DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING			
							C
		345312	B. WING	_		12/	21/2016
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE		
					HENDERSONVILLE, NC 28791		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	E	(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIATE			DATE	
					DEFICIENCY)		
			1				
F 000	INITIAL COMMENTS		F	00	0		
	1. 483.25 (F323) at J	l					
		began on 12/06/16 when					
	Resident #2 went out	side with his oxygen tank					
		nnula in his nares, and lit a					
	0	ed in him catching himself					
	-	cond degree facial and hand					
	extinguish the fire and	t effectively attempt to					
	•	te jeopardy was removed on					
		when the facility provided					
	and implemented an						
	-	nce. The facility remains out					
	of compliance at a low	ver scope and severity of D					
	-	al harm with potential for					
		irm that is not immediate					
		e education and ensure					
		ut into place are effective to prevent accidents.					
		to prevent accidents.					
	2. 483.75 (F490) at J						
	· · ·	egan on 12/06/16 when					
	Resident #2 went out	side with his oxygen tank					
	-	nnula in his nares, away					
	from the designated s	-					
	-	ed in him catching himself					
	-	cond degree facial and hand					
		who was in a nearby area dent, failed to effectively					
		aw Resident #2 on fire. She					
		e outside blocking the facility					
		nd the building to the front					
	door while calling 911	in order to obtain additional					
	staff assistance. Imm						
		at 3:26 PM when the facility					
		ented an acceptable credible					
	allegation of compliar	nce. The facility remains out					
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(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.

01/20/2017

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345312	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			870 PISGAH DRIVE IENDERSONVILLE, NC 28791		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	of compliance at a low (isolated with no actu more than minimal ha jeopardy) to complete monitoring systems p related to supervision smoking material stor to extinguish a reside 3. 483.75 (518) at J Immediate Jeopardy I Resident #2 went out running, the nasal car from the designated s cigarette which result on fire resulting in sec burns. Nurse Aide #1 at the time of the incid out the flames via the fire blanket which wer resident on fire outsid as she attempted to c another facility door. removed on 12/21/16 provided and impleme allegation of complian of compliance at a low (isolated with no actu more than minimal ha jeopardy) to complete monitoring systems p related to staff being resident who is on fire An amended Stateme	wer scope and severity of D al harm with potential for irm that is not immediate e education and ensure ut into place are effective , oxygen storage and use, rage and staff preparedness int who is on fire. began on 12/06/16 when side with his oxygen tank nula in his nares, away smoking area and lit a ed in him catching himself cond degree facial and hand who was in a nearby area dent, failed to attempt to put use a fire extinguisher or re nearby. She left the le blocking the facility door obtain assistance by entering Immediate jeopardy was at 3:26 PM when the facility ented an acceptable credible nce. The facility remains out wer scope and severity of D al harm with potential for irm that is not immediate e education and ensure ut into place are effective prepared to extinguish a e. ent of Deficiencies was y on 01/24/17 to correct hat were in the original CMS	F	000			

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		ND HUMAN SERVICES			PRINTED: 02/15/2017 FORM APPROVED OMB NO. 0938-0391			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345312	B. WING		12/21/2016			
	ROVIDER OR SUPPLIER	ENDERSONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION			
F 323 SS=J			F 323		1/20/17			
	(d) Accidents. The facility must ensu	ure that -						
	(1) The resident envir from accident hazard	ronment remains as free s as is possible; and						
		eives adequate supervision es to prevent accidents.						
	(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.							
	(1) Assess the reside from bed rails prior to	ent for risk of entrapment installation.						
		and benefits of bed rails with ent representative and obtain or to installation.						
	This REQUIREMENT	ed's dimensions are sident's size and weight. 「 is not met as evidenced						
	interviews, and reside failed to keep 2 of 2 s smoked and utilized of smoking with their ox back of their wheelch Resident #2 sustaine face and hand when	ygen tanks connected to the airs (Residents #2 and #4). d 2nd degree burns to his his oxygen tubing ignited as his oxygen cannula in place		F323 1. On 12/6/16 Resident #2 was immediately assessed by the Char Nurse and the EMS Responder the transferred to the Emergency Rood further evaluation and admission. returned to the facility on 12/7/16 a declined to smoke since his hospitalization. Resident #4 discharged from the fa	en m for He and has			

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		O. 0938-03 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	. ,	IPLETED	
				·	с		
		345312	B. WING		1:	2/21/2016	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI			
				1870 PISGAH DRIVE			
BRIANCI	R HEALTH & REHAB/HE	ENDERSONVILLE		HENDERSONVILLE, NC 2879	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 323	Continued From page	e 3	F 32	23			
		ent an effective intervention		on 1/7/17.			
	to extinguish the fire			Summary of event:			
		t #4 was observed smoking		On 12/6/16 at approxima	ately 8:30pm		
		on with her oxygen tank on		Resident # 2 was observ			
		Ichair but turned to the off		the 400 Hall Door near the	he Resident and		
	position.			Staff smoking area by C	NA #1 who was		
				exiting the facility, she di			
		began on 12/06/16 when		Resident #2 was smokin	-		
		side with his oxygen tank		walked past Resident # 2			
		nnula in his nares, and lit a		smoking area less than			
		ted in him catching himself		she turned to sit down at			
	-	cond degree facial and hand ot effectively attempt to		she noticed flames at Re and hands. CNA#1 imm			
	extinguish the fire and	• •		that Resident # 2 had an	•		
	-	ite jeopardy was removed on		his wheelchair and a car			
		when the facility provided		she attempted to turn of			
	and implemented an	÷ -		the regulator but Reside			
		nce. The facility remains out		his arms and had position	÷		
		wer scope and severity of D		the back of the wheelcha			
	(isolated with no actu	al harm with potential for		door and she was unable	e to reach the		
	more than minimal ha	arm that is not immediate		regulator. She was also	o unable to		
		e education and ensure		re-enter the facility for he	elp because the		
		out into place are effective		wheelchair was blocking			
		n to prevent accidents.		was reluctant to cover th the Fire Blanket for fear	of trapping more		
	The findings included			oxygen and worsening 1 CNA#1 then ran around	the left corner of		
		noking / Tobacco Use Policy,		the facility and called 91	-		
	revised November 20	is NOT permitted while		as she was running to th			
	oxygen is in use." and			facility for help. As she e she notified the Charge	-		
		u tain all smoking materials as		Supervisor #1. Charge I			
		ibute smoking materials to		immediately ran to the 4			
	residents at smoking	-		Resident #2 was no long			
				he had extinguished the			
	The facility's Oxygen	Storage and Assembly		returned to his Resident			
		007 included "Do not smoke		the Charge Nurse #1 en			
	or allow others to sm	oke within 10 feet while		Resident Room #207 sh			
	oxygen is in use."			Resident #2 had applied	his pobulizor		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-	-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		345312	B. WING		- 12/21/2010	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
BRIAN CI	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 2875	91	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT	ETIO
F 323	Continued From page	e 4	F 32	23		
	1. Resident #2 was a 06/03/16. His diagnor respiratory failure, ch disease (COPD), and Review of physician of revealed oxygen was continuously at 3 liter A Safe Smoking Eval completed by Minimu assessed Resident # that smoking materia only, that smoking materia only that smoking materia materia only that smoking and voiced that matches, lights and he remained alert dur The evaluation detern safe smoker and no s while smoking. Under "instructed not to use smoking and voiced that AM revealed that she smoke during his smo October 2016. She s while smoking in his material	dmitted to the facility on oses included acute ronic obstructive pulmonary d being oxygen dependent. orders since 06/03/16 to be administered rs per minute. uation dated 10/05/16 and um Data Set (MDS) Nurse #1 2 as able to communicate ls were for personal use aterials were for use only in ing area, and that the physically hold the smoking to Upon observations it was ght and smoke a cigarette safe technique for putting out and disposing of ash and that ring the course of smoking. mined Resident #2 was a supervision was required er the notes section was to O2 (oxygen) when out understanding."		mask and started a neb he stated I am fine, just breathing treatment. Cl and Supervisor # 1 imm the mask and began to #2 for injuries. Observa black soot to the lower I singed hair on the left si and surrounding his fac Department and the Em Services arrived and im transported Resident #2 Emergency Room, whe admitted in stable condit observation of burns to respiratory monitoring. C Supervisor # 1 notified daughter, the On Call F Facility Medical Director Administrator and the F Nursing. Facility Admin the Administrator and D developed an immediate to ensure safe smoking assigning an attendant f Smoking Area to ensure attempting to smoke we supervision, 12 resident as current smokers and to determine status for o designate supervised of smoking status. A mee conducted on 12/7/16 a	need to finish my harge Nurse # 1 hediately removed assess Resident ations included half of his face and ide of his head e. The Fire hergency Medical mediately 2 to the re he was ition to the ICU for the nasal area and On 12/6/16 Resident #2 s Physician, the r, the Facility acility Director of istration including irector of Nursing e and interim plan that included to the Resident e all Residents ere provided ts were identified were re-assessed poygen use and to r unsupervised ting was t 1pm with the tor of Nursing and	
	further stated that she tank was turned off b turned it off or if she j	ack of his wheelchair. She e made sure the oxygen ut could not recall if he ust made sure it was turned present at this interview, and		the District Support tear full investigation into the on 12/6/16 involving Re Root Cause Analysis ar development of a perma	e events occurring sident #2 and a nd further	

