENTER HEALTH AND REHAB/WAYNESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Nurse #1 nor Nurse #2 called the police or medically assessed Resident #4, and neither nurse or the Director of Nursing (DON) called the Administrator. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused and following the abuse policy. 5. 483.75 (F490) at J Immediate Jeopardy began on 02/25/16 when Resident #3 was sexually assaulted by Nurse Aide (NA) #1. Resident #3 told Nurse #1 she had been raped by NA #1 and the Director of Nursing (DON) allowed the perpetrator to remain in the building without supervision for 3 additional hours. Neither Nurse #1 nor the DON informed the Administrator of the abuse allegation, called the police, called the responsible party, or called the physician. In addition, the 24 hour initial report was not faxed to the HCPR within the required 24 hours. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, and neither Nurse #1, Nurse #2, or the DON called the police, the administrator immediately, the responsible party, or called the physician. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY STULL REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 2 Nurse #1 nor Nurse #2 Called the police or medically assessed Resident #4, and neither nurse or the Director of Nursing (DON) called the Administrator. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm, that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to protecting residents from being abused and following the abuse policy. 5. 483.75 (F490) at J Immediate Jeopardy began on 02/25/16 when Resident #3 was sexually assaulted by Nurse Aide (NA) #1. Resident #3 told Nurse #1 she had been raped by NA #1 and the Director of Nursing (DON) allowed the perpetrator to remain in the building without supervision for 3 additional hours. Neither Nurse #1 nor the DON informed the Administrator of the abuse allegation, called the physician. In addition, the 24 hour initial report was not faxed to the HCPR within the required 24 hours. Immediate Jeopardy began on 02/28/16 for Resident #4 when she told Nurse #1 and Nurse #2 she was sexually abused by NA #1, and neither Nurse #1, Nurse #2, or the DON called the police, the administrator immediately, the responsible party, or called the physician. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D	ROWIDER OR SUPPLIER THER HEALTH AND REHAB/WAYNESVILLE SUMMARY STREMENT OR DEPOSITORS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 F 000 Resident #4 for the Doly and page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	COMP	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		03/2	24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	jeopardy) to complete monitoring systems prelated to protecting notifying the physicia	arm, that is not immediate e education and ensure out into place are effective residents from being abused, in and responsible parties ility's abuse policy and	F 0			5/4/16	
SS=J	(INJURY/DECLINE/F A facility must immed consult with the resid known, notify the residence or an interested family accident involving the injury and has the pointervention; a significantly in either life the clinical complications significantly (i.e., a nexisting form of treat consequences, or to treatment); or a decist the resident from the §483.12(a). The facility must also and, if known, the resident rights under regulations as specified in §483.15 resident rights under regulations as specifithis section.	diately inform the resident; lent's physician; and if ident's legal representative by member when there is an e resident which results in tential for requiring physician cant change in the resident's psychosocial status (i.e., a h, mental, or psychosocial reatening conditions or s); a need to alter treatment eed to discontinue an				31 4 7 10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345411	B. WING		0	3/24/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
				516 WALL STREET			
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			WAYNESVILLE, NC 28786				
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETION DATE	
F 157	Continued From p	page 4	F 15	57			
	the address and r	phone number of the resident's					
		ve or interested family member.					
	This REQUIREMI	ENT is not met as evidenced					
		nt interviews, responsible party		F157			
		nterviews, physican interviews		Actions taken for the identif	fied residents		
		vs, the facility failed to inform the					
		es and the physician when 2 of 4		Resident #3□'s physician w	vas notified on		
		s alleged sexual abuse by a		2/29/16 of allegation of abu			
		sidents #3 and #4).		#3 is responsible for her ov			
	,	•		she notified her family on 2			
	Immediate Jeopa	rdy began on 02/26/16 when		Resident #4'□s physician w	vas notified on		
	Resident #3 told I	Nurse #1 she was raped by		2/29/16 regarding allegation	n of abuse.		
	Nurse Aide (NA) #	#1 and neither the physician nor		Resident #4 is responsible	for her own		
	responsible party	were notified. Immediate		affairs and she notified her	responsible		
		on 02/28/16 for Resident #4		party on 2/28/16. Resident			
		rse #1 and Nurse #2 she was		Resident #4'□s physician w			
		d by NA #1 and neither the		of all changes in resident	s' condition.		
		responsible party were notified.					
		rdy was removed on 03/24/16 at		Action taken for residents v	vith the		
		e facility provided and		potential to be affected:			
	1	acceptable credible allegation of					
		facility remains out of		Licensed nurses were educ			
		ower scope and severity of D		Area Staff Development co			
	,	actual harm with potential for		the Director of Nursing on 3			
		al harm, that is not immediate		regarding the facility policy			
		plete education and ensure		Physician/Responsible Par	ty notifications.		
		ns put into place are effective		On 2/24/46 Number Assist	anta wasa		
	related to notificat	tion of a significant change.		On 3/24/16, Nursing Assist			
	The findings in the	dod:		educated by the Area Staff	•		
	The findings inclu	ueu.		coordinator and the Unit Ma	•		
	1 Decident #3 w	as admitted to the facility on		regarding notification to the concerns, incidents, change			
		agnoses included chronic		and allegations of abuse/ne			
		nary disease, anxiety disorder,		and anegations of abuse/fit	ogi o ot.		
		nic episode without psychotic		Social Service Director con	nnleted		
		najor depressive disorder single		interviews by 3/3/16, with r			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345411	B. WING _	. WING			/24/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIAN OF	NITED HEALTH AND	DELLA D #4/4//ALEOV#LLE		51	16 WALL STREET			
BRIAN CE	NIER HEALIH AND I	REHAB/WAYNESVILLE		W	AYNESVILLE, NC 28786			
(X4) ID PREFIX TAG			ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 157	Continued From pa	age 5	F,	157				
	•	290 0	'		were glort oriented and able to answe	r		
	episode.				were alert, oriented and able to answe questions to verify any other unreported			
	The appual Minimu	um Data Set (MDS) dated			allegations of abuse.	:u		
		r with having intact cognition.			allegations of abuse.			
		understanding others and			On 3/23/16, Social Service Director			
		with clear speech and no			completed interviews with families and			
		blems. She was coded as			responsible parties for those residents			
		rs, no signs of delirium, feeling			unable to participate in the prior intervi			
	tired 2-6 days over	the previous 2 weeks, and			to verify if any other unreported allega	tion		
		on of one person physical			of abuse occurred.			
		t activities of daily living skills						
	_	ility, transfers, walking, toileting			On 3/3/16, the Administrator, Social			
	and hygiene.				Services Director, District Director of			
	Nursing potos data	od 02/26/16 at 7:20 DM written			Operations and the district Director of			
	_	ed 02/26/16 at 7:20 PM, written aled Resident #3 asked to			Care Management completed interview with facility staff to verify if any other	vs		
		e privately. During this			unreported allegations of abuse occur	han		
		dent #3 told Nurse #1 that			unreported anegations of abase occur	cu.		
		1 "stuck it in" her and her			On 3/23/16, the Administrator complete	ed		
		Resident #3 refused to have			and audit of all previously reported			
	_	to go to the hospital. The			allegations of abuse or neglect for the			
	note did not indicat	te any notification of the			past six months to validate Physician a	and		
	physician or the re-	sponsible party.			Responsible Party notification was			
					completed.			
		ent report dated 02/26/16						
		M Resident #3 "made			No further notifications were required a			
	_	g sexually assaulted by (NA			result of these interviews. There were	no		
		dicated that she said no (to was just scared. Then she			new allegations of abuse/neglect.			
	· ·	inal pain & said he penetrated			System in place to ensure the alleged			
		report was completed by			deficient practice does not recur:			
		ident report noted the			assione practice accornic recuir.			
		out not the date or time of			Licensed nurses were educated by the)		
		ication the responsible party			Area Staff Development coordinator a			
	was notified.	· · ·			the Director of Nursing on 3/22/16			
					regarding the facility policy for			
		se #1 on 03/21/16 at 2:35 PM			Physician/Responsible Party notification	ons.		
		n she spoke to Resident #3 on						
	02/26/16, Resident	t #3 began crying and pointed			On 3/24/16, Resident Care Specialist			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						، ا	c	
		345411	B. WING _				24/2016	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				51	6 WALL STREET			
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		W	AYNESVILLE, NC 28786			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 157	F 157 Continued From page 6		F 1	157				
	to her genital area st	ating it hurt. She stated NA			were educated by the Area Staff			
		ich Nurse #1 stated referred			Development coordinator and the Unit			
	to his penis. Nurse #	f1 called the Director of			Manager regarding notification to the			
	Nursing (DON) from	her office. The DON told			nurse of any concerns, incidents, chan	ges		
	Nurse #1 she would	take care of the issue and			of condition and allegations of			
	instructed the nurse	to have NA #1 call her.			abuse/neglect.			
		was not given instructions						
	other than making su			Newly hired nurses and Nursing				
		om. Nurse #1 stated she did			Assistants will receive education			
not call the physician because the DON said she					regarding notification of the above			
	would handle everyth	ning.			mentioned during orientation and prior			
	llman fallass un intam	iou on 02/22/40 of 2/50 DM			working the floor. Unit Managers/desig			
		riew on 03/22/16 at 3:59 PM, asked the DON if she should			will audit residents records with cha	ige		
		en she spoke to her on			of condition, incident reports or allegations of neglect or abuse to verify	,		
	02/26/16 and the DC	•			MD and Responsible Party notification.			
		NV Stated No.			The audits will be conducted 5 times a			
	Nursing notes dated	02/27/16 at 1:30 PM written			week for 4 weeks and then 3 times a			
	_	d Resident #3 stated a nurse			week for 2 months. DON will validate			
	_	the note) helped her to the			with Unit Managers/designee that MD	,		
	bathroom, pushed he	er against the wall and put			has been notified on change of conditi	on,		
	his penis in her vagir	na. She stated that she then			incident reports and allegations of			
		nurse aide kissed her			neglect/abuse. These audits will be			
		e department was called and			performed 5 times per week for 4 week			
	Resident #3 was sen	t to the hospital for a rape kit			then 3 times a week for 2 months. Res	ults		
		did not indicate notification			will be reviewed monthly during QAPI.			
	of the physician or re	sponsible party.						
	A				Quality Assurance measures in place to)		
		as conducted with Nurse #2 PM. Nurse #2 stated she			ensure the practices are sustained.			
		2/27/16 and Resident #3 told			The Administrator and Director of Nurs	ina		
		NA #1 asked if she needed			The Administrator and Director of Nurs will analyze the data obtained, and rep	-		
	to go to the bathroon				patterns/trends to the Quality Assurance			
	. •	bathroom. Resident #3			Performance Improvement committee	•		
		er into the bathroom, closed			monthly for 6 months. The Quality			
		door, pushed her against the			Assurance Performance Improvement			
		where she grabbed the grab			committee will evaluate the effectivene	SS		
					of the above plan, and will add addition			
	bar and he put his penis between her legs, moved around a bit and then actually penetrated				interventions based on outcomes			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 3/24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786		0/24/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 157	had kissed her about recently bought her DON about the allegt would handle it. Nurthey needed to keep and when Nurse #2 not ok with that, the be called. Once the Nurse #2 agreed it version Resident #3 to the her During an interview at 9:53 AM, Resider "raped" by NA #1. So bed when NA #1 sugbathroom before her smoke break. NA #1 the bathroom, locked of his penis in her version has been been been been been been been bee	Resident #3 told her NA #1 It 15 times previously and perfume. Nurse #2 called the pation. The DON stated she se #2 stated the DON told her of everyone out of the issue told the DON that she was DON agreed for the police to police arrived, the officer and was appropriate to send ospital. With Resident #3 on 03/21/16 at #3 stated that she was She stated she was lying in aggested she go to the roommate returned from a followed Resident #3 into de the door, and placed the tip agina. Resident #3 stated and did not tell anyone until he told a nurse. Resident #3	F 19	identified to ensure continued	compliance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	03/24/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 157	02/27/16 presented no notes related to physician. Follow up interview 9:26 AM revealed sithe phone on 02/27 they were going to hospital for a rape I #3 was her own residual call the resprequested it. Durin DON on 03/22/16 as thought Reside notified since her	DON on 02/26/16 and I by the Administrator, revealed notification of the RP or the with the DON on 03/22/16 at the spoke to the Detective on 1/16 who informed the DON transport Resident #3 to the kit. The DON stated Resident sponsible party and the nurses consible party if the resident g follow up interview with the at 3:46 PM, the DON stated ent #3's physician had been ame was listed on the incident was interviewed on 03/22/16 at inistrator stated he was sician or family were notified of administrator stated the lave been notified of the ther stated since Resident #3 insible party, the staff should sident #3 wanted her RP	F 15	,		
	Resident #3's phys Medical Director of PM. The physician abuse situation on physician stated sh office assistant who information for the	ician, who was also the the facility on 03/22/16 at 4:09 stated that she learned of the Sunday 02/28/16. The e received a call from her was in the facility gathering next physician's visit. The rd about another resident's				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 157	physician to make s was happening in the stated she then spot her Resident #3 had evaluation. The phywas not sure the potook it upon herself protective services. 2. Resident #4 was 03/24/15. Her diagn without residual defichronic obstructive anxiety disorder. The quarterly Minimal 11/18/15 coded her being understood and communication issure quiring supervision activities of daily living mobility, toileting and continent of bowel as feeling bad about last 2 weeks, having delirium. The annual MDS daintact cognition, have communication proficeling bad about he weeks, and requiring with ADL. A phone interview woon 03/21/16 at 3:43 02/28/16 she was a	ge 9 ation of abuse and called the sure she was aware of what he facility. The physician like to Nurse #2 who informed di gone to the hospital for an exician stated at this time, she elice had been called so she to call the police and adult admitted to the facility on moses included cerebral infarct icits, acute respiratory failure, pulmonary disease, and aum Data Set (MDS) dated with intact cognition and and understanding with no less. She was coded as no fone staff for mosting skills (ADL) including bed and hygiene, and being and bladder. She was coded at herself 2-6 days over the geno behaviors and no signs of lated 02/12/16 coded her with lying no behaviors, no polems, no signs of delirium, erself 2-6 days over the last 2 gest up or limited assistance with Nurse #2 was conducted PM. Nurse #2 stated on sked by Resident #8 to talk esident #4 stated NA #1 had	F1	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		, ,	(X3) DATE SURVEY COMPLETED	
	345411	B. WING_			C 03/24/2016	
	I		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1	03/24/2010	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
been kissing her whill multiple times. Then 2-3 weeks ago, NA # bathroom, and as she around, pushed her into penetrate her. She fingers inside her vacher. Nurse #2 called not to send her to the There were no nursing about the allegations any notification to the responsible party. Nursing notes dated written by Nurse #1 refrom Nurse #2 who remade an allegation that taken "sexual advant indicated she came in statement. Resident been going on for 2 very woke up to NA #1's to Then 3 to 4 days late and he rubbed her brown Another time she was returned and as she wheelchair, he put his she was over the chapulled up yet, he pulled up yet, he yet yet yet yet yet yet yet yet yet ye	the resident stated about 1 was helping her in the e stood, he turned her into the wheelchair and tried e reported he had put his ginal area, and ejaculated on the physician who agreed e hospital for an exam. In gnotes written by Nurse #2 made by Resident #4. or e physician or Resident #4's 102/28/16 at 11:00 AM, evealed she received a call eported that Resident #4 had hat Nurse Aide (NA) #1 had hat Nurse Aide (NA) #1 had hat Nurse #1 this had hat hat Nurse #1 this had hat hat hat had hat hat had hat hat had hat hat had had hat had had hat had hat had	F 15	57			
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR INTER HEALTH AND RE SUMMARY ST (EACH DEFICIENCE REGULATORY OR INTER HEALTH AND RE Continued From page been kissing her while multiple times. Then 2-3 weeks ago, NA # bathroom, and as she around, pushed her in to penetrate her. She fingers inside her vag her. Nurse #2 called not to send her to the There were no nursin about the allegations any notification to the responsible party. Nursing notes dated written by Nurse #1 re from Nurse #2 who re made an allegation the taken "sexual advant indicated she came in statement. Resident been going on for 2 w woke up to NA #1's to Then 3 to 4 days late and he rubbed her br Another time she was returned and as she if wheelchair, he put his she was over the cha pulled up yet, he pulle not get his penis in he between her inner thi indicate notification to responsible party. Interview with Nurse if revealed she received.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 called the physician who agreed not to send her to the hospital for an exam. There were no nursing notes written by Nurse #2 about the allegations made by Resident #4. or any notification to the physician or Resident #4's responsible party. Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aide (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom, NA #1 returned and as she turned to get into the wheelchair, he put his hand on her back where she was over the chair, her pants had not been pulled up yet, he pulled his pants down but could not get his penis in her vagina so he ejaculated between her inner thighs. This note did not indicate notification to her physician or	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 called the physician who agreed not to send her to the hospital for an exam. There were no nursing notes written by Nurse #2 about the allegations made by Resident #4, or any notification to the physician or Resident #4's responsible party. Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aide (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and	ROVIDER OR SUPPLIER INTER HEALTH AND REHAB/WAYNESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY) Continued From page 10 been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported he had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 called the physician who agreed not to send her to the hospital for an exam. There were no nursing notes written by Nurse #2 about the allegations made by Resident #4. or any notification to the physician or Resident #4 had made an allegation that Nurse Aife (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her breast and genital area. Another time she was in the bathroom and he rubbed her preast and genital area. Another time she was in the bathroom, NA #1 returned and as she turned to get into the wheelchair, he put his hand on her back where she was over the chair, her pants had not been pulled up yet, he pulled his pants down but could not get his penis in her vagina so he ejaculated between her inner thighs. This note did not indicate notification to her physician or responsible party.	A BUILDING 345411 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 been kissing her while she slept. It occurred multiple times. Then the resident stated about 2-3 weeks ago, NA #1 was helping her in the bathroom, and as she stood, he turned her around, pushed her into the wheelchair and tried to penetrate her. She reported the had put his fingers inside her vaginal area, and ejaculated on her. Nurse #2 called the physician who agreed not to send her to the hospital for an exam. There were no nursing notes written by Nurse #2 about the allegations made by Resident #4 to ray notification to the physician or Resident #4's responsible party. Nursing notes dated 02/28/16 at 11:00 AM, written by Nurse #1 revealed she received a call from Nurse #2 who reported that Resident #4 had made an allegation that Nurse Aid (NA) #1 had taken "sexual advantage of her." Nurse #1's note indicated she came into work to get Resident #4's statement. Resident #4 told Nurse #1 this had been going on for 2 weeks. First, Resident #4 woke up to NA #1's tongue being in her mouth. Then 3 to 4 days later she was in the bathroom and he rurbbed her breast and genital area. Another time she was in the bathroom and her urbbed her breast and genital area. Another time she was in the bathroom and he rurbbed her breast and genital area. Another time she was in the bathroom and he rurbbed her breast and genital area. Another time she was in the bathroom and her urbbed her breast and genital area. Another time she was in the bathroom the proper time thighs. This note did not indicate notification to her physician or responsible party. Interview with Nurse #1 on 03/21/16 at 2:38 PM revealed she received a call from Nurse #2 on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157	stated she told Nurs report and concern went to the facility at Resident #4 and the #1 stated she was rehad done and she to everything was in or police. There was no incide completed related to sexual assault. An interview with Re 03/21/16 at 10:19 A was assaulted by N she was sound asle being in her mouth, incident as a "violati ago. The second tinhad gotten up, pulle hold of her, pulled hagainst her. The the bathroom, had not put came into the bathro bent her over and reand tried to put his phis penis was too flot finished by putting hand ejaculated. He with soap and water up. Follow up interview at 8:24 AM revealed responsible party Resident #4 stated	ge 11 saulted by NA #1. Nurse #1 se #2 to complete an incident form. Nurse #1 stated she and got a statement from en the police arrived. Nurse not sure exactly what Nurse #2 old Nurse #2 to make sure reder and she left after the ent report or concern form o Resident #4's allegation of esident #4 was conducted on M. Resident #4 stated she A #1 3 times. The first time teep and woke to his tongue Crying, she referred to this fon" that took place a month the, she was in the bathroom, and her pants up, he grabbed tier to him and started gyrating fird time she was in the coulled her pants up yet and he compushed her forward and the pants between her legs to be penetrate her so he to be penetrate her thighs then brought her wash cloths or and instructed her to clean with Resident #4 on 03/23/16 of she definitely wanted her P called about the incident. She asked the DON if her RP of no, so she called the RP	F1	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345411	B. WING _			C 03/24/2016	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABA	WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
Phone interview with Residual States of the abuse from Resident as the facility never called she absolutely wanted to be incident. Follow up interview with the 9:45 AM revealed on Sundate and called the police becard also." The DON stated she responsible party and if she be called the nurse should the responsible party and if she called the nurse should the allegation about Residual The Administrator provided DON relating to what she allegation about Residual The note indicated the DO the Administrator, several Resident #4's physician. The physician's response of party was notified. The Administrator was interested the physician of the incident. The Administrator unaware if the physician of the incident. The Administrator was interested inquired if Resident and the further states have inquired if Resident and the states of the situation. A telephone interview was Resident #4's physician, was Resident #4's physician.	ealed she learned about #4 on Monday 02/29/16 her. She further stated be called about the see DON on 03/22/16 at day (02/28/16), Nurse do her that Resident #4 use NA #1 "got her le talked to Resident #4 use NA #1 "got her le talked to Resident #4 uppened a long time resident was her own he wanted the family. In donotes written by the did once she received lent #4 on 02/28/16. In Made phone calls to corporate staff and the note did not indicate for if the responsible herviewed on 03/22/16 at long stated he was a refamily were notified of trator stated the len notified of the lated the staff should #4 wanted her RP	F1	57			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345411	B. WING			С	
			B. WING_			3/24/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
BRIAN CE	NTER HEALTH AND	REHAB/WAYNESVILLE		516 WALL STREET			
2.1				WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 157	Continued From p	page 13	F 1	57			
	PM. The physicia abuse situation of physician stated soffice assistant with information for the office assistant he allegation of abuse make sure she with happening in the then spoke to Nurshe felt it was too send Resident #4 stated at this time had been called so the police and ad On 03/22/16 at 4: the DON were inf The Administration	of the facility on 03/22/16 at 4:09 in stated that she learned of the in Sunday 02/28/16. The she received a call from her no was in the facility gathering enext physician's visit. The eard about Resident #4's in early and called the physician to eas aware of what was facility. The physician stated hate and there was no need to to the hospital. The physician stated hate and there was no need to to the hospital. The physician is, she was not sure the police to she took it upon herself to call the protective services. 46 PM, the Administrator and formed of Immediate Jeopardy. In provided a credible allegation 03/24/16 at 6:32 PM.					
	1. On 02/29/16 th Physician of Resi of abuse received responsible for he her family on 02/2 of Nursing notified regarding the alle 02/28/16. Reside	rnesville respectfully submits the on of compliance for F 157: The Director of Nursing notified the dent # 3 regarding the allegation of no 02/26/16. Resident #3 is the rown affairs and she notified 29/16. On 02/29/16 the Director of the Physician of Resident #4 gation of abuse received on the entire of the responsible for her own outfield her responsible party on					
		nts have the potential to be me alleged deficient practice.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C 03/24/2016
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1 03/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 157	completed interview alert, oriented and verify no other unresponsible parties participate in the prunreported allegation (03/03/16 the Admir Director, District Director of conterviews with all funreported allegation (03/23/16 the Admir all previously reported to the proviously reported to the proviously reported to the Admir all previously reported to the proviously rep	rector of Operations and the Care Management completed acility staff to verify no other ons of abuse occurred. On instrator completed an audit of ted allegations and the Care Management completed acility staff to verify no other ons of abuse occurred. On instrator completed an audit of ted allegations of abuse or uring the last 6 months to and Responsible Party impleted. No further Physician equired as a result of these ew allegations were identified.	F 15	7	
	deficient practice d All Licensed nurses Area Staff Develop Director of Nursing facility's policy for Party Notification a *A Change in Resid *When an Incident *When an allegatio On 03/24/16 All Re (CNAs) were re-ed Development Cooregarding notification	dent Condition			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	COMPLETED	
		345411	B. WING _		C 03/24/2016
	AJAS411 NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 157 Continued From page 15 change of condition, or when an allegation of abuse or neglect occurs. Resident Care Specialists shall not be allowed to work before receiving this re-education. All new Resident Care Specialists will be educated on notification of Licensed Nurses of any concerns, incidents or accidents, significant change of condition, or when an allegation of abuse or neglect occurs This education will be completed by the Area Staff Development Nurse or the Director of Nursing during orientation. Immediate Jeopardy was removed on 03/24/16 at 8:12 PM when interviews with nursing staff and administrative staff confirmed they had received in-service training on notification of the RP and physician related to allegations of abuse or any change in condition. F 223 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	03/24/2010	
PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION
F 223	change of condition abuse or neglect of Resident Care Spework before receiving All new Resident Care Spework before receiving any concerns, incided change of condition abuse or neglect of completed by the Around the Director of North Englet Departs a single physician related to change in condition 483.13(b), 483.13(c) ABUSE/INVOLUNT The resident has the sexual, physical, and punishment, and in The facility must no or physical abuse, or involuntary seclusion.	cialists shall not be allowed to any this re-education. are Specialists will be ation of Licensed Nurses of ents or accidents, significant and or when an allegation of cours. This education will be rea Staff Development Nurse ursing during orientation. by was removed on 03/24/16 at reviews with nursing staff and confirmed they had received on notification of the RP and allegations of abuse or any allegations of abuse or any allegations. c)(1)(i) FREE FROM ARY SECLUSION e right to be free from verbal, and mental abuse, corporal voluntary seclusion. at use verbal, mental, sexual, corporal punishment, or	F 1		5/4/16
	staff interviews, the	facility failed to maintain 2 of s' right to be free of sexual		Actions taken for the identified reside On 2/26/16, immediately following th	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		,	c l
		345411	B. WING _			03/	24/2016
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
DDIAN OF	NITED HEALTH AND I			51	16 WALL STREET		
BRIAN CE	NIER HEALIH AND I	REHAB/WAYNESVILLE		W	AYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From particles of the annual Minimut 2/211/15 coded he scoring a 15 out of Mental Status, which	age 16 dy began on 02/25/16 when aped by Nurse Aide (NA) #1. Idy began for Resident #4 on a told Nurse #2 she was by NA #1. Immediate oved on 03/24/16 at 8:12 PM ovided and implemented an a allegation of compliance. If our of D (isolated with no actual for more than minimal harm, at e jeopardy) to complete our emonitoring systems put into related to resident rights to be red: It is admitted to the facility on anoses included chronic arry disease, anxiety disorder, arry disease, anxiety disorder, arry disease, anxiety disorder, arry disease, anxiety disorder in Data Set (MDS) dated are with having intact cognition, 15 on the Brief Interview for the measures long and short		223	notification from Nurse #1, the Director Nursing removed NA #1 from the reside care assignment and was suspended pending the facility investigation. NA # was terminated on 3/15/16. Resident #3 was transferred to the hospital for medical evaluation and treatment. Resident # 3 received psych services on 2/29/16 for ongoing emotion support. Resident # 4 refused to go to the hospital for evaluation or treatment. Resident #4 received psych services on 3/9/16 and 3/23/16 for ongoing emotion support. Resident #3 and Resident #4 was educated on the definition of abuse and who to report to on 3/24/16. The police were notified of the allegation of abuse for Resident #4 on 2/28/16. The Director of Nursing informed the Administrator on 2/27/16 of the allegation of abuse for Resident #3. Director of Nursing informed the Administrator on 2/28/16 of the allegation of abuse for Resident #4.	of ent 1 n nal n nal e ons he f	
	coded as understa understood with cle communication pro having no behavior days over the previ supervision of one most activities of days	remporal orientation. She was anding others and being ear speech and no oblems. She was coded as as as, no delirium, feeling tired 2-6 ious 2 weeks, and requiring person physical assistance for aily living skills including bed walking, toileting and hygiene.			A 24 hour report for was submitted by t Director of Nursing on 2/29/16 regardin Resident #3. The 5 day report was submitted by the Administrator on 3/4/1 A 24 hour report was submitted on 2/29/16 by the Director of Nursing regarding Resident #4. The 5 day report was submitted for	ıg	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
			D WING		С	
		345411	B. WING		03/24/2016	
	ROVIDER OR SUPPLIER ENTER HEALTH AND R	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 223	bowel and bladder. Nursing notes dated by Nurse #1, reveal speak to this nurse conversation, Resid Nurse Aide (NA) #1 genital area hurt. Review of an incide revealed at 7:20 PM allegations of being (named NA #1). Initiation (pain/hurt) at Then she complained penetrated her." The #1. Interview with Nurse revealed that when 02/26/16, Resident to her genital area she #1 stuck it in her, what to his penis. Nurse Resident #3's room Nursing. Nurse #1 could call the police but Resident #3 state to call the DON or the stated that Resident allegations against the related to treatment Nurse #1 described stable and further expectations.	always being continent of I 02/26/16 at 7:20 PM, written ed Resident #3 asked to privately. During this ent #3 told Nurse #1 that "stuck it in" her and her Int report dated 02/26/16 I Resident #3 "made sexually assaulted by CNA tially she indicated that she and she was just scared. Ed of vaginal pain & said he is was completed by Nurse If a 1 on 03/21/16 at 2:35 PM Ishe spoke to Resident #3 on If a 2 began crying and pointed tating it hurt. She stated NA nich Nurse #1 stated referred If a 1 told NA #1 to not return to and called the Director of tasked the resident if she or send her to the hospital ted she only wanted Nurse #1 If a 43 had never made any this nurse aide or others or other types of abuse. Ithe resident as not always explained that she would have ever very simple things. She allegation Resident #3 made	F 223	Resident #4 on 3/4/16 by the Administrator. Nurse #1 was educated by the Directo Nursing on the facility's policy for Abus Prohibition and the Elder Justice Act. Nurse #2 is no longer employed with the facility. The Administrator and the Director of Nursing, who were employed at Briar Center Waynesville at the time of the alleged incident, were terminated. Actions taken for those residents with potential to be affected: By 3/3/16, the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to determine any other unreported allegations of abuse occurred. On 3/24/16, the Social Services Director completed interviews of families and responsible parties for those residents unable to participate in the prior intervitor determine if any other unreported allegations of abuse occurred. On 3/3/16, the Administrator, Social Services Director, District Director of Operations and the District Director of Care Management completed interview with all facility staff to determine if any other unreported allegations of abuse occurred.	the the r ho red. tews	
	related to treatment Nurse #1 described stable and further ed outbursts verbally of	or other types of abuse. the resident as not always xplained that she would have ver very simple things. She allegation Resident #3 made		Operations and the District Director of Care Management completed interview with all facility staff to determine if any other unreported allegations of abuse	ws	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING _				C 24/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	24/2010
					16 WALL STREET		
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE			VAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 223	Continued From page	e 18	F 2	223			
F 223	Nursing notes dated by Nurse #2 revealed aide helped her to the against the wall and page She stated that she t	D2/27/16 at 1:30 PM written I Resident #3 stated a nurse be bathroom, pushed her but his penis in her vagina. hen moved away and the forcefully. The police were #3 was sent to the hospital m. If records revealed Resident mergency room on 02/27/16 bed sexual assault and be. Laboratory tests were sure prophylaxis were Is conducted with Nurse #2 DM. Nurse #2 stated she D2/27/16 and Resident #3 aide was for the day,	F2	223	result of these interviews. These audit and interviews were completed on 3/24/16. The facility's Abuse Prohibition Policy verviewed by the District Director of Operations, District Director of clinical Services, Director of Nursing and the Administrator. The facility residents were educated or the definition of abuse and who to report to. Education was completed by 3/24/15. The facilities staff was educated on the facility's Abuse Prohibition policy addressing: allegations of abuse to be reported to the Administrator, Law enforcement officials if suspicion of a crime, reporting to the Health Care Personnel Registry within 24 hours of tallegation of abuse, and Physician and Responsible Party notification. This was completed by 3/24/16.	vas n ort 16.	
	the door, locked the owall, over the toilet wall bar and he put his pe	door, pushed her against the here she grabbed the grab nis between her legs,			Systems in place to ensure the alleged deficient practice does not recur:		
	her. Nurse #2 stated had kissed her about bought her perfume. of Nursing who reluct be called.	nd then actually penetrated Resident #3 told her NA #1 15 times and recently Nurse #2 called the Director antly agreed for the police to			Unit Managers/Interdisciplinary Team vaudit residents on abuse prevention to determine satisfaction and staff treatment of residents 5 times a week x 4 weeks then 3 times a week x 2 months and wareport results to the monthly QAPI meeting for review.	ent	
		#3 stated that she was			On 3/24/16, the Interim Administrator a	ınd	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
			7 t. BOILBII			С	
		345411	B. WING _			/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COD	•	124/2010	
				516 WALL STREET			
BRIAN CE	NTER HEALTH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
	0.000	V 07475145147 05 D55(0)510(50					
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 223	Continued From p	page 19	F 2	223			
	told the nurse (02 lying in bed when	d it occurred the day before she /25/16). She stated she was NA #1 suggested she go to the ner roommate returned from a		Interim Director of Nursing we by the District Director of clini regarding Abuse Prohibition F completion of 24 hour and 5 c	cal Services Policy, timely		
	smoke break. NA	k#1 followed Resident #3 into		to HCPR and the Elder Justic	•		
	of his penis in her vagina. Resident #3 stated she returned to bed and did not tell anyone until the next day when she told a nurse. Resident #3			On 3/23/16, the Nursing Depa Business Office Staff, Housek			
				Dietary and Therapy staff wer			
	cried during this in			by the Director of Nursing, Un			
				and Area Staff Development of	-		
	Follow up intervie	w with Resident #3 on 03/23/16		regarding the Abuse Prohibition			
	at 9:15 AM, revea	led in the past, NA #1 had		the Elder Justice Act. Staff w	ere		
	kissed her and to	uched her breast. She stated		educated and instructed rega	rding the		
	she liked his frien	dliness. He then bought her		immediate notification to the A	Administrator		
		y liked. She stated she did not		regarding allegations of abuse	e or neglect.		
	report the sexual	assault because she was afraid					
		her more perfume which she		Newly hired staff will receive e			
		g, Resident #3 stated she had		regarding the Abuse Prohibition	•		
		n about getting perfume and		Elder Justice Act and the imm			
		she decided she did not want to		notification to the Administrate	•		
	be raped again so	she reported it.		allegation of abuse or neglect			
	_	w with Nurse #3 on 03/23/16 at cribed Resident #3 as alert and		Education regarding the Abus Policy and the Elder Justice A			
	oriented. Her mer	ntal stability was less steady as udden outburst saying the world		continue annually for all emplo			
		end. One minute she would be		Quality Assurance Measures	in place to		
	happy and the ne	xt she would be mad. Nurse #3 having manic episodes. She		ensure the practice is sustained	•		
		that Resident #3 never reported		As part of the facility's ongoin	g Quality		
		nent, or being "ugly" to her. She		Assurance program, a schedu			
		her" referring to staff but give no		established for unannounced			
		s. Nurse #3 stated there was		care rounds to be completed			
		had problems with NA#1, no		Administrator, Director of Nurs	•		
		nts about him and she never		Director of Clinical Services, I	-		
	said she did not li			Director of Operations or men			
				facility management team. Th			
	Interview with NA	#4 on 03/23/16 at 1:18 PM		scheduled visits will occur we			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 516 WALL STREET WAYNESVILLE, NC 28786	DDE	00/2-1/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 223	and then confused complained about her ever having primembers. She de wanting what she complaining if she #3 did not complai. Interview with the 03/23/16 at 1:48 P scored high on the lower related to de she has been impost stated she wo claim them as her never known Resident the properties of the pr	#3 can be very cognitive intact at other times. She never staff and NA #4 could not recall oblems with certain staff scribed her as demanding, wanted immediately, and had to wait too long. Resident n of any staff treatment issues. Social Worker (SW) on M revealed Resident #3 always cognitive issues but scored pression scores. SW stated roving over the last 2 months. Uld take things from others and own. She stated she had dent #3 to complain about staff reviewed on 03/24/16 at 10:25 at Resident #3 sometimes got es but she had no complaints aff or staff treatment. He hat Resident #3 would let little	F 2	off hours, weekends and ho assess and monitor the abu program for 6 months. A m leadership team will be avairounding within the facility d working hours as well. The Administrator and Direct will analyze the data obtained patterns/trends to Quality Ast Performance Improvement of monthly for 6 months. The Assurance Performance Impevaluate the effectiveness of plan, and will add additional based on outcomes identified continued compliance.	se prevention nember of this lable and luring regular stor of Nursing ed, and report ssurance committee Quality provement wil of the above interventions		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		33/2-1/2310
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	Continued From page	_	F 2	23		
	stated the hospital of could be months be available. The Dete surveyors not intervable to interview hir arrested or charged stated he most likely arrested.	ney this week. The Detective completed a rape kit but it fore the results would be ective stated she preferred the iew NA #1 prior to her being n. NA #1 had not been at this time but the Detective y would be charged and viewed. Review of the				
	interview notes conwith NA #1 dated 03 he was suspended from Resident #3. In he made Resident # independent and he shower or toileting, accusation and den her genital area or their relationship, N with her and was "rethat she would som he could not do what	ducted by the Administrator 8/04/16 revealed NA #1 knew as there was an accusation NA #1 stated that on 02/26/16 #3's bed. He stated she was a did not help her with a NA #1 denied Resident #3's ied ever making contact with preasts. When asked about A #1 stated he did not joke eal serious." NA #1 stated etimes get upset with him if at she requested immediately fee but he could not recall				
	03/24/15. Her diagon without residual def	admitted to the facility on noses included cerebral infarct icits, acute respiratory failure, pulmonary disease, and				
	11/18/15 coded her a 14 out of 15 on th Status (BIMS) (a sy long term memory a	num Data Set (MDS) dated with intact cognition, scoring e Brief Interview for Mental stem for measuring short and and temporal orientation), and and understanding with no				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C 03/24/2016		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 516 WALL STREET WAYNESVILLE, NC 28786	•	3/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 223	requiring supervisio activities of daily livi mobility, toileting an continent of bowel a as feeling bad abou last 2 weeks, having delirium. The annual MDS daintact cognition, sco BIMS, having no be problems, feeling bad over the last 2 week limited assistance with the work of the	es. She was coded as an of one staff for most any skills (ADL) including bed d hygiene, and being and bladder. She was coded therself 2-6 days over the group no behaviors and no signs of atted 02/12/16 coded her with ring a 13 out of 15 on the haviors, no communication and about herself 2-6 days s, and requiring set up or	F 2				
	revealed she receive 02/28/16 who stated	e #1 on 03/21/16 at 2:38 PM ed a call from Nurse #2 on I Resident #4 claimed she by NA #1. Nurse #2 came					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 03/24/2016
	ROVIDER OR SUPPLIER NTER HEALTH AND R			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		33/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	02/28/16 and wrote account in the nursi had been taking sex weeks. There was no incide completed related to sexual assault. A phone interview won 03/21/16 at 3:43 02/28/16 she was a was friends with Re Resident #4. Nurse comfortable talking forward with allegati stated NA #1 had be slept. It occurred m weeks ago, he was and as she stood, hher into the wheelch She reported he had vaginal area, and ej then stated after tall via phone, Nurse #2 police. Nurse #2 sta happened a couple there was no need to evidence would be get the stated after would be get the stated after was no need to evidence would be get the stated after would be get the stated after was no need to evidence would be get the stated after would be get the stated after was no need to evidence would be get the stated after would be get the stated after was no need to evidence would be get the stated after would be get the stated after was no need to evidence would be get the stated after would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence would be get the stated after was no need to evidence was no need to evidence was no need to evidence was n	the resident's detailed ng notes. who stated NA #1 kual advantage of her for two ent report or concern form to Resident #4's allegation of With Nurse #2 was conducted PM. Nurse #2 stated on sked by Resident #8 (who sident #4) to talk with #2 stated Resident #4 felt since Resident #3 had come ions of abuse. Resident #4 een kissing her while she wiltiple times then about 2-3 helping her in the bathroom, e turned her around, pushed hair and tried to penetrate her. In did put his fingers inside her acculated on her. Nurse #2 king to the Director of Nursing 2 told Resident #4 to call the other to the hospital as gone. Nurse #2 called the	F 2.	,		
	An interview with Re 03/21/16 at 10:19 A was assaulted by N. she was sound asle being in her mouth.	ed not to send her to the n. esident #4 was conducted on M. Resident #4 stated she A #1 3 times. The first time tep and woke to his tongue Crying, she referred to this tion" that took place a month				

