PRINTED: 07/05/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345493	B. WING _				C <b>10/2016</b>
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
					04 COLLEGE DRIVE		
HENDERS	ONVILLE HEALTH AND	REHABILITATION			LAT ROCK, NC 28731		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	FC	000			
F 241 SS=D		e cited as a result of the on. Event ID #56XD11. AND RESPECT OF	F 2	241			7/8/16
	manner and in an en	mote care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.					
	by: Based on record revinterviews, the facility while assisting them reviewed for dignity ( The findings included 1. Resident #25 was 08/29/13. Her diagnon-Alzheimer's dem reflux disease. According to Minimum 03/29/16, Resident # severely impaired. The #25 as having minimum unclear speech, and with all activities of depension physical assist The care plan dated #25 as having impair self-care deficits that with ADL that include goal specified the Refrom immobility compared.	admitted to the facility on uses included hypertension, mentia, and gastroesophageal on Data Set (MDS) dated 25's cognition was coded as the MDS specified Resident all difficulty in hearing, required total assistance ally living (ADL) care and one			Preparation and or execution of this pl does not constitute admission or agreement by the Provider of the truth facts alleged or conclusion set forth on statement of deficiencies. The plan is prepared and or executed solely becaut it is required by the provisions of the St and Federal law.  The affected residents will be observed for 3 meals per day for the first week at then 1 meal per week thereafter for 1 month by the charge nurse. Counsellin of CNA #5 was completed 6/11/2016.  Education of all CNAs as to sitting while feeding was completed 7/5/2016.  Observations will be made by Charge nurses, Unit Managers or other designated staff for all meals of dependent residents weekly for 4 week then monthly for 2 months.	of the use eate	
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u> =		TITLE		(X6) DATE

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

06/30/2016

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

**Electronically Signed** 

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	` ,	(X3) DATE SURVEY COMPLETED	
		345493	B. WING _			C	
NAME OF P	ROVIDER OR SUPPLIER	343433	S:	STREET ADDRESS, CITY, STATE, Z		06/10/2016	
NAME OF T	NOVIDEN ON 3011 EIEN			104 COLLEGE DRIVE	II CODE		
HENDERS	SONVILLE HEALTH AND	REHABILITATION					
				FLAT ROCK, NC 28731			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 241	Continued From page 1		F 2	241			
	ADL that included fee basis. On 06/07/16 at 1:15 observed delivering a room. NA #5 knocked before entry. She platable and began to s #25 was sitting on he started to feed Resid NA #5's right hand wo find the time during the Throughout the course observed standing at feeding was complet An interview was cor 06/07/16 at 1:41 PM nurse aide in the fact recalled feeding train the orientation when She indicated feeding the same level with the Residents in the dinitial about feeding Reside An attempt to intervie at 3:04 PM was unsuimpaired cognition. In an interview with 106/10/16 at 3:58 PM hired staff were offer preceptorship that rattraining was part of the expectation for the same level with the Feeding, regardless of the dining room or in	PM, Nurse Aide (NA) #5 was a lunch tray to Resident #25's d on the Resident's door aced the tray on the bedside et up the tray while Resident er Geri chair. Then, NA #5 lent #25 with her left hand. as rested on her waist most er feeding process. See of feeding, NA #5 was and facing Resident #25. The ed at 1:22 PM. Inducted with NA #5 on a She started she worked as a fility for seven years. She sing was included as part of she started in this facility. In the Resident when feeding and room, but became unsure		The DON/designee will see results will be submitted committee monthly for 3 determine the continued frequency of monitoring.	to the QAPI months to need and		
	02/18/11. Her diagno	s admitted to the facility on ses included hypertension, depression, and seizure					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(	c l
		345493	B. WING _				10/2016
NAME OF PR	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2010
				10	04 COLLEGE DRIVE		
HENDERS	ONVILLE HEALTH AND	REHABILITATION			LAT ROCK, NC 28731		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 241	Continued From page	2	F 2	241			
	disorder.						
	Resident #122's Minir	num Data Set (MDS) dated					
	04/05/16 indicated he	r cognition as severely					
		pecified Resident #25 as					
		h, impaired vision, and					
		nce with all activities of daily					
	living (ADL) care and						
	assistance with eating						
	•	02/16 identified Resident					
	self-care deficits that	red physical mobility with					
		ed total assistance with all					
		ncluded feeding. The care					
		e Resident would remain					
		omplications. Interventions					
	_	sident with ADL such as					
		dressing as needed on an					
	ongoing daily basis.						