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 02/15/201 RM APPROVE NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345312	B. WING _			1	C 2/21/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				18	370 PISGAH DRIVE		
BRIANCI	R HEALTH & REHAB/HE	INDERSONVILLE		Н	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 5	F3	323			
	MDS Nurse #1 both s Resident #2 smoking area while in his whe located on the back of Nurse #1 and MDS N question the safety of tank in the same area for the facility. Resident #2's quarter coded him with intact issues or behavior iss supervision with bed locomotion, dressing, was coded as having read newspaper/book functional limitations extremities. He was of therapy. Review of the Situation Assessment, Recomm dated 12/06/16 reveal smoking and his oxyg hair was singed and P areas. This report als thought his oxygen w Investigation Follow-u Resident #2 was out and set fire to his hair sent to the emergence intervention listed to p for supervised smokin Review of the hospita 12/06/16 revealed Re with 10 to 19% burn (stated they had observed in the designated smoking elchair with the oxygen tank of the wheelchair. Both MDS Jurse #2 stated they did not f smoking with an oxygen a as this practice was normal "IV MDS dated 11/30/16 cognition, having no mood sues, and required mobility, transfers, walking, eating and hygiene. He impaired vision, unable to coprint, and having no to his upper and lower coded as receiving oxygen on, Background, mendation (SBAR) report led Resident #2 was outside gen tubing caught fire. His his nose had black singed to indicated he stated he as off. The Incident/Accident up dated 12/06/16 revealed smoking with his oxygen on r and face. Resident #2 was cy room. The new prevent reoccurrence was		523	 ensure safe resident smoking. Resident #2 is alert and oriented with BIMS score of 15 last assessed 9/2/1 with no recent changes in condition or mental status. His last Smoking assessment was completed on 10/5/1 which time he was deemed safe smo On 10/5/16 the nurse educated Resid #2 to remove his oxygen prior to smo and he verbalized understanding. Resident # 2 was care planned as a smoker and able to remove his own oxygen prior to smoking. On 12/20/16 Resident #4, who uses oxygen on an as needed basis, was reviewed by the Director of Nursing. Resident #4 s assessment and care were validated as a supervised smoking was observed and oxygen taremoved from wheelchair prior to enter the designated smoking area. On 12/20/16 CNA #1 received one or education by the Director of Nursing tinclude the facility spolicy regarding Management, Fire Extinguisher usage the use of a Fire Blanket to extinguish personal fire, turning off any Oxygen use during a fire, and to supervise an attend to a resident during an emerge situation by not leaving the resident us further assistance has arrived. 2. Current Residents who smoke has the potential to be affected by this practice. By 12/7/16 the Director of Nursing an Nurse Managers completed new Smot Assessments for current residents with supervise and attend to a resident during an emerge situation by not leaving the resident us further assistance has arrived. 	6 r I6 at ker. lent king safe plan er, ank ering o one o Fire e, n a in d ency ntil ave d oking	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/15/2 FORM APPRO' OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345312	B. WING		C 12/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE
BRIAN CI	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 2	8791
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLET ED TO THE APPROPRIATE DATE FICIENCY)
F 323	Resident #2 was adm unit for steroid intrave monitoring. The hosp dated 12/08/16 includ as follows: *principal problem wa 10-19% of body surfa *active problems includ of face; 2nd degree be exacerbation; chronid anemia, and tobacco Resident #2 was read 12/08/16 with physici applied antibiotics to Observations on 12/1 smoking area was ob fire extinguisher, fire stating smoking area Nurse Aide (NA) #1 w at 12:22 PM. She sta #2 smoke previous to Resident #2 would tu he went outside but go oxygen tank located of wheelchair. She statt that the oxygen tank back of the wheelcha stated she had conce present during smoki otherwise. She state of 12/06/16 to go on area. She passed Re the alcove outside of the smoking areas. So oxygen in place or no	hitted to the intensive care enous therapy and close bital discharge summary ded the discharge diagnoses as burn any degree involving ace; uded partial thickness burn burn of left hand; COPD c respiratory failure, chronic abuse. dmitted to the facility an orders for topically bilateral nares. 19/16 at 10:01 AM the oserved and noted to have a blanket, and 3 bright signs no oxygen. vas interviewed on 12/19/16 ated she had seen Resident o the accident. She stated irn his oxygen tank off before generally smoked with the	F 3	 supervised smoking a resident □ s use of oxy Resident □ s careplan individualized intervet assessment to includ A. The need for Supervised Smoking B. The storage of set C. The use of smoking B. The storage of set C. The use of smoking By 12/8/16 the Admin of Nursing conducted current residents who and discuss the follow A. The Facility Poli Safe Smoking B. The Difference b and Unsupervised Sr C. The storage of set D. The schedule for and allowing resident E. Designated smol available safety equip fire extinguisher and and receptacles. Far interested in assisting will see the Nurse for smoking and will be a smoking areas. F. Smoking attendate umbrellas during inclusted Smoking areas. H. Oxygen is not all Designated Smoking 	ygen. Each was updated with nitions based on the de: upervision while smoking materials ing aprons at of oxygen while histrator and Director 2 meetings with 12 o smoke to review wing: cy for Resident □s etween Supervised nokers moking materials supervised smoking input in scheduling king area and oment- fire blanket, acceptable ashtrays mily and visitors g residents to smoke direction prior to allowed in designated ant and use of ement weather to ed smoking area. aprons lowed in the Area place to ensure the

Facility ID: 922985

		ID HUMAN SERVICES				FOF	ED: 02/15/201 RM APPROVE
STATEMENT C	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
		345312	B. WING			1	C 2/21/2016
NAME OF PF	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	2/21/2010
				18	870 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		н	ENDERSONVILLE, NC 28791		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	saw he had flames in stated he was flailing get close to turn off th in front of the door ar the building so she ra building while at the s She stated she thoug blanket but was afraid blanket over his head gather under the blar more damage and point explode. When she et help, she and Nurses in his room with his b Upon follow up interv 12/20/16 at 2:09 PM, been an emergency in to 10 years ago. She in the use of a fire bla benefit someone or in that she could not ge flames and could not turn it off. She stated situation was unsafe not want to use the fit his breathing problem blanket would create build up and feed the get help as he was bl the facility and called She stated she made on her EMT training. On 12/19/16 at 2:32 I	She turned around and front of his face. She his arms and she could not he oxygen. He was situated ad she could not get inside an to the front entrance of the same time she called 911. The about using the fire d that when she placed the d, the running oxygen would aket and fuel the fire causing basibly causing the oxygen to intered the facility and got #1 and Nurse #2, found him reathing treatment in place. iew via a phone call on NA #1 stated that she had medical technician (EMT) 6 e stated that she was trained anket but knew it could either nake it worse. She stated t close to him due to the reach the oxygen tank to d due to the fire, she felt the for him and for her. She did re extinguisher because of ns and was afraid the fire a pocket for the oxygen to fire. She left him in order to ocking the door to reenter 911 while going to get help.	F	323	On 12/8/16 a plan was developed to included educating Facility Staff, curr Residents who smoke, and Residents Families on re-implementation of the Facility Policy for Safe Smoking, new requirements for storage of smoking materials, how Residents are assess to determine needs for supervision du smoking, the facility schedule for supervised smoking, no Oxygen allow in the designated smoking areas, no smoking allowed outside of the designated area. As part of this plan a smoking attendat was assigned to monitor the designate smoking area and another attendant the monitor non-designated areas on 12/7 These smoking attendants will assist Residents to the designated areas to ensure there is no smoking in these areas. Any issues with compliance we reported to the Administrator or Direct Nursing. Education was completed as follows: 1. By 12/8/16 the Director of Nursing educated the Facility staff on regarding the Facility Policy for Safe Smoking to include the following: A. Assessment and Care Planning current resident who smoke on admiss and quarterly and as needed with	ed uring ved ant ed co 7/16. area s will ill be tor of g ug o of	
	wheelchair with oxyg	himself down the hall in the en running at 3 liters per re located on the back of his			changes. Designating resident as Supervised and Unsupervised smoke B. Receiving and Storing resident		

Facility ID: 922985

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
					С	
		345312	B. WING			2/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
BRIAN CT	R HEALTH & REHAB/HE			1870 PISGAH DRIVE		
				HENDERSONVILLE, NC 28791		
(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 BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From page	e 8	F 32	23		
		ople that oxygen was	-	smoking materials		
		chair. He agreed to be		C. Location of Designate	d Smoking	
		ne and proceeded to leave		Areas for Residents and S		
		kygen in the hall as he		visitors who want to assist	•	
		Resident #2 was observed		smoke.		
	with slight pinkness o	n his cheeks where oxygen		D. Smoking schedules a		
	tubing would rest, his	nares were shiny with what		of smokers in designated	smoking areas	
		tic ointment and his left		and the use of smoking ap		
		ut quarter size between the		and use of safety equipme		
		d base of his forefinger,		including the fire blanket, t		
		from the fire. Resident #2		extinguisher and ashtrays	and	
		vatching television in the		receptacles.		
	-	e decided to go outside to		E. There is no Oxygen a	llowed in the	
		ne was permitted to keep his ettes. He stated the wind		designated smoking are Additional education was	aravidad on	
		ayed close to the door of the		12/20/16 to all facility staff		
	-	esignated smoking area of		Administrator, Director of I		
		lit his cigarette. He stated		Staff Development Directo		
		oxygen tubing was on his		Managers to include:		
		was running at this time. He		-the Facility policy for Fire	Management	
		hen he went to take another puff on the and flames "flashed" up. Resident #2		- Fire Extinguisher usage	-	
				Pull, Aim, Squeeze and S		
	-	cannula, eyebrows, nose		effective fire extinguishing		
	and hand as he yank	ed the nasal cannula off his		-use of a Fire Blanket to c	over and	
		the fire just went out. He		smother flames to manage		
		member was outside and		-discontinuing any Oxyger		
	-	an around the building to get		removing the tank as soor	as possible	
		es were out, he went back		during a fire		
	•	his room and applied his		-Supervise and attend to a		
		Resident #2 stated he didn't		during an emergency situa	•	
		ntil staff and the emergency		leaving the resident until for assistance has arrived	unner	
		IS) arrived. Resident #2 ways gone outside with his		No staff shall work after 12	2/20/16 before	
		of his wheelchair. He stated		receiving this education.		
		ed to remove the cannula		has been added to the Fa		
	-	m the flames/cigarette.		program for all new hires a		
		e tank would still be running		to be completed prior to be		
		annula would be away from		resident care areas after 1		