AND DI AN OF COPPECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		03/24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1 03/24/2010	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
F 223	had gotten up, pulled hold of her, pulled he against her. The thir bathroom, had not put came into the bathro bent her over and ra and tried to put his phis penis was too flous finished by putting hi and ejaculated. He to with soap and water up. Follow up interview wat 8:24 AM revealed fear and that it happer finally felt comfortable what NA #1 did to he either she had to tell would tell someone at Nurse #3 was intervited AM. Nurse #3 descrated and oriented with medication. She state complained about and NA #3 was interview. NA #3 stated sometime confusion. She did round tell would tell someone at NA #3 was interview. NA #4 was interview. NA #4 was interview. NA #4 was interview. NA #4 described Reserview. NA #4 described Reserview.	e, she was in the bathroom, I her pants up, he grabbed er to him and started gyrating d time she was in the ulled her pants up yet and he om pushed her forward and in his hands between her legs enis inside her. She stated opy to penetrate her so he is penis between her thighs hen brought her wash cloths and instructed her to clean with Resident #4 on 03/23/16 she did not tell anyone for ened often. She stated she e when she told Resident #8 er and Resident #8 told her someone about it or he	F 22	23		

AND DI AN OF CORRECTION INTERPRETATION NUMBER		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		03/24/2016	
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 COMPLETION	
F 223	o3/23/16 at 1:48 PM was highly cognitive issues involved self being has improved SW stated she may something accompliattributed this as new Nurse #4 was intervient AM. Per Nurse #4 Fromplained or made member. The Administrator st 03/24/16 at 9:20 AM had some psychiatri documentation, comfabricated stories abtrouble. Interview with the De AM revealed Reside herself. The Detectiongoing investigation counsel and the poli an interview with NA stated she preferred NA #1 prior to her be #1 had not been arrebut the Detective stacharged and arreste. NA #1 was not intervient information gathered he interviewed NA # he denied ever puttin kissing or hugging here.	SW) was interviewed on . SW stated Resident #4 ly intact and her psychiatric harm. Her emotional well since coming to this facility. fabricate in order to get shed medically. SW eding some control. lewed on 03/24/16 at 10:25 Resident #4 has never allegations against any staff atted during interview on that although Resident #4 c issues, there was no plaints or indications that she out staff to get them in etective on 03/22/16 at 10:21 nt #4 called the police we stated this was an n, NA #1 had secured legal ce were hoping to arrange for a#1 this week. The Detective the surveyors not interview eing able to interview him. NA ested or charged at this time atted he most likely would be	F 22	23		