	On 06/07/16 at 1:24 F	PM, Nurse Aide (NA) #5 was					
	observed delivering a	lunch tray to Resident					
		nocked on the Resident's					
		ne placed the tray on bed					
		et up the tray while Resident					
		r bed. NA #5 raised the bed					
		ree angle, then started to					
		vith her left hand. NA #5's ved leaning on Resident					
	#122's bed rails most						
		#5 was observed standing					
	• .	\$122 throughout the course					
	of feeding that comple	<del>-</del>					
	An interview was con-						
		She stated she worked as a					
		ity for seven years. She					
		ng was included as part of					
		she started in this facility.					
		staff were required to sit at					
	the same level with th	e Resident when feeding					
	Residents in the dinin	g room, but became unsure					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345493	B. WING		C 06/10/2016
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  104 COLLEGE DRIVE  FLAT ROCK, NC 28731	00/10/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 241 F 242 SS=D	06/10/16 at 3:04 PM severely impaired or In an interview with 06/10/16 at 3:58 PM hired staff were offe preceptorship that ratraining was part of her expectation for the same level with the feeding, regardless room or in the Resident Has the schedules, and healther interests, assessinteract with member inside and outside the about aspects of his are significant to the sampled residents where the sampled residents where the sampled residents were referred each weel staff.	emts in their room.  ew Resident #122 on  I was unsuccessful due to her ognition.  Director of Nursing (DON) on  I, she stated that all the newly red an orientation and anged from 3-7 days. Feeding the orientation process. It was he feeding staff to sit at the Resident when performing the feeding was in the dining lents' room.  TERMINATION - RIGHT TO  e right to choose activities, th care consistent with his or sments, and plans of care; ers of the community both the facility; and make choices or her life in the facility that a resident.  T is not met as evidenced and staff interviews and acility failed to provide 3 of 5 with the number of showers of who were reviewed for	F 24	The affected residents have been interviewed as to the number of showe preferred each week and staff will com with an acceptable number on the	
	The findings include  1. Resident #71 was 11/25/15. Her diagne	admitted to the facility on		resident's part. 6/29/16  All residents will be asked by the Social Worker's/Designee as to the number of showers preferred each week and what acceptable to the resident.	f

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ISTRUCTION		DATE SURVEY COMPLETED
	345493	B. WING _				C 06/10/2016
	D REHABILITATION		104 C	OLLEGE DRIVE		00/10/2010
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
walking.  Resident #71's Mini 05/25/16 coded her requiring physical he assistance with bath Review of Resident revealed the followir (Activity of Daily Liviphysical mobility red ADL's & toileting. Reesily". Care plan a allow resident choic and "Provide bed m bathing & hygiene a basis."  Review of Resident revealed she was so showers per week of Saturdays during the On 06/07/16 at 4:25 during an interview how many times a with The resident stated a week on Wednesoresident specified the four showers per we staff had never aske than two showers per interview on 06/08/1 stated she would lik week on Mondays, Wednesdays, Friday resident stated she	mum Data Set (MDS) dated as having intact cognition and elp with one person physical ining.  #71's current care plan no "Problem/Need"; "ADL ng) Deficits: Impaired quiring daily staff assist with esident fatigues persoaches included; "If able, es to promote independence" obility, transfers, toileting and is needed on an ongoing  #71's current care guide cheduled to receive two in Wednesdays and e 7:00 AM to 3:00 PM shift.  PM, Resident #71 stated chat she did not get to choose week she received a shower. She received a shower twice days and Saturdays. The lat she would like to receive each she week. During a follow up 6 at 4:05 PM, Resident #71 et to receive four showers per lays and Saturdays. The had asked staff at times to	F2	Stree earling the short of the	sident's preferred number of show ach week. Each new admission with formed of facility practice and then at is acceptable.  The Social Workers will review residuate records weekly for 12 weeks as ure resident requests are being proored. Results of the audits will be viewed by the QAPI committee more 3 months to ensure compliance agreemine continued need and frequents.	ers II be ask if ents s to e onthly	
	SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY OF Continued From page walking.  Resident #71's Minit 05/25/16 coded her requiring physical he assistance with bath Review of Resident revealed the followir (Activity of Daily Livi physical mobility red ADL's & toileting. Re easily". Care plan ar allow resident choice and "Provide bed me bathing & hygiene a basis."  Review of Resident revealed she was so showers per week o Saturdays during the On 06/07/16 at 4:25 during an interview thow many times a w The resident stated a week on Wedneso resident specified th four showers per we staff had never aske than two showers per interview on 06/08/1 stated she would like week on Mondays, Wednesdays, Friday resident stated she is provide her with mo	OVIDER OR SUPPLIER  DNVILLE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4 walking.  Resident #71's Minimum Data Set (MDS) dated 05/25/16 coded her as having intact cognition and requiring physical help with one person physical assistance with bathing.  Review of Resident #71's current care plan revealed the following "Problem/Need"; "ADL (Activity of Daily Living) Deficits: Impaired physical mobility requiring daily staff assist with ADL's & toileting. Resident fatigues easily". Care plan approaches included; "If able, allow resident choices to promote independence" and "Provide bed mobility, transfers, toileting and bathing & hygiene as needed on an ongoing basis."  Review of Resident #71's current care guide revealed she was scheduled to receive two showers per week on Wednesdays and Saturdays during the 7:00 AM to 3:00 PM shift.  On 06/07/16 at 4:25 PM, Resident #71 stated during an interview that she did not get to choose how many times a week she received a shower. The resident stated she received a shower twice a week on Wednesdays and Saturdays. The resident specified that she would like to receive four showers per week During a follow up interview on 06/08/16 at 4:05 PM, Resident #71 stated she would like to receive four showers per	OVIDER OR SUPPLIER  DNVILLE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  walking.  Resident #71's Minimum Data Set (MDS) dated 05/25/16 coded her as having intact cognition and requiring physical help with one person physical assistance with bathing.  Review of Resident #71's current care plan revealed the following "Problem/Need"; "ADL (Activity of Daily Living) Deficits: Impaired physical mobility requiring daily staff assist with ADL's & toileting. Resident fatigues easily". Care plan approaches included; "If able, allow resident choices to promote independence" and "Provide bed mobility, transfers, toileting and bathing & hygiene as needed on an ongoing basis."  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The resident stated she had asked staff at times to provide her with more than two showers per	ONVILLE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  walking.  Resident #71's Minimum Data Set (MDS) dated 05/25/16 coded her as having intact cognition and requiring physical help with one person physical assistance with bathing.  Review of Resident #71's current care plan revealed the following "Problem/Need"; "ADL (Activity of Daily Living) Deficits: Impaired physical mobility requiring daily staff assist with ADL's & toileting. Resident fatigues easily". Care plan approaches included; "If able, allow resident choices to promote independence" and "Provide bed mobility, transfers, toileting and bathing & hygiene as needed on an ongoing basis."  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The resident stated she had asked staff at times to provide her with more than two showers per	OVIDER OR SUPPLIER  DIVILLE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  Walking.  Resident #71's Minimum Data Set (MDS) dated 05/25/16 coded her as having intact cognition and requiring physical help with one person physical assistance with bathing.  Review of Resident #71's current care plan revealed the following "Problem/Need"." *ADL (Activity of Daily Living) Deficits: Impaired physical mobility requiring daily staff assist with ADL's & toileting. Resident fatgues easily". Care plan approaches included; "If able, allow resident choices to promote independence" and "Provide bed mobility, transfers, toileting and bathing & hygiene as needed on an ongoing basis."  Review of Resident #71's current care guide revealed she was scheduled to receive two showers per week on Wednesdays and Saturdays. The resident specified that she would like to receive four showers per week he accessed a shower. The resident specified that she would like to receive four showers per week because she sweats, but staff had never asked her if she wanted more than two showers per week could like to receive four showers per week because she sweats, but staff had never asked her if she wanted more than two showers per week on Mondays,  Wednesdays, Fridays and Saturdays. The resident stated she had asked staff at times to provide her with more than two showers per week head asked staff at times to provide her with more than two showers per	OWIDER OR SUPPLIER  DNVILLE HEALTH AND REHABILITATION  SUMMARY STATEMENT OF DEFCICIENCIES (EACH DEPICIENCIES (EACH DEPICIENCE OF THE PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCE OF THE APPROPRIATE DEPICIENCY) (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  Continued From page 4 walking.  Continued From page 4 walking.  Continued From page 4 walking.  Resident #71's Minimum Data Set (MDS) dated obj25/16 code her as having intact cognition and requiring physical help with one person physical assistance with bathing.  