Event ID: HH2B11

Facility ID: 922985

If continuation sheet Page 9 of 45

F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE (CONSTRUCTION	(X3) DATE	SURVEY	
CORRECTION	IDENTIFICATION NUMBER:	· ,			COMP	LETED	
					С		
	345312	B. WING			12/	21/2016	
ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
R HEALTH & REHAB/HE	NDERSONVILLE						
			HE	ENDERSONVILLE, NC 28791			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG				(X5) COMPLETIO DATE	
Continued From page	e 9	F 32	23				
told that he could not	have his tank with him when			Director of Nursing conducted 2 meetin	igs		
he went outside to sm	noke.			with 12 current residents who smoke a	nd		
• • • • • • • • • • • • • • •				their families to review and discuss the			
			-				
•							
					bd		
				•	,a		
				C. The storage of smoking materials			
nasal cannula and ha	inging it on the oxygen tank.			D. The schedule for supervised smok	ing		
					ıg		
					ys		
	-				ke		
				will see the Nurse for direction prior to			
					ted		
•							
•			-				
anyone of his concern							
The Nurse #1 stated	on 12/19/16 at 4:21 PM that						
she had seen Reside	nt #2 smoke but did not			New Residents who smoke and are			
•				admitted after 12/8/16 will receive this			
				-			
•	-				or		
,				Nurse Manager are monitoring the			
				resident smoking area daily on each sh	lift		
				for 30 days, 3 times per week on each			
	-				re		
this facility a few mon	iths ago.						
	RHEALTH & REHAB/HE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page told that he could not he went outside to sm On 12/19/16 at 3:19 F housekeeper #1 reve #2 smoke outside and oxygen tank off. She keep the oxygen tank wheelchair while he s nasal cannula and ha On 12/19/16 at 3:24 F on the MDS dated 11 stated that when he f Resident #2 had com oxygen tank off. At times, expressed concern to dangers of smoking v in their smoking area visible between the tw anyone of his concern The Nurse #1 stated she had seen Resider recall him smoking w stated she responded running in the building saying he was on fire located him in his roo near his eyebrows an had already called 91 Interview with the Dim 12/19/16 at 5:50 PM	OVIDER OR SUPPLIER REALTH & REHAB/HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 told that he could not have his tank with him when he went outside to smoke. On 12/19/16 at 3:19 PM an interview with housekeeper #1 revealed she had seen Resident #2 smoke outside and he would have turned his oxygen tank off. She further stated he would keep the oxygen tank on the back of his wheelchair while he smoked after removing the nasal cannula and hanging it on the oxygen tank. On 12/19/16 at 3:24 PM Resident #10, assessed on the MDS dated 11/16/16 as cognitively intact, stated that when he had been outside smoking, Resident #2 had come out smoking with his oxygen tank of the times, Resident #2 turned the tank off. At times, he and other residents expressed concern to Resident #2 about the dangers of smoking with oxygen. Staff would be in their smoking area, about 20 feet away and visible between the two areas. He never told anyone of his concerns. The Nurse #1 stated on 12/19/16 at 4:21 PM that she had seen Resident #2 smoke but did not recall him smoking with oxygen in place. She stated she responded to NA #1 and another staff running in the building looking for Resident #2 saying he was on fire. Nurse #1 stated she located him in his room with soot on his face, near his eyebrows and had singed hair. NA #1 had already called 911.	345312 B. WING COVIDER OR SUPPLIER RHEALTH & REHAB/HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 told that he could not have his tank with him when he went outside to smoke. On 12/19/16 at 3:19 PM an interview with housekeeper #1 revealed she had seen Resident #2 smoke outside and he would have turned his oxygen tank off. She further stated he would keep the oxygen tank on the back of his wheelchair while he smoked after removing the nasal cannula and hanging it on the oxygen tank. On 12/19/16 at 3:24 PM Resident #10, assessed on the MDS dated 11/16/16 as cognitively intact, stated that when he had been outside smoking, Resident #2 had come out smoking with his oxygen tank on the back of the wheelchair. He stated that most of the times, Resident #2 turned the tank off. At times, he and other residents expressed concern to Resident #2 about the dangers of smoking with oxygen. Staff would be in their smoking area, about 20 feet away and visible between the two areas. He never told anyone of his concerns. The Nurse #1 stated on 12/19/16 at 4:21 PM that she had seen Resident #2 smoke but did not recall him smoking with oxygen in place. She stated she responded to NA #1 and another staff running in the building looking for Resident #2 saying he was on fire. Nurse #1 stated she located him in his room with soot on his face, near his eyebrows and had singed hair. NA #1 had already called 911. Interview with the Director o	345312 B. WING The ALEATH & REHAB/HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEPERFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 told that he could not have his tank with him when he went outside to smoke. On 12/19/16 at 3:19 PM an interview with housekeeper #1 revealed she had seen Resident #2 smoke outside and he would have turned his oxygen tank off. She further stated he would keep the oxygen tank on the back of his wheelchair while he smoked after removing the nasal cannula and hanging it on the oxygen tank. On 12/19/16 at 3:24 PM Resident #10, assessed on the MDS dated 11/16/16 as cognitively intact, stated that when he had been outside smoking, Resident #2 had come out smoking with his oxygen tank on the back of the wheelchair. He stated that most of the times, Resident #2 turned the tank off. At times, he and other residents expressed concern to Resident #2 about the dangers of smoking with oxygen. Staff would be in their smoking area, about 20 feet away and visible between the two areas. He never told anyone of his concerns. The Nurse #1 stated on 12/19/16 at 4:21 PM that she had seen Resident #2 smoke but did not recall him smoking with oxygen in place. She stated she responded to NA #1 and another staff running in the building looking for Resident #2 saying he was on fire. Nurse #1 stated she located him in his room with soot on his face, near his eyebrows and had singed hair. NA #1 had already called 911. Interview with the Director of Nursing (DON) on 12/19/16 at 5:5	JA5312 B. WING COVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE RHEALTH & REHABHENDERSONVILLE 170 PISGAH DRIVE HENDERSONVILLE, NC 28791 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECENDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) IP Continued From page 9 IP told that he could not have his tank with him when he went outside and he would have turned his oxygen tank off. She further stated he would keep the oxygen tank off. She further stated he would keep the oxygen tank off. She further stated he would keep the oxygen tank off. She further stated he would keep the oxygen tank off. She further stated he would keep the oxygen tank on the back of his oxygen tank off. At imes, he and other residents stated that when he had been outside smoking, Resident #2 had come out smoking with his oxygen tank off. At times, he and other residents expressed concern to Resident #2 turned the tank off. At times, he and other residents expressed concern to Resident #2 turned the tank off. At times, he and other residents expressed concern to Resident #2 turned the tank off. At times, he and other staff or ther smoking with oxygen. Staff would be tracell him smoking with oxygen in place. She stated bar responded to NA #1 and another staff running in the building locking for Resident #2 travel to the designated smoking area. C. Use of smoking with oxygen in place. She stated she responded to NA #1 and another staff running in the building locking for Resident #2 saying he was on fire. Nurse #1 stated on 12/19/16 at 4:21 PM that she had seen Resident #2 smoke build not recall him smoking with oxygen in place. She stated she responded to NA #1 and another staff runereal him in is room with soot on his face, neareal him	JA45312 B. WIND Junc Junc	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/15/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345312	B. WING				C /21/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHAB/HE			18	70 PISGAH DRIVE		
BRIANCI		ENDERSONVILLE		H	ENDERSONVILLE, NC 28791		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 323	Interview with the Sta on 12/20/16 at 9:26 A Resident #2's smokin training about the des the need to remove a smoking in her orient On 12/20/16 at 10:03 stated she was unaw smoking with their ox area until 12/06/16. Resident #5, assesse 09/20/16 as being co 12/20/16 at 10:21 AW #2 smoking with the of his wheelchair. She s this behavior and exp on occasion remindin his oxygen tank was Interview with the Ma 12/20/16 at 3:30 PM new employees prior the location of fire ala fire blanket. He state signs located in plast area stating this was oxygen was allowed. been replaced since to brighter, sturdier ones Nurse #2 was intervie PM. Nurse #2 stated observations, Reside oxygen tank on the b had the tank turned on NA #1 alerting staff sl	Aff Development Coordinator AM revealed that prior to ag accident, she included signated smoking area and all oxygen prior to residents ation of new employees. AM, the Administrator are that residents were ygen tanks in the smoking ed per the MDS dated gnitively intact, stated on 1 that she had seen Resident oxygen tank on the back of stated staff were aware of blained she witnessed staff ag Resident #2 to make sure turned off. intenance Supervisor on revealed that he trained all to Resident #2's accident on arms, fire extinguishers and ed there had been 2 paper ic sleeves at the gazebo a smoking area and no These paper signs had the accident with larger, s.	F	323	fire blanket, fire extinguisher, acceptal ashtrays and receptacles are available and in use as required. During this monitoring they are validating that Oxygen is removed prior to entering th designated smoking area. They are a validating that supervision is present f resident assessed as a supervised smoker. This monitoring will continue 6 months and opportunities will be corrected immediately as they are identified. 4. The Administrator and Director of Nurs will analyze the data obtained during t monitoring and report any patterns an trends to the QAPI Committee month 12 months. The QAPI Committee will evaluate the effectiveness of the abov plan and will add additional informatio based on the outcomes identified to ensure continued compliance Date of Compliance 1/20/17	e ne Iso or for for sing his d/or y for e	

Facility ID: 922985

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		ECONSTRUCTION	(X3) DATE	
			A. BUILDI	NG _			С
		345312	B. WING			12/	21/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)			(X5) COMPLETION DATE		
F 323	giving himself a breat ready for him. She fu warned him about the the wheelchair while h assured her staff the f stated his upper lip ar blackened and the ox his cheek. Nurse #2 s when she also smoke oxygen tank off, wrap and tubing and sat on 2. Resident #4 was ac 08/29/16 with chronic disease and dementia Resident #4's safe sm 10/04/16 stated she n with smoking. Physician orders date to be administered via per minute as needed above 90%. The most recent Minin 11/29/16 coded Resid impaired cognition, ac supervision for most a She was coded as us Interview with the Dire 12/19/16 at 5:50 PM r observed the resident this facility a few mon Interview with the Sta	hing treatment she had left in ther stated that she had a tank being on the back of he was smoking and he tank was turned off. She hd under his nose was ygen tubing had melted on stated she saw him smoke ed and he usually turned the ped up the nasal cannula hit while he smoked. dmitted to the facility on obstructive pulmonary a. hoking assessment dated heeded constant supervision ed 11/29/16 included oxygen a nasal cannula at 2 liters d to keep oxygen levels mum Data Set dated dent #4 with moderately dequate vision, requiring activities of daily living skills. ing oxygen. ector of Nursing (DON) on revealed she had not ts smoke since coming to	F	323			
		M revealed that prior to					

Facility ID: 922985

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			LETED
		345312	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> 127</u>	21/2010
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE		
					HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	. 10		~~~			
F 323	Continued From page			323	3		
designated smoking area and the need to remov all oxygen prior to residents smoking in her orientation of new employees.		idents smoking in her					
	Interview with the MD	S Nurses #1 and #2 on					
	12/20/16 at 9:35 AM,	revealed they assessed					
	-	safety by watching them designated area. Both					
		observed Resident #4 since					
		e smoking area with the					
	explaining again it wa	ack of her wheelchair, is permitted.					
		AM, the Administrator					
		are that residents were ygen tanks in the smoking					
	area until 12/06/16.	ygen tanks in the smoking					
		AM, Resident #4 was					
		ing area, wearing an apron sed by agency staff #1. She					
		r but had no oxygen tank or					
	-	g this observation, Resident					
		d when she asked staff what e agency staff who was					
	monitoring her explain	ned she was outside					
		ns revealed bright colored gen' signs in front of the					
	gazebo and inside the						
		on 12/20/16 at 10:15 AM					
		rvised Resident #4 when that the oxygen tank was					
	-	f her wheelchair during					
	smoking as she was i	never instructed to remove					
	-	g her to smoke. NA #2 n tank was turned off prior to					
		She further stated Resident					
		garettes in her coat pocket					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
	CONTRECTION	BERTH IO, HON NONBER.	A. BUILD	ING _			C
		345312	B. WING				21/2016
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		21/2010
				1	1870 PISGAH DRIVE		
BRIAN CI	R HEALTH & REHAB/HE	INDERSONVILLE		ŀ	HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 323	cigarettes and lighters and anyone assessed not have access to the Interview with the Mai 12/20/16 at 3:30 PM of 12/06/16 he trained a location of fire alarms blanket. He stated the located in plastic slee stating this was a smo was allowed. These of replaced since 12/06/ sturdier ones. The Administrator and Immediate Jeopardy of On 12/21/16 at 12:58 following Credible Allow 1. On 12/6/16 at appr #2 was observed sittin near the Resident and #1 who was exiting the if Resident #2 was smo Resident #2 to the stat 10 feet away, as she picnic table she notice face and hands. NA# Resident #2 had an o wheelchair and a can attempted to turn off the but Resident #2 was allow regulator. She was allow	hter. NA #2 stated that all s were now kept locked up d as an unsafe smoker does e smoking materials. Intenance Supervisor on revealed that prior to II new employees on the , fire extinguishers and fire ere had been 2 paper signs ves at the gazebo area oking area and no oxygen paper signs had been 16 with larger, brighter, d DON were informed of on 12/20/16 at 1:43 PM. PM, the facility provided the egation of Compliance: oximately 8:30pm Resident ng outside the 400 Hall Door d Staff smoking area by NA e facility, she did not notice hoking. NA #1 walked past aff smoking area less than turned to sit down at the ed flames at Resident #2's 1 immediately noticed that xygen tank on his nula in his nares, she he oxygen at the regulator failing his arms and had h the back of the wheelchair she was unable to reach the so unable to re-enter the	F	323			
	but Resident #2 was to positioned himself with against the door and regulator. She was also	flailing his arms and had h the back of the wheelchair she was unable to reach the					

Facility ID: 922985

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
	CONTRECTION		A. BUILDING	G		
						С
		345312	B. WING			2/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
	R HEALTH & REHAB/HE			1870 PISGAH DRIVE		
BRIANCI		ENDERSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE
F 323	Continued From page	e 14	F 32	23		
1 020			F 32	23		
	•	A #1 was reluctant to cover Fire Blanket for fear of				
		Fire Blanket for fear of n and worsening the flames.				
		nd the left corner of the				
		1 on her cell phone as she				
	-	on her cell phone as she				
		the facility she notified the				
		d the Supervisor #1. Charge				
		y ran to the 400 Hall Door				
		s no longer located there, he				
		flames and returned to his				
		7. As the Charge Nurse #1				
		Room #207 she noticed				
		lied his nebulizer mask and				
		eatment, he stated "I am				
		sh my breathing treatment."				
		d Supervisor #1 immediately				
	-	nd began to assess Resident				
		rvations included black soot				
	-	s face and singed hair on the				
		and surrounding his face.				
		and the Emergency Medical				
		immediately transported				
		mergency Room, where he				
		le condition to the ICU for				
		to the nasal area and				
		g. On 12/6/16 Supervisor #1				
		s responsible party, the On				
		acility Medical Director, the				
	-	and the Facility Director of				
	-	ninistration including the				
		rector of Nursing developed				
		erim plan to ensure safe				
		d assigning an attendant to				
	the Resident Smokin					
		to smoke were provided				
		ents were identified as				
	current smokers and					
	determine status for o					

