		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			IPLETED
		345312	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			06/07/2017	
				18	370 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		н	ENDERSONVILLE, NC 28791		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 282 SS=D			F	282			6/27/17
	(h)(2) Comprohensiv	e Care Diana					
	(b)(3) Comprehensive	d or arranged by the facility,					
		mprehensive care plan,					
accordan care. This REC		ualified persons in h resident's written plan of					
		Γ is not met as evidenced					
		iews and staff interviews the			Preparation and / or execution of this		
		the care plan for proper npled residents (Resident			plan does not constitute admission or	of	
	#1).	npied residents (Resident			agreement by the provider of the truth the facts alleged or conclusions set for on the statement of deficiencies. This	rth	
	The findings included	1:			of correction is prepared and / or executed solely because required.		
	dated 02/03/17 indica	I Minimum Data Set (MDS) ated Resident #1 had short					
	understood, and was	ry problems, was rarely severely impaired in daily ne MDS also indicated			F282-D services by Qualified Persons. Care Plan	Per	
	Resident #1 had diag				(a) What corrective actions will be accomplished for those residents foun	d to	
		d Resident #1 required			have been affected:		
	extensive assistance limited range on moti	with transfers and had on on one side.			Information for Resident #1 was taken from a closed medical record review.		
	Review of the care pl	lan initiated on 02/03/17 and			(b) How will you identify other resident	s	
	updated on 05/17/17	at the quarterly review			having the potential to be affected and		
	indicated Resident # ² with 2 staff assistanc	1 required a mechanical lift			what corrective action will be taken:		
	with ∠ stan assistd10				The Director of Nursing and or Nursing	3	
		ent Care Specialist (RCS)			Managers re-educated current nursing	l	
	· · ·	ndicated what care a resident			staff to include Licensed Nurses, Certi	fied	
		16 indicated Resident #1 had nce with transfers and the			Nursing Assistants and Certified Medication Aides on following the		
		SUPPLIER REPRESENTATIVE'S SIGNATUR			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.

06/27/2017

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	LE CONSTRUCTION		ATE SURVEY OMPLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	i		
						С
		345312	B. WING			06/07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
BRIAN CT	R HEALTH & REHAB/HE			1870 PISGAH DRIVE		
BRIANOT				HENDERSONVILLE, NC 28791		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLETIO DATE
F 282	Continued From page	e 1	F 28	2		
	use of a mechanical I	lift with 2 people.		residents care plan with a	focus on	
				transfer status and reportir		
	During an interview o	n 06/05/17 at 1:51 PM,		in resident status related to		
	Nurse #1 stated Resi	dent #1 required total care		transfer needs to the nurse	-	
		communicate. Nurse #1		re-education was complete	ed by 6/27/17.	
		nk the RCSs always used				
		1. Nurse #1 also stated she		(c) What measures will be		
		was fearful of the lift. Nurse		what systemic changes wil	I be made to	
		had not told Administration		ensure this will not recur:	lude literated	
	Resident #1 was fear			Current nursing staff to inc		
	whether they were av	vare of this.		Nurses, Certified Nursing A Medication Aides were re-		
	During an interview o	n 06/05/17 at 3:02 PM, RCS		Director of Nursing, and or	•	
		1 required total care and the		Managers. Education was		
		nical lift for transfers. RCS		6/27/27 regarding the requ		
		at she and RCS #7 had		compliance with F282 with		
		#1 without the mechanical		mechanical lift transfers. N		
		to her hospital bed on the		will be educated by the Sta	aff Development	
	afternoon of 05/22/17	7. RCS #2 also		Coordinator/designee on th	nis component	
	acknowledged she th	ought she was the only RCS		as well.		
	who transferred Resid	dent #1 without the use of a				
	mechanical lift.			(d) How the corrective active		
				monitored to ensure the pr		
	-	on 06/06/17 at 9:20 AM, the		recur, ie, what quality assu	irance program	
	-	er (RM) stated she was		will be put into place:		
		t #1 and knew the resident		The Director of Nursing an		
		I no active movement. The		Managers will observe 3 tr		
		lent #1 had always required cal lift for transfers. The RM		each shift, each week x 12 validate the resident is bei		
		I not imagine staff attempting		according to the care plan.		
		using a lift; she was a rather		opportunities identified will	•	
	large lady and unable			immediately. The Director		
		I stated "it would have been		report the results of these		
		transfer her without a lift"		observations to the QAPI of		
	because Resident #1			monthly. The committee w		
		-		recommendations to change		
	During an interview o	n 06/06/17 at 9:58 AM, RCS		this plan based on the rest		
	-	orked with Resident #1 on		audits and observations Su		
	05/20/17 and 05/21/1	7. RCS #3 also stated that		compliance will be sustained	ed through	