Review of Resident #71's current care plan revealed the following "Problem/Need"; "ADL (Activity of Dally Living) Deficits: Impaired physical mobility requiring daily staff assist with ADL's & toileting. Resident fatigues assily". Care plan approaches included; "If able, allow resident choices to promote independence" and "Provide bed mobility, transfers, toileting and bathing & hygiene as needed on an ongoing basis."  Review of Resident #71's current care guide revealed she was scheduled to receive two showers per week on Wednesdays and Saturdays. The resident stated she received a shower. The resident stated she received a shower. The resident stated she received a shower wice a week on Wednesdays and Saturdays. The resident stated she would like to receive four showers per week because she sweats, but staff had never asked her if she wanted more than two showers per week During a follow up interview on 60/60/816 at 4.25 PM, Resident #71 stated she would like to receive four showers per week on Wondows, Wednesdays, AFD PM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345493	B. WING		0.	C 6/ <b>10/2016</b>	
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 104 COLLEGE DRIVE FLAT ROCK, NC 28731		0/10/2010	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	10:30 AM. NA #1 states schedule was posted Resident #71 was so showers per on Wedner the resident required and is always ready to showers. NA #1 explained residents were offered if a resident requested would do the best the resident's request.  Interview with the Dir 06/10/16 at 11:15 AM the facility residents were not introceive two showers residents were not introceive more than two week if they preferred staff would begin to into admission that most showers per week conthey are aware that a scheduled showers we stated when a resident than two showers per accommodate this residents and their fact coordinator on 06/10 residents and their fact informed during the aresidents received two	who provided care to terviewed on 06/10/16 at ted the resident shower in the clean utility room and heduled to receive two nesdays and Saturdays of 3:00 PM shift. NA #1 stated assistance with showers or receive her scheduled ained to her knowledge dined to her knowledge dined to try to honor the ector of Nurses (DON) on a revealed on admission to the ector of Nurses (DON) on a revealed on admission to the end of the provided showers per different that they could the scheduled showers per different that they could on scheduled showers per different than two scheduled und be requested to ensure request for additional transport to the staff should quest.  Illity's Admissions /16 at 2:25 PM, revealed	F 24	42			

			PLETED				
		345493	B. WING			1	C 10/2016
	ROVIDER OR SUPPLIER			104 (	EET ADDRESS, CITY, STATE, ZIP CODE  COLLEGE DRIVE  T ROCK, NC 28731	1 00/	10/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 242	residents were not as preferences or inform to receive more than week.  2. Resident #319 wa 06/02/16. Her diagnod aortocoronary bypas failure.  Review of Resident # Evaluation dated 06/ and oriented, able to required assistance of the revealed she was to week on Tuesdays a AM to 3:00 PM shift.  On 06/07/16 at 3:53 during an interview the facility and receive per week. The resident per week, but no one has with more showers.	sked about their shower ned that they could request two scheduled showers per admitted to the facility on oses included presence of signaft and congestive heart and salert understand others and with bathing.  #319's current care guide receive two showers per not Fridays during the 7:00  PM, Resident #319 stated not she was a new admission to seek she received a shower. She was a new admission to seek two scheduled showers ent specified she would be than two showers per diever offered to provide her The resident stated that her	F2	242	DEFICIENCY)		
	week or a shower ever follow up interview of Resident #319 stated facility last week and choice about how may receive each week. Was informed by staff showers per week and state of the st	to receive four showers per ery day if possible. During a n 06/09/16 at 11:36 AM, d she was admitted to the no one provided her with a any showers she could The resident explained she if that she would receive two nd staff never asked her eferences. The resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	L COV		TE SURVEY MPLETED	
		345493	B. WING _			C 06/10/2016	
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 104 COLLEGE DRIVE FLAT ROCK, NC 28731	•	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 242	Interview with the D 06/10/16 at 11:15 A the facility residents receive two shower residents were not it receive more than the week if they preferred staff would begin to of admission that mushowers per week of they are aware that scheduled showers stated when a reside than two showers per accommodate this resident #319, was 11:57 AM. NA #2 stated the facility for about a the facility for a the facility for about a the facility for a the facili	rirector of Nurses (DON) on M revealed on admission to were informed they would so per week. The DON stated informed that they could wo scheduled showers per ed. The DON explained that inform residents at the time ore than two scheduled could be requested to ensure a request for additional was permissible. The DON ent requested to receive more er week the staff should	F2	242			