12 /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345411	B. WING _			C 03/24/2016
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		I	03/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	making contact with rubbing her breasts trying to put his per ejaculating on her so on 03/24/16 at 9:20 the District Director informed of Immedia Administration provallegation of compliants of Center Wayn following allegation of Compliants of Center Wayn following allegation of Center Wayn following the notifice Director of Nursing Resident Care Area to the facility and with the Director of Nurphone from Nurses on 02/26/2016. On contacted the Policiand Resident #3 was for medical evaluat STD testing and promote Truvada and Raltegreceived Psych ser emotional support. the Administrator on 1:30 PM to inform the 24 hour report for	ping her dress and denied in her body when asked about is and groin area. He denied his in her vagina and stating she was lying. O AM, the Administrator and of Clinical Services were late Jeopardy. The rided an acceptable credible lance on 03/24/16 at 6:32 PM. Desville respectfully submits the of compliance for F223: If the DON of an allegation of esident #3 on 02/26/16. Immediately ation from Nurse #1 the removed NA #1 from the last terminated on 03/15/2016. In sing took statements over the last terminated on 03/15/2016. In and NA #1 and Resident #3 in 02/27/2016 Resident #3 e, who came into the Facility, as transferred to the hospital ion. Resident #3 received ophylactic treatment with gravir for 30 days. Resident #3 vices on 02/29/16 for ongoing The Director of Nursing called in 02/27/2016 at approximately him of Resident #3 was submitted	F 2	23		
	A 24 hour report for by the Director of N 5 Day report was s					

	(X3) DATE SURVEY COMPLETED	
345411 B. WING 03/3	; 24/2016	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	24/2016	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 223 Continued From page 27 Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act. 2. On 02/28/2016 Resident #4 called the Police to report an allegation of abuse. Resident #4 notified Nurse #2 of same allegation. Resident #4 alleged that NA #1 came into the bathroom and sexually abused her and was unable to remember the date or time. Nurse #2 then immediately notified the Director of Nursing on 02/28/16. NA #1 was previously suspended on 02/28/16/26 and continued to remain out of the facility. The Police came into the Facility and Resident #4 declined to go to the hospital for medical evaluation and STD testing. Resident #4 received Psych Services on 03/9/16 and 03/23/16 for ongoing emotional support. A 24 Hour Report was submitted on 02/29/20/16, by the Director Nursing for Resident #4's allegation of abuse. The 5 Day Report was submitted for Resident #4 on 03/04/20/16 by the Administrator. Nurse #1 was re-educated on 03/22/20/16 by the Director of Nursing on the Facility's Policy for Abuse Prohibition including the Elder Justice Act. Nurse #2's last day worked in facility was February 28, 2016. Current Residents have the potential to be affected by the same alleged deficient. By 03/03/20/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to verify no other unreported allegations of abuse occurred. On 03/23/16 the Social Services Director completed interviews to those resident unable to participate in the prior interviews to verify no		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTIC)N 	(X3) DATE SURVEY COMPLETED		
		345411	B. WING _				C 24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRES 516 WALL STRE WAYNESVILLE		1 03/	24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD E S-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 223	Director, District Director of C interviews with all fa unreported allegation new allegations were these interviews. The were completed on C Abuse Prohibition Podirector of Operation Clinical Services, the Administrator and all related to F226 were 3. Measures put in prodeficient practice do The Director of Nurse Administrator on Felinvestigation related allegation to the Administrator on Felinvestigation of investigation of investigation as a final warm Performance Improver reporting allegations appropriate parties in the investigation immediate work on 03/08/2016. The Director of Nurse 03/24/16 and replaced Nursing who was im District Director of C Abuse Prohibition to 24 Hour and 5 Day F Care Personnel Reg	ector of Operations and the are Management completed cility staff to verify no other as of abuse occurred. No elidentified as a result of asse audits and interviews 03/23/16. The Facility's olicy was reviewed the District as, the District Director of a Director of Nursing and the required components apresent. Ilace to ensure the alleged as not recur include: and interviews of a present. Ilace to ensure the alleged as not recur include: and timely agation. The Administrator and timely agation. The Administrator and ement Plan that included of abuse/neglect to the and a timely manner and initiate and at timely manner and initiate and at timely manner and initiate and with an Interim Director of mediately re-educated by the linical Services regarding include timely completion of Reports to the Administrator of or neglect.	F2	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C 03/24/2016	
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE	5′	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NC 28786	1 00/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 223	(CNAs), Business (Dietary and Therap Director of Nursing Development Coord*The definition of Ainfliction of injury, u intimidation, or pun pain, or mental angorigin may occur as *Immediately interv*A schedule has be Administrator, to be days to include dail shifts. All staff invol agreed to the schee Director of Nursing District Director of Oparticipate in this w this leadership tear rounding within the the ongoing performensure there is not *No tolerance for all No staff shall work education. All new on the above prior area. This education Area Human Reson Nursing during orie Immediate jeopardy 8:12 PM when interest administrative staff confirmed they had and knew the differ	of gresident Care Specialists Diffice Staff, Housekeeping, y were re-educated by the Unit Manager, and Area Staff dinator regarding: buse meaning the willful nreasonable confinement, ishment with resulting harm, uish. Injuries of unknown a result of abuse. ene to stop. ene developed by the egin 03/24/16, for the next 7 y supervision during all 3 ved have reviewed and dule. The Administrator, (DON), Unit Manager (UM), Clinical Services (DDCS) or Operations (DDO) will eekly schedule. A member of m will be available and facility each day assessing nance of the facility staff to colerance for abuse. prior to receiving this employees will be educated to working in resident care on will be completed by the urce Officer or the Director of	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 03/24/2016
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		1 00/2-9/2010
(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 SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 223 F 225 SS=J	Continued From pag for residents in order yet caring relationshi 483.13(c)(1)(ii)-(iii), (INVESTIGATE/REPO ALLEGATIONS/INDI	to maintain a professional p with residents. c)(2) - (4) DRT	F 22		5/4/16
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have d into the State nurse aide abuse, neglect, mistreatment propriation of their property; ledge it has of actions by a can employee, which would service as a nurse aide or the State nurse aide registry es.			
	involving mistreatme including injuries of umisappropriation of rimmediately to the act to other officials in act through established State survey and cer	esident property are reported dministrator of the facility and ecordance with State law procedures (including to the tification agency). e evidence that all alleged ghly investigated, and must tial abuse while the			
	to the administrator of representative and to with State law (include certification agency)	estigations must be reported or his designated of other officials in accordance ling to the State survey and within 5 working days of the leged violation is verified			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 03/24/2016
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/24/2010
DDIAN OF	NITED HEALTH AND DE			516 WALL STREET	
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 225	Continued From pag appropriate correctiv	e 31 e action must be taken.	F 22	5	
	by: Based on resident ir and record reviews to allegations of abuse suspicion of a crime complete and send to Health Care Personr required. This affects for abuse (Residents Immediate Jeopardy after Resident #3 alle neither Nurse #1 nor Administrator of the a police. The DON dio report to the HCPR to Jeopardy began on to when she told Nurse sexually abused by N Nurse #2 called the p the Director of Nursir Administrator. Imme on 03/24/16 at 8:12 f and implemented an allegation of complia of compliance at a lo (isolated with no actu	began on 02/26/16 when eged rape to Nurse #1, the DON informed the abuse allegation or called the I not fax the 24 hour initial until 02/29/16. Immediate 02/28/16 for Resident #4 #1 and Nurse #2 she was NA #1, neither Nurse #1 nor police and neither nurse nor no (DON) called the diate Jeopardy was removed PM when the facility provided		F225 Actions taken for the identified reside On 2/26/16 the Director of Nursing removed NA #1 from the resident ca assignment and was suspended per investigation. NA #1 was terminated 3/15/16. Resident #3 and Resident were educated on 3/24/16 on the definition of neglect/abuse and who report allegations to. Action taken for residents with the potential to be affected. On 2/29/16, the Social Worker condinterviews with all interviewable reside to ensure no other allegations of abunce were noted. 100% audit of stawas conducted on 2/29/16 through 3 by the Administrator, Social Worker, District Director of Operations and the District Director of Care Managemer and revealed no new allegations of a Area Staff Development Coordinator DON, and Unit Managers educated by 3/23/16 on reporting allegations of	re inding I on #4 to lucted dents use. iff id/3/16 ide ints abuse. is, staff
	monitoring systems prelated to informing tallegations of abuse, of the suspicion of a	e education and ensure but into place are effective he Administrator of informing law enforcement crime and making reports to hours of an allegation of		abuse to Administrator, reporting suspicion of a crime to law enforcem and completing and sending the 24 I reporting to Health Care Registry. Residents were educated by 3/24/16 the Interdisciplinary Team on definition	nour S by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 03/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2 1/20 10	
				516 WALL STREET			
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	Continued From pag	e 32	F 22	25			
	abuse.			abuse and who to report allega	ations to.		
	The findings included			System in place to ensure the a deficient practice does not recu			
	12/11/14. Her diagnobstructive pulmonal fibromyalgia, manic e symptoms, and major episode. The annual Minimum 12/11/15 coded her vas understanding off with clear speech an problems. She was behaviors, no signs of days over the previous supervision of one pomost activities of dail	coded as having no of delirium, feeling tired 2-6 us 2 weeks, and requiring erson physical assistance for		On 2/29/16 the District Director Services re-educated the Direct Nursing on the facility's Abuse Neglect Policy to include timeling reporting of 24 hour and 5 Day NC Division of Health Service Frontification of residents physicifamilies with change of conditionallegation of abuse and the Eld Act. The Director of Nursing we suspended on 2/29/16 pending investigation and was given disaction as a final warning and won a Performance Improvement upon returning to work on 3/8/1 On 2/29/16 the District Director Operations re-educated the Adon the facility's Abuse and Neg	ctor of and ness of Report to Regulation an and on and/or der Justice vas placed at Plan 16.		
	speak to this nurse p conversation, Reside Nurse Aide (NA) #1 ' genital area hurt. Th Resident #3 if she was be sent out (for evaluated she only want or the Administrator. immediately instructed Resident #3's room a and called the DON. instructed Nurse #1 to go back into the room DON immediately wh	rivately. During this ent #3 told Nurse #1 that stuck it in" her and her are nurse noted she asked anted the police called or to uation) and the resident ed the nurse to call the DON Nurse #1 wrote that she ed NA #1 not to go back into and then went to her office The note stated the DON to make sure NA #1 did not and to have NA #1 call the		the Elder Justice Act, reporting for the 24 hour and 5 Day repo Division of Health Service Reginis responsibilities in investigat abuse coordinator. On 2/29/16, the District Directo Services instructed the Administ the Director of Nursing to immenotify her of any new incidents allegations to ensure facility's A Neglect policy was followed. T Director of Clinical Services is weekly call thru 5/27/16 with fadiscuss all incidents and allegations and incidents and allegations and services is lightly in the services and services are services and services and services and services and services and services are services and services and services and services are services and services and services are services and services are services and services and services are services and services are services and services are services and services and services are services and ser	guidelines of to the No ulation, and tion as the or of Clinical strator and ediately or Abuse and The District holding a acility to ations to	s C d	

PRINTED: 05/02/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(С
		345411	B. WING _			03/	24/2016
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	·	
				516	6 WALL STREET		
BRIAN CE	NTER HEALTH AND	REHAB/WAYNESVILLE		WA	AYNESVILLE, NC 28786		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	'	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 225	Continued From p	age 33	F 2	225			
	revealed at 7:20 P	PM Resident #3 "made			educated by Director of Nursing, Unit		
	allegations of bein	ig sexually assaulted by NA #1.			Manager, District Director of Clinical		
	_	ted that she said no (to			Services and/or Area Staff Developmen	nt	
	pain/hurt) and she	was just scared. Then she			Nurse on the facility's Abuse and Negle	ect	
	complained of vag	inal pain & said he penetrated			policy and Elder Justice Act. No staff v	vill	
	her." This inciden	t report was completed by			be allowed to work until education has		
	Nurse #1.				been completed.		
					Nurse #1 was re-educated on 3/22/16		
		se #1 on 03/21/16 at 2:35 PM			Director of Nursing on facility's abuse a	and	
		n she spoke to Resident #3 on			neglect policy, Elder Justice Act		
		nt #3 began crying and pointed			notification of families and physicians for		
	_	stating it hurt. She stated NA			all change of conditions or allegations		
		which Nurse #1 stated referred e #1 told NA #1 to not return to			to perform head to toe assessment on resident who alleges physical abuse.	any	
		m and called the DON from her			Administrator/DON will audit any		
		old Nurse #1 she would take			allegations of abuse to ensure that		
		and instructed the nurse to have			allegations have been reported to		
		ter talking to the DON, Nurse			Administrator, if there is a suspicion of	а	
		#1 to call the DON and said she			crime that it has been reported to Law		
	did not talk to the	DON again that evening. Nurse			Enforcement and that the 24-hour repo	ort	
	#1 stated she was	not given instructions other			has been completed and sent to the		
	than making sure	NA #1 did not go back into			Health Care Registry. This audit will be	į.	
		m. Nurse #1 stated she			conducted 5 times a week for 4 weeks		
		t #3 and her roommate to			and then 3 times a week for 2 months.		
		e and did not see NA #1 again.			The results of the audits will be reporte	d	
		d not think NA #1 was on the			at the monthly QAPI meeting.		
		guarantee it. She saw him at			0 17 4		
		t when he left the facility with			Quality Assurance measures in place to	O	
		Nurse #1 stated DON said re of everything and so she did			ensure the practices are sustained:		
		or address it again during her			The Administrator and Director of Nurs	ina	
	l	ated that she understood her			will began monitoring the management		
		to call her supervisor (DON)			allegations by reviewing all allegations		
		and the DON was to give			with the Division Director of Clinical		
		andle the situation. Nurse #1			Services. This practice is completed		
		call the police or send her to			anytime there is an allegation to ensure	Э	
		ise Resident #3 was crying and			adherence to the Facility Policy on Abu		
		amant she call the DON or			Prohibition. A weekly focus call is		
		ither the DON nor the			conducted to further review events		

Facility ID: 923009

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345411	B. WING				C / 24/2016
NAME OF PROVIDER OR	SUPPLIER	0.0111	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	24/2016
					16 WALL STREET		
BRIAN CENTER HEA	ALTH AND RE	HAB/WAYNESVILLE			VAYNESVILLE, NC 28786		
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Upon foll Nurse #1 call anyo 02/26/16 assumed handling #1 furthe NA #1's I what the DON gave no Administ comforte she thou Nursing I by Nurse aide (not bathroon his penis moved a forcefully #3 was sexam. Review of #3 was sexam. Review of #3 was sexam. Review of #3 was sexam.	low up interview way and the DON with allegation stated she residents be DON told N after the initianstructions rator so Nurred Resident and the DON motes dated at 2 revealed at identified in an pushed here. The police of the hospital seen in the element to the hospital seen in the element of the hospital seen in the	e 34 o the facility. riew on 03/22/16 at 3:59 PM, asked the DON if she should in she spoke to her on in stated no. She stated she ould take the lead in on and investigation. Nurse did not reassign the rest of cause she was not aware of A #1 and she did not talk to tial phone call. The DON to call the police or the se #1 just held and #3. Nurse #1 kept saying I was handling the situation. 02/27/16 at 1:30 PM written in Resident #3 stated a nurse in the note) helped her to the erragainst the wall and put in a. She stated that she then nurse aide kissed her is were called and Resident in popital for a rape kit and in records revealed Resident mergency room on 02/27/16 ed sexual assault and in the spital for a rape kit	F2	2225	occurring throughout the week, for 6 months, to ensure completion of investigations and reporting as requirer. The Administrator and Director of Nurs will analyze the data obtained, and rep patterns/trends to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement evaluate the effectiveness of the above plan, and will add additional intervention based on outcomes identified to ensure continued compliance.	ing ort will e ons	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	(X3) DATE SURVEY COMPLETED	
			A. BOILDII			С	
		345411	B. WING _			03/24/2016	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	00.22010	
DDIAN C	ENTER HEALTH AND	DELLA DAMAYNEGVILLE		516 WALL STREET			
BRIAN CI	ENIER HEALIH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CORRECTIVE ACTION CORRECTIVE ACTION CORRECTION THE ACTION CORRECTION CORRE	SHOULD BE	(X5) COMPLETION DATE	
F 225	scheduled, Reside stated she was un Resident #3 made When asked what Resident #3 told hasked if she needs she walked indeperent Resident #3 stated bathroom, closed pushed her agains she grabbed the gobetween her legs, actually penetrate #3 told her NA #1 previously and reconstruction with the DON stated so #2 told the DON the police (Nurse #2 called the The DON stated so #2 told the DON the police (Nurse #3 to call the police). her they needed to issue and when Nowas not ok with the police to be called officer and Nurse send Resident #3 stated neither the to the facility over During an intervier at 9:53 AM, Resid "raped" by NA #1. bed when NA #1 so bathroom before his moke break. NA the bathroom, lock of his penis in her she returned to be she was to the same part of the police.	ent #3 started crying. Nurse #2 aware of the allegations a to Nurse #1 the previous day. was wrong, Nurse #2 stated her that 2 days prior, NA #1 ed to go to the bathroom and endently to the bathroom. If he followed her into the the door, locked the door, so the wall, over the toilet where har bar and he put his penis moved around a bit and then had her. Nurse #2 stated Resident had kissed her about 15 times her bon about the allegation. he would handle it. Then Nurse hat Resident #3 was told to call her stated she told Resident #3 Nurse #2 stated the DON told have be everyone out of the hat, the DON agreed for the hon once the police arrived, the her agreed it was appropriate to to the hospital. Nurse #2 DON or the Administrator came	F 2	25			