Facility ID: 922985

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345312	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	supervised or unsuper meeting was conduct the Administrator and District Support team investigation into the involving Resident #2 and further developm ensure safe resident \$2 Resident #2 is alert at Interview for Mental \$2 assessed 9/2/16 with condition or mental st assessment was com time he was deemed the nurse educated R oxygen prior to smoki understanding. Resident the nurse educated R oxygen prior to smoki Understanding. Resident a safe smoker and ab oxygen prior to smoki On 12/20/16 Resident an as needed basis, w of Nursing. Resident plan were validated a smoking was observe from wheelchair prior smoking area. On 12/20/16 NA #1 re education by the Dire the facility's policy reg Fire Extinguisher usat to extinguish a persor Oxygen in use during attend to a resident d	rvised smoking status. A ed on 12/7/16 at 1pm with Director of Nursing and the to complete a full events occurring on 12/6/16 and a Root Cause Analysis ent of a permanent plan to smoking. Ind oriented with a Brief Status score of 15 last no recent changes in atus. His last Smoking pleted on 10/5/16 at which safe smoker. On 10/5/16 esident #2 to remove his ng and he verbalized dent #2 was care planned as ble to remove his own ng. It #4, who uses oxygen on was reviewed by the Director #4's assessment and care s a supervised smoker, ed and oxygen tank removed to entering the designated eceived one on one ctor of Nursing to include garding Fire Management, ge, the use of a Fire Blanket hal fire, turning off any a fire, and to supervise and uring an emergency ing the resident until further	F	323			

Facility ID: 922985

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345312	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER		•	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	 Current Residents potential to be affected By 12/7/16 the Direct Managers completed for current residents we need for supervised seresident's use of Oxy plan was updated with based on the assesser A. The need for Supe B. The storage of smoc C. The use of smokin D. The management By 12/8/16 the Admin Nursing conducted 2 residents who smoke following: A. The Facility Policy Smoking B. The Difference bet Unsupervised Smoke C. The storage of smok D. The schedule for se allowing resident input E. Designated smoki equipment- fire blank acceptable ashtrays a visitors interested in a will see the Nurse for and will be allowed in F. Smoking attendand during inclement weat designated smoking a G. Use of smoking a 	who smoke have the ad by this practice. or of Nursing and Nurse new Smoking Assessments who smoke to determine the smoking and to evaluate the gen. Each Resident's care h individualized interventions ment to include: rvision while smoking oking materials g aprons of oxygen while smoking istrator and Director of meetings with 12 current to review and discuss the for Resident's Safe ween Supervised and rs noking materials upervised smoking and it in scheduling ng area and available safety et, fire extinguisher and and receptacles. Family and assisting residents to smoke direction prior to smoking designated smoking areas. t and use of umbrellas ther to travel to the area.	F	323			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG .			
		345312	B. WING				C 21/2016
NAME OF PF	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page Smoking Area 3. Measures put in deficient practice doe On 12/8/16 a plan wa educating Facility Sta smoke, and Residents re-implementation of f Smoking, new requires smoking materials, ho to determine needs for smoking, the facility s smoking, no Oxygen smoking areas, no sm the designated area. As part of this plan a assigned to monitor th and another attendan areas on 12/7/16. Th assist Residents to th and monitor for use o oxygen use. These att non-designated areas smoking in these areas compliance will be rep or Director of Nursing Education was 1. By 12/8/16 the D Assistant Director of N Facility staff on regard Safe Smoking to inclu	e 17 place to ensure the alleged s not recur include: s developed to included aff, current Residents who s' Families on the Facility Policy for Safe ements for storage of ow Residents are assessed or supervision during chedule for supervised allowed in the designated noking allowed outside of smoking attendant was ne designated smoking area t to monitor non-designated ese smoking attendants will e designated smoking area f smoking aprons and no tendants will also monitor a to ensure there is no as. Any issues with ported to the Administrator to completed as follows: irrector of Nursing and Nursing educated the ding the Facility Policy for ide the following:		323	DEFICIENCY)		

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/15/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	
	CONTROLING		A. BUILDI	ING _			C
		345312	B. WING				21/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	 smokers. B. Receiving and Sf materials. C. Location of Desig Residents and Staff. to assist a resident to D. Smoking schedul smokers in designate use of smoking apronesing apronesing approximate safety equipment in the blanket, the fire extingereceptacles. E. There is no Oxyges smoking area. Additional education wall facility staff by the Nursing, Area Staff D Nurse Managers to in the Facility policy for Fire Extinguisher us Squeeze and Sweep extinguishing use of a Fire Blanket flames to manage a p discontinuing any Ox the tank as soon as p Supervise and attended until further assistance No staff shall work aff this education. This e 	coring resident's smoking gnated Smoking Areas for Directing visitors who want smoke. les and Supervision of d smoking areas and the s. Location and use of his area including the fire guisher and ashtrays and gen allowed in the designated was provided on 12/20/16 to Administrator, Director of evelopment Director and clude: Fire Management age to include the Pull, Aim, method for effective fire to cover and smother personal fire tygen in use and removing ossible during a fire d to a Resident during an by not leaving the resident e has arrived the for all new hires e completed prior to	F	323			

Facility ID: 922985

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		345312	B. WING				C 21/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> 12/</u>	21/2010
				1	1870 PISGAH DRIVE		
BRIAN CI	R HEALTH & REHAB/HE	INDERSONVILLE		ŀ	HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	 By 12/8/16 the AM Nursing conducted 2 residents who smoke and discuss the follow A. The Facility Polic Smoking B. The Difference by Unsupervised Smoke C. The storage of sr D. The schedule for allowing resident input E. Designated smoke safety equipment- fire and acceptable ashtra and visitors interested smoking areas. F. Smoking attenda during inclement wea designated smoking a G. Use of smoking a H. Oxygen is not all Smoking Area New Residents who sa after 12/8/16 will rece Smoking Assessment Plan developed. The Facility's new Addupdated to include thi Immediate jeopardy w 3:26 PM when intervit staff, administrative si confirmed they had rece 	dministrator and Director of meetings with 12 current and their families to review ving: cy for Resident's Safe etween Supervised and rs moking materials r supervised smoking and it in scheduling king area and available e blanket, fire extinguisher ays and receptacles. Family d in assisting residents to urse for direction prior to illowed in designated ant and use of umbrellas ther to travel to the area.	F	323			

Facility ID: 922985

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		ID HUMAN SERVICES MEDICAID SERVICES					ORM APPROVE 3 NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			· · ·	DATE SURVEY COMPLETED
		345312	B. WING				C 12/21/2016
NAME OF PI	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	INDERSONVILLE		1870 PISGA	AH DRIVE SONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE # DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	smoking area, the ne smoking materials, the equipment including s fire extinguisher and demonstration of how and what actions to ta	ing into the designated w storage system for	F	23			
F 490 SS=J	found on fire. 483.70 EFFECTIVE ADMINISTRATION/R 483.70 Administration	RESIDENT WELL-BEING	F	90			1/20/17
	enables it to use its re efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation interviews, and staff if failed to oversee and smoking policy and p sampled residents (R smoked and utilized of oxygen tanks on their were educated and for In addition, the admir leadership in ensuring prepared to react in a one resident (Reside smoking with oxygen degree burns on his for	mental, and psychosocial sident. is not met as evidenced ins, record review, resident nterviews, the administration enforce the facility's rocedures to ensure 2 of 2 tesidents #2 and #4) who boxygen did not smoke with r wheelchairs and that staff bollowed the smoking policy. histration failed to provide g staff was adequately an emergency situation when int #2) caught fire while running resulting in 2nd		immed Nurse transfe further return declin hospit Reside on 1/7 Summ On 12 Reside the 40	On 12/6/16 Resident #2 w diately assessed by the C e and the EMS Responde ferred to the Emergency f er evaluation and admissioned to the facility on 12/7/ ned to smoke since his talization. lent #4 discharged from the	Charge er then Room for on. He '16 and has he facility :30pm ting outside sident and	
	running, the nasal ca	side with his oxygen tank nnula in his nares, away smoking area and lit a		Resid	g the facility, she did not i lent #2 was smoking. CN ed past Resident # 2 to th	IA# 1	

Facility ID: 922985

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 02/15/20 [.] RM APPROVE IO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DAT	E SURVEY IPLETED
		345312	B. WING		1:	C 2/21/2016
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(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) COMPLETIO DATE
F 490	on fire resulting in se burns. Nurse Aide # at the time of the inci intervene when she s left the resident on fir door as she ran arou door while calling 91' staff assistance. Imm removed on 12/21/16 provided and implem allegation of compliance of compliance at a lov (isolated with no actu more than minimal ha jeopardy) to complete monitoring systems p related to supervision smoking material stot to extinguish a reside The findings included 1. Cross Refer to F32 Based on observation interviews, and reside failed to keep 2 of 2 s smoked and utilized of smoking with their ox back of their wheelch Resident #2 sustaine face and hand when he was smoking with and oxygen running. immediately implement to extinguish the fire	ted in him catching himself cond degree facial and hand 1 who was in a nearby area dent, failed to effectively waw Resident #2 on fire. She e outside blocking the facility ind the building to the front 1 in order to obtain additional ediate jeopardy was 6 at 3:26 PM when the facility ented an acceptable credible nce. The facility remains out wer scope and severity of D al harm with potential for arm that is not immediate e education and ensure but into place are effective n, oxygen storage and use, rage and staff preparedness ent who is on fire.	F 49		picnic table ht #2 □s face iely noticed gen tank on in his nares, Dxygen at was flailing himself with ainst the each the ble to ecause the door. CNA#1 ident with pping more ames. eft corner of her cellphone ht door of the ed the facility e #1 and the e# 1 all Door and cated there, es and m # 207. As the ticed hebulizer treatment, to finish my Nurse # 1 ely removed is Resident included	