Facility ID: 922985

If continuation sheet Page 2 of 14

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
						С
		345312	B. WING		0	6/07/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
BRIAN CT	R HEALTH & REHAB/HI	ENDERSONVILLE		1870 PISGAH DRIVE		
				HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 282	Continued From pag	e 2	F 28	2		
		#8 on 5/20/17 and RCS #9	120	ongoing monitoring through p	erformance	
	0	sferred Resident #1 without		improvement projects.	ononnanoo	
	the lift. When asked	why the lift was not used,				
		a "time saver" to move				
	Resident #1 with and the lift.	other RCS instead of using				
	During an interview of	on 06/06/17 at 12:54 PM,				
	RCS #4 stated she h	ad assisted RCS #5 to get				
		ed and into the geri-chair on				
		ing. RCS #4 stated she				
		sferred Resident #1 out of				
		-chair by each of them				
		te side of the resident, lifting				
		vhile grabbing her pants at				
		e her over. RCS #4 also				
		ised a sling or a sheet under oving her to the geri-chair.				
		d she felt like they could				
		t #1, she and RCS #5 had				
		, and it was a "time saver" for				
	them.					
	During an interview o	on 06/06/17 at 3:03 PM, RCS				
	-	sistance from RCS #4 to get				
		ed and into the geri-chair on				
		ing. RCS #5 stated they				
		and arm by putting their arms				
		and holding the back of her r into the geri-chair. RCS #5				
		s an assignment sheet				
	indicating what assis	tance a resident needed.				
		d she did not know this sheet				
		arch 2017. RCS #5 stated				
		king at it and thought it said I a lift and 2 people for				
	-	ated she had been trained				

Facility ID: 922985

If continuation sheet Page 3 of 14

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345312	B. WING		C 06/07/2017
NAME OF P	ROVIDER OR SUPPLIER	•	- <u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	• • •
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	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 282	facility, to transfer Re arm" technique which manually using 2 peo never used the mech Resident #1 but she of one person and alwa her for transfers. During an interview of #6 stated she did not Resident #1 had resid cared for her several had been told she co people assisting and but could not rememb During an interview of Nurse #2 stated she it to transfer Resident # the RCS was not usin Resident #1 could be the lift, the RCS need Nurse #2 stated that not aware if that requi During an interview of RCS #7 stated Resid transferred by mecha assisting. RCS #7 state one time she had not Resident #1 and this During an interview of Minimum Data Set Co between therapy and was made how best to MDSC stated althoug transfer of Resident #	sident #1 using the "arm and n was transferring her ople. RCS #5 stated she had anical lift to transfer could not be moved with just ys had a second RCS with an 06/06/17 at 5:39 PM, RCS work the hall where ded very often, but she had times. RCS #6 stated she uld move Resident #1 with 2 without the mechanical lift, ber who told her. an 06/06/17 at 5:49 PM, had never assisted an RCS #1. Nurse #2 also stated if ng the lift or thought transferred easier without led to let a nurse know. was an easy fix and she was est had been made. an 06/07/17 at 11:05 AM, ent #1 was supposed to be unical lift with 2 persons ated she could think of only used the mechanical lift for	F 2	82	