C 03/24/2016
(X5) COMPLETION DATE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 02/24/2046
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	03/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 225	want the police call would take care of *(still noted as 02/2 called the Administ #3 wanted the polic raped by NA #1 on Resident #3 called *(still noted as 02/2 came to the facility statement. She ha (EMS) coming to the resident to the host test. DON noted she to go. Follow up interview 9:26 AM revealed spolice when she was rape on 02/26/16 be the police called. Sphone on 02/26/16 be the police called. Sphone on 02/26/16 suspended and told when informed he did not recall telling instruct anyone to ras he waited for his come into the facility On Saturday (2/27/report Resident #3 were on their way. Detective on the phethey were going to hospital for a rape of Administrator on 02 started the HCPR 22 informed of the reshad trouble getting	again and she still did not ed and asked if the DON it. 6/16) at 2:45 PM, the DON rator to inform him Resident be called because she was 02/25/16. Per this note,	F 2	25	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA	DATE	
F 225	police, stated she ha and on Monday 02/2	e 38 ason for not calling the ndled the situation wrong 9/16 she was told she should cab and she was suspended	F 2	225			
	for 5 days and did no with the investigation	ot have anything more to do					
	tried to fax the 24 ho home fax/scan mach through, so when sh 02/29/16 she faxed t called and verified th	ur report to HCPR from her ine but couldn't get it to go e came to work on Monday he report to HCPR then ey had received the report. didn't have a reason for not					
	the report. She then	ty over the weekend to fax stated she thought the 24 ours of business days not					
	2:57 PM. The Admir informed by the DON that Resident #3 acc assaulting her, that the police came to the forensic examination.	as interviewed on 03/22/16 at histrator stated he was I in the afternoon (02/27/16) sused NA #1 of sexually he DON suspended NA #1, he facility and arranged for a . At the time of the call,					
	she was ok and coop Administrator stated facility as the police stated she had comp report. The Administ	he hospital and he was told perating with the police. The he did not come to the were involved and the DON poleted the HCPR 24 hour rator stated he was not hade the initial allegation on					
	Friday night (02/26/1 occurred on Thursda at work Monday 02/2 further stated that he 02/26/16 and the inte	6) and the actual abuse by (02/25/16) until he arrived by (02/25/16). The Administrator be should have been called on berviews started immediately as interviewed, NA #1 was not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 3/24/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786			3/24/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 225	suspected by Reside out on 02/29/16 that the facility over the washould have called the should have called the was unaway were notified and un assessment had been visit. In addition, the should have seen that he was shall have shall have a shall have	e police had been called (he ent #3). He stated he found the DON did not come into veekend. He stated the DON he police and made sure NA hey since talked about calling alleged perpetrator. He are if the physician or family aware if a physical en done prior to the hospital endone prior to the first prior to the hospital endone prior to the first prior to the hospital endone prior to the first prior to the first prior to the hospital endone prior to	F 2	25		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	, ,	OATE SURVEY COMPLETED
		345411	B. WING _			C 03/24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP (516 WALL STREET WAYNESVILLE, NC 28786	CODE	0012-112010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 225	to her being able to 2. Resident #4 was 03/24/15. Her diagr without residual defichronic obstructive anxiety disorder. The quarterly Minim 11/18/15 coded her understood and unc communication prob signs of delirium. S supervision of one s living skills. The annual MDS da intact cognition, hav communication prob and requiring set up ADL. A phone interview w on 03/21/16 at 3:43 02/28/16 she was a with Resident #4. N felt comfortable talk come forward with a #4 stated NA #1 had slept. It occurred m resident stated about helping her in the ba turned her around, p wheelchair and tried	wors not interview NA #1 prior interview him. admitted to the facility on noses included cerebral infarct licits, acute respiratory failure, pulmonary disease, and aum Data Set (MDS) dated with intact cognition, being derstanding, having no olems, no behaviors and no he was coded as requiring staff for most activities of daily ated 02/12/16 coded her with ring no behaviors, no olems, no signs of delirium, or limited assistance with with Nurse #2 was conducted PM. Nurse #2 stated on sked by Resident #8 to talk curse #2 stated Resident #4 ing since Resident #3 had allegations of abuse. Resident dependent with the prior of the prior	F2	225		
	DON who told her th	d on her. Nurse #2 called the nat Resident #4 just heard vith Resdient #3 and "got on				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345411	B. WING _			C 03/24/2016
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	I	03/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	and the Administrate talk to her. Nurse # the Director of Nurse # the Director of Nurse Resident #4 to call she used Resident There were no nurse about the allegation Nursing notes date written by Nurse #1 from Nurse #2 who made an allegation taken "sexual advaindicated she came statement. Resided been going on for 2 woke up to NA #1's Then 3 to 4 days la and he rubbed her Another time she wreturned and as she wheelchair, he put she was over the old pulled up yet, he punot get his penis in between her inner to the facility a stated she told Nurserevaled she was as stated she told Nurserevaled to the facility a Resident #4 and the she was distanced to the facility and Resident #4 and the she was as the she told Nurserevaled the facility and Resident #4 and the she was as stated she told Nurserevaled the facility and Resident #4 and the she was as stated she told Nurserevaled she was as stated she told Nurserevale	The DON told Nurse #2 she for would be in on Monday to #2 then stated after talking to sing via phone, Nurse #2 told the police. Resident #4 stated #8's phone to call the police. Sing notes written by Nurse #2 is made by Resident #4. If 02/28/16 at 11:00 AM, revealed she received a call reported that Resident #4 had that Nurse Aide (NA) #1 had intage of her." Nurse #1's note into work to get Resident #4's int #4 told Nurse #1 this had the weeks. First, Resident #4 tongue being in her mouth. It is her was in the bathroom breast and genital area. It is in the bathroom, NA #1 is turned to get into the his hand on her back where hair, her pants had not been alled his pants down but could her vagina so he ejaculated	F 2	25		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345411	B. WING _			C 3/24/2016
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786		3/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	Continued From pag	e 42	F 2	25		
	facility. She assumed situation.	the DON was handling the				
		nt report or concern form Resident #4's allegation of				
	03/21/16 at 10:19 AN was assaulted by NA she was sound aslee being in her mouth. (incident as a "violatic ago. The second time had gotten up, pulled hold of her, pulled he against her. The thir bathroom, had not put came into the bathro bent her over and rail and tried to put his penis was too flop finished by putting hi and ejaculated. He to with soap and water up.	sident #4 was conducted on M. Resident #4 stated she with 13 times. The first time ep and woke to his tongue Crying, she referred to this on that took place a month ep, she was in the bathroom, I her pants up, he grabbed er to him and started gyrating ditime she was in the utilled her pants up yet and he om pushed her forward and in his hands between her legs enis inside her. She stated ppy to penetrate her so he is penis between her thighs hen brought her wash cloths and instructed her to clean				
	at 8:24 AM revealed fear and that it happe finally felt comfortabl about what NA #1 did	with Resident #4 on 03/23/16 she did not tell anyone for ened often. She stated she e when she told Resident #8 d to her and Resident #8 told e4 had to tell someone about neone about NA #1.				
	(HCPR) 24 hour repo	Care Personnel Registry ort signed and faxed by the 12:24 PM marked there was sion of a crime.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345411	B. WING _			C 03/24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		3072472010
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	Continued From pag	e 43	F 2	25		
	PM who stated NA # 02/26/16 for a previous assault made by Res					
	9:45 AM revealed or #2 called her and inf had called the police also." The DON stativia phone who state ago. When asked w Resident #4 stated s DON stated the resid (Resident #4) should but the DON said sh to call the police. Rethe hospital. The DO	with the DON on 03/22/16 at a Sunday (02/28/16), Nurse formed her that Resident #4 because NA #1 "got her ted she talked to Resident #4 di thappened a long time thy she waited to report it, the just didn't want to. The dent asked her if she di not have called the police told the resident it was ok the sident #4 refused to go to DN did not come to the facility that already been called, NA				
	want to go to the host talked with the Admir	ded and the resident did not spital. The DON stated she nistrator via phone on d neither she nor the in on Sunday.				
	DON relating to what the allegation about *on 02/28/16 at about received a phone can informed her that Reference ago and that the rest the notes, the DON sphone and was told her legs while she were to the allegation of the second statement of the	at 11:00 AM, the DON Il from Nurse #2 who esident #4 was accusing NA This occurred a long time ident called the police. Per espoke to Resident #4 on the NA #1 ejaculated between as in the bathroom. Resident other time waking up with NA				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 03/24/2016
	PROVIDER OR SUPPLIER	EHAB/WAYNESVILLE	5	TREET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NC 28786	03/24/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 225	Resident #4 it was and that the resident hospital. Resident hospital. Resident hospital. The DON Administrator. Whe Administrator instruct District Director of Corporate attorney, The DON then called the physician per the Another interview was 3:46 PM revealed some Monday 02/29/16 as in the investigation. The Administrator was suspended. The Administrator was suspended on Mon the policy for allegational found out on 02/29/16 into the facility over understanding was police before he was police before he was a come to the facility abuse allegations. #1 was terminated allegations made as definitive hard core	ok that she called the police of twould probably go to the #4 declined to go to the called and texted the en he returned her call, the coted the DON to call the Deprations. She noted the Depration told her to call the who she spoke with twice. End other corporate staff and dese notes. With the DON on 03/22/16 at the was suspended on and had no more involvement. She further stated she felt fe since NA #1 was already was interviewed on 03/22/16 at inistrator stated the DON was day 02/29/16 for not following tions of abuse. He stated he 16 that the DON did not come of the weekend. He stated his the resident had called the last informed of the allegation. It atted the District Director of this request to conduct the no reason why he did not when he was alerted to the The Administrator stated NA on 03/15/16 for "the pattern of gainst him" as there was no	F 225		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED
		345411	B. WING		C 03/24/2016
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1 00/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 225	#3 refused to be in secured an attorne The HCPR 5 day in 03/04/16 at 8:58 PI reasonable suspicion resident abuse and unsubstantiated at ongoing police investigation of the AM revealed Residherself. The Detection on the policy in the policy	rviews on 03/04/16. Resident terviewed explaining her family by. avestigation report faxed M marked that there was no on of a crime related to the allegation was this time and there was an	F 225		
	Assistant (NA) #1 f but NA #1 was allow unsupervised in a r shift concluded. The	lursing removed Nursing rom the Resident Care Areas, wed to stay in the facility while non resident care area until his ne accused NA did not return ras terminated on 03/15/16.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED
			7 56.25			С
		345411	B. WING _		ا ا	3/24/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				516 WALL STREET		
BRIAN CE	ENTER HEALTH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 225	phone from Nurse #3 on 02/26/16. (contacted the Pol and Resident #3 of for medical evaluated the Administ approximately 1:3 #3 's allegation. The Police to repo NA #1. Resident same allegation. The Police to repo NA was previously continued to rema Police came into the Resident #4 declimedical evaluation submitted on 02/2 for Resident #3's Resident #4's allegation.	page 46 aursing took statements over the et # 1 and NA #1 and Resident Dn 02/27/16 Resident #3 ice, who came into the Facility, was transferred to the hospital ation. The Director of Nursing strator on 02/27/16 at 10 PM to inform him of Resident On 02/28/16 Resident #4 called rt an allegation of abuse against #4 then notified Nurse #2 of Nurse #2 then immediately or of Nursing on 02/28/16. NA resuspended on 02/26/16 and ain out of the facility. The the Facility on 02/28/16 and ned to go to the hospital for n. A 24 Hour Report was 19/16, by the Director Nursing allegation of abuse and gation of abuse. The 5 Day itted for Resident #3 and	F2	225		
	Nurse #1 was re- Director of Nursin the Elder Justice of for a reasonable s last day worked in being a no call no never returned to 2. Current Reside affected by the sa 030/3/16 the Soci interviews with re- and able to answe unreported allega 03/23/16 the Soci	2/4/16 by the Administrator. Educated on 03/22/16 by the g on the Prohibition including Act to include calling the police suspicion of a crime. Nurse #2's in facility was 02/28/16 due to her is show on 02/29/16 and has if facility. Into have the potential to be ime alleged deficient. By al Services Director completed is idents who were alert, oriented ar questions to verify no other itions of abuse occurred. On al Services Director completed is and responsible parties for				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 03/24/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 225	interviews to verify allegations of abuse Administrator, Social Director of Operation Care Management of facility staff to verify allegations of abuse allegations were identerviews. These accompleted on 03/23 and Measures put in deficient practice do On 02/29/2016 the Inservices re-educate the following: * Prohibition to inclust Hour and 5 Day Repersonnel Registry, immediate notificational allegations of abuse The Director of Nurs Administrator on 02 related to delayed rethe Administrator an investigation. The Director of Nursing final warning and was Improvement Plan the example, maintain pallegations of abuse parties in a timely man serious nature and immediately with following the delayed rethe Administrator and interview in a timely manufacture and immediately with following the serious nature and immediately with serious nature	le to participate in the prior no other unreported e occurred. On 03/03/16 the al Services Director, District ns and the District Director of completed interviews with all no other unreported e occurred. No new intified as a result of these audits and interviews were 1/16. In place to ensure the alleged less not recur include: District Director of Clinical and the Director of Nursing on the Mc Health Care the Elder Justice Act and on to the Administrator of	F 22	25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786	•	00/2-4/2010	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	O3/24/16 and replace Nursing who was in District Director of CAbuse Prohibition to 24 Hour and 5 Day Care Personnel Re and immediate noticallegations of abuse On 02/29/16 the Dire-educated the Ad Prohibition, the Eld guidelines for the 2 the NC Health Carresponsibilities to convestigation by ensassessments, revied etermining interve opportunities identify and replaced with a was immediately redirector of Operation prohibition, the Eld guidelines for the 2 the NC Health Carresponsibilities to convestigation by ensassessments, revied etermining interve opportunities identify on 03/23/16 all fact housekeeping, diet re-educated by the Manager, and Area	sing was terminated on ced with an Interim Director of need with an Interim Ports to the NC Health gistry, the Elder Justice Act fication to the Administrator of e or neglect. Strict Director of Operations ministrator on Abuse er Justice Act, reporting 4 Hour and 5 Day Reports to e Personnel Registry, and his coordinate an effective suring timely interviews and twing results and findings, and ntions according to fied during the investigation. Was terminated on 03/24/16 an Interim Administrator who reducated by the District ons regarding Abuse er Justice Act, reporting 4 Hour and 5 Day Reports to be Personnel Registry, and her coordinate an effective suring timely interviews and wing results and findings, and intions according to fied during the investigation.	F 2	225			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	1 ' '	(X3) DATE SURVEY COMPLETED	
		345411	B. WING			С	
NAME OF DE	ROVIDER OR SUPPLIER	343411	1 2:	STREET ADDRESS, CITY, STATE, ZIP CODE	03	/24/2016	
	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 PREFI TAG) BE	(X5) COMPLETION DATE	
F 225	the police for a reason No staff will be allowed this re-education. All new employees wifacility's Policy for Abdustice Act and their is police for a reasonable education will be completed the management of a events with the Division Services daily to ensure Prohibition and Elder weekly focus call to foccurring throughout completion of investigation and investigation and the mediate jeopardy with the Mediate jeopardy with the Mediate jeopardy with the Mediate jeopardy with the different types of allegations of abuse to need to compete a 24 report within required.	reporting allegations use coordinator and calling hable suspicion of a crime. Ed to work before receiving ill be educated on the use Prohibition, the Elder responsibility of calling the le suspicion of a crime. This upleted by the Area Human he Director of Nurse during inistrator and Director of a new system to monitor llegations by reviewing all on Director of Clinical ure adherence to the Abuse Justice Act and conduct a urther review events	F	225			
F 226 SS=J	483.13(c) DEVELOP/ ABUSE/NEGLECT, E	IMPLMENT	F:	226		5/4/16	
	The lacility must deve	nop and implement written					

	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		IG	(X3) DATE SURVEY COMPLETED	
	345411	B. WING		C	
NAME OF PROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE	03/24/2016	
			516 WALL STREET	-	
BRIAN CENTER HEALTH AND REHAE	8/WAYNESVILLE		WAYNESVILLE, NC 28786		
PREFIX (EACH DEFICIENCY MU	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 226 Continued From page 50 policies and procedures mistreatment, neglect, ar and misappropriation of the second	that prohibit nd abuse of residents	F 2	26		
left the facility, call law er suspicion of a crime, faile the residents for injuries, notify the Administrator, a hour report to the Health as required. This affecte sampled for abuse (Resident #3 told Nurse # Nurse Aide (NA) #1 and (DON) allowed the perpebuilding without supervis Neither Nurse #1 nor the Administrator of the abus police, or sought medica #3. Immediate Jeopardy Resident #4 when she to #2 she was sexually abu Nurse #1 nor Nurse #2 comedically assessed Resinurse or the Director of Nadministrator. Immediation 03/24/16 at 8:12 PM Nand implemented an according to the Director of Nadministrator. Immediation 03/24/16 at 8:12 PM Nand implemented an accordinate in the Administrator.	riews, staff interviews, aclity failed to implement areas of identification, responding. The facility leged perpetrator until he inforcement to report ed to immediately assess failed to immediately and failed to file the 24 Care Personnel Registry ed 2 of 4 residents dents #3 and #4). Itan on 02/26/16 when et she had been raped by the Director of Nursing etrator to remain in the ion for 3 additional hours. DON informed the leattention for Resident began on 02/28/16 for eld Nurse #1 and Nurse sed by NA #1, neither alled the police or dent #4, and neither larsing (DON) called the leattention (DON) called the leattenti		F 226 Actions taken for the identified On 2/26/16 the Director of Nu removed NA#1 from the Resid Assignment and suspended poinvestigation. NA #1 did not re facility and was terminated on Resident #3 was transferred the for medical evaluation. Reside received Psych services on 2/2 ongoing emotional support. Nurse #1 was re-educated by of Nursing on the facility's policy Prohibition to include removing alleged person from resident of the contact Law Enforcement Of when there is suspicion of a crassess resident for injuries, to Administrator immediately and hour report with the Health Carpersonnel Registry within 24 hr Resident #4 declined to go to for medical evaluation. Reside received Psych Services on 3/3/23/16 for ongoing emotional The DON was educated on 2/2	dent Care ending the eturn to the 3/15/16. to hospital ent #3 29/16 for If the Director cy for Abuse g the care areas, Officers rime, to notify the d to file a 24- are nours. the hospital ent #4 /9/16 and support.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С		
		345411	B. WING			03/	24/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIAN OF	NTED HEALTH AND D			51	16 WALL STREET			
DRIAN CE	NTER HEALTH AND RE	EHAB/WATNESVILLE		W	AYNESVILLE, NC 28786			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	(isolated with no act more than minimal higopardy) to complet monitoring systems related to protecting and following the about the facility's Abuse with a revision date the facility administ Coordinator. Sexual abuse includes exual harassment, assault. Facility supervisors intervene in reported the facility will protect any employee alleginstance of abuse with facility will report the state agency in a regulation. In accordance with facility will report to lany reasonable suspindividual who is a result of the state agency in a regulation. 1. Resident #3 was a 12/11/14. Her diagnobstructive pulmona fibromyalgia, manic	wer scope and severity of D ual harm with potential for harm, that is not immediate te education and ensure put into place are effective residents from being abused use policy. d: and Neglect Prohibition policy of June 2013 included: trator is the Abuse Prevention des, but is not limited to, sexual coercion, or sexual will immediately correct and d situations of abuse. ged to be involved in an ill be suspended immediately. ect residents from harm	F2	2226	Education on Facility's Prohibition Polic to include: removing alleged person fror resident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately, and to file a 24- hour repowith the Health Care Personnel Registr within 24 hours. Actions taken for those residents with the potential to be affected: By 3/3/16 the Social Services Director completed interviews with residents who were alert, oriented and able to answer questions to determine if any other unreported allegations of abuse occurron 3/23/16 the Social Services Director completed an audit of families and responsible parties for those residents unable to participate in the prior interviet to determine if any other unreported allegations of abuse occurred. On 3/3/the Administrator, Social Services Director, District Director of Operations and the District Director of Operations and the District Director of Care Management completed interviews with facility staff to determine if any other unreported allegations of abuse occurred. No new allegations were identified as a result of these interviews. These audit and interviews were completed on 3/23/16. The Residents will be educated by 4/29/16 on Facility's Prohibition Policy include the definition of abuse and who	t ort ry he o ed. r ews 16 n all ed. is s		
	The annual Minimun	n Data Set (MDS) dated			report it to.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	, , ,	(X3) DATE SURVEY COMPLETED C	
		345411	B. WING _		03	/24/2016	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COL	DE		
				516 WALL STREET			
BRIAN CE	NIER HEALIH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
				22.16.2.16.1			
F 226	Continued From p	age 52	F 2	26			
		er with having intact cognition,					
	_	f 15 on the Brief Interview for		Current employees were edu			
		ich measures long and short		3/24/16 on Facility's Prohibiti	•		
		temporal orientation. She was		include: removing the alleged			
		anding others and being		resident care areas, to conta			
		ear speech and no		Enforcement Officers when the			
		oblems. She was coded as		suspicion of a crime, to asses			
	having no behaviors, no signs of delirium, feeling tired 2-6 days over the previous 2 weeks, and requiring supervision of one person physical assistance for most activities of daily living skills			for injuries, to notify the Admi			
				immediately and to file a 24-			
				with the Health Care Personr within 24 hours.	nei Registry		
		ility, transfers, walking, toileting		within 24 hours.			
	_	was coded as always being		Staff will be educated during	oriontation		
	continent of bowel			and annual inservice on Fac			
	Continent of bower	and bladder.		Prohibition Policy to include:	-		
	Nursing notes date	ed 02/26/16 at 7:20 PM, written		alleged person from resident			
	_	aled Resident #3 asked to		to contact Law Enforcement			
		e privately. During this		when there is suspicion of a			
		ident #3 told Nurse #1 that		assess resident for injuries, to			
	Nurse Aide (NA) #	1 "stuck it in" her and her		Administrator immediately, a			
	genital area hurt.	The nurse noted she asked		24- hour report with the Heal	th Care		
	Resident #3 if she	wanted the police called or to		Personnel Registry within 24	hours.		
	be sent out (for ev	aluation) and the resident					
	stated she only wa	anted the nurse to call the DON		System in place to ensure the	e alleged		
		or. Nurse #1 wrote that she		deficient practice does not re	cur:		
		cted NA #1 not to go back into					
		n and then went to her office		On 2/29/16 the District Direct			
		N. The note stated the DON		Services educated the Direct	or of Nursing		
		1 to make sure NA #1 did not		on the following:	B 1333		
	•	oom and to have NA #1 call the		The facility's Policy for Abuse			
	DON immediately	wnich sne aid.		to include: removing the alleg			
	Dovious of an incid	ant raport dated 02/26/46		from resident care areas, to o			
		ent report dated 02/26/16 M Resident #3 "made		Enforcement Officers when the			
		g sexually assaulted by NA #1.		suspicion of a crime, to asset for injuries, to notify the Admi			
		ed that she said no (to		immediately and to file a 24-			
		was just scared. Then she		with the Health Care Personr			
		inal pain & said he penetrated		within 24 hours.	ioi regioti y		
		t report was completed by					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDII	A. BOLEBING		C		
		345411	B. WING _			03/24/2016		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIAN CE	NTER HEALTH AND RI			51	6 WALL STREET			
DRIAN CE	INTER HEALTH AND RI	ENAB/WATNESVILLE		W	AYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 226	revealed that when a 02/26/16, Resident at to her genital area s #1 stuck it in her, who his penis. Nurse Resident #3's room office. The DON tolecare of the issue and NA #1 call her. Afte #1 instructed NA #1 did not talk to the DO #1 stated she was not than making sure NA Resident #3's room. assigned Resident # another nurse aide at She stated she did not talk to the DO with the end of the shift whis girlfriend NA #2. she would take care not call the police or shift. Nurse #1 state responsibility was to regarding abuse and instructions and han stated she did not cathe hospital because very upset and adar Administrator. Neith Administrator came	e #1 on 03/21/16 at 2:35 PM she spoke to Resident #3 on #3 began crying and pointed tating it hurt. She stated NA nich Nurse #1 stated referred #1 told NA #1 to not return to and called the DON from her d Nurse #1 she would take d instructed the nurse to have r talking to the DON, Nurse to call the DON and said she DN again that evening. Nurse ot given instructions other A #1 did not go back into Nurse #1 stated she #3 and her roommate to and did not see NA #1 again. Not think NA #1 was on the tarantee it. She saw him at when he left the facility with Nurse #1 stated DON said of everything and so she did address it again during her ed that she understood her to call her supervisor (DON) of the DON was to give dle the situation. Nurse #1 all the police or send her to be Resident #3 was crying and mant she call the DON or ner the DON nor the	F 2	2226	The Director of Nursing was terminated on 3/24/16 and replaced with an Interin Director of Nursing who was immediate re-educated by the District Director of Clinical Services regarding Abuse Prohibition to include: removing the alleged person from resident care area to contact Law Enforcement Officers when there is suspicion of a crime, to assess resident for injuries, to notify the Administrator immediately and to file a hour report with the Health Care Personnel Registry within 24 hours. The Administrator was terminated on 3/24/16 and replaced with an Interim Administrator who was immediately re-educated by the District Director of Operations regarding Abuse Prohibition to include: removing the alleged persor from resident care areas, to contact La Enforcement Officers when there is suspicion of a crime, to assess residen for injuries, and to file a 24- hour report with the Health Care Personnel Registr within 24 hours. On 3/23/16 all facility staff were re-educated by the Director of Nursing, Unit Manager, and Area Staff Development Coordinator regarding the facility's Policy for Abuse Prohibition to include: removing the alleged person fresident care areas, to contact Law Enforcement Officers when there is suspicion of a crime, to assess residen for injuries, to notify the Administrator	n ely s, e24-		
	call anyone else who	en she spoke to her on ON stated no. She stated she			immediately and to file a 24- hour repo with the Health Care Personnel Registr			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 t. BOILDI				С	
		345411	B. WING				/24/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	24/2010	
					6 WALL STREET			
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE			AYNESVILLE, NC 28786			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE	
F 226	F 226 Continued From page 54		F 2	226				
	assumed the DON w				within 24 hours.			
		on and investigation. Nurse			Maint 2 i riodro.			
		did not reassign the rest of			All new employees will be educated on	the		
	I .	cause she was not aware of			facility's Policy for Abuse Prohibition to			
	I .	A #1 and she did not talk to			include: removing the alleged person			
	the DON after the ini	tial phone call. The DON			from resident care areas, to contact La	W		
	gave no instructions	for a physical assessment of			Enforcement Officers when there is			
		he police or the Administrator			suspicion of a crime, to assess residen	t		
		I and comforted Resident #3.			for injuries, to notify the Administrator			
		she thought the DON was			immediately and to file a 24- hour repo			
	handling the situation	1.			with the Health Care Personnel Registr	У		
					within 24 hours. This education will be			
		02/27/16 at 1:30 PM written			completed by the Area Human Resource			
		d Resident #3 stated a nurse			Officer or the Director of Nursing during	3		
		the note) helped her to the			orientation.			
		er against the wall and put na. She stated that she then			By 4/29/16 all residents and /or familie:			
		nurse aide kissed her			were educated by the Social Worker, A			
		e were called and Resident			Staff Development Nurse and Unit	u Ca		
		ospital for a rape kit and			Manager on the definition of abuse, the	ir		
	exam.	sopharior a rapo int and			right to be free from abuse, and to report			
					abuse immediately to the Administrator			
	Review of the hospita	al records revealed Resident			Director of Nursing or the Charge Nurs			
	#3 was seen in the e	mergency room on 02/27/16						
	at 3:13 PM for report	ed sexual assault and			All new residents and/or Responsible			
		e. Laboratory tests were			Party will be education by Social Work	er		
	drawn and post expo	sure prophylaxis were			within 72 hours of admission on the			
	ordered.				facility's Abuse Prohibition Policy to			
					include: the definition of abuse, their ri	ght		
	I	as conducted with Nurse #2			to be free from abuse, and to report			
		PM. Nurse #2 stated she			abuse immediately to the Administrator			
		2/27/16 and Resident #3			Director of Nursing or the Charge Nurs	€.		
	asked who her hurse around 10:00 AM. W	aide was for the day,			The Administrator and Director of News	sing		
		#3 started crying. Nurse #2			The Administrator and Director of Nurs will audit all allegations of abuse to	my		
		rare of the allegations			include: removing the alleged person fi	om		
	I .	Nurse #1 the previous day.			resident care areas, to contact Law	OIII		
	I .	as wrong, Nurse #2 stated			Enforcement Officers when there is			
	I .	that 2 days prior. NA #1			suspicion of a crime, to assess residen	t		