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A. BUILI B. WINC	STREET ADD 1870 PISGA HENDERS	DRESS, CITY, STATE, ZIP CODE	(X3) DATE COMF 12/ TION JLD BE	0. 0938-0391 SURVEY PLETED C 21/2016
PRE TA	STREET ADD 1870 PISGA HENDERS	H DRIVE ONVILLE, NC 28791 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO	TION JLD BE	21/2016
PRE TA	1870 PISGA HENDERS	H DRIVE ONVILLE, NC 28791 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO	JLD BE	(VE)
PRE TA	HENDERS	ONVILLE, NC 28791 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO	JLD BE	(YE)
PRE TA) FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO	JLD BE	(75)
PRE TA	FIX	(EACH CORRECTIVE ACTION SHOUR ROSS-REFERENCED TO THE APPRO	JLD BE	(Y5)
		,		COMPLETION DATE
I F	= 490			
n jen , g 00 did it rely n or air he	Service transpo Emerg admitte observ respira Superv daught Facility Admini Nursin the Add develo to ensu assign Smokin attemp superv as curr to dete design smokir conduc Admini the Dis full inve on 12/0 Root C develo ensure Reside BIMS s with no mental assess	es arrived and immediately orted Resident #2 to the lency Room, where he was ed in stable condition to the l vation of burns to the nasal a atory monitoring. On 12/6/16 visor #1 notified Resident # ter, the On Call Physician, the v Medical Director, the Facility istrator and the Facility Director g. Facility Administration incoministrator and Director of N uped an immediate and interi- ure safe smoking that include ing an attendant to the Resident of smoke were provided vision, 12 residents were ider rent smokers and were re-as- ermine status for oxygen use ate supervised or unsupervis- ing status. A meeting was cited on 12/7/16 at 1pm with istrator and Director of Nursi strict Support team to comple- estigation into the events occ 6/16 involving Resident #2 a cause Analysis and further poment of a permanent plant a safe resident smoking. ent #2 is alert and oriented w score of 15 last assessed 9/2 o recent changes in condition I status. His last Smoking sment was completed on 10/	ICU for area and 2 □ s he ity ctor of cluding lursing im plan ed dent ents d ntified ssessed and to sed the ing and ete a curring and a to /5/16 at	
	n en , g DO did it ely n or air he	Depart Service transpice Emerging admitted observice respiration en Supervice admitted observice respiration en Supervice Admin Nursin g the Ad develop to ensu- assign Smoking attemp supervice as curri- out o detect design did smoking conduct Admin supervice as curri- out o detect design did smoking conduct Admin supervice as curri- out o detect design did smoking conduct Admin to design did smoking conduct Admin to design the with no sesses to which On 10/	Department and the Emergency M Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the observation of burns to the nasal a respiratory monitoring. On 12/6/16 en Supervisor # 1 notified Resident # daughter, the On Call Physician, t Facility Medical Director, the Facil Administrator and the Facility Direc Nursing. Facility Administration into the Administrator and Director of N developed an immediate and interi- to ensure safe smoking that includ assigning an attendant to the Resi Smoking Area to ensure all Reside attempting to smoke were provided supervision, 12 residents were ide as current smokers and were re-as code to determine status for oxygen use designate supervised or unsupervi- did smoking status. A meeting was conducted on 12/7/16 at 1pm with Administrator and Director of Nurs the District Support team to compli- full investigation into the events oc ely on 12/6/16 involving Resident #2 a n Root Cause Analysis and further development of a permanent plan ensure safe resident smoking. Resident #2 is alert and oriented w air alir BIMS score of 15 last assessed 9/ with no recent changes in condition mental status. His last Smoking assessment was completed on 10/ which time he was deemed safe sis On 10/5/16 the nurse educated Resident #2	Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16enSupervisor #1 notified Resident #2 is daughter, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing. Facility Administration including the Administrator and Director of Nursing developed an immediate and interim plan to ensure safe smoking that included assigning an attendant to the Residents Smoking Area to ensure all Residents attempting to smoke were provided supervision, 12 residents were identified as current smokers and were re-assessed to determine status for oxygen use and to designate supervised or unsupervised smoking status. A meeting was conducted on 12/7/16 at 1pm with the Administrator and Director of Nursing and the District Support team to complete a full investigation into the events occurring on 12/6/16 involving Resident #2 and a Root Cause Analysis and further development of a permanent plan to ensure safe resident smoking. Resident #2 is alert and oriented with a BIMS score of 15 last assessed 9/2/16 with no recent changes in condition or mental status. His last Smoking assessment was completed on 10/5/16 at

Facility ID: 922985

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		ND HUMAN SERVICES MEDICAID SERVICES			FO	ED: 02/15/201 RM APPROVE NO. 0938-039
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		345312	B. WING		1	C 2/21/2016
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI		
				1870 PISGAH DRIVE		
BRIANCI	R HEALTH & REHAB/HE	ENDERSONVILLE		HENDERSONVILLE, NC 2879	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 490	and called 911 on he running to the front d As she entered the fa Nurse #1 and the Su 1 immediately ran to Resident #2 was no I extinguished the flam Resident Room #207 entered the Resident Resident #2 had app started a nebulizer tra- fine, just need to finis Charge Nurse #1 and removed the mask ar #2 for injuries. Obse- to the lower half of hi- left side of his head a The Fire Department Services arrived and Resident #2 to the En- was admitted in stabl observation of burns respiratory monitoring notified Resident #2's Call Physician, the Fa Facility Administrator Nursing. Facility Adm Administrator and Dir an immediate and int smoking that included the Resident Smokin Residents attempting supervision, 12 reside current smokers and determine status for	d the left corner of the facility r cell phone as she was oor of the facility for help. acility she notified the Charge pervisor #1. Charge Nurse# the 400 Hall Door and onger located there, he had nes and returned to his 7. As the Charge Nurse #1 Room #207 she noticed lied his nebulizer mask and eatment, he stated "I am the my breathing treatment." d Supervisor #1 immediately nd began to assess Resident rvations included black soot is face and singed hair on the and surrounding his face. and the Emergency Medical immediately transported mergency Room, where he e condition to the ICU for to the nasal area and g. On 12/6/16 Supervisor #1 is responsible party, the On acility Medical Director, the and the Facility Director of ninistration including the rector of Nursing developed erim plan to ensure safe d assigning an attendant to g Area to ensure all to smoke were provided ents were identified as were re-assessed to oxygen use and to designate	F 45	90 and he verbalized unders Resident # 2 was care pl smoker and able to remo oxygen prior to smoking. On 12/20/16 Resident #4 oxygen on an as needed reviewed by the Director Resident #4 □s assessme were validated as a supe smoking was observed a removed from wheelchai the designated smoking On 12/20/16 CNA #1 rec education by the Director include the facility □s poli Management, Fire Exting the use of a Fire Blanket personal fire, turning off use during a fire, and to attend to a resident durin situation by not leaving th further assistance has ar 2. Current Residents w the potential to be affected practice. By 12/7/16 the Director of Nurse Managers comple Assessments for current smoke to determine the n supervised smoking and resident □s use of oxygen Resident □s careplan wa individualized interventio assessment to include: A. The need for Super smoking	standing. lanned as a safe ove his own 4, who uses 1 basis, was 5 of Nursing. eent and care plan ervised smoker, and oxygen tank ir prior to entering area. beived one on one or of Nursing to icy regarding Fire guisher usage, to extinguish a any Oxygen in supervise and ng an emergency he resident until rrived. who smoke have ed by this of Nursing and eted new Smoking residents who need for to evaluate the n. Each as updated with ons based on the rvision while	
	determine status for of supervised or unsuper meeting was conduct			smoking	oking materials aprons	

Facility ID: 922985

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB ((X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	j	co	MPLETED
						С
		345312	B. WING	· · · · · · · · · · · · · · · · · · ·	1	2/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
BRIAN CT	R HEALTH & REHAB/H	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 2879	1	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETIO
F 490	Continued From page	e 24	F 49	o		
	District Support team	to complete a full		smoking		
		events occurring on 12/6/16		By 12/8/16 the Administr	ator and Director	
		2 and a Root Cause Analysis		of Nursing conducted 2 I	•	
		nent of a permanent plan to		current residents who sn		
	ensure safe resident	smoking.		families to review and di	scuss the	
	Desident #0 is short a			following:		
		and oriented with a BIMS seed 9/2/16 with no recent		A. The Facility Policy	for Resident s	
		or mental status. His last		B. The Difference betw	een Supervised	
	-	t was completed on 10/5/16		and Unsupervised Smok	•	
	-	deemed safe smoker. On		C. The storage of smol		
	10/5/16 the nurse ed	ucated Resident #2 to		D. The schedule for su		
	remove his oxygen p	rior to smoking and he		and allowing resident inp	out in scheduling	
		ding. Resident #2 was care		E. Designated smoking		
	•	noker and able to remove his		available safety equipme		
	own oxygen prior to s	smoking.		fire extinguisher and acc		
	On 12/20/16 Desider			and receptacles. Family		
		nt #4, who uses oxygen on was reviewed by the Director		interested in assisting re will see the Nurse for dir		
		#4's assessment and care		smoking and will be allow		
	-	as a supervised smoker,		smoking areas.	inea in deelighteted	
		ed and oxygen tank removed		F. Smoking attendant	and use of	
	-	to entering the designated		umbrellas during incleme		
	smoking area.			travel to the designated	-	
				G. Use of smoking apr		
	On 12/20/16 NA #1 r			H. Oxygen is not allow		
	-	ector of Nursing to include		Designated Smoking Are		
		egarding Fire Management, ige, the use of a Fire Blanket		New Residents who smo admitted after 12/8/16 w		
		nal fire, turning off any		education when the Smo		
	• ·	a fire, and to supervise and		is completed and Care F		
	attend to a resident of			The Facility s new Adm		
		ng the resident until further		been updated to include		
	assistance has arrive	-		and education.		
				3. Measures put in pla		
		ts who smoke have the		alleged deficient practice	e does not recur	
	potential to be affected	ed by this practice.		include:		
				On 12/7/16 the Administ		
	1 BV 12/7/16 the Direct	or of Nursing and Nurse		Nursing, District Director	or Operation and	1

Event ID: HH2B11

Facility ID: 922985

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345312	B. WING		C
	ROVIDER OR SUPPLIER	040012		STREET ADDRESS, CITY, STATE, Z	
NAME OF F	ROVIDER OR SUFFLIER			1870 PISGAH DRIVE	
BRIAN CI	R HEALTH & REHAB/HE	ENDERSONVILLE		HENDERSONVILLE, NC 287	91
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETIC
F 490	Continued From page	a 25	F 49	20	
	determine the need for to evaluate the resider Resident's careplan windividualized intervel assessment to includ A. The need for Su B. The storage of s C. The use of smok D. The management By 12/8/16 the Admin Nursing conducted 2 residents who smoke and discuss the follow A. The Facility Police Smoking	ntions based on the e: apervision while smoking smoking materials ting aprons ht of oxygen while smoking histrator and Director of meetings with 12 current and their families to review		meeting with the Interdi conduct a Root Cause A Resident non-compliand Facility □s policy for Saf for Residents who smol Oxygen, and Residents in areas not designated The Team reviewed the discussed the current m assessing Residents, of designated smoking are environmental needs ar addressed Oxygen stor entering the designated identified an opportunity storage for resident □s s and recommended a ne both designated and no areas to ensure complia	Analysis regarding ce with the e Smoking, safety ke and use identified smoking for smoking. e current policy, hethod for bserved ea for nd improvements, age prior to smoking area, v with effective smoking materials eed for monitoring n-designated ance.
	Unsupervised Smoke C. The storage of si D. The schedule for allowing resident inpu E. Designated smol safety equipment- fire and acceptable ashtra and visitors interested smoke will see the Nu smoking and will be a smoking areas. F. Smoking attenda during inclement wea designated smoking a G. Use of smoking a	ers moking materials r supervised smoking and ut in scheduling king area and available e blanket, fire extinguisher ays and receptacles. Family d in assisting residents to urse for direction prior to allowed in designated ant and use of umbrellas other to travel to the area.		Analysis a plan was dev Facility specific policy a ensure safe smoking by plan was developed by Interdisciplinary team in Administrator, Director of Facility Department Hea Facility specific policy a ensure safe smoking by These policies were imp educating current Facil Residents who smoke, Families on the Facility Smoking. New require of smoking materials, he assessed to determine supervision during smol	veloped to included nd procedures to v Residents. A the including the of Nursing and ads to include nd procedures to v Residents. blemented by ity Staff, current and Residents□ Policy for Safe ments for storage ow Residents are needs for king, the facility