Facility ID: 922985

If continuation sheet Page 4 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/30/2017 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345312	B. WING			(06/	07/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NO	28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282 F 323 SS=D	which RCS she spoke she showed the RCS asked if the information MDSC further stated follow what was put or reflected on the assig daily. During a 2nd interview the DON acknowledg had not been aware of following the care play use of the mechanical expectations were for if they felt like the assis changed to tell the nur re-evaluated and chain During an interview of Administrator acknow she had not been aware for use of the mechan stated her expectation the care plan as a livit changes needed to be come to her and discu- needed. The Adminis had identified the use issue and this had be Quality Assurance an a Performance Improv 06/01/17, but had yet close of this investiga	ut she was unable to recall e to. The MDSC also stated the assignment sheet and on was still the same. The she expected the RCSs to in the care plan as this was inment sheet and updated w on 06/07/17 at 1:01 PM, ed that prior to 5/30/17 she of any RCSs that were not in or assignment sheet for I lift. The DON stated her the RCSs to use the lift and ignment sheet needed to be irse so it could be inged if needed. in 06/07/17 at 2:08 PM, the fieldged that prior to 5/30/17 are of any RCSs that were plan or assignment sheet nical lift. The Administrator is were for staff to "follow ing, breathing tool" and if e made that staff would uss why the change was strator also stated the facility of mechanical lifts as an en brought before the d Assurance Committee and vement Plan was started on to be completed at the tion. (3) FREE OF ACCIDENT	F 2				6/27/17

If continuation sheet Page 5 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/30/2017 (I APPROVED): 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION		LETED
		345312	B. WING _				C 07/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHAB/HE			18	70 PISGAH DRIVE		
BRIANCI				H	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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	from accident hazards (2) Each resident rece and assistance device (n) - Bed Rails. The f appropriate alternative bed rail. If a bed or si must ensure correct in maintenance of bed ra- to the following eleme (1) Assess the residen from bed rails prior to (2) Review the risks a the resident or residen informed consent prior (3) Ensure that the be appropriate for the res This REQUIREMENT by: Based on record revi facility failed to transfe mechanical lift and 2 p sampled residents (Re- The findings included Resident #1 was adm 09/09/08 originally, wi	ure that - onment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility nstallation, use, and ails, including but not limited ents. In for risk of entrapment installation. Ind benefits of bed rails with nt representative and obtain or to installation. ed's dimensions are sident's size and weight. is not met as evidenced ews and staff interviews the er a resident with a people assisting for 1 of 5 esident #1). : itted to the facility on ith a readmit date of	F3	323	F323 Free of Accident hazards/supervision/devices (a) What corrective action will be accomplished for those residents found have been affected: Information for Resident #1 was taken from a closed medical record review.		
	05/24/17 after a brief the annual Minimum I	hospitalization. A review of			(b) How will you identify other residents having the potential to be affected and what corrective action will be taken:	5	

Event ID: ZFQN11

Facility ID: 922985

If continuation sheet Page 6 of 14

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SUR	938-03
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLETE	
			A. BOILDING	<u> </u>	с	
		345312	B. WING		06/07/2	2017
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP		
				1870 PISGAH DRIVE		
BRIAN CI	R HEALTH & REHAB/HE	INDERSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	THE APPROPRIATE	DMPLETIO DATE
F 323	Continued From page	e 6	F 32	23		
	long term memory pro	oblems, was rarely		The Director of Nursing a	nd / or Nursing	
	understood, and was	severely impaired in daily		Managers conducted an		
		e MDS also indicated		residents requiring a med		
	Resident #1 had diag	.		transfer to validate transfer		
		entia among others. The		are complete and accurate		
		d Resident #1 required		plan reflects the accurate		
		with 2 persons assisting for range on motion on one		Incident reports for the la assessed to ensure those	-	
	side, and could not st			requiring a total lift had no		
		and and bear weight.		audit was completed by 6		
	Review of the Reside	ent Care Specialist (RCS)				
		ndicated what care a resident		(c) What measures will be	e put into place	
		16 indicated Resident #1 had		or what systemic changes		
	required total assista	nce with transfers and the		ensure this will not recur:		
	use of a mechanical I			Current nursing staff to in Nurses, Certified Nursing		
		an initiated on 02/03/17 and		Certified Medication Aide		
		at the quarterly review		re-educated by the Direct		
		1 required a mechanical lift		and or Nurse Managers in		
	with 2 staff assistance	e for transfers.		Staff Development nurse the resident lift status as		
	During an interview o	n 06/04/17 at 5:43 PM,		planned, obtaining the ap		
	Resident Care Specia			pad, position the lift pad u		
	Resident #1 had beer			resident, attaching the lift		
		ft leg and right arm. RCS #1		mechanical lift, all aspect		
	-	people to move her. RCS #1		and safe movement durin		
		2 people to move her from		will return demonstrate sa		
		RCS #1 stated Resident #1		techniques using the med		
	•	e lift hurt her and that she		according to the facility lif		
	did not seem to mind	μ being in the lift.		policy. Education was con	-	
	During an interview o	n 06/05/17 at 1:51 PM,		6/27/17. Newly hired staft by the Staff Development		
	-	dent #1 had been total care		Coordinator/designee on		
		communicate. Nurse #1		as well.		
		nk the RCSs always used				
		1. Nurse #1 also stated she		(d) How the corrective ac	tion will be	
		was fearful of the lift. Nurse		monitored to ensure the p		
	#1 further stated she			recur, i.e., what quality as		
	Administrator Reside	nt #1 was fearful and was		program will be put into p	lace:	