PRINTED: 05/02/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _	B. WING		C 03/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE		
				516 WALL STREET			
BRIAN CE	NTER 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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA		
F 226	she walked independ Resident #3 stated he bathroom, closed the pushed her against the she grabbed the grabbetween her legs, mo actually penetrated he #3 told her NA #1 had previously and recent Nurse #2 called the DThe DON stated she #2 told the DON that the police (Nurse #2 to call the police). Not her they needed to ke issue and when Nurse was not ok with that, police to be called. Cofficer and Nurse #2 send Resident #3 to the stated neither the DC to the facility over the During an interview wat 9:53 AM, Resident "raped" by NA #1. Sided when NA #1 sugbathroom before her smoke break. NA #1 the bathroom, locked of his penis in her vag she returned to bed at the next day when she	to go to the bathroom and ently to the bathroom. The followed her into the door, locked the door, he wall, over the toilet where to bar and he put his penis oved around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and then the entry and the period around a bit and the entry and th	F 2		dministrator 24- hour repo onnel Registro ongoing ults will be for review. A cted thru events occurrisure complete rting as to ensure the ector of Nursined, and repo Assurance it committee e Quality in of the above al interventio	ry A ing tion e ing ort will e ns	
	the next day when sh cried during this inter Follow up interview w	e told a nurse. Resident #3					

kissed her and touched her breast. She stated

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	C (X3) DATE SURVEY		
		345411	B. WING		03/24/2016		
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			TREET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NC 28786	•		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 226	she liked his friendle the incidents. She sperfume which she did not report the swas afraid he would which she really like she had to make a perfume and being did not want to be received in the perfume and being did not want to be received in the perfume and being did not want to be received in the perfume and being did not want to be received in the perfument of the perfument in the perfument	iness and so never reported stated NA #1 bought her really liked. She stated she exual assault because she d not buy her more perfume ed. Crying, Resident #3 stated decision about getting raped and she decided she raped again so she reported it. Ith Care Personnel Registry port revealed it was completed gned it on 02/27/16. The was a reasonable suspicion of a abuse as Resident #3 alleged in her vagina. The report ere called and she was taken from. This form was noted to PR on 02/29/16 at 9:43 AM. OON on 03/21/16 at 12:03 PM is suspended at 8:04 PM on ind no ride home so he stayed in the locked out for supper at 8:04 in at 8:32 PM and out again at DON, presented by the	F 226				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		C 03/24/2016		
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	03/24/2010		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION		
F 226	due to a pending in sexual assault which leave the facility, Noride and needed to told him to go to the do not enter any respective to the leave the facility, Noride and needed to told him to go to the do not enter any respective to the leave to told him to go to the leave to told him to go to the leave the facility of the leave the lea	od told him he was suspended exestigation of an allegation of the denied. When told to A #1 stated he did not have a wait for his friend so the DON to television room and wait and sident room. O PM, the DON wrote she again and she still did not ed and asked if the DON it. 16/16) at 2:45 PM, the DON rator to inform him Resident to called because she was 02/25/16. Per this note,	F 220				
	9:26 AM revealed spolice when she warape on 02/26/16 bthe police called. Sphone on 02/26/16 suspended and told when informed he did not recall telling instruct anyone to as he waited for his come into the facili On Saturday (2/27/report Resident #3	with the DON on 03/22/16 at she told Nurse #1 to call the as informed of the allegation of ut Resident #3 did not want she spoke to NA #1 on the and told him he was d to wait in the television room did not have a ride home. She him to clock out and did not make sure he was supervised a ride. She stated she did not ty at all during the weekend. 16) Nurse #2 called her to called the police and they The DON spoke to the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	-	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, S' 516 WALL STREET WAYNESVILLE, NC 28'		1 0011	24/2010
(X4) ID PREFIX TAG			ID PREFI TAG	(EACH CORRE CROSS-REFERE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 226	they were going to trahospital for a rape kith Administrator on 02/2 started the HCPR 24 informed of the reside had trouble getting the arrived at the facility stated she had no respolice, stated she had and on Monday 02/25 days and did not had the investigation. The Administrator was 2:57 PM. The Administrator was 2:57 PM. The Administrator was 2:57 PM. The Administrator was assaulting her, that the police came to the forensic examination Resident #1 was at the she was ok and coop Administrator stated facility as the police was tated she had compreport. The Administraware Resident #3 m Friday night (02/26/1 occurred on Thursda at work Monday 02/2 further stated that he 02/26/16 and the interior but that everyone was in the facility, and the suspected by Reside out on 02/29/16 that the facility over the was the suspected by Reside out on 02/29/16 that the facility over the was the police was in the facility over the was the facility over t	ne who informed the DON ansport Resident #3 to the ansport Resident #4 the ansport Resident #4 the ansport after being and the fact to go through until she and for not calling the andled the situation wrong and anything more to do with as interviewed on 03/22/16 at anstrator stated he was and in the afternoon (02/27/16) and the afternoon (02/27/16) and the time of the call, and anything with the police. The and and the hospital and he was told and the hospital and the DON alleted the HCPR 24 hour and the hospital allegation on and the actual abuse by (02/25/16) until he arrived and the initial allegation on and the actual abuse by (02/25/16) until he arrived and the actual abus	F	226			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			TREET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET //AYNESVILLE, NC 28786	•	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 226	and unaware if a ph done prior to the ho Administrator stated language was Engli he was suspend un just told to sit in the The Administrator s called a cab to reme He gave no reason facility when he was allegations. The Adterminated on 03/18 allegations made as definitive hard core Review of the invest Administrator reveal interviewing staff, in #3, until 03/03/16 at 03/04/16. The HCF faxed 03/04/16 at 8 allegation was unsuthere was an ongoin linterview with the DAM revealed this was NA #1 had secured were hoping to arra #1 this week. The Emonths before the rat the hospital woul stated she preferred NA #1 prior to her but NA #1 was not interview. Resident #4 was 2. Resident #4 was	icician or family were notified hysical assessment had been spital visit. In addition, the distance that NA #1's second shand he did not understand till the next day. NA #1 was television room on 02/26/16. Itated the DON should have ove NA #1 from the premises. Why he did not come to the salerted to the abuse diministrator stated NA #1 was 5/16 for "the pattern of gainst him" as there was no proof of guilt. Itigative notes taken by the led he did not begin including NA #1, or Resident and completed interviews on PR 5 day investigation report 154 PM marked that the instantiated at this time and mg police investigation. Interective on 03/22/16 at 10:21 as an ongoing investigation, legal counsel and the police inge for an interview with NA Detective stated it could be results of the rape kit collected in the surveyors not interview eing able to interview him.	F 226			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			TREET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NC 28786	1 03/24/2010	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETION	
F 226	chronic obstructive anxiety disorder. The quarterly Minin 11/18/15 coded her being understood a communication issurequiring supervisic activities of daily liv mobility, toileting ar continent of bowel as feeling bad about last 2 weeks, havin delirium. The annual MDS daintact cognition, have communication profeeling bad about h	ge 60 ficits, acute respiratory failure, pulmonary disease, and num Data Set (MDS) dated with intact cognition and and understanding with no uses. She was coded as on of one staff for most ing skills (ADL) including bed and hygiene, and being and bladder. She was coded at herself 2-6 days over the g no behaviors and no signs of ated 02/12/16 coded her with wing no behaviors, no blems, no signs of delirium, erself 2-6 days over the last 2 and set up or limited assistance	F 226			
	on 03/21/16 at 3:43 02/28/16 she was a with Resident #4. N felt comfortable talk come forward with #4 stated NA #1 ha slept. It occurred m resident stated abo helping her in the b turned her around, wheelchair and tried reported he had pu area, and ejaculate stated after talking	with Nurse #2 was conducted B PM. Nurse #2 stated on asked by Resident #8 to talk lurse #2 stated Resident #4 king since Resident #3 had allegations of abuse. Resident d been kissing her while she nultiple times. Then the ut 2-3 weeks ago, NA #1 was athroom, and as she stood, he pushed her into the d to penetrate her. She t his fingers inside her vaginal d on her. Nurse #2 then to the Director of Nursing via ld Resident #4 call the police.				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 03/24/2016
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	, 33.2 20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 226	happened a couple there was no need evidence would be physican who agree hospital for an exar. There were no nurs about the allegation. Nursing notes date written by Nurse #1 from Nurse #2 who made an allegation taken "sexual advarindicated she came statement. Resider been going on for 2 woke up to NA #1's Then 3 to 4 days la and he rubbed her Another time she wreturned and as she wheelchair, he put I she was over the cl pulled up yet, he punot get his penis in between her inner to Inteview with Nurse revealed she receiv 02/28/16 at 11:00 A claimed she was as stated she told Nurseport and concern went to the facility a Resident #4 and the	at because the incident of weeks prior to the report, to send her to the hospital as gone. Nurse #2 called the ed not to send her to the m. sing notes written by Nurse #2 as made by Resident #4. d 02/28/16 at 11:00 AM, revealed she received a call reported that Resident #4 had that Nurse Aide (NA) #1 had intage of her." Nurse #1's note e into work to get Resident #4's int #4 told Nurse #1 this had weeks. First, Resident #4 tongue being in her mouth. ter she was in the bathroom breast and genital area. ras in the bathroom, NA #1 e turned to get into the his hand on her back where hair, her pants had not been ulled his pants down but could her vagina so he ejaculated	F 226		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, 516 WALL STREET WAYNESVILLE, NC 28786	ZIP CODE	03/24/2010	
(X4) ID PREFIX TAG			ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 226	facility. There was no incider completed related to sexual assault. An interview with Re 03/21/16 at 10:19 AN was assaulted by NA she was sound asleed being in her mouth. Or incident as a "violatic ago. The second time had gotten up, pulled hold of her, pulled her against her. The third bathroom, had not pure came into the bathrown bent her over and rare and tried to put his published by putting his penis was too floe finished by putting his and ejaculated. Here with soap and water up. Follow up interview wat 8:24 AM revealed fear and that it happer finally felt comfortable about what NA #1 disher either Resident # it or he would tell sor	nt report or concern form Resident #4's allegation of sident #4 was conducted on M. Resident #4 stated she M. Hesident #4 on 03/23/16 M. Hesident #4	F2	226			
		arked there was no n of a crime. The allegation nt was a long time ago and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, 2 516 WALL STREET WAYNESVILLE, NC 28786	ZIP CODE	33/24/2313	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE	
F 226	described the allegal into the bathroom and Resident #4's legs. also stated another kissed her with his to not report these inci 02/28/16. The DON was interved the police assault made by Resident #4 stated so DON stated the police also." The DON stated the police also. When asked we Resident #4 stated so DON stated the resi (Resident #4) should but the DON said shad to call the police. Rethe hospital. The DON distated the police also who was her own refamily to be called the family. The DON distated the police has had been suspende want to go to the hotalked with the Admi 02/28/16. She state Administrator came	tition was that NA #1 came and ejaculated between The allegation on this report time she was sleeping and he ongue in her mouth. She did dents to anyone until viewed on 03/21/16 at 12:03 #1 had been suspended on ous allegation of sexual sident #3. with the DON on 03/22/16 at an Sunday (02/28/16), Nurse formed her that Resident #4 are because NA #1 "got her ted she talked to Resident #4 and it happened a long time why she waited to report it, she just didn't want to. The dent asked her if she do not have called the police are told the resident it was ok esident #4 refused to go to ON stated that if the resident sponsible party wanted the ne nurse should call the do not come to the facility and do already been called, NA #1 do and the resident did not spital. The DON stated she inistrator via phone on and neither she nor the in on Sunday.	F2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	I	00/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 226	received a phone cainformed her that Ref #1 of raping her too ago and that the rest the notes, the DON phone and was told her legs while she w #4 told her about an #1's tongue in her m Resident #4 it was and that the resident hospital. Resident #4 hospital. The DON of Administrator. Whe Administrator instruct District Director of Corporate attorney, The DON then calle the physician per the Another interview w 3:46 PM revealed sh Monday 02/29/16 ar in the investigation. have completed a benot looked at the rec was completed. She resident was safe si suspended. The Administrator w 2:57 PM.	ut 11:00 AM, the DON all from Nurse #2 who esident #4 was accusing NA This occurred a long time ident called the police. Per spoke to Resident #4 on the NA #1 ejaculated between was in the bathroom. Resident other time waking up with NA bouth. The DON told ok that she called the police t would probably go to the f4 declined to go to the called and texted the in he returned her call, the operations. She noted the operation told her to call the who she spoke with twice, d other corporate staff and	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 03/24/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786		J3/24/2016	
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	police before he was He stated he was una family were notified a assessment had been stated the District Dire his request to conduct reason why he did not he was alerted to the Administrator stated 1 03/15/16 for "the patter against him" as there proof of guilt. Review of the investig Administrator revealed interviewing staff, included and completed interviewing staff, included and completed interviewing staff, included and completed interview with a secured an attorney. The HCPR 5 day inversionally and the secured and the unsubstantiated at the ongoing police invest. Interview with the Deta AM revealed Resider herself. The Detective ongoing investigation counsel and the policinal interview with NA stated she preferred to the state of	informed of the allegation. aware if the physician or and unaware if a physical and done. The Administrator ector of Operations came at at interviews. He gave no at come to the facility when abuse allegations. The NA #1 was terminated on ern of allegations made was no definitive hard core gative notes taken by the d he did not begin luding NA #1, until 03/03/16 fews on 03/04/16. Resident viewed explaining her family estigation report faxed marked that there was no of a crime related to ne allegation was is time and there was an igation. tective on 03/22/16 at 10:21 at #4 called the police e stated this was an , NA #1 had secured legal e were hoping to arrange for #1 this week. The Detective the surveyors not interview ng able to interview him.	F2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING _				24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	Ē			
(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 226	the DON were inform The Administration proceedible allegation of 6:32 PM. Brian Center Waynes following allegation of 1. Nurse #1 notified to abuse related to Res Resident #3 alleged to shower on Thursday immediately following #1 the Director of Nu the Resident Care Ar return to the facility a 03/15/2016. The Director statements over the p NA #1 and Resident #3 came into the Facility transferred to the hos Resident #3 received prophylactic treatment Raltegravir for 30 day Psych services on 02 emotional support. called the Administra approximately 1:30 P #3's allegation. A 24 was submitted by the 02/29/16 and the 5 D the Administrator on re-educated by the D	PM, the Administrator and ed of Immediate Jeopardy. Tovided an acceptable compliance on 03/24/16 at a swille respectfully submits the frompliance for F 226. The DON of an allegation of Ident #3 on 02/26/16. The notification from Nurse raing removed NA #1 from leas. The accused did not not was terminated on lector of Nursing took of the Police, who was a contacted the Police, who was a contacted the Police, who was a contacted the Police, who was terminated and least the string and least with Truvada and was resident #3 received 1/29/16 for ongoing The Director of Nursing	F 2	26				
	Elder Justice Act. 2. On 02/28/16 Resid	ent #4 called the Police to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. BI		TIPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CO 516 WALL STREET WAYNESVILLE, NC 28786	DDE	0.2 1.20 1.0	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 226	notified Nurse #2 of alleged that NA #1 of sexually abused her remember the date immediately notified 02/28/16. NA#1 was 2/26/16 and continus facility. The Police Resident #4 decline medical evaluation areceived Psych Serfor ongoing emotion was submitted on 0. Nursing for Resident The 5 Day Report won 03/04/16 by the pre-educated on 03/2 Nursing on the Faci Prohibition including #2 last day worked 3. Current Resident affected by the sam 03/03/16 the Social interviews with resident and able to answer unreported allegation 03/23/16 the Social an audit of families those resident unabinterviews to verify allegations of abuse	of abuse. Resident #4 then same allegation. Resident #4 came into the bathroom and r and was unable to or time. Nurse #2 then I the Director of Nursing on as previously suspended on led to remain out of the came into the Facility and red to go to the hospital for leand STD testing. Resident #4 vices on 03/9/16 and 03/23/16 and support. A 24 Hour Report 12/29/16, by the Director of 14 the distribution of abuse. The vices are submitted for Resident #4 Administrator. Nurse #1 was 12/16 by the Director of 15 lity's Policy for Abuse of the Elder Justice Act. Nurse in facility was 02/28/16. Is have the potential to be alleged deficient. By Services Director completed dents who were alert, oriented questions to verify no other loss of abuse occurred. On Services Director completed and responsible parties for the to participate in the prior no other unreported occurred. On 03/03/16 the	F	226			
	Director of Operatio Care Management of facility staff to verify allegations of abuse	al Services Director, District ns and the District Director of completed interviews with all no other unreported e occurred. No new entified as a result of these					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	completed on 03/23. Prohibition Policy was Director of Operation Clinical Services, the Administrator and all related to F 226 were 4. Measures put in publication of the Disservices re-educate the following: *The Facility's Polici include timely computed timely computed to the NC Harmonification to the Adabuse or neglect. The Director of Nurse Administrator on 02/2 related to delayed residues.	audits and interviews were 216. The Facility's Abuse as reviewed the District as, the District Director of be Director of Nursing and the I required components be present. Clace to ensure the alleged be not recur include: trict Director of Clinical d the Director of Nursing on Y for Abuse Prohibition to betion of 24 Hour and 5 Day be ealth Care Personnel bustice Act and immediate ministrator of allegations of ing was suspended by the 29/16 pending investigation be porting of abuse allegation to	F 2	· · · · · · · · · · · · · · · · · · ·		
	investigation. The A Director of Nursing was final warning and was Improvement Plan the allegations of abuse parties in a timely minvestigation immed on 03/08/2016. The Director of Nursing who was im District Director of C Abuse Prohibition to	d timely completion of administrator provided the with disciplinary action as a as placed on a Performance nat included reporting /neglect to the appropriate anner and initiate the liately upon returning to work sing was terminated on ed with an Interim Director of mediately re-educated by the linical Services regarding of include timely completion of Reports to the NC Health				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
		345411	B. WING		0:	C 3/ 24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1 03/24/2010		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 226	Care Personnel Reand immediate not allegations of abus On 02/29/16 the Dire-educated the Ad Policy for Abuse Practice Act, reporting guide Day Reports to the Registry, and his reeffective investigation interviews and assumed findings, and according to opportinvestigation. The Administrator vand replaced with a was immediately redirector of Operation prohibition, the Eld guidelines for the 2the NC Health Carresponsibilities to convestigation by en assessments, revied termining interversion on 03/23/16 All factory and Theragonetic CNAs), Business Dietary and Theragonetic CNAs, Business Dietary and Theragonetic CNAs, Subsiness Dietary and Theragonetic CNAs (CNAs)	egistry ,the Elder Justice Act iffication to the Administrator of	F 226				