Event ID: HH2B11

Facility ID: 922985

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						0.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	PLETED
			A. BUILDING	3		С
		345312	B. WING			21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		21/2010
				1870 PISGAH DRIVE	, =:: 0001	
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		HENDERSONVILLE, NC 28	3791	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PL	AN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	/E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	COMPLETIO
F 490	Continued From page	e 26	F 49	90		
	New Residents who	smoke and are admitted		Oxygen allowed in the	e designated	
	after 12/8/16 will rece	eive this education when the		smoking areas, no sm	•	
	Smoking Assessmen	t is completed and Care		outside of the designation	-	
		e Facility's new Admission		safety were included		
	packet has been upd			As part of this plan a s		
	information and educ	ation.		was assigned to moni	5	
				smoking area and and		
		place to ensure the alleged		monitor non-designate		
	deficient practice doe	es not recur include:		These smoking attend		
	On 12/7/16 the Admir	nistrator, Director of Nursing,		Residents to the designant monitor for use of		
		peration and District Director		and no oxygen use.	÷ .	
	-	eld a meeting with the		also monitor non-desi		
		n to conduct a Root Cause		ensure there is no sm		
		esident non-compliance with		areas. Any issues wit	-	
		or Safe Smoking, safety for		reported to the Admin	-	
		e and use Oxygen, and		Nursing.		
	Residents identified s	smoking in areas not		Education was co	mpleted as follows:	
	designated for smoki	ng.		1. By 12/8/16 the Di	rector of Nursing	
				and Assistant Director	•	
		he current policy, discussed		educated the Facility		
		or assessing Residents,		Administration, Nursin		
	observed designated	-		Housekeeping and Di		
	environmental needs	-		Facility Policy for Saf	e Smoking to	
		torage prior to entering the		include the following:	Care Diamains of	
	designated smoking a			A. Assessment and		
		ctive storage for resident's nd recommended a need for		current resident who s and quarterly and as r		
		gnated and non-designated		changes. Designating		
	areas to ensure com			Supervised and Unsu		
		-		B. Receiving and St	-	
	Based on the results	of this Root Cause Analysis		smoking materials	2	
		d to included Facility specific		C. Location of Desig	nated Smoking	
	policy and procedure	s to ensure safe smoking by		Areas for Residents a		
	Residents. A plan wa			visitors who want to a	ssist a resident to	
		n including the Administrator,		smoke.		
	-	nd Facility Department		D. Smoking schedul	-	
		ility specific policy and		of smokers in designa		
	procedures to ensure	e safe smoking by Residents.		and the use of smokin	a aprons Location	1

Facility ID: 922985

If continuation sheet Page 27 of 45

		ND HUMAN SERVICES				FOF	ED: 02/15/201 RM APPROVE
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DAT	I <u>O. 0938-039</u> E SURVEY IPLETED
		345312	B. WING _			1:	C 2/21/2016
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				18	70 PISGAH DRIVE		
BRIANCI	R HEALTH & REHAB/HE	ENDERSONVILLE		HE	ENDERSONVILLE, NC 28791		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 490	Continued From page	e 27 mplemented by educating	F 4	190	and use of safety equipment in this a	rea	
	current Facility Staff, smoke, and Resident	current Residents who s' Families on the Facility			including the fire blanket, the fire extinguisher and ashtrays and		
	storage of smoking m	ing. New requirements for naterials, how Residents are ne needs for supervision			receptacles. E. There is no Oxygen allowed in the designated smoking area	ne	
	during smoking, the facility schedule for supervised smoking, no Oxygen allowed in the				An educational plan was developed I Interdisciplinary Team consisting of the	ne	
	• •	areas, no smoking allowed ated area, and fire safety education.			Administrator, Director of Nursing, So Services, Director of Rehab, Director Housekeeping and Director of Dietar Services on 12/20/16 to include Faci	r of Y	
	assigned to monitor t	smoking attendant was he designated smoking area			specific policy and procedures for Fir Management and Smoking that addr	e	
	areas on 12/7/16. Th	nt to monitor non-designated nese smoking attendants will ne designated smoking area			Oxygen is prohibited in designated smoking areas. On 12/20/16 this Fire Safety education	onal	
	oxygen use. These a	of smoking aprons and no ttendants will also monitor s to ensure there is no			plan was reviewed and further develops by the Administrator, Director of Nurs and the Area Staff Development Dire	sing	
	smoking in these area				with assistance from the District Field		
		ported to the Administrator			Support Team. This review include involvement with the local Fire Marsh	d nall	
	Education was c	ompleted as follows:			who reviewed and accepted this plan Additional education was provided or 12/20/16 to all facility staff including		
	Assistant Director of	Director of Nursing and Nursing educated the			Administration, Nursing, Therapy, Housekeeping and Dietary by the		
	Therapy, Housekeep	Administration, Nursing, ing and Dietary regarding Safe Smoking to include			Administrator, Director of Nursing, A Staff Development Director and Nurs Managers to include:		
	the following:	-			AThe Facility policy and procedu Fire Management, Smoking and that		
	resident who smoke	d Care Planning of current on admission and quarterly changes. Designating			Oxygen is not prohibited in designate smoking areas. BFire Extinguisher usage to inclu		
	resident as Supervise smokers.				the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing		
	B. Receiving and S	toring resident ' s smoking			outlined in the facility policy for Fire		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 02/15/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/21/2016	
		345312	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
BRIAN CT	R HEALTH & REHAB/HE	INDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 490	Residents and Staff. to assist a resident to D. Smoking schedu smokers in designate use of smoking apror safety equipment in the blanket, the fire exting receptacles. E. There is no Oxyg smoking area An educational plan w Interdisciplinary Team Administrator, Director Services, Director of Housekeeping and D on 12/20/16 to include procedures for Fire M that address Oxygen smoking areas. On 12/20/16 this Fire reviewed and further Administrator, Director Staff Development Di the District Field Supp included involvement who reviewed and ac Additional education all facility staff includ Therapy, Housekeep Administrator, Director Development Director include:	gnated Smoking Areas for Directing visitors who want o smoke. les and Supervision of d smoking areas and the hs. Location and use of his area including the fire guisher and ashtrays and gen allowed in the designated was developed by the n consisting of the or of Nursing, Social Rehab, Director of irector of Dietary Services e Facility specific policy and lanagement and Smoking is prohibited in designated Safety educational plan was developed by the or of Nursing and the Area rector with assistance from port Team. This review with the local Fire Marshall	F 49	 Management. CUse of a Fire Blanket to smother flames to manage a as outlined in the facility polic Management. DDiscontinuing any Oxyg removing the tank as soon as during a fire as outlined by th policy for Fire Management. ESupervise and attend to during an emergency situation leaving the resident until furth assistance has arrived. The Administrator and Direct will oversee this updated edu for completion and effective morientation and annual trainin observations and ongoing patraining sessions. Monthly o education and return demons staff during educational sess observed and completed by fadministrator and Director of validate the effectiveness of 6 months. Fire Drills will be omonthly by the Maintenance oversight from the Administrator Existing to further compliance. Ongoing education will include Fire Safety training for currer provided by the local Fire Macompleted by January 15, 20 education will include: -General Fire Safety with a v presentation -When and How to correctly Extinguisher -When and How to correctly 	a personal fire cy for Fire gen in use and s possible he facility to a Resident on by not her tor of Nursing ucational plan hess during hg based on articipation in bservation of stration by bions will be the f Nursing to education for conducted Director with ator and t validate de additional ht facility staff arshall to be 017. This rideo use a Fire	

Facility ID: 922985

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/15 FORM APPRO OMB NO. 0938-	OVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345312		B. WING		C 12/21/2016	6
NAME OF PI	NAME OF PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, Z		
				1870 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB/H	ENDERSONVILLE		HENDERSONVILLE, NC 2879	91	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLE	ETIO
F 490	Continued Frame and	- 20				
F 490			F 4			
		ing and that Oxygen is not		Blanket		
	prohibited in designa	-		-Oxygen precautions wi	th regards to Fire	
		er usage to include the Pull,		Safety		
		weep method for effective		This training is schedule	a on the following	
		outlined in the facility policy		dates:	_	
	for Fire Managemen	۱. Ianket to cover and smother		-January 4, 2017 at 7an		
		personal fire as outlined in		-January 5, 2017 at 2:30 -January 11, 2017 at 10		
	the facility policy for	-		-January 12, 2017 at 3:		
		iny Oxygen in use and		A Fire Safety Video has		
		s soon as possible during a		the local Fire Marshall f		
	-	e facility policy for Fire		ongoing training.		
	Management.			The Administrator and E	Director of Nursing	
		attend to a Resident during		will have no tolerance for		
		ion by not leaving the		with the Facility Safe Sr		
		assistance has arrived.		and Fire Safety.		
				No staff shall work after	12/20/16 before	
	The Administrator ar	nd Director of Nursing will		receiving this education	. This education	
	oversee this updated	d educational plan for		has been added to the F	Facility Orientation	
	completion and effect	tiveness during orientation		program for all new hire	s and agency staff	
	and annual training b	based on observations and		to be completed prior to	beginning work in	
		n in training sessions.		resident care areas afte		
		of education and return		Ongoing Fire Safety trai		
		aff during educational		annually for all facility st		
		erved and completed by the		frequently if an opportur	-	
		rector of Nursing to validate		compliance is identified.		
		education for 6 months. Fire		The Administrator, Direc	-	
	Drills will be conduct			Nurse Manager are mor		
		or with oversight from the		resident smoking area o	-	
		rector of Nursing to further		for 30 days, 3 times per		
	validate compliance.			shift for 8 weeks, then w		
	Ongoing oducation w	vill include additional Fire		weeks to validate reside in designated areas, sat	-	
		vill include additional Fire Irrent facility staff provided by		including the smoking a		
		all to be completed by		fire extinguisher, accept	-	
		This education will include:		receptacles are availabl		
		The calcation will include.		required. During this m		
	-General Fire Safety	with a video presentation		validating that Oxygen is		
	-When and How to c			entering the designated		

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED	
						С	
		345312	B. WING		1	2/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC	
F 490	Continued From page	e 30	F 49	0			
	Extinguisher			They are also validating that s	upervision		
		prrectly use a fire Blanket		is present for resident assesse			
		with regards to Fire Safety		supervised smoker.			
				The Administrator or Director of	-		
	This training is sched	uled on the following dates:		will monitor observe orientatio			
	-January 4, 2017 at 7	am		hires as it occurs and monthly 6 months to validate Fire Safe			
	-January 5, 2017 at 2			is effective and completed as	, ,		
	-January 11, 2017 at			This monitoring will continue for	•		
	-January 12, 2017 at			and opportunities will be corre			
				immediately as they are identi	fied.		
		d Director of Nursing will		4.			
		noncompliance with the		The Administrator and Directo	-		
	Facility Sale Smoking	policies and Fire Safety.		will analyze the data obtained monitoring and report any patt	-		
	No staff shall work af	ter 12/20/16 before receiving		trends to the QAPI Committee			
		education has been added to		12 months. The QAPI Commit	•		
	the Facility Orientatio	n program for all new hires		evaluate the effectiveness of t	he above		
	and agency staff to be			plan and will add additional inf			
	U	ident care areas after		based on the outcomes identif	ied to		
	held annually for all fa	ire Safety training will be		ensure continued compliance Date of Compliance 1/20/17			
	-	tunity with compliance is					
	identified.						
	Immediate jeopardy v	vas removed on 12/21/16 at					
		ews with residents, nursing					
		taff and non-nursing staff					
		eceiving in-service training to remove all oxygen tanks					
		ing into the designated					
	smoking area, the ne						
	smoking materials, th	e available smoking					
	equipment including	smoking aprons, ashtrays,					
		fire blankets, the returned					
		to use a smoking blanket					
	found on fire. Intervie	ake when a resident was					
	monitors and observa						

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/15/207 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345312		B. WING		C 12/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		370 PISGAH DRIVE ENDERSONVILLE, NC 28791	
(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)	
F 490 F 518 SS=J	and verified by staff, removed prior to goin supervision with nece provided to all unsafe the administration rev smoking area regular maintained away fror designated area befo smoking area and ov related to emergency Administration put int schedule and secure local fire marshall. 483.75(m)(2) TRAIN PROCEDURES/DRII The facility must train procedures when the periodically review th staff; and carry out un those procedures. This REQUIREMENT by: Based on record rev interviews and reside failed to provide effect prevention and fire en resulted in second de dependent residents	ained in a secured location all oxygen tanks were og to the smoking area and essary equipment was e smokers. Interview with vealed they observe the rly to ensure that oxygen is in the smoking area in the ore residents enter the ersee the education of staff or preparedness. to place ongoing fire drill d additional training from the ALL STAFF-EMERGENCY	F 490	F518 1. On 12/6/16 Resident #2 was immediately assessed by the Charge Nurse and the EMS Responder then transferred to the Emergency Room fo further evaluation and admission. He returned to the facility on 12/7/16 and 1 declined to smoke since his	
	Resident #2 went out running, the nasal ca from the designated s	began on 12/06/16 when tside with his oxygen tank nnula in his nares, away smoking area and lit a ted in him catching himself		hospitalization. Resident #4 discharged from the facilit on 1/7/17. Summary of event: On 12/6/16 at approximately 8:30pm Resident # 2 was observed sitting outs	