Facility ID: 922985

TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) D	NO. 0938-039 DATE SURVEY OMPLETED
			A. BUILDIN	G			C
		345312	B. WING				06/07/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			PISGAH DRIVE DERSONVILLE, 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 323	Continued From page	27	F 32	23			
C	not sure whether they			M	ne Director of Nursing and Nurse anagers will observe 3 transfers,	one on	
	During an interview on 06/05/17 at 3:0 #2 stated Resident #1 had been total required the use of a total lift for transf #2 acknowledged that she and RCS #	I had been total care and total lift for transfers. RCS		va ac	ach shift, each week x 12 weeks alidate the resident is being trans ccording to the care plan. Any	ferred	
	transferred Resident #1 manually from the geri-chair to her hospital bed on 05/22/17. RCS #2 also acknowledged she thought she was the			in re	pportunities identified will be corre- nediately. The Director of Nursi port the results of these audits a pservations to the QAPI committ	ng will nd	
		erred Resident #1 without		m re	onthly. The committee will make commendations to change or im is plan based on the results of th	prove	
	During an interview o Rehabilitation Manag familiar with Resident		au co	udits and observations. Substantion ompliance will be sustained throu ngoing monitoring through perform	ial ugh		
	had contractures and RM also stated Resid	no active movement. The ent #1 had always required cal lift for transfers. The RM			provement projects	mance	
	further stated "I could to move her without u	not imagine staff attempting sing a lift; she was a rather					
		l stated "it would have been ransfer her without a lift"					
	#3 stated she had wo 05/20/17 and 05/21/1 she along with RCS #	n 06/06/17 at 9:58 AM, RCS rked with Resident #1 on 7. RCS #3 also stated that t8 on 5/20/17 and RCS #9 sferred Resident #1 without					
	the lift. When asked RCS #3 stated it was	why the lift was not used, a "time saver" to move ther RCS instead of using					
	RCS #4 stated she ha Resident #1 out of be	n 06/06/17 at 12:54 PM, ad assisted RCS #5 to get d and into the geri-chair on ng. RCS #4 stated she					

		MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			MPLETED
					-	С
		345312	B. WING			6/07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		0/01/2011
				1870 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		HENDERSONVILLE, N	C 28791	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER	'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX		ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO
F 323	Continued From page	e 8	F 3	23		
		osed to use a total lift, but		20		
		sferred Resident #1 out of				
		-chair by each of them				
		ne resident, lifting her under				
		ing her pants at the waistline				
	-	ne RCS stated her feet were				
da th		not touch anything while				
		g her over to the geri-chair.				
		they had not used a sling or				
		ent #1 while moving her to				
		#4 further stated she felt like				
		ve Resident #1, she and				
		lems doing it, and it was a				
	"time saver" for them					
	During on interviews	- 00/00/47 at 2:02 DM DOO				
		on 06/06/17 at 3:03 PM, RCS				
		sistance from RCS #4 to get				
		ed and into the geri-chair on				
		ing. RCS #5 stated they and arm by putting their arms				
		and holding the back of her				
		into the geri-chair. RCS #5				
		#1 showed no signs or				
		en she had been transferred				
	-	ormal when they transferred				
		RCS #5 also stated there				
	was an assignment s					
	-	t needed. RCS #5 further				
		ow this sheet even existed				
		en though she had worked at				
		nonths. RCS #5 stated she				
	-	at it and thought it said				
	-	a lift and 2 people for				
	transfers. RCS #5 st	ated she had been trained				
	by another RCS who	no longer worked at the				
		sident #1 using the "arm and				
	arm" technique which	n was transferring her				
	manually using 2 peo	pple. RCS #5 stated she had				
	"never" used the med	1	1			1