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING_			C 03/24/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	<u> </u>	03/24/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 226	Prohibition and the included maintainin with residents and f Right to live in the faneglect. The facility will follow the policy investigate all allegathoroughly. The Facility perform	Education also included Abuse Elder Justice Act. Education g a professional relationship amilies and the Resident's acility free from abuse and will not tolerate abuse and for Abuse Prohibition to ations of abuse or neglect	F 2	26			
	and obtains referen Area Human Resou of Nursing prior to co All new employees facility's Policy for A Justice Act and thei police for a reasonal education will be co	ws license and certifications ces on all new employees by cree Officer and or the Director orientation. will be educated on the labuse Prohibition, the Elder responsibility of calling the lable suspicion of a crime. This impleted by the Area Human the Director of Nurse during					
	Nursing implemented the management of events with the Divi Services daily to en Policy on Abuse Profocus call to further throughout the wee investigations and run On 03/24/16 all resi been educated by the Development Nurse	ministrator and Director of ed a new system to monitor allegations by reviewing all sion Director of Clinical sure adherence to the Facility phibition and conduct a weekly review events occurring k to ensure completion of eporting as required. dents and or families have the Social Worker, Area Staff e and Unit Manager on the their right to be free from					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345411	B. WING _		C 03/24/2016
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/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 .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 226 F 281 SS=D	Continued From page abuse, and to report a Administrator, Director Nurse. Immediate jeopardy v 8:12 PM when intervitinely were aware and abuse incidents immediate incidents immediate administrative staff, noresidents confirmed the training and knew the the need to report alle Administrator and/or 124 hour and 5 day HC time frames, the need suspicion of a crime, resident and obtain a interventions for the administrator and/or 1483.20(k)(3)(i) SERV PROFESSIONAL STATE The services provided must meet profession	abuse immediately to the or of Nursing or the Charge was removed on 03/24/16 at ews with residents revealed felt comfortable reporting ediately. Nursing staff, on-nursing staff, and ney had received in-service different types of abuse, egations of abuse to the DON, the need to compete a CPR report within required at to call the police to report the need to evaluate the ppropriate medical effected residents.	F 2	226	5/4/16
	Based on record revi facility failed to obtain wound care treatmen to obtain laboratory to Resident #7. This def 5 sampled residents in	ew and staff interview the physician's orders for tor Resident #1 and failed ests that were ordered for ficient practice affected 2 of reviewed (Residents #1 and		F 281: Actions taken for the identified residen Resident #1 was discharged from facil on 3/11/2016 and Resident #7 was discharged from facility on 3/25/2016	
	#7). The findings included			Actions taken for residents that have the potential to be affected:	
	i. Residelil #1 Was a	dmitted to the facility on		The Director of Nursing and Unit Mana	ıycı

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			
		345411	B. WING _			03/	24/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE			6 WALL STREET AYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	diabetes mellitus type complications, cerebr peripheral vascular di Minimum Data Set (Mindicated Resident #1 for daily decision mak Resident #1 required all activities of daily lirindicated Resident #1 and surgical wound care at to feet. A care plan dated 02/#1's cellulitis, skin im wounds. Interventions ordered by physician Review of the nurses dated 03/05/16, 03/06 dressing changes to fill Review of an undated the following entry: "Fill sutures - Cleanse wo Cover with Mepilex sit to fit then cover with Kerlix. Must be done the treatment record done days 1 through Further review of Resrevealed no physiciar care or treatments for excoriated sacrum.	ses including cellulitis, a 2 with circulatory ovascular accident and isease. An admission MDS) dated 02/17/16 I was cognitively impaired king. The MDS indicated extensive assistance with ving. The MDS also I had a diabetic foot ulcer or which she received and application of dressings 17/16 addressed Resident pairment and surgical is included treatments as and assess skin weekly. notes revealed entries 3/16 and 03/11/16 of foot and sacral wounds. Id treatment record revealed Right foot incision and und with cleanser daily. Silver grey foam dressing, cut 4 X 4 gauze. Wrap with DAILY." Documentation on indicated the treatment was	F	281	completed an audit 4/14/16 of resident with wounds to ensure treatment orders are in place. The MD was notified and orders were received on the residents being identified as not having wound treatment orders. On 4/15/16, the Director of Nursing/Unit Managers completed an audit of physician orders labs to ensure all labs were obtained as ordered. The MD was notified for residents identified as being affected at orders were received to re-obtain labs of the labs were discontinued. No advers outcome was noted to the residents identified as having been affected. System in place to ensure the alleged deficient practice does not recur included. The Director of Nursing and Unit Managers will educate licensed nurses 4/20/16 regarding obtaining physician orders for treatments and following physicians orders related to the lab process. Once the order is received, the nurse is to log the lab into the lab book and fill out the lab requisition. The Unit Managers/Nurses are to track, per the book, when the lab results are obtained ensure follow through has been completed with the MD. Unit Managers will audit residents with wounds to ensure appropriate MD order in place and lab orders to ensure labs obtained as ordered. These audits will performed 5 times per week for 4 week and the 3 times a week for 2 months to	for some end or ee end or	
	excoriated sacrum. An interview with Nur				obtained as ordered. These audits will performed 5 times per week for 4 week	s	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		DNSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345411	B. WING _			03/	24/2016
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		516	EET ADDRESS, CITY, STATE, ZIP CODE WALL STREET YNESVILLE, NC 28786	1 031	24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	any dressings or treat When asked about the Resident #1 not being record, he stated the lot of missing docume the undated treatment thought it was the recof the dates the treat done. An interview with the 03/24/16 at 12:00 PM having physician's or or treatments for the revealed her expectate a physician's order for change provided for the revealed her expectate a physician's order for the revealed her expectate and coldisease and end stage. Review of Resident #1 revealed the following a) an order dated 02/ standing Lab orders: panel, aspartate aminaminotransferase (Al February, May, Auguladmission orders." A found primarily in the blood levels often indicate the provided for	d be a physician's order for tments applied to resident. The treatment orders for g on the closed medical facility had a problem with a centation. When asked about at record, Nurse #4 stated he cord for March 2016 because ments were initialed as Director of Nursing on a labout Resident #1 not ders for surgical wound care foot and sacral wounds tion was for nurses to obtain ar any treatment or dressing the resident. Admitted to the facility on sees including diabetes early artery disease, pronic obstructive pulmonary greenal disease. Et's physician's orders g: 11/16 read: "Clarification hemoglobin (Hgb) A1c, lipid notransferase (AST), alanine at and November per ST and ALT are enzymes heart and liver. Elevated licate heart or liver damage.	F2		reported to the monthly QAPI meeting a review. Quality Measures in place to ensure the practice is sustained: The Administrator and Director of Nursi will analyze the data obtained, and repopatterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectivener of the above plan, and will add addition interventions based on outcomes identified to ensure continued compliant	e ing ort e e ss	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION NG	' '	TE SURVEY MPLETED
		345411	B. WING			C 03/24/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 516 WALL STREET WAYNESVILLE, NC 28786		33/24/2016
(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 C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281	no results on the chapanel, AST or ALT the There were also no rehemoglobin and hemoglobin and putting a revealed the nurse were sponsible for compit in the lab book for the drawn and putting a rewind wing of the facility who nurse #4 was asked following up to ensurordered. He stated the responsible for following up to ensurordered. He stated the responsible for following up to ensurordered the not following orders for was responsible for whook and should fill casked about her expetests that were ordered stated the labs should the physician ordered. The DON stated the not following up on labut she was unaware after the Unit Coordinant interview on 03/24.	et1's medical record revealed rt for the Hgb A1c, lipid at were ordered on 02/11/16. esults on the chart for the atocrit that were ordered on 4/16 with Nurse #4 about the ascribing orders for lab tests ho received the order was leting a lab requisition, listing he date the lab was to be note on the calendar for the are the resident resided. who was responsible for that labs were obtained as a library of the order and stated the difference and stated the difference that labs were stated the difference and stated the difference and stated the difference the order for labs that was 4/16 at 1:00 PM with the DON) about the process for a labs revealed the nurse writing the order on the lab and a lab requisition. When estation for obtaining lab and for a resident, the DON difference the way she should have a there was a problem until	F2	281		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345411	B. WING _			C
PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 281 Continued From page 75 ordered by the physician to be done. An interview on 03/24/16 at 4:34 PM with the Medical Records Director revealed she did not have any unfiled lab results for Resident #1 and she had called the facility's lab provider and verified they had not obtained the Hgb A1c, lipid panel, AST or ALT that were ordered on 02/11/16 and also had not obtained the hemoglobin and hematocrit that were ordered on 02/12/16. F 323		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	I	03/24/2016		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	ordered by the physi An interview on 03/2 Medical Records Dirhave any unfiled lab she had called the fa verified they had not panel, AST or ALT th and also had not obt hematocrit that were 483.25(h) FREE OF HAZARDS/SUPERV The facility must ens environment remains as is possible; and e adequate supervision	cian to be done. 4/16 at 4:34 PM with the ector revealed she did not results for Resident #1 and cility's lab provider and obtained the Hgb A1c, lipid at were ordered on 02/11/16 ained the hemoglobin and ordered on 02/12/16. ACCIDENT ISION/DEVICES ure that the resident as free of accident hazards ach resident receives	F 2			5/4/16
	by: Based on record revision facility failed to evaluate circumstances and/or interventions to reduinjuries. This affected for falls who fell multifractured shoulder (Fig. 1) The findings included Resident #9 was addro7/12/13. Her diagnidisorders, dementia,	riew and staff interviews, the ate and analyze the r trends of falls and modify ce the risk of falls and/or d 1 of 3 residents sampled iple times resulting in a Resident #9).		F323 Actions taken for the identified Resident #9 is no longer a resifacility. Actions taken for those resident potential to be affected: The Director of Nursing and U Managers will evaluate and an residents who had falls for a round analysis in the last 30 days	dent at the ats with the nit alyze all ot cause	

PRINTED: 05/02/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	` ′	SURVEY PLETED
							С
		345411	B. WING _			03	/24/2016
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
				516	6 WALL STREET		
BRIAN CE	NTER HEALTH AND	REHAB/WAYNESVILLE		W	AYNESVILLE, NC 28786		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFIC	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
F 323	Continued From բ	page 76	F3	323			
					of Nursing and Unit Managers will revi	ew	
	A plan of care wa	s originally developed on			all recommendations to ensure that		
	'	entified the problem that			interventions were implemented to red	uce	
	Resident #9 was	at risk for falls related to mental			the risk of falls and/or injury. The audit	will	
	status and the use	e of sedatives/hypnotics. The			be completed by 5/1/16.		
		dent #9 to "have a reduction in					
	· .	and injury." This generic plan of			Systems in place to ensure the alleged	t	
		arks by the following			deficient practice does not recur:		
	pre-printed interve				D:		
	*Falling Star Prog				Director of Nursing/Unit Managers	_	
		ent to ask for assist			educated nurses by 4/20/16, regarding	•	
	indicated and acc	lent has proper footwear as			determining the root cause of the fall a implementing interventions to prevent		
		referral to physical therapy,			fall from reoccurring. Audits will be	uie	
		apy, restorative nursing and			performed 5 times per week for 4 wee	ks	
	social services	apy, rooterative riaroning and			and then 3 times a week for 2 months		
		room/environment			ensure compliance and results will be		
	*place call light w	ithin reach			reported to the monthly QAPI for revie	W.	
		let frequently and as accepted					
	*observe for pote	ntial medication causes.			Quality measures in place to ensure the	ıe	
	The Care Area As	sessment (CAA) dated			practice is sustained:		
		to falls stated Resident #9 was			The Administrator and Director of Nurs	sina	
		ent with advanced dementia.			will analyze the data obtained, and rep	-	
	She was describe	ed as ambulating around the			patterns/trends to the Quality Assuran		
	facility independe	ntly, having an unsteady gait at			Performance Improvement committee		
		be reminded to walk close to			monthly for 6 months. The Quality		
		support. The last fall per this			Assurance Performance Improvement		
		06/23/15 during which she was			committee will evaluate the effectivene		
	not injured.				of the above plan, and will add additio	nal	
					interventions based on outcomes		
		the Director of Nursing (DON)			identified to ensure continued complia	nce.	
		n 03/24/16 at 12:18 PM to					
		^t 9's falls. She explained that Interdisciplinary Team (IDT)					
		ind discussed the falls and					
		own to determine if care plan					
		ded to be added or changed.					
		he falling star program listed on					