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 02/15/20 ⁻ MAPPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	345312		B. WING	B. WING			C / 21/2016
NAME OF P	NAME OF PROVIDER OR SUPPLIER		[ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				18	370 PISGAH DRIVE		
BRIANCI	R HEALTH & REHAB/HI	ENDERSONVILLE		HI	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 318	518 Continued From page 32 on fire resulting in second degree facial and hand burns. Nurse Aide #1 who was in a nearby area at the time of the incident, failed to attempt to put out the flames via the use a fire extinguisher or fire blanket which were nearby. She left the resident on fire outside blocking the facility door as she attempted to obtain assistance by entering another facility door. Immediate jeopardy was removed on 12/21/16 at 3:26 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		F	518	the 400 Hall Door near the Resident Staff smoking area by CNA #1 who we exiting the facility, she did not notice Resident #2 was smoking. CNA# 1 walked past Resident # 2 to the staff smoking area less than 10 feet away she turned to sit down at the picnic ta she noticed flames at Resident #2 is and hands. CNA#1 immediately noti that Resident # 2 had an oxygen tank his wheelchair and a cannula in his m she attempted to turn off the Oxygen	vas if as ble face ced con ares, at	
	more than minimal ha jeopardy) to complete monitoring systems p related to staff being resident who is on fir The findings included	1:			the regulator but Resident #2 was fla his arms and had positioned himself the back of the wheelchair against th door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because wheelchair was blocking the door. C was reluctant to cover the resident w the Fire Blanket for fear of trapping n	with e he NA#1 th	
	Emergency Direction discovering fire or sn 1. Remove the reside	d June 2012 included the is under Fire Response-upon			oxygen and worsening the flames. CNA#1 then ran around the left corner the facility and called 911 on her cell as she was running to the front door facility for help. As she entered the finshe notified the Charge Nurse #1 and Supervisor #1. Charge Nurse# 1	ohone of the acility	
	Confine and Extingui The facility's Safe Sn	noking / Tobacco Use Policy,			immediately ran to the 400 Hall Door Resident #2 was no longer located th he had extinguished the flames and returned to his Resident Room # 207 the Charge Nurse #1 entered the Desident Room #207	ere,	
	oxygen is in use." No policy revised June 2	s NOT permitted while either this policy nor the Fire 2012 indicated the distance om any ignition source.			Resident Room #207 she noticed Resident #2 had applied his nebulize mask and started a nebulizer treatment he stated I am fine, just need to finish breathing treatment. Charge Nurse # and Supervisor # 1 immediately remo	ent, n my ¢ 1	

Facility ID: 922985

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TID	LE CONSTRUCTION	(X3) DATE SU)938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLE	
				С		
		345312	B. WING		12/21	/2016
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	CODE	
BRIAN CT	R HEALTH & REHAB/HE			1870 PISGAH DRIVE		
				HENDERSONVILLE, NC 28791	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE	(X5) COMPLETIO DATE
F 518	Continued From page	= 33	F 51	8		
		Storage and Assembly		the mask and began to a	ssess Resident	
		007 included "Do not smoke		#2 for injuries. Observati		
		oke within 10 feet while		black soot to the lower ha		
	oxygen is in use."			singed hair on the left sid	e of his head	
				and surrounding his face		
		nitted to the facility on		Department and the Eme		
	06/03/16. His diagno			Services arrived and imm		
		ronic obstructive pulmonary		transported Resident #2		
	disease, and being of			Emergency Room at, whe admitted in stable conditi		
	included oxygen was	orders dated 06/03/16		observation of burns to th		
	continuously at 3 liter			respiratory monitoring. O		
	continuousiy at 5 nici	s per minute.		Supervisor # 1 notified R		
	A Safe Smoking Eval	uation dated 10/05/16 and		daughter, the On Call Ph		
		m Data Set (MDS) Nurse #1		Facility Medical Director,	-	
		2 as a safe smoker and no		Administrator and the Fa	-	
	supervision was requ	ired while smoking. Under		Nursing.		
		s "instructed not to use O2		On 12/20/16 CNA #1 rec		
	(oxygen) when out sr	noking and voiced		education by the Director	u	
	understanding."			include the facility s poli		
				Management, Fire Exting	.	
	0	vith the Minimum Data Set		the use of a Fire Blanket	-	
		ducted on 12/20/16 at 9:35		personal fire, turning off a		
	smoke during his smo	e watched Resident #2		use during a fire, and to s attend to a resident durin	-	
	-	stated she assessed him in		situation by not leaving th		
		e oxygen tank on the back		further assistance has an		
		he further stated that she				
		n tank was turned off but		2. Current residents have	the potential to	
		turned it off or if she just		be affected by this same	-	
	made sure it was turr	ned off. MDS #1 stated that		practice.		
		essment, oxygen was		By 12/8/16 the Director o	_	
	-	he resident in the smoking		Assistant Director of Nurs	-	
		ank was turned off. MDS		Facility staff including Ad		
		this interview, and MDS		Nursing, Therapy, House		
		they had observed Resident		Dietary regarding the Fac		
	-	smoking area smoking with		Safe Smoking to include	-	
	the oxygen tank on th	ne back of his wheelchair		- Location and use of safe		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/15/20 APPROVE . 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE S COMPL	SURVEY LETED
	345312		B. WING			12/2	; 21/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/HI			18	370 PISGAH DRIVE		
Dianator				H	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 518	Continued From pag	e 34	F	518			
		mitted in the smoking area as			extinguisher and ashtrays and		
	long as the oxygen ta				receptacles.		
					On 12/20/16 an updated educational p	lan	
	Resident #2's quarte	rly MDS dated 11/30/16			was developed by the Interdisciplinary		
	coded him with intac			Team consisting of the Administrator,			
	issues or behavior is			Director of Nursing, Social Services,			
		mobility, transfers, walking,			Director of Rehab, Director of		
		, eating and hygiene. He			Housekeeping and Director of Dietary		
	had impaired vision,	able to see large print not			Services on to include Facility specific		
	newspaper print and	had no functional limitations			policy and procedures for Fire		
	of his upper and lowe	er extremities. He was			Management and Smoking that addres	s	
	coded as receiving o	xygen therapy.			Oxygen is prohibited in designated		
					smoking areas.		
	Review of the Situati				On 12/20/16 this Fire Safety education		
		mendation (SBAR) report			plan was reviewed and further develop		
		aled Resident #2 was outside			by the Administrator, Director of Nursin	•	
		gen tubing caught fire. His			and the Area Staff Development Direct	or	
		his nose had black singed			with assistance from the District Field		
	-	so indicated he stated he			Support Team. This review included		
	thought his oxygen w				involvement with the local Fire Marsha	I	
		vestigation Follow-up dated			who reviewed and accepted this plan.		
		esident #2 was out smoking			On 12/20/16 all facility staff including		
		nd set fire to his hair and			Administration, Nursing, Therapy,		
		sent to the emergency room.			Housekeeping and Dietary by the Administrator, Director of Nursing, Are		
	The new intervention	r supervised smoking.			Staff Development Director and Nurse	a	
		r supervised smoking.			Managers received this updated		
	Review of the hospit	al history and physical dated			education to include:		
	-	esident #2 was assessed			-The Facility policy and procedures for		
		(any degree) of his body			Fire Management, Smoking and that		
		ed to have second degree			Oxygen is not prohibited in designated		
	burns to his bilateral	0			smoking areas.		
		nitted to the intensive care			-Fire Extinguisher usage to include the		
		steroids and close monitoring.			Pull, Aim, Squeeze and Sweep method		
		-			effective fire extinguishing as outlined i	n	
	Resident #2 was rea	dmitted to the facility			the facility policy for Fire Management.		
	12/08/16 with physic	ian orders for topically			-Use of a Fire Blanket to cover and		
	applied antibiotics to	bilateral nares.			smother flames to manage a personal	fire	
					as outlined in the facility policy for Fire		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/15/201 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345312		B. WING		C 12/21/2016
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE			1870 PISGAH DRIVE HENDERSONVILLE, NC 28	791	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCED	IN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 518	Nurse Aide (NA) #1 w at 12:22 PM. She sta #2 smoke previous to Resident #2 would tu he went outside but g oxygen tank located of wheelchair. She stat that the oxygen tank back of the wheelcha stated she clocked of on break in the staff s Resident #2 who was the alcove just outsid to the smoking areas had oxygen in place of staff smoking area ar and crackling sound.' saw he had flames in stated he was flailing get close enough to t was sitting backed up facility and she could She stated she ran to building to obtain helf 911 on her cell phone about using the fire b when she placed the head, the running oxy the blanket and fuel t damage and possibly explode. Upon follow up interv 12/20/16 at 2:09 PM, been an emergency r to 10 years ago. She in the use of a fire bla benefit someone or n	vas interviewed on 12/19/16 ated she had seen Resident o the accident. She stated rn his oxygen tank off before generally smoked with the on the back of his ed she was never instructed should not be kept on the ir while he smoked. She ut the night of 12/06/16 to go smoking area. She passed a sitting in his wheelchair in e of the facility's exit leading . She could not recall if he or not. She proceeded to the nd then heard a "popping ' She turned around and front of his face. She his arms and she could not urn off the oxygen tank. He o, blocking the door to the not get inside the building. o the front entrance of the p at the same time calling e. She stated she thought lanket but was afraid that blanket over Resident #2's ygen would build up under	F 5	18 Management. -Discontinuing any Oxy removing the tank as as during a fire as outline policy for Fire Manage -Supervise and attend during an emergency as leaving the resident un assistance has arrived The Administrator and will oversee the ongoin of this updated educat completion and effective orientation and annual observations and ongo training sessions. More education and return d staff during educationat observed and complet Administrator and Dire validate the effectivent 6 months. Fire Drills w monthly by the Maintel oversight from the Adm Director of Nursing to f compliance. Ongoing education will Fire Safety training for provided by the local F completed by January education will include: -General Fire Safety w presentation -When and How to cor Extinguisher -When and How to cor Blanket -Oxygen precautions w	a spossible d by the facility ment. to a Resident situation by not situation by not raining based on bing participation in the based on bing participation in the based on bing participation in the based on bing participation of semonstration by al sessions will be ed by the ctor of Nursing to eas of education for vill be conducted nance Director with hinistrator and further validate I include additional current facility staff Fire Marshall to be 15, 2017. This with a video rectly use a Fire rectly use a fire