Facility ID: 922985

If continuation sheet Page 9 of 14

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345312	B. WING					C 07/2017
	Rovider or Supplier R Health & Rehab/He	NDERSONVILLE	•		STREET ADDRESS, CITY, STAT 1870 PISGAH DRIVE HENDERSONVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 323	could not be moved w always had a 2nd RC During an interview o #6 stated she did not Resident #1 had resid cared for her several had been told she cou- people assisting withour remember who told h were mechanical lifts required the use of 2 During an interview o Nurse #2 stated she H to transfer Resident # the RCS was not usin Resident #1 could be the lift, the RCS need Nurse #2 stated that w not aware if that required During an interview o Director of Nursing (Di interview with RCS # stated she and anoth mechanical lift to trans geri-chair to the bed of The DON stated they re-educating staff abo protocol for mechanical During an interview o RCS #7 stated Resid transferred by mechan assisting. RCS #7 states	5 also stated Resident #1 vith just one person and S with her for transfers. In 06/06/17 at 5:39 PM, RCS work the hall where ded very often, but she had times. RCS #6 stated she uld move Resident #1 with 2 but a lift, but could not er. RCS #6 stated there available and they always people. In 06/06/17 at 5:49 PM, had never assisted an RCS 41. Nurse #2 also stated if fig the lift or thought transferred easier without led to let a nurse know. was an easy fix and she was est had been made. In 06/07/17 at 9:44 AM, the DON) stated during an 1 on 05/30/17, RCS #1 er RCS had not used the sfer Resident #1 from the on the afternoon of 05/22/17. began the process of but the proper use and cal lift use on 05/30/17. In 06/07/17 at 11:05 AM, ent #1 was supposed to be nical lift with 2 persons ited she could think of only used the mechanical lift for	F	32:	3			

Facility ID: 922985

If continuation sheet Page 10 of 14

		8. MEDICAID SERVICES OMB DOCATO SERVICES OMB DOCATO SERVICES (x1) PROVIDERSUPPLENCIAL DENTIFICATION NUMBER: A BUILDING (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE SURVEY COMPLETED 346312 B. WIND STREET ADDRESS. CITY. STATE, ZIP CODE 1970 PISGAH ORVE HENDERSONVILLE (x3) DATE SURVEY HENDERSONVILLE, NC 28791 STREET ADDRESS. CITY. STATE, ZIP CODE 1970 PISGAH ORVE HENDERSONVILLE, NC 28791 (x4) DATE SURVEY HENDERSONVILLE (x4) DATE SURVEY HENDERSONVILLE (x4) DATE SURVEY HENDERSONVILLE, NC 28791 STREET ADDRESS. CITY. STATE, ZIP CODE 1970 PISGAH ORVE HENDERSONVILLE, NC 28791 (x4) DATE SURVEY HENDERSONVILLE (x4) DATE SURVEY DEPICIENCY (x4	APPROVED				
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	• •			(X3) DATE COMP	SURVEY PLETED
		345312	IERVICES vsupPLIERCLIA ATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345312 B. WING ILE STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791 FICIENCIES CEDED BY FULL 3 INFORMATION) PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTIONS CROSS-REFERENCED TO THE A DEFICIENCY) F 323 F 323 t 12:05 PM, IDSC) stated commendation esident. The to observed a d her they were ? person assist o recall which so stated she sheet which lift and 2 e information ther stated she was put on the the assignment 7 at 1:01 PM, to 5/30/17 she that were not eent sheet for dent #1. The e for the RCSs if they felt like ed to tell the and changed if			-	
NAME OF P	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
BRIAN CT	R HEALTH & REHAB/HE	INDERSONVILLE					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
F 323	05/22/17 in the aftern During an interview of Minimum Data Set Co between therapy and was made how best to MDSC stated althoug transfer of Resident # still using the mechan for transfers, but she RCS she spoke to. T showed the RCS the indicated the use of a person assistance an was still the same. T expected the RCSs to care plan as this was sheet and updated da During a 2nd interview the DON acknowledg had not been aware of following the care pla use of the mechanica DON stated her expe to use the lift for Resi use of the lift needed nurse so it could be re needed. During an interview of Administrator acknow she had not been aware	oon. n 06/07/17 at 12:05 PM, bordinator (MDSC) stated nursing a recommendation o transfer a resident. The th she had not observed a 41, a RCS told her they were nical lift and 2 person assist was unable to recall which the MDSC also stated she assignment sheet which mechanical lift and 2 d asked if the information he MDSC further stated she o follow what was put on the reflected on the assignment aily. w on 06/07/17 at 1:01 PM, ed that prior to 5/30/17 she of any RCSs that were not n or assignment sheet for I lift for Resident #1. The ctations were for the RCSs dent #1 and if they felt like to be changed to tell the e-evaluated and changed if n 06/07/17 at 2:08 PM, the vedged that prior to 5/30/17 are of any RCSs that were	F	323			
	for use of the mechar stated her expectation care plan as a "living, changes needed to b	nical lift. The Administrator ns were for staff to follow the breathing tool" and if					