Facility ID: 923009

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		345411	B. WING _			C 3/24/2016	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE (X4) ID PREFIX TAG COntinued From page 77 Resident #9's care plan just identified the resident as a fall risk and indicated to staff that they should keep an eye on her. Resident #9 was found on the floor by the side of the bed. She sustained a skin tear to her left hand between her thumb and index finger. The Situation, Background, Assessment, Recommendation (SBAR)/progress note dated 12/15/15 stated she was continually more confused and agitated and needed more assistance with activity of daily living skills. The SBAR stated she had small emesis. The (IDT) post fall review for the unwitnessed fall on 12/25/15 stated that staff were instructed to increase visual checks due to resident's severe dementia and that the resident would not leave the bedroom door open. The intervention recommendations included a check for care plan revision and for "other" with a note for staff education. The care plan noted 12/25/15 to increase visual checks.		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786			1 33.2 1.20 1.0	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	Resident #9's care plas a fall risk and indices should keep an eye of the should had between her the situation, Backgroun Recommendation (Sl 12/15/15 stated should be confused and agitate assistance with activity SBAR stated she had post fall review for the 12/25/15 stated that sincrease visual check dementia and that the the bedroom door op recommendations increvision and for "other education. The care increase visual check." The DON stated during 12:18 PM that the introften was that staff wand try to keep her down was no set time or from the she could not describe the she appeared the sit and rest. She stated pass the information	an just identified the resident cated to staff that they on her. Irring falls as follows: PM, an incident report noted and on the floor by the side of sted a skin tear to her left numb and index finger. The d, Assessment, BAR)/progress note dated was continually more d and needed more ty of daily living skills. The d small emesis. The (IDT) is unwitnessed fall on staff were instructed to see due to resident's severe eresident would not leave en. The intervention cluded a check for care plan er" with a note for staff plan noted 12/25/15 to	F3	23			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345411	B. WING		,	C 3/24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	, v	3/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Resident #9 was for beside the bed. The contained no addition thought the problem vomiting. The IDT punwitnessed fall statement to leave the increase visual check recommendations in revision and for "othe ducation. The card continue approach a leave the door open visual checks. The DON stated du 12:18 PM that staff the bedroom door of since both Resident closed the door. The quarterly Minim coded her as being having wandering be able to stabilize her most activities of da ambulation, being of bladder and having since the previous a antidepressant and There were no new relative to falls at the Resident #9 continue. On 01/02/16 at 2:00 Resident #9 was for	is PM, an incident report noted and on the floor vomiting a SBAR/progress note onal note other than nursing in may be dizziness from post fall review of this ted staff were instructed to be bedroom door open and cks. The intervention included a check for care plan inter" with a note for staff a plan noted 12/30/15 to and encourage the resident to and continue to increase or increase or increase visual checks are and the roommate often of the plan intervention increase of the plan intervention increase or increase or increase or increase or increase or increase of the plan increase of the pl	F 3.	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 3/24/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 516 WALL STREET WAYNESVILLE, NC 28786		3/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 323	was noted on the for stated she complaind nurse thought the pragitation. Physician 01/02/16 for Xrays oright elbow and nasa 01/02/16 revealed el negative and the res Xrays of the nasal be review for this unwith to continue visual chrecommendations in revision and for "othe education. The care the date of the fall. The DON stated dur 12:18 PM that she of were expected to vis The DON stated bed there was nothing sther from falling. She IDT meetings, the teframes for visually clidentified no trends is she fell at all different on 01/18/16 at 10:00 indicated Resident # anxiety. Trazodone medication) 25 milligneeded every 6 hour On 01/31/16 at 9:00 Resident #9 was fou bathroom between the	A bruise on the right elbow m. The SBAR/progress note ed of nausea post fall and the oblem may be confusion and orders were obtained on f the right hip, right pelvis, all bones. Results dated bow, hip and pelvis were ident was uncooperative for ones. The IDT post fall nessed fall stated staff were ecks. The intervention cluded a check for care plan er" with a note for staff plan was only updated with eight intervention of the plan was only updated with further stated that during the amount of the plan was ambulatory aff could do to try to prevent further stated that during the amount of the plan was energially energy of the plan was any time necking on Resident #9 and involved with her falling as it times. O AM a physician note 9 was seen for increased (an antidepressant rams (mg) was added as as for anxiety. PM, an incident report noted and lying on the floor in the ne toilet and the wall. She whurt but there was no	F3	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			ATE SURVEY DMPLETED
		345411	B. WING _			C 03/24/2016
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 516 WALL STREET WAYNESVILLE, NC 28786 (X4) ID PREFIX PREFIX FIG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, 516 WALL STREET WAYNESVILLE, NC 28786 PREFIX (EACH CORRECTIVI) TAG CROSS-REFERENCED		E, ZIP CODE			
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	SBAR/progress not falling more frequer (PT) eval and treatr The IDT post fall restated staff were adbed. Also the resid physician was awar was made. The interior included a check fo "other" with a note of plan noted 01/02/16 visual checks. The request for physicia falls on 01/31/16. The care plan regard. The DON stated du 12:18 PM that she disgnificance of havin night entailed, as the socks in the incident #9 normal when up and dresse analyzed and talked staff could do to kee On 02/04/16 Reside practitioner (NP) duphysician note state for her frequent falls Procardia (a hypertic blood pressure, have (OT) evaluate, and	e stated the resident was alty and that physical therapy ment should be considered. View for this unwitnessed fall livised to remove socks before ent has had frequent falls and re and a request for a PT evaluation recommendations or care plan revision and for for staff education. The care continue approach, increase care plan was updated with a record to eval for PT for frequent there was nothing added to ding socks. Tring interview on 03/24/16 at could not recall what the registaff remove her socks at the ere was nothing related to the report. The DON stated they do in IDT committee about what the per the resident safe. The Was seen by the nurse rediction to the reason of the reason of the reason of the resident was no clear reason of the NP's plan was to hold remain medication) due to low the PT/occupational therapy obtain a CT scan to evaluate	F3	23		
	2009. PT began working v	with the resident on 02/09/16 cises, neuromuscular				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	, ,	ATE SURVEY OMPLETED
		345411	B. WING			C 03/24/2016
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	revealed Resident #8 her room. She hit he sustained 2 small but head. Neurochecks of fall review for this un resident was severel short term memory of could not remember the call light. Reside checks and staff was open by repeatedly of door. The intervention a check for care plant. The DON stated during 12:18 PM that the fact her from falling as short for more falling as short ped and denied for resting. The SBAR/proted the resident fect treated with ice to her	AM, an incident report O was found on the floor in or head on the floor and mps on the back of her were initiated. The IDT post witnessed fall stated the y cognitively impaired. Her vas absent. The resident to ask for assistance or ring ont #9 was on frequent visual attempting to leave the door eminding her to not close her or recommendations included or revision. In interview on 03/24/16 at cility was unable to prevent	F 32	3		
	has had frequent fall and has been placed noted as non-complicate plan was update had a fall in her room hematomas to her he noted was to continuate review. The DON stated duri 12:18 PM that the interest of the place of the p	s due to severe dementia I on visual checks. She was ant with any instruction. The ed on 03/03/16 noting she				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X:	3) DATE SURVEY COMPLETED
		345411	B. WING			C 03/24/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786	E	03/24/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	was nothing the star falling. She further more confused in the "sundowning." The resident was set (NP) on 03/03/16 for pressures were noted. NP noted tremors we "worse than previous awareness, she was and her falls were greated by the surgical needs of the surgical neck was medial displaced and medial apex an ordered Resident #8 treatment of the factors."	ff could do to stop her from stated Resident #9 did get e afternoons due to een by the nurse practitioner refollowup. Her blood ed essentially normal. The rere noted at rest which were s", she had very poor safety so unaware of her surroundings enerally unwitnessed. An intricular bradycardia. The NP eations of Metoprolol (a action) and requested a On 03/24/16 at 10:01 AM the eark stated Resident #9 died gry appointment. FM, an incident report noted the floor and was found with a eff upper arm. The IDT note bound lying in the hall and it if fall. A physician's order was any of the left shoulder, left rist. Mobile X-ray results and greater tuberosity. There ement of the distal fragment gulation. The physican is to be sent to the hospital for exture. Resident #9 returned to	F3	323		
	changed. During interview on DON stated there w supervision for Resi	ng. The care plan was not 03/24/16 at 12:18 PM, the ras no written plan to increase dent #9 and the DON was often staff were expected to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	' '	E SURVEY PLETED
		345411	B. WING		03	C / 24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1 00	12-12010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	developed a tempe eating, diaphoretic laboratory testing a 03/13/16. Resident 03/16/16. On 03/24/16 at 10:2 interviewed. Nurse dementia progressi poor short term me ambulation became fractured her should interventions were	•	F 32	23		
	Nurse #4 stated she basically did not am On 03/24/16 at 2:06 Resident #9 ambula confused and staff eye on her. He was meant by frequent of the part of	6 PM the Administrator stated ated independently, was were expected to keep their unable to explain what was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C	•
	ROVIDER OR SUPPLIER NTER HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	03/24/201	<u>6</u>
(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)	COMPL	(5) LETION ATE
F 490 SS=J	NA #6, who worked 7 during interview on 03 Resident #9 was progunsteady over the last could not recall receive to visual checks and alarm used for her. During interview with to 7:00 AM, NA #7 deconfused. She stated steady up until the last started falling. She diplace. She further stated falling. She diplace is started falling. She diplace is starte	ny directions regarding tently. 200 PM to 7:00 AM, stated 8/24/16 at 7:28 PM that gressively becoming more to 3 months. She stated she wing any instruction related that she did not recall an	F4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
						c	
		345411	B. WING _		03	/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO			
				516 WALL STREET			
BRIAN CE	NTER HEALTH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		ION SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 490	Continued From page	age 85	F 4	90			
	suspected, failed t	o empower staff to make the		terminated on 3/15/16.			
	1	ment when a crime is					
	suspected, and fai	led to impose expectations that					
		be informed immediately of an		Nurse # 1 was educated on	1 3/22/16 by the		
	allegation of abuse	e, failed to impose expectations		Director of Nursing on the F	⁻ acility□s		
		re Personnel Registry (HCPR)		Policy for Abuse Prohibition			
		24 hours of an allegation of		Elder Justice Act, and the p			
		ember and failed to impose		notification of Physicians ar	•		
		he physician and responsible		Parties when a resident has	•		
	·	lents involved were notified of		condition, incident, or allega			
	allegations of abus	se and health status.		abuse/neglect. Nurse #2 no	o longer is		
	Immodiate leener	dy hogan on 02/25/16 when		employed by our facility.			
		dy began on 02/25/16 when sexually assaulted by Nurse		Resident #3 and Resident #	#4 woro		
		sident #3 told Nurse #1 she had		educated on who to report			
	· ·	#1 and the Director of Nursing		the definition of abuse on 3			
		e perpetrator to remain in the		Interdisclipnary Team.	2 11 10 Dy 1110		
		pervision for 3 additional hours.					
	_	nor the DON informed the		The facility staff, including A	Administrator		
	Administrator of th	e abuse allegation, called the		and Director of Nursing, we			
	police, called the r	esponsible party, or called the		on the facility'□s abuse pro	hibition policy		
	physician. In addit	ion, the 24 hour initial report		including who to report to, t	o contact law		
		ne HCPR within the required 24		enforcement if a suspicion			
		Jeopardy began on 02/28/16		immediately remove the alle	• .		
		nen she told Nurse #1 and		from the resident care area			
		sexually abused by NA #1, and		Administrator must be conta			
		Nurse #2, or the DON called		immediately of the allegatio			
		ninistrator immediately, the		physician must be notified,			
		or called the physician.		responsible party must be r			
		dy was removed on 03/24/16 at		Health Care Personnel Reg	jistry must be		
		facility provided and cceptable credible allegation of		notified within 24 hours.			
	'	facility remains out of		Actions Taken for those res	idents with the		
		wer scope and severity of D		potential to be affected:	Idente with the		
	· •	ctual harm with potential for		potential to be affected.			
	·	I harm, that is not immediate		On 3/3/16, Social Service D)irector		
		lete education and ensure		completed interviews with r			
		s put into place are effective		were alert, oriented and abl			
		ng residents from being abused,		questions to determine any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345411	B. WING _		03	3/24/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
DDIAN OF		DELLA DAMAYAJEOVAL I E		516 WALL STREET			
BRIAN CE	NIER HEALIH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 490	Continued From p	page 86	F 4	90			
	notifying the phys	ician and responsible parties facility's abuse policy and		unreported allegations of ab	use occurred.		
	procedure.	facility 3 abuse policy and		On 3/24/16, Social Services	e Director		
	procedure.			completed an audit of familie			
	The findings inclu	ided:		responsible parties for those			
	l			unable to participate in the p			
	Cross refer to F 1	57: Based on resident		to determine any other unre			
	interviews, respor	nsible party interviews, staff		allegations of abuse occurre			
	interviews, physic	can interviews and record					
		ty failed to inform the		On 3/3/16, the Administrator			
		es and the physician when 2 of 4		Services Director, District Di			
	staff member (Residents #3 and #4).			Operations and the District I			
			Care Management complete				
	Cross refer to E 2	23: Based on resident		with facility staff to determine	-		
		I review and staff interviews, the		unreported allegations of ab No new allegations were ide			
		aintain 2 of 4 sampled residents'		result of these interviews. In			
		sexual abuse (Residents #3		completed on 3/23/16.	norviewe were		
	,			All facility residents will be e	ducated on		
	Cross refer to F 2	25: Based on resident		the definition of abuse and v			
	interviews, staff in	nterviews, and record reviews		to by the Interdisclipnary Tea	am to be		
		o report allegations of abuse to		completed by 4/29/16.			
		report suspicion of a crime to					
		and complete and send the 24		All facility staff, including Ad			
		Health Care Personnel Registry		and Director of Nursing were			
	, , ,	ed. This affected 2 of 4		the facility'□s Abuse Prohibi			
	1	d for abuse (Residents #3 and		include removing the alleged			
	#4).			the resident care areas, to relaw enforcement officials, to	•		
	Cross refer to E 2	26: Based on resident		Administrator immediately, t	•		
		nterviews, and record reviews		physician, to notify the response			
		implement their abuse policy in		and to report to the Health C			
		ification, protection, reporting		Personnel Registry within 24			
		The facility failed to supervise					
		trator until he left the facility, call		Systems in place to ensure	the alleged		
	law enforcement	to report suspicion of a crime,		deficient practice do not rec			
		tely assess the residents for					
	injuries, failed to i	mmediately notify the		On 2/29/16, District Director	of Clinical		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	PLE CONS	TRUCTION		LETED
		345411	B. WING			1	24/2046
	ROVIDER OR SUPPLIER			516 WA	ADDRESS, CITY, STATE, ZIP CODE LL STREET ESVILLE, NC 28786	1 03/	24/2016
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From pag Administrator, and fat to the Health Care P required. This affect for abuse (Residents On 03/22/16 at 4:46 the DON were inform The Administration p credible allegation of 6:32 PM. Brian Center Waynes following allegation of abuse related to Res 02/26/16, immediate from Nurse #1 the Di CNA #1 from the Res accused did not retur terminated on 03/15/ took statements over and CNA #1 and Res 02/27/16 Resident #1 came into the Facility transferred to the hos The Director of Nursi	e 87 iled to file the 24 hour report ersonnel Registry as ed 2 of 4 residents sampled	F 4	-Th Pro 24 Hea hou imm of a rem care enfor- Phy a re inci alle Nev faci incl the law Adr phy and		aing of 24 ator t of nen and	DATE
	him of Resident #3's Resident # 4 called tallegation of abuse. Nurse #2 of same all immediately notified 02/28/16. CAN#1 wo 02/26/16 and continutacility. The Police of Resident #4 declined medical evaluation.	allegation. On 02/28/16 he Police to report an Resident #4 then notified egation. Nurse #2 then the Director of Nursing on as previously suspended on led to remain out of the came into the Facility and I to go to the hospital for A 24 Hour Report was 6, by the Director Nursing		Adr alle alle Adr crin Enf bee Car Res	ministrator/DON will audit any egations of abuse to ensure that egations have been reported to ministrator if there is a suspicion of ane that it has been reported to Law forcement, the 24-hour report has en completed and sent to the Health re Registry and the physician and sponsible Party have been notified. It is a sudit will be conducted 5 times a lek for 4 weeks and then 3 times a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	343411	B. WING_		CTREET ADDRESS SITV STATE ZID SODE	03	3/24/2016	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER HEALTH AND F	REHAB/WAYNESVILLE			516 WALL STREET			
				V	WAYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 490	Continued From pa	age 88	F4	490				
		llegation of abuse and			week for 2 months. The results of the			
		ation of abuse. The 5 Day			audits will be reported at the monthly			
	_	ted for Resident #3 and			QAPI meeting.			
		04/16 by the Administrator.			w. Thioding.			
		ducated on 03/22/16 by the			Quality Assurance measures in place to	0		
		on the Facility's Policy for			ensure the practices are sustained:			
	Abuse Prohibition i	ncluding the Elder Justice Act,						
	and the policy for n	otification of Physicians and			The Administrator and Director of Nurs	ing		
		s when Residents have a			will analyze the data obtained, and rep			
		n, incident or allegation of			patterns/trends to the Quality Assurance	е		
		Nurse # 2 last day worked in			Performance Improvement committee			
	facility was 02/28/1			monthly for 6 months. The Quality				
		e Physician of Resident #3 ation of abuse received on			Assurance Performance Improvement committee will evaluate the effectivene			
		t #3 is responsible for her own			of the above plan, and will add addition			
		fied her family on 02/29/16.			interventions based on outcomes	iai		
		rector of Nursing notified the			identified to ensure continued compliar	ice.		
		ent #4 regarding the allegation			,			
		on 02/28/16. Resident #4 is						
	responsible for her	own affairs and she notified						
	her Responsible Pa	arty on 02/28/16.						
		ts have the potential to be						
		ne alleged deficient. By						
		I Services Director completed dents who were alert, oriented						
		questions to verify no other						
		ons of abuse occurred. On						
		ministrator, Social Services						
		rector of Operations and the						
		Care Management completed						
		acility staff to verify no other						
		ons of abuse occurred No						
		re identified as a result of						
		These audits and interviews						
		03/23/16. By 03/03/16 the						
		ector completed interviews						
		were alert, oriented and able						
	to answer question	s to verify no other unreported						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		33/2-1/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	Social Services Dire families and responunable to participate verify no other unre occurred. On 03/03 Services Director, Dand the District Directompleted interview no other unreported occurred. On 03/23 completed an audit allegations of abuse the last 6 months to Responsible Party in No further Physicial as a result of these allegations were ideinterviews were conducted interviews were conducted to 2/29/16 the Dist Services re-educate the following: *The Facility's Policy include timely compression to the NC in Registry, the Elder notification to the Adabuse or neglect. *The Facility Policy and Responsible Pachange of Conditio	ge 89 e occurred. On 03/23/16 the ector completed an audit of sible parties for those resident in the prior interviews to ported allegations of abuse 8/16 the Administrator, Social District Director of Operations ector of Care Management is with all facility staff to verify allegations of abuse 8/16 the Administrator of all previously reported in previously reported in or neglect received during invalidate Physician and notification was completed. In notifications were required interviews as no new entified. These audits and inpleted on 03/23/16. Solace to ensure the alleged on the Director of Clinical end the Director of Nursing on the Director of Nursing on the Director of Abuse Prohibition to obletion of 24 Hour and 5 Day Health Care Personnel Justice Act and immediate diministrator of allegations of the Notification of Physicians arties when a Resident has a not allegation of abuse or neglect allegation of abuse or neglect.	F 4	90			
	The Director of Nurs	sing was suspended by the //29/16 pending investigation					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 03/24/2016	
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 490	the Administrator are investigation. The Director of Nursing final warning and w Improvement Plant example, maintain pallegations of abuse parties in a timely ma serious nature an immediately with fo witnesses and involved work on 03/08/16. On 02/29/16 the Distreted the Administrator was and findings, and disaccording to opport investigation. On 03/24/16 the Administrator was and an Interim Administrator was a Director of Clinical Seatility's Policy for Administrator was an in the facility free for facility will not tolerate policy for Abuse Profession of Claration of Clinical Seatility will not tolerate policy for Abuse Profession of Abuse Profession of Clinical Seatility will not tolerate policy for Abuse Profession of Abuse Profess	ge 90 eporting of abuse allegation to and timely completion of Administrator provided the with disciplinary action as a as placed on a Performance that included leading by professionalism and report expreglect to the appropriate manner, take each allegation in dinitiate the investigation allow through with interviewing ved persons upon returning to estrict Director of Operations ministrator on the Facility's pohibition, the Elder Justice Act, as for the 24 Hour and 5 Day Health Care Personnel sponsibilities to coordinate an on by ensuring timely essments, reviewing results eletermining interventions unities identified during the extreme assigned by the District Services regarding the Abuse Prohibition to include est. Education also included assional relationship with and the Resident's Right to live on abuse and neglect. The ate abuse and will follow the oblibition to investigate all as or neglect thoroughly. As	F 49	90			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			1	24/2016
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		516	EET ADDRESS, CITY, STATE, ZIP CODE WALL STREET YNESVILLE, NC 28786	1 00.	24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From pag	e 91	F4	190			
	expected to ensure t	or the Administrator is he implementation of Abuse ut the facility and maintain an idents that is free from abuse Staff including					
	housekeeping, dietal re-educated by the E Manager, and Area S Coordinator on the F Prohibition to include Education also include professional relations families and the Res facility free from aburwill not tolerate abus	ry, and therapy were Director of Nursing, Unit Staff Development Facility's Policy for Abuse The Elder Justice Act. The ded maintaining a Ship with residents and Tident's Right to live in the Se and neglect. The facility The and will follow the policy for Tinvestigate all allegations of					
	receiving this re-edu	t be allowed to work before cation. vill be educated on Abuse					
	Prohibition, the Elderesponsibility of calling suspicion of a crime, maintaining a profest residents and families live in the facility free The facility will not to the policy for Abuse allegations of abuse. This education will be Human Resource Of	r Justice Act and their ng the police for a reasonable Education will also include sional relationship with s and the Resident's Right to e from abuse and neglect. elerate abuse and will follow Prohibition to investigate all or neglect thoroughly. e completed by the Area ficer or the Director of Nurse					
	during orientation. On 02/29/16 the Adn	ninistrator and Director of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	REHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		03/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 490	Continued From pa	ge 92 ed a new system to monitor	F	490			
	events with the Div Services daily to er Policy on Abuse Pr focus call to further throughout the wee investigations and dall Licensed nurses by the Area Staff Double the Director of Nurse facility's policy for Party Notification a *A Change in Resid *When and Inciden *When an allegation Licensed Nurses are to work before received to the Policy of the Policy of the Policy of the Party Notification a *A Change in Resid *Uhen and Inciden *Uhen						
	complete a root cau regarding abuse wi Administrator and I weekly staff meetin Abuse Prohibition. leadership will reinfremain free from at A schedule has bee Administrator, begindays to include dail shifts. All staff involagreed to the schedule abuse with the schedule abuse and the schedule abuse with the schedule and the schedule abuse with the schedule abuse wit	and Director of Nursing will use analysis by 04/01/16 thin the facility. The Director of Nursing will hold gs to review and re-educate During these meetings the force the Resident's right to buse and neglect. en developed by the enning 03/24/16, for the next 7 y supervision during all 3 ved have reviewed and dule. The Admnistrator, (DON), Unit Manager (UM),					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345411	B. WING		C 03/24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	00/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 490	District Director of Opparticipate in this weethis leadership team rounding within the fa	nical Services (DDCS) or perations (DDO) will ekly schedule. A member of will be available and acility each day assessing ance of the facility staff to	F 49	90		
F 504 SS=D	complete Performand Licensed and Certified 2016, then annually. Immediate jeopardy via 8:12 PM when interviting were aware and abuse incidents immediate administrative staff, residents confirmed to training and knew the the need to report allow Administrator, the need to call the perime, the need to call the perime, the need to call the physican, and the resident and obtain a interventions for the administration for the administrat	hey had received in-service of different types of abuse, segations of abuse to the ed to compete a 24 hour and within required time frames, colice to report suspicion of a ll the responsible party and e need to evaluate the ppropriate medical affected residents.	F 50	04	5/4/16	
	This REQUIREMENT	is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345411	B. WING		03	/24/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
				516 WALL STREET			
BRIAN CE	NTER HEALTH AND	REHAB/WAYNESVILLE		WAYNESVILLE, NC 28786			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLÉTION DATE	
F 504	Continued From p	page 94	F 50	04			
	by:						
	Based on record	review and staff interview the		F 504			
	facility failed to ob	tain a physician's order for a lab					
	test for Resident #	#7. This deficient practice		Actions taken for the identif	fied resident:		
		mpled residents reviewed as					
	part of the extend	ed survey. (Resident #7).		Resident #7 was discharge 3/25/2016.	d on		
	The findings inclu	ded:					
				Actions taken for those resi	idents with the		
	Resident #7 was	admitted to the facility on		potential to be affected:			
		gnoses including diabetes					
		oronary artery disease,		The Director of Nursing, Un	•		
hyperlipidemia, chronic obstructive pulmonary and Area Staff Development							
		stage renal disease. Further		completed a lab audit on 4			
		nt #7's medical record revealed		last 30 days of labs perform			
		umin level drawn on 02/12/16.		all labs have a corresponding			
		er on Resident #7's medical		order. Lab orders will be cr			
	record for an albu	min level.		with Clinical Laboratory Ser ensure accuracy on 4/20/16			
	An interview on 0	3/24/16 at 1:00 PM with the					
	Director of Nursin	g (DON) about her expectation		Measure implemented to er	nsure the		
	for obtaining phys	sician's orders prior to		alleged deficient practice do	oes not recur:		
		sts revealed she expected					
		order before completing a lab		The Director of Nursing and			
		The DON stated the facility had		Managers will provide educ			
	discovered a prob	-		licensed nurses by 4/20/16			
		ter the former Unit Coordinator		correctly obtaining the phys			
		week ago. The DON stated she		prior to collecting labs. Unit			
		hat was an order that didn't get		audit residents receiving lat			
		ent's chart by the former UC,		weekly for 4 weeks then 3 t	•		
		ng all her assigned duties which		for 2 months to ensure lab			
		ing orders for labs and filing the dent's medical record.		place, labs have been comp			
	orders in the resid	ieni s medicai record.		physician notified and lab rechart. Results of audits wil			
	Δn interview on 0	3/24/16 at 2:04 PM with the		monthly during QAPI meeti			
		ealed he thought the problem		Inonting during QAFT meeting	ng.		
		the Albumin level not being on		Quality Assurance measure	es in nlace:		
		dical record was because of the		guality / issurance measure	o in piace.		
		n the past 2 weeks.		The Administrator and Direct	ctor of Nursing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 516 WALL STREET WAYNESVILLE, NC 28786		30.220	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 504 F 507 SS=E	Medical Records Dir didn't know why ther on Resident #7's cha any unfiled physiciar A call was placed to 03/24/16 at 4:52 PM requesting a return preturned. 483.75(j)(2)(iv) LAB LAB NAME/ADDRES The facility must file record laboratory rep	3/16 at 3:49 PM with the ector (MRD) revealed she e wasn't an order for Albumin art and stated she didn't have n's orders in her office. the Medical Director on and a message was left shone call. Call was not	F 5	will analyze the data obtained patterns/trends to Quality Ass Performance Improvement comonthly for 6 months. The Quasimance Performance Imprevaluate the effectiveness of plan, and will add additional ir based on outcomes identified continued compliance.	urance mmittee uality ovement will the above nterventions	5/4/16	
	by: Based on record revision facility failed to file revision the clinical records of This deficient practic residents reviewed a survey. (Residents # The findings included 1. Resident #2 was a 03/01/16 with diagnoral diabetes mellitus typichronic obstructive procession of Resident #2 Review of Resident #3	d: admitted to the facility on oses including cellulitis, e 2, hypertension and		F507 Actions taken for the identified Resident #2, Resident #7, at #9 no longer reside in the fact Actions taken for residents wire potential to be affected: The Director of Nursing and L Managers have performed at I which was completed by 4/20 last 30 days to ensure all label been filed in the residents me Residents were identified as	and Resident cility. th the Unit ab audit 0/16, for the results have dical record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345411	B. WING _				C 24/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	24/2010
					16 WALL STREET		
BRIAN CE	NTER HEALTH AND RE	HAB/WAYNESVILLE			VAYNESVILLE, NC 28786		
(V4) ID	SUMMMIS CO	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 507	Continued From pag	e 96	F 5	507			
	record revealed resu the record and conta and 3+ bacteria. A no Practitioner stated: "a result for the urine cu	w of Resident #2's medical Its of the urinalysis were on ined 4 - 8 white blood cells ote on the lab by the Nurse await C&S." There was no ulture on Resident #2's			affected. Labs were obtained and filed the medical record for affected residen by 4/20/16. System in place to ensure the alleged deficient practice does not recur:		
	Medical Records Diredidn't know why the redidn't know why the rewasn't on Resident # contacted the facility' a copy of the urine of the culture was positicoli), a bacteria often a clean catch urine so the culture was positicoli), a bacteria often a clean catch urine so the culture was positicoli), a bacteria often a clean catch urine so the collection of Nursing (If or lab results being of record revealed sheem edical record within obtained. The DON's Coordinator (UC) was on lab tests and make obtained and put on DON stated the UC of that was when she diffulfilling all her assign obtaining and filling later assign obtaining and filling later with lab results not be with lab results not be	s lab provider and obtained ulture results which indicated five for Escherichia coli (E. found in urine cultures when pecimen was not obtained. 4/16 at 1:00 PM with the DON) about her expectation on the resident's medical expected results to be on the 24 hours of when they were stated the former Unit is responsible for following uping sure results were the resident's chart. The quit about a week ago and iscovered that the UC wasn't ned duties which included the results. 4/16 at 2:04 PM with the ed he thought the problem eing on the resident's pecause of the UC who quit			The Director of Nursing and Unit Managers provided education for licensed nurses on 4/20/16 regarding ensuring that once the MD has been notified of the results that they are to be filed to the resident medical record. U managers will audit residents whom had labs drawn to ensure that the lab had labs drawn to ensure the stimes a week x 4 weeks then 3 time a week x 2 months and results will be reported to the monthly QAPI meeting review. Quality Measures in place to ensure the practice is sustained: The Director of Nursing will analyze the data obtained, and report patterns/tren to Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement will evaluate the effectiveness of the above plan, an will add additional interventions based outcomes identified to ensure continue compliance.	nit ave nas ord es for e e ds	
	-	the Medical Director on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345411	B. WING		C 03/24/2016			
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786				
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION			
F 507	requesting a return returned. 2. Resident #7 was 02/08/16 with diagr mellitus type 1, conhyperlipidemia, chr disease and end st review of Resident an order dated 02/0 count (CBC), basic Magnesium (Mg) le Resident #7's medior Mg level that wa An interview on 03/Director of Nursing for lab results being record revealed shemedical record with obtained. The DON Coordinator (UC) won lab tests and material obtained and put on DON stated the UC that was when she fulfilling all her assiobtaining and filing An interview on 03/Administrator reveal with lab results not	admitted to the facility on access including diabetes onary artery disease, onic obstructive pulmonary age renal disease. Further #7's medical record revealed 09/16 for a complete blood metabolic panel (BMP) and vel. There was no result on cal record for the CBC, BMP is ordered on 02/09/16. 24/16 at 1:00 PM with the (DON) about her expectation is on the resident's medical expected results to be on the in 24 hours of when they were is stated the former Unit is responsible for following up aking sure results were in the resident's chart. The equit about a week ago and discovered that the UC wasn't igned duties which included lab results. 24/16 at 2:04 PM with the alled he thought the problem being on the resident's because of the UC who quit	F 507					
	Medical Records D	23/16 at 3:49 PM with the irector (MRD) revealed she lab results weren't on						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345411	B. WING		03/24/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	1 03/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 COMPLETION
F 507	facility's lab provider lab results which income lab results which inco	The MRD contacted the and obtained a copy of the icated resident had a normal range: 12.0 - 16.5), normal range: 34.0 - 50.0), rmal range: 0.5 - 1.5). The Medical Director on and a message was left ohone call. Call was not obsess included delusional a osteoporosis, benign es and anxiety disorder. The note indicated that the remperature was coming of thargic, not eating, nmy. She was also noted to humerus secondary to a fall. Scribed as lying in bed, with coarse right lung fields. For normal saline was ordered at culture and sensitivity to a physician order was yesis on 03/13/13. 03/14/16 at 12:00 PM sis was obtained via in and and sent to the laboratory.	F 50	7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED		
		345411	B. WING _			C 03/24/2016	
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, S 516 WALL STREET WAYNESVILLE, NC 28		33/2 1120.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		1
F 507	Continued From pag	e 99	F 5	507			
	Review of the medica urinalysis was in the						
		s Director stated on 03/23/16 d look for the urinalysis					
		s Director had to obtain the boratory via fax on 03/24/16 sults were negative.					
	Nurse #4 was interviewed regarding the process for obtaining laboratory testing. Nurse #4 stated that once there was a physician's order for a lab, the nurse filled out a lab requisition and marked						
	(no longer employed making sure labs we	ther stated the unit manager,), was responsible for re drawn. He further stated ir frequently in this facility nation.					
	Director of Nursing (I for lab results being or record revealed she medical record within obtained. The DON's Coordinator (UC) wa on lab tests and mak obtained and put on a	4/16 at 1:00 PM with the DON) about her expectation on the resident's medical expected results to be on the 24 hours of when they were stated the former Unit is responsible for following uping sure results were the resident's chart. The quit about a week ago and					
	that was when she d	iscovered that the UC wasn't ned duties which included					
	Administrator reveale	4/16 at 2:04 PM with the ed he thought the problem eing on the resident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345411	B. WING		C 03/24/2016		
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
F 507 F 511 SS=D	within the past 2 wee 483.75(k)(2)(ii) RADI FINDINGS-PROMPT The facility must prorphysician of the findin This REQUIREMENT by: Based on record rev facility failed to notify results for of 1 of 3 sa #9). The findings included	pecause of the UC who quit ks. OLOGY LY NOTIFY PHYSICIAN Inptly notify the attending lags. T is not met as evidenced liew and staff interviews, the the physician of X-ray ampled residents (Resident	F 507	,			
	07/12/13. Her diagnor disorders, dementia, neoplasm of meninger. On 01/02/16 at 2:00 If Resident #9 was four room. She complaint hip and nasal pain. A was noted on the form obtained on 01/02/16 right pelvis, right elbor order dated 01/02/16 X-ray due to her bein Review of the medical in the medical record elbow.	oses included delusional osteoporosis, benign es and anxiety disorder. PM, an incident report noted and lying in another resident's ed about right elbow, right a bruise on the right elbow m. Physician orders were for X-rays of the right hip, aw and nasal bones. Another discontinued the nasal		Area Staff Development Coordinator completed a record review by 4/15/10 those residents that had received an x in the last 30 days. Physicians were notified of results and radiology report placed in medical record. System in place to ensure the alleged deficient practice does not recur: The Director of Nursing and Unit Managers educated licensed nurses 4/20/16 regarding notification to the physician when x-ray results are received at the facility. Unit Managers will audit those residents having received an x-to ensure physician was notified of the x-ray results. These audits will be	by ved t ray		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY LETED
		345411	B. WING_				24/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1 03/	24/2010
DDIAN CE	NTER HEALTH AND REI	JA DAMAVNESVILLE		516 WALL STREET			
DRIAN CE	NIER HEALIH AND REI	HAB/WATNESVILLE		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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 511	Continued From page	<u>:</u> 101	F 5	511			
	03/23/16 at 5:56 PM a locate them in the fact the pelvis and elbow Interview with Nurse a	e X-ray company via fax on after she was unable to ility. Both X-rays indicated were negative for fractures.		performed 5 times per week for and then 3 times weekly for ensure compliance. Results or audits will be reported at QAP for review.	2 months f these	s to	
	physician ordered an the X-ray to be done. X-ray was responsible were obtained. If the the end of the shift, for the next shift via report physician was notified in the chart. He reveat the reports, he would the date and who he stated the physicial	X-rays was that once a X-ray, the nurse called for The nurse who ordered the e for making sure results results were not obtained by ellow up would be done by rt. He could not recall if the d since the reports were not led that once he received stamp the report and note spoke to about the results. an came every Monday and s were in Tuesdays and		Quality Measures in place to e practice is sustained: The Administrator and Director will analyze the data obtained patterns/trends to the Quality Performance Improvement comonthly for 6 months. The Quality Assurance Performance Improcommittee will evaluate the effort the above plan, and will addinterventions based on outcomidentified to ensure continued	or of Nurs , and repo Assurance mmittee uality ovement fectivenesed addition nes	sing ort ce ss aal	
F 513 SS=D	notes related to the X no nursing notes indic discussed with the ph A call was placed to the 4:52 PM and a messareturn phone call. Call 483.75(k)(2)(iv) X-RAIN RECORD-SIGN/D.	ne physician on 03/24/16 at age was left requesting a I was not returned. Y/DIAGNOSTIC REPORT ATED In the resident's clinical ted reports of x-ray and	F 5	13			5/4/16
	This REQUIREMENT	is not met as evidenced					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C
NAME OF PE	ROVIDER OR SUPPLIER	0.04.11	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD)3/24/2016
TAPAWIE OF TH	TO VIDER OR OUT FIER			516 WALL STREET	_	
BRIAN CE	NTER HEALTH AND R	EHAB/WAYNESVILLE		WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 513	Continued From pag	ge 102	F 5	13		
	Based on record re	view and staff interviews, the (-ray results in the medical		F 513		
		pled residents (Resident #9).		Actions taken for the identified	d resident:	
	The findings include	d:		X-ray results were obtained a Resident □s #9 Medical Reco		
	Resident #9 was add	mitted to the facility on				
	07/12/13. Her diagn	noses included delusional		Actions taken for residents wi	th the	
	disorders, dementia	, osteoporosis, benign		potential to be affected:		
	neoplasm of mening	es and anxiety disorder.				
				The Director of Nursing, Unit	Managers	
	On 01/02/16 at 2:00	PM, an incident report noted		and Area Staff Development (Coordinator	
	Resident #9 was fou	ınd lying in another resident's		completed an audit of the last	30 days to	
	room. She complair	ned about right elbow, right		ensure all x-rays ordered have	e been	
		A bruise on the right elbow		obtained and are filed in the N		
		rm. Physician orders were		Record. This audit was compl	eted on	
	obtained on 01/02/1	6 for X-rays of the right hip,		4/15/16.		
	right pelvis, right elb	ow and nasal bones. Another				
	order dated 01/02/16	6 discontinued the nasal		System in place to ensure the	alleged	
	X-ray due to her bei	ng uncooperative.		deficient practice does not rec	our:	
	Review of the medic	cal record revealed no results		The Director of Nursing and U	Jnit	
	in the medical record	d of the X-rays to the pelvis or		Managers have educated lice		
	elbow.	,		by 4/20/16, to ensure x-rays a		
				when ordered, and filed in the	Medical	
	The Medical Record	s Director obtained the		Records after the physician ha	as reviewed.	
	X-rays from the mob	oile X-ray company via fax on				
	03/23/16 at 5:56 PM	l after she was unable to		Unit Managers will audit those	e residents	
	locate them in the fa	cility. Both X-rays indicated		having an x-ray to ensure x-ra	ay results	
	the pelvis and elbow	were negative for fractures.		were received and filed in the	medical	
				record. These audits will be p	performed 5	
		s Director stated on 03/24/16		times per week for 4 weeks a		
	at 8:49 AM that it wa	as the responsibility of the unit		week for 2 months to ensure	compliance	
	managers to follow t	up to ensure X-ray results		and results will be reported to	the monthly	
	were obtained.			QAPI for review.		
		#4 on 03/24/16 revealed the		Quality Measures in place to	ensure the	
	process for obtaining	g X-rays was that once a		practice is sustained:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345411	B. WING		C 03/24/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/24/2010
BRIAN CENTER HEALTH AND RE	FHAR/WAYNESVILLE		516 WALL STREET	
DIGAR OLIVER HEALTH AND RE	ENAB/WATNEOVICE		WAYNESVILLE, NC 28786	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
the X-ray to be done X-ray was responsib were obtained. If the the end of the shift, the next shift via rep any details as to why medical record. He papers were discove records. Interview with the Di 03/24/16 at 1:07 PM ordered an X-ray, th requisition, keeping Nurses then called for the X-ray results car removed, indicating were responsible for X-ray results. The Di manger, no longer e job. The DON state her all the time about formal action was ex manager has since of 483.75(I)(1) RES RECORDS-COMPL LE The facility must ma resident in accordan standards and pract accurately documen systematically organ The clinical record in information to identifi	n X-ray, the nurse called for e. The nurse who ordered the ole for making sure results eresults were not obtained by follow up would be done by wort. He was unable to recall by the X-rays were not in the further stated that often ered missing from the medical erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once the physician erector of Nursing (DON) on a revealed once with accepted the unit erector of Nursing (DON) on a revealed once with accepted professional incesting the professio	F 5	The Administrator and Director of N will analyze the data obtained, and patterns/trends to the Quality Assur Performance Improvement committe monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effective of the above plan, and will add additinterventions based on outcomes identified to ensure continued company.	report ance ee ent eness itional