Facility ID: 922985

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		0.15040				С
			B. WING			12/21/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(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 ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 518	Continued From page	e 36	F 5	18		
		reach the oxygen tank to		Safety		
		due to the fire, she felt the		This training is scheduled	on the following	
		for him and for her. She did		dates:		
		re extinguisher because of		-January 4, 2017 at 7am		
		ns and was afraid the fire		-January 5, 2017 at 2:30pr	n	
		a pocket for the oxygen to		-January 11, 2017 at 10am		
		fire. She left him in order to		-January 12, 2017 at 3:30p		
	-	locking the door to reenter		A Fire Safety Video has be		
	the facility and called	911 while going to get help.		the local Fire Marshall for	use with	
	She stated she made	the decisions she did based		ongoing training.		
	on her EMT training.			The Administrator and Dire	ector of Nursing	
				will have no tolerance for r	noncompliance	
	On 12/19/16 at 2:32 I	PM, Resident #2 was		with the Facility Safe Smol	king policies	
	interviewed. Resider	nt #2 was observed with		and Fire Safety.		
	slight pinkness on his	s cheeks where oxygen		No staff shall work after 12	2/20/16 before	
	tubing would rest, his	nares were shiny with what		receiving this education.	This	
		tic ointment and his left		education has been added		
		ut quarter size between the		Orientation program for all		
		d base of his forefinger,		agency staff to be complet		
		from the fire. Resident #2		beginning work in resident		
		vatching television in the		after 12/20/16. Ongoing F	•	
		e decided to go outside to		training will be held annua		
		he was permitted to keep his		staff and more frequently it	••••••	
		ettes. He stated the wind		with compliance is identifie		
	•	ayed close to the door of the		The Administrator, Directo	-	
		esignated smoking area of		Nurse Manager are monito	-	
		lit his cigarette. He stated		resident smoking area dail		
		oxygen tubing was on his was running at this time. He		for 30 days, 3 times per we shift for 8 weeks, then wee		
		to take another puff on the		weeks to validate residents		
		"flashed" up. Resident #2		in designated areas, safety	•	
	-	cannula, eyebrows, nose		including the smoking apro		
		ed the nasal cannula off his		fire extinguisher, acceptab		
	-	the fire just went out. He		receptacles are available a		
		member was outside and		required. During this moni		
		an around the building to get		validating that Oxygen is re		
	-	es were out, he went back		entering the designated sn		
		his room and applied his		They are also validating th	-	
		Resident #2 stated he didn't		is present for resident asse		

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	ECONSTRUCTION		NO. 0938-039 TE SURVEY		
AND PLAN OF	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A. BUILDING				
						С		
	345312		B. WING			2/21/2016		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E				
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791				
(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 518	Continued From page	e 37	F 518					
	medical services (EM On 12/19/16 at 5:50 F (DON) stated that if a would expect staff to fire blanket as long as blowing oneself up. S the location of the res on the body. She sta individualized and she rescue and or making possible. The DON ful listened to NA #1's ex not use the fire blanket made logical sense to was thinking through she supported the act felt unsafe and wanter Resident #2. Interview with the Sta (SDC) on 12/20/16 at trained all new emplo smoking area and the prior to residents smot training upon orientat staff watched. She si to use the fire extingu there were no smoking	PM, the Director of Nursing resident was on fire, she try to smother the fire with a s there was no chance of She stated it depended on sident and where the fire was ted each situation would be e would expect some form of		supervised smoker. The Administrator or Director will monitor observe orientation hires as it occurs and monthly 6 months to validate Fire Safe is effective and completed as This monitoring will continue f and opportunities will be corre- immediately as they are ident 4. The Administrator and Director will analyze the data obtained monitoring and report any pat trends to the QAPI Committee 12 months. The QAPI Commitee 12 months. The QAPI Commitee plan and will add additional in based on the outcomes identi ensure continued compliance Date of Compliance 1/20/17	on for new of fire drills for ety Training required. for 6 months ected ified. or of Nursing during this terns and/or e monthly for ttee will the above formation fied to			
	routinely and as need	ompleted on admission, led for changes in condition. that the Maintenance wed fire safety with						

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY PLETED		
		345312	B. WING _			C 12/21/201	
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			870 PISGAH DRIVE ENDERSONVILLE, NC 28791		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 518	facility's smoking polity noncompliance to a s RACE. The video shift extinguisher. The vida a fire blanket or what fire, just what to do if was on fire. On 12/20/16 at 1:43 F that if a resident was do the best they could could. She stated that extinguisher should b fire blanket could be u of the fire. The Admin calling 911 was extrea felt the nurse aide did situation. The admininher decision to leave call 911. A phone interview witt 12/20/16 at 3:04 PM for would have been to u the fire. He further st oxygen gathering in a creating a possible ex- and mostly control the Phone interview with responding emergence on 12/20/16 at 3:30 PM for would have smothered Interview with the Ma 12/20/16 at 3:30 PM for new employees on the	cy, the need to report upervisor and training in owed how to use a fire eo did not show how to use to do if a resident was on a resident room or building PM the Administrator stated on fire, she expected staff to d and assist the best they it she was not sure if a fire e used on a person and the used depending on the size histrator stated that NA #1 mely important and that she what she could in that strator supported the NA in the resident to get help and h the local fire marshal on revealed that his first choice se a fire blanket to smother ated that the likelihood of pocket under the blanket splosion would be unlikely e fire. the Battalion Chief of the cy response team conducted M revealed that using a ent with oxygen flowing	F 5	518			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:				COMPLETED		
						С		
		345312	B. WING			12/	21/2016	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE					870 PISGAH DRIVE			
	HENDERSONVILLE, NC 28791							
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B					(X5) COMPLETION DATE		
F 518	Continued From page	30	E	518				
		ns located in plastic sleeves		010				
		ating this was a smoking						
	-	was allowed. He stated he						
	did not review with en blanket.	nployees how to use a fire						
		ewed on 12/20/16 at 4:47						
		she responded to NA #1						
		seen him on fire. Nurse #1 back in his room giving						
		eatment she had left ready						
		is upper lip and under his						
	nose was blackened a melted on his cheek.	and the oxygen tubing had						
		d Director of Nursing were e jeopardy on 12/20/16 at						
	4.57 FWI.							
	•	an acceptable allegation of /16 at 1:51 PM as follows:						
		oximately 8:30pm Resident						
		ng outside the 400 Hall Door d Staff smoking area by NA						
		he facility, she did not notice						
		noking. NA #1 walked past						
		aff smoking area less than						
	-	turned to sit down at the						
	-	ed flames at Resident #2's #1 immediately noticed that						
	Resident #2 had an o	-						
		nula in his nares, she						
	attempted to turn off t	the Oxygen at the regulator						
		flailing his arms and had						
		th the back of the wheelchair						
	-	she was unable to reach the lso unable to re-enter the						
	-	se the wheelchair was						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/15/2017 1 APPROVED): 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345312					C 12/21/2016		
	ROVIDER OR SUPPLIER	NDERSONVILLE		1870 P	T ADDRESS, CITY, STATE, ZIP C IISGAH DRIVE IERSONVILLE, NC 28791	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE		(X5) COMPLETION DATE
F 518	blocking the door. Na the resident with the I trapping more oxyger NA #1 then ran aroun facility and called 911 was running to the fro help. As she entered Charge Nurse #1 and Nurse #1 immediately and Resident #2 was had extinguished the Resident Room # 207 entered the Resident Resident #2 had appl started a nebulizer tre fine, just need to finis Charge Nurse #1 and removed the mask ar #2 for injuries. Obser to the lower half of his left side of his head a The Fire Department Services arrived and Resident #2 to the Er was admitted in stabl observation of burns respiratory monitoring notified Resident #2's Call Physician, the Fa Facility Administrator Nursing. On 12/20/16 NA #1 re education by the Dire the facility's policy reg Fire Extinguisher usa to extinguish a person	A #1 was reluctant to cover Fire Blanket for fear of and worsening the flames. In the left corner of the on her cell phone as she out door of the facility for the facility she notified the the Supervisor #1. Charge y ran to the 400 Hall Door no longer located there, he flames and returned to his 7. As the Charge Nurse #1 Room #207 she noticed lied his nebulizer mask and eatment, he stated "I am h my breathing treatment." I Supervisor #1 immediately nd began to assess Resident rvations included black soot is face and singed hair on the and surrounding his face. and the Emergency Medical immediately transported mergency Room, where he e condition to the ICU for to the nasal area and g. On 12/6/16 Supervisor #1 is responsible party, the On acility Medical Director, the and the Facility Director of	F	518				

Facility ID: 922985

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/15/2017 MAPPROVED O. 0938-0391	
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345312	B. WING		12	C 2/21/2016	
	ROVIDER OR SUPPLIER	ENDERSONVILLE	18	REET ADDRESS, CITY, STATE, ZIP CO 70 PISGAH DRIVE ENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 518	situation by not leavin assistance has arrive 2. Current residents h affected by this same By 12/8/16 the Direct Director of Nursing et including Administrati Housekeeping and D Policy for Safe Smok - Location and use of area including the fire extinguisher and ash On 12/20/16 an upda developed by the Inte consisting of the Adm Nursing, Social Servi Director of Housekee Services on to includ procedures for Fire M that address Oxygen smoking areas. On 12/20/16 this Fire reviewed and further Administrator, Directo Staff Development Di the District Field Sup included involvement who reviewed and act On 12/20/16 all facilit Administration, Nursi and Dietary by the Adv Nursing, Area Staff D	ng the resident until further d. have the potential to be alleged deficient practice. or of Nursing and Assistant ducated all Facility staff on, Nursing, Therapy, ietary regarding the Facility ing to include the following: safety equipment in this a blanket, the fire trays and receptacles. ted educational plan was erdisciplinary Team hinistrator, Director of ces, Director of Rehab, ping and Director of Dietary le Facility specific policy and lanagement and Smoking is prohibited in designated Safety educational plan was developed by the or of Nursing and the Area irector with assistance from port Team. This review with the local Fire Marshall cepted this plan.	F 518				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/15/2017 1 APPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345312	B. WING _					_ 21/2016
	ROVIDER OR SUPPLIER	ENDERSONVILLE		187	EET ADDRESS, CITY, STATE, ZIP CO 0 PISGAH DRIVE NDERSONVILLE, NC 28791	DE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI		(X5) COMPLETION DATE
F 518	to include: -The Facility policy ar Management, Smokin prohibited in designat -Fire Extinguisher usa Squeeze and Sweep extinguishing as outli Fire Management. -Use of a Fire Blanke flames to manage a p the facility policy for F -Discontinuing any O the tank as soon as p outlined by the facility Management. -Supervise and attended emergency situation further assistance The Administrator and oversee the ongoing updated educational effectiveness during of training based on obse participation in training observation of educat demonstration by stat sessions will be obse Administrator and Dir the effectiveness of e Drills will be conducted Maintenance Director Administrator and Dir validate compliance. Ongoing education w Safety training for all	nd procedures for Fire ng and that Oxygen is not ted smoking areas. age to include the Pull, Aim, method for effective fire ned in the facility policy for t to cover and smother bersonal fire as outlined in Fire Management. xygen in use and removing bossible during a fire as y policy for Fire d to a Resident during an by not leaving the resident are has arrived. d Director of Nursing will implementation of this plan for completion and prientation and annual servations and ongoing to sessions. Monthly tion and return ff during educational rved and completed by the rector of Nursing to validate aducation for 6 months. Fire	F	518				

Facility ID: 922985

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM): 02/15/2017 1 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345312	B. WING			_ 21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 518	Continued From page	e 43	F 518			
	15, 2017. This educa	tion will include:				
	-General Fire Safety -When and How to co Extinguisher	with a video presentation prrectly use a Fire				
		prrectly use a fire Blanket with regards to Fire Safety				
	This training is sched	luled on the following dates:				
	-January 4, 2017 at 7 -January 5, 2017 at 2 -January 11, 2017 at -January 12, 2017 at	2:30pm 10am				
	have no tolerance for	d Director of Nursing will noncompliance with the policies and Fire Safety.				
	this education. This e the Facility Orientation and agency staff to b beginning work in res 12/20/16. Ongoing F held annually for all fa	sident care areas after ire Safety training will be				
	3:26 PM when intervi administrative staff, a confirmed they had re facility's procedure to extinguisher, correctl discontinue oxygen if resident involved unt staff training was revi	eceived training on the correctly use a fire				

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		ID HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION		0. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
							С	
		345312	B. WING			12/	21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/HE				870 PISGAH DRIVE			
				F	IENDERSONVILLE, NC 28791			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	O THE APPROPRIATE		
					DEFICIENCY)			
		- 44	_					
F 518	Continued From page		F	518				
		oking are, storage for oxygen oking area and storage of						
	smoking materials wa							
	-	-						

Facility ID: 922985

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