Facility ID: 922985

If continuation sheet Page 11 of 14

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
		345312	B. WING		0	C 6/07/2017
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COE	DE	
BRIAN CT	R HEALTH & REHAB/H	ENDERSONVILLE		870 PISGAH DRIVE IENDERSONVILLE, 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 323 F 520 SS=D	needed. The Admini had identified the use issue and this had be Quality Assurance and a Performance Impro 06/01/17, but had no of this investigation. 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS (g) Quality assessme (1) A facility must ma and assurance comm minimum of: (i) The director of nur (ii) The Medical Direct (iii) At least three oth staff, at least one of v administrator, owner, individual in a leaders (g)(2) The quality ass committee must : (i) Meet at least quar coordinate and evalu identifying issues witt assessment and assi necessary; and (ii) Develop and imple	strator also stated the facility e of mechanical lifts as an een brought before the ad Assurance Committee and ovement Plan was started on t been completed at the end (i)(ii)(h)(i) QAA BERS/MEET Sent and assurance. intain a quality assessment nittee consisting at a rsing services; etor or his/her designee; er members of the facility's who must be the a board member or other ship role; and sessment and assurance terly and as needed to ate activities such as h respect to which quality	F 323			6/27/17

If continuation sheet Page 12 of 14

		ND HUMAN SERVICES				FOF	ED: 06/30/20 MAPPROVE O. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345312			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345312	B. WING		C 06/07/2017			
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/HE			1870 PISGAH DRIVE				
			HI	ENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	TAG (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO T		IOULD BE COMPLETION		
F 520	A HEALTH & REHAB/HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility's Quality Assurance (QA) Committee failed to maintain implemented procedure and monitor those procedures put into place in August of 2016 to correct deficient practice in the area of following the care plan (F282). F282 was recited again on the current survey. The continued failure of the facility during a federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F 282 - Based on record reviews and staff interviews the facility failed to follow the care plan for proper transfer for 1 of 5 sampled residents (Resident #1). During an interview on 06/07/17 at 2:08 PM the Administrator stated the QA Committee met monthly but would also have Ad Hoc QA meetings between monthly meetings if an opportunity for		F 520		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	This tag is cross refer F 282 - Based on rec interviews the facility for proper transfer for (Resident #1). During an interview of Administrator stated to monthly but would also			Clinical Services on June 23,2017. The education included the QAPI program the expectations associated with the program. The program enables the identification of opportunities for improvement, prioritization of those opportunities, root cause analysis, performance improvement plans and	ne n and			

Facility ID: 922985

If continuation sheet Page 13 of 14

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345312		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C	
		B. WING			06/07/2017			
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE			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			ULD BE COMPLETIC		
F 520	identified issues and analysis to determine done, how it affected be done for everyone monitoring and auditi place. The Administr re-education is often needed to be more m corrective actions we	the Administrator verified they attempted a root cause what happened, what was everyone, what needed to e else, and what type of ng needed to be put in rator further stated a main focus and there nonitoring to make sure ere being followed. The oted the care plan was a tool	F 5	220	QAPI committee has reviewed the meeting minutes for the past 3 months identify trends and ensure actions hav been completed as it relates to the previous cited tag of 282. Education was provided on June 23, 2 for the QAPI committee members regarding the purpose of the QAPI committee meeting and their responsibilities as QAPI members. QAPI will be held weekly x 4 weeks the monthly to discuss F282 following the care plan. The Administrator/Director Nursing will analyze the data obtained report patterns/trends to the QAPI monthly x 3 months with ongoing monitoring as the committee deems appropriate for any trends identified.	ve 2017 en of		

If continuation sheet Page 14 of 14