	residents and their t	acility's Admissions 0/16 at 2:25 PM, revealed family members were admission process that					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345493	B. WING _			C 06/10/2016
	ROVIDER OR SUPPLIER	REHABILITATION		STREET ADDRESS, CITY  104 COLLEGE DRIVE  FLAT ROCK, NC 28		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	
F 242	residents received tw week. The Admissior residents were not as preferences or inform	e 8  yo scheduled showers per ns Coordinator stated that sked about their shower ned that they could request two scheduled showers per	F2	42		
	03/09/16 with diagnomuscle weakness an Resident #160's Qua (MDS) dated 05/22/1 intact. The MDS special having moderate diffivision, and required with personal hygiene assistance with bathin The care plan dated #160 as having activity deficits that required ADL which included I included providing Resident includes including the was scheduled to weekly on Monday at In an interview on 06 #160 stated he had resident included providing the admission coabout his shower free the admission process he would get shower admission. According	arterly Minimum Data Set 6 indicated his cognition was cified Resident #160 as culty in hearing, impaired extensive staff assistance e and one person physical ng. 03/29/16, identified Resident ities of daily living (ADL) extensive assistance with cathing. Interventions esident choices to promote  #160's bath roster revealed receive showers twice				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345493	B. WING			C <b>06/10/2016</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<b></b> E	06/10/2016	
				104 COLLEGE DRIVE			
HENDERS	SONVILLE HEALTH AND	REHABILITATION		FLAT ROCK, NC 28731			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	Continued From page	9	F 2	242			
F 428 SS=D	been told he could haweek. Interview with Nurse AM revealed Resider twice weekly based or room number. She rehad requested once to for her husband. Nurse and requests if her busy soon 06/10/16 at 11:42 Coordinator was interested on the had informed addressed to be offered added the admission informing admitting Report to be offered added the admission informing admitting Report to the property of the property o	Aide #4 on 06/10/16 at 10:41 at #160 received showers in a schedule determined by ported Resident #160's wife to have additional showers as Aide #4 stated she would attend additional shower schedule permitted.  AM, the Admission viewed and explained that mitting Residents or families in two showers weekly. She process did not include esidents or families of a f showers.  Cted on 06/10/16 at 3:09 cursing (DON) stated that additional shower in the facility would request to the fullest admission staff to inform admission. The DON ware of Resident #160's nowers once every other tation for the nurse aides to over frequency preferences sidents' preferences with the GIMEN REVIEW, REPORT		128		7/8/16	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUC		, ,	(X3) DATE SURVEY COMPLETED		
		345493	B. WING			C 6/10/2016
	ROVIDER OR SUPPLIER	D REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 104 COLLEGE DRIVE FLAT ROCK, NC 28731		0/10/2010
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	the attending physic nursing, and these	est report any irregularities to cian, and the director of reports must be acted upon.	F 42	28		
	by: Based on record reinterviews, the facilic consultant pharmaco of 5 sampled reside for unnecessary me The findings include Resident #160 was 03/09/16 with diagn mellitus (DM), depre The quarterly Minim 05/22/16 coded Resintact. The MDS spendaving moderate diffusion, and required with activities of dai The care plan dated #160 as having a pescondary to DM. The Resident would complications related included continuous symptoms of hypoghyperglycemia. In a 03/29/16, Resident potential risk of drug drug usage. The care psychotropic medical resident medical resident would rempsychotropic medical resident medical resident would rempsychotropic medical resident resident medical resident would rempsychotropic medical resident medical resident medical resident resident medical resident reside	admitted to the facility on oses which included diabetes ession, and anxiety disorder. The facility on oses which included diabetes ession, and anxiety disorder. The facility of the facility		The affected resident's pharm recommendations were follow with the attending physician. 6/27.  The monthly pharmacy report reviewed for timeliness of the response by the DON/Design physician does not respond to pharmacist recommendation. Medical Director/designee will recommendation and respond. The DON/designee will review pharmacy report monthly to e recommendations have been and responded to by the physical time of the next pharmacy. The DON/designee will report timeliness of completion of the recommendations monthly at compliance and determine conneed and frequency of monitors.	wed up on 6/9, 6/10,  It will be exphysicians' nee. If the othe timely, the ll review the d.  We the ensure that all reviewed sician prior to by review.  It the nee pharmacy on to ensure continued	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345493	B. WING				C <b>10/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