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345411	B. WING		C 03/24/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	03/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 514	Continued From pag services provided; the preadmission screen and progress notes. This REQUIREMEN' by: Based on record reversacility failed to main medical documentated 1 of 9 sampled resided record failed to incluservices provided for illness and death. The findings included Resident #9 was addro7/12/13. Her diagned disorders, dementia, neoplasm of mening Nurse's notes dated revealed Resident #9 wheelchair without a room, hitting her head applied and the on continuous resident without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied and the on continuous resident #10 without a room, hitting her head applied without a room, hitting her head applied without a room resident #10 without a room resi	the 104 the results of any shing conducted by the State; This not met as evidenced where and staff interview, the tain accurate and complete ion in the medical record for ents. Resident #9's medical de nursing monitoring and or her related to falls, acute the distribution of the facility on oses included delusional osteoporosis, benign es and anxiety disorder.	F 5	DEFICIENCY)	the trof dent with view lls to urty
	review and incident record), this fall actu 3:00 AM.	report (not part of the medical ally occurred on 03/02/16 at		Systems in place to ensure the practic does not recur: Residents with an acute illness or who	5
	(SBAR) note stating 03/02/16. Interdisci incident report (not p	revealed a Situation, ement, Recommendation she fell a second time on plinary post fall review and eart of the medical record) 9 fell a second time on		have had a fall are reviewed by nursing Unit Managers will audit those resident who have had a fall and those resident with an acute illness to ensure nursing documentation is complete. These are will be performed 5 times per week for 20 weeks and then 3 times a week for 20 weeks.	nts nts g udits or 4

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345411	B. WING _				24/2016
	ROVIDER OR SUPPLIER	HAB/WAYNESVILLE		51	REET ADDRESS, CITY, STATE, ZIP CODE 16 WALL STREET 1/AYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	Weekly/Monthly sum indicated she fell this shoulder pain. The In review indicated she and her left arm was Although review of the dated 03/12/16 indicated interest of her shoulder and whospital for an evaluating the record did not incomplete the	ng notes until the Nursing mary dated 03/12/16 which date and experienced sterdisciplinary post fall was found lying in the hall swollen and painful. The physician telephone orders ated Resident #9 had a X-ray was subsequently sent to the ation of a fractured shoulder, clude nursing notes related to	F	514	months to ensure compliance. Results the audits will be reported at QAPI monthly meeting for review Quality Assurance measures implement to ensure the practice is sustained: The Administrator and Director of Nurs will analyze the data obtained, and reppatterns/trends to the Quality Assurance Performance Improvement committee monthly for 6 months. The Quality Assurance Performance Improvement committee will evaluate the effectivene of the above plan, and will add addition interventions based on outcomes identified to ensure continued compliance.	ing ort ce ss	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED			
		345411	B. WING			C 03/24/2016
	ROVIDER OR SUPPLIER	EHAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786	•	03/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pag	ge 106	F 5	14		
	responsible party re Resident #9 in hous firm decision about as leaning toward or					
	physician or the nur dated 03/15/16 at 11 of Resident #9's cor note, pre-typed to b This form was dated Resident #9 was ab at 8:10 PM and she	r progress notes either by the ses after the physician note 0:00 AM. The next indication adition or status was nurses's ecompleted at discharge. I 03/16/16 and noted sent of vital signs on 03/16/16 was discharged to the funeral signed by Nurse #3.				
	revealed she was w took her last breath, stated it was shortly family had left, and did not want Reside she did not write a r reason, but stated s	e #3 on 03/23/16 at 5:06 PM ith Resident #9 when she holding her hand. She after she came on duty, the death was imminent and she nt #9 to die alone. She stated jursing note, could give no he wrote the discharge note. staff were providing comfort int #9.				
	revealed he charted She was on comfort not being taken and end. He stated he v contact with the nur stated there probab notes regarding her	e #4 on 03/24/16 at 10:25 AM on residents "by exception." measures so vital signs were staff were waiting for the was sure the staff were in se practitioner. He further y could have been some condition and death.				
	03/24/16 at 1:07 PM	sing was interviewed on I. When asked about her ng notes related to Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		C 03/24/2016	
	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 BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 514 F 520 SS=G	out the discharge not and was sent to the f there was no other no 483.75(o)(1) QAA	n, she stated the nurse did fill the which indicated she died tuneral home and confirmed tote in the medical record.	F 514		5/4/16	
	assurance committee nursing services; a p facility; and at least 3 facility's staff. The quality assessment committee meets at I issues with respect to and assurance activities develops and implements.	ain a quality assessment and the consisting of the director of thysician designated by the stother members of the stother members appropriate plans of tified quality deficiencies.				
	except insofar as suc compliance of such of requirements of this s Good faith attempts I	ords of such committee ch disclosure is related to the committee with the section. by the committee to identify eficiencies will not be used as				
	by: Based on record rev facility's Quality Asse	Γ is not met as evidenced iew and staff interview the essment and Assurance (QA illed to maintain implemented		F520 Actions taken for the alleged deficient practice:	:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ITIEICATION NI IMBED:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
			A. BOILDII	A. BUILDING				
	345411 B. WING			03/24/2016				
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE			
RDIAN CE	NTER HEALTH AND RE	HAR/WAYNESVII I E		516	6 WALL STREET			
BRIAN CE	INTER HEALTH AND RE	HAB/WAT NESVILLE		W	AYNESVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	RECTIVE ACTION SHOULD BE COMPLETION DATE		
F 520	committee put in place for 5 deficiencies tha 2015 on a recertificate deficiencies were recomplaint survey. The areas of Services Mesupervision to Prever Obtained with a Physician of the facility during two feed a pattern of the facility effective Quality Asservices Meet Program. The findings included This tag is cross refer East: Services Meet Based on record reviracility failed to obtain wound care treatment to obtain laboratory to Resident #7. During the recertificate 2015, the facility was obtain lab tests that the physician. On the curto obtain physician's treatment and failed were ordered by the F323: Supervision to	itor the interventions that the be December 2015. This was at were cited in December tion survey. These cited on the current e deficiencies were in the ext Professional Standards, and Accidents, Labs Only sician's Order, Lab Reports uality Assessment and The continued failure of the leral surveys of record shows by's inability to sustain an essment and Assurance described by the in physician's orders for at for Resident #1 and failed ests that were ordered for tion survey of December of cited for F281 for failure to were ordered by the reent survey the facility failed orders for wound care to obtain laboratory tests that physician. Prevent Accidents: Based	F	520	Education has been provided for Administrator by District Director of Clinical on 4/15/16. Education include SAVA 's Quality Assurance and Performance Improvement Program ar the expectations associated with that program. This process enables the identification of opportunities for improvement. Root causes are identificand corrective actions are determined, monitored and followed up on to ensurimprovements are sustained. Actions taken for those residents with the potential to be affected: Quality Assurance monitoring of these areas will be completed as specified in Plan of Correction related to the recitin F281, F323, F504, and F514. Quality Assurance Committee has reviewed the meeting minutes for past three months to ensure any identified trends or action items have been completed as it relates to the previousl cited tags. Systems in place to ensure the alleged deficient practice does not recur: Education was provided on 4/15/16 for the Quality Assurance and Performance Improvement Committee members regarding the responsibilities of the Quommittee to ensure sustainability with	ed e the the g of		
	on record review and staff interviews, the facility failed to evaluate the circumstances and/or trends of falls in order to develop interventions to				identified areas of opportunity.			

PRINTED: 05/02/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345411	B. WING _			1	C 24/2016	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	24/2010	
				5	16 WALL STREET			
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				٧	WAYNESVILLE, 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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 520	Continued From page 109		F 5	520				
	reduce the number of falls or injuries.				Quality Assurance Performance			
					Improvement Committee meetings are			
		uring the recertification survey of December			being held weekly for 4 weeks and th			
		cited for F323 for failure to			monthly to discuss the deficient tags of			
	protect residents from potential environments hazards by leaving the biohazard waste of				and plans of correction. The results of any audits will be discussed by commit			
	, ,	carts unlocked. On the			members to ensure ongoing compliance			
		cility failed to evaluate the			incompose to employed england	•		
	circumstances or pattern of falls in a resident with recurring falls.				Quality Assurance measures in place:			
	FF04. Laba amb Obtained with a Physician				The Administrator sends the QAPI			
	F504: Labs only Obtained with a Physician's Order: Based on record review and staff interview				meeting minutes weekly for 4 weeks to the District Director of Operations and			
		otain a physician's order prior			District Director of Clinical for review a			
	to obtaining a lab test for one resident.				recommendations.			
	During the recertificat			The Administrator and Director of Nurs	ing			
	2015, the facility was			will analyze the data obtained, and rep				
		order prior to obtaining a lab			patterns/trends to the Quality Assurance	:e		
		On the current survey the a physician's order prior to			Performance Improvement committee monthly for 6 months. The Quality			
	obtaining a lab test for				Assurance Performance Improvement			
		ar one resident.			committee will evaluate the effectivene	SS		
	F514: Lab Reports Fi	led in Chart: Based on			of the above plan, and will add additior	ıal		
		aff interview the facility failed			interventions based on outcomes			
		atory tests in the clinical			identified to ensure continued compliar	ice.		
	records of three resid	lents.						
	During the recertificat	tion survey of December						
	2015, the facility was	cited for F514 for failure to						
		accurate medication orders.						
		the facility failed to file the						
		ests in the clinical records of						
	three residents.							
	F520 Quality Assessr	ment and Assurance						
	Program: Based on re	ecord review and staff						
		Quality Assessment and						
	Assurance (QA and A	A) Committee failed to						

Facility ID: 923009

AND PLAN OF CORRECTION IDENTIFICATIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345411	B. WING			C 03/24/2016	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				STREET ADDRESS, CITY, STATE, ZIP CO 516 WALL STREET WAYNESVILLE, NC 28786	•	0/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 520	maintain implemente the interventions that in December 2015. During the recertifica 2015, the facility was maintain compliance since the previous re 02/27/15. On the currecurring noncomplia F514 and F520. An interview was helewith the Director of Nexpectation for obtainincluding wound care The DON stated she order for anything that When asked about the falls and the lack of a DON stated she didned do because the independently. When expectation for havin obtaining laboratory to laboratory tests should physician's order. An interview on 03/24 Administrator about the non-compliance at F2 revealed he thought not being on the residuance of the other isses Coordinator who quit The Administrator states.	Continued From page 110 maintain implemented procedures and monitor the interventions that the committee put in place in December 2015. During the recertification survey of December 2015, the facility was cited for F520 for failure to maintain compliance at F253, F312 and F514 since the previous recertification survey of 02/27/15. On the current survey the facility had recurring noncompliance at F 281, F323, F504, F514 and F520. An interview was held on 03/24/16 at 1:00 PM with the Director of Nursing (DON) about her expectation for obtaining orders for treatments including wound care and medicated ointments. The DON stated she expected staff to have an order for anything that was put on the resident. When asked about the resident with recurring falls and the lack of a change in interventions, the DON stated she didn't feel there was much they could do because the resident ambulated independently. When asked about her expectation for having a physician's order prior to obtaining laboratory tests, the DON stated no laboratory tests should be obtained without a		20			