HENDERS	ONVILLE HEALTH AND	REHABILITATION			4 COLLEGE DRIVE .AT ROCK, NC 28731		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page	e 11	F.	428			
F 428	reporting of behavior needed. A review of the facility monthly medication revealed the MRRs we month since Resident consultant pharmacis 04/21/16 indicated he recommendations to Nursing (DON) for Resident Pharmacis (DON) for Resident Pharmacis (DON) for Resident Physician records of following recommenders a trial disconsidered increased the or considered increased the dosage multiple finger sticks (All the above recommended the above recommended the phymedical records was Further review of Resident Physician of the physician of	abnormality to physician as  consultant pharmacist egimen review (MRR) cere conducted once each t #160's admission. The t's monthly MRR dated had documented four the physician/Director of esident #160. Review of the ist Communication to ated 04/21/16 revealed the ations: continued need for Zyprexa continued need for Zyprexa continuation. easing Aggrenox to once d of once every morning to turer recommendations. Ing Lisinopril 2.5 milligram opropriate for Resident's DM. rersion of sliding scale to egimen of Lantus, or of glimepiride to eliminate daily. Inendations were not signed sician when Resident #160's reviewed on 06/09/16. Sident #160's medical was no documentation to out pharmacist's d been addressed or acted of follow-up had been done of the review of the t's initial recommendations 16. PM, an interview was ON. She stated the		428			
	physician had only or	ne Resident in this facility. Eceived the consultant					

ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
345493	B. WING _	B. WING		C 06/10/2016	
	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		00.1	0.2010
HENDERSONVILLE HEALTH AND REHABILITATION		104 COLLEGE DRIVE			
		FLAT ROCK, NC 28731			
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	SHOULD BE		(X5) COMPLETION DATE
	F4	428			
copies to the physician's ay. For the month of April e consultant pharmacist's d been delivered to the 04/22/16. Incted on 06/09/16 at 6:12 narmacist stated that he d 1-2 hours with DON and wer his findings and er the completion of monthly print the recommendations anded it to the DON. The et to transmit the the respective physicians in a consultant pharmacist ceive a response from the earne back for the next MRR, recommendation(s). He adations for Resident #160 in the physician. In d 05/19/16 indicated the est did resend one garding the continued need ar recommendations from follow-up with the other ons.  PM, an attempt to conduct a the physician was unavailable and exphone message. View conducted on 06/10/16 specified she should have all Director in a timely manner ario occur again. In addition, ow-up with the consultant lendations if it had not been					
	IDENTIFICATION NUMBER: 345493	REHABILITATION  ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  The total consultant pharmacist's deen delivered to the 04/22/16. Incted on 06/09/16 at 6:12 harmacist stated that he did 1-2 hours with DON and wer his findings and er the completion of monthly print the recommendations anded it to the DON. The exit to the physicians in the consultant pharmacist creive a response from the lamb back for the next MRR, recommendation(s). He exit did resend one garding the continued need in recommendations from follow-up with the other ins.  PM, an attempt to conduct a the physician was unavailable and exphone message. View conducted on 06/10/16 specified she should have all Director in a timely manner ario occur again. In addition, ow-up with the consultant tendations if it had not been	REHABILITATION  REPRESENT AND CODE PREFIX  REAGE OF REFICE PROVIDER'S PLAN OF CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND CODE REPRESENT AND CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  REPRESENT AND REMARKS REHABILITATION  FEATURE STATE, ZIP CODE (REACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)  F 428  F 428	A BUILDING  345493  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  104 COLLEGE DRIVE FLAT ROCK, NC 28731  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (ECAC CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  P 428  Lendations in hard copy, she copies to the physician's ay. For the month of April e consultant pharmacist's d been delivered to the  D4/22/16. Loted on 06/09/16 at 6:12 narmacist stated that he at 1-2 hours with DON and wer his findings and er the completion of monthly print the recommendations anded it to the DON. The et the respective physicians in consultant pharmacist Leive a response from the ame back for the next MRR, recommendation(s). He dations for Resident #160 h the physician. d 05/19/16 indicated the t did resend one garding the continued need or recommendations from follow-up with the other ins. PM, an attempt to conduct a the physician was ysician was unavailable and ap phone message. view conducted on 06/10/16 specified she should have il Director in a timely manner ario occur again. In addition, ow-up with the consultant tendations if it had not been	DENTIFICATION NUMBER:   A BUILDING   COMPL   COMPL