PRINTED: 10/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING_				C 22/2017
	ROVIDER OR SUPPLIER R HEALTH & REHAB/HE	NDERSONVILLE		1870 PISC	DDRESS, CITY, STATE, ZIP CODE GAH DRIVE RSONVILLE, 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 279 SS=D	assessments completed months in the resident results of the assessment and revise the resident plan. 483.21 (b) Comprehensive Comprehensive persodured each resident, consist set forth at §483.10(c) includes measurable to meet a resident's mand psychosocial need comprehensive assess care plan must describility. The services that a or maintain the resident physical, mental, and required under §483.24 (ii) Any services that winder §483.24, §483.25 (iii) Any specialized services provided as a result of	est maintain all resident red within the previous 15 t's active record and use the nents to develop, review nt's comprehensive care are Plans evelop and implement a n-centered care plan for tent with the resident rights (2) and §483.10(c)(3), that objectives and timeframes nedical, nursing, and mental reds that are identified in the sement. The comprehensive be the following - are to be furnished to attain rent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not resident's exercise of rights ling the right to refuse .10(c)(6).	F	279			10/20/17
ARODATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>		TITI F		(X6) DATE

10/16/2017

Electronically Signed

Facility ID: 922985

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345312	B. WING _		0.0	C 9/ 22/2017	
	ROVIDER OR SUPPLIER	HENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	•	57 22 /2517	
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F 279	rationale in the resident (iv) In consultation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. I whether the reside community was as local contact agenentities, for this puture (C) Discharge plan plan, as appropriar requirements set if section. This REQUIREME by: Based on observatinct include psychoact individualized care reviewed for unnerside was a section. The findings included Resident #165 was 06/20/17 with diagonal dementia, symbolicand ataxia. Resident #165's a section resident #165's a section in the	SARR, it must indicate its sident's medical record. with the resident and the ntative (s)- goals for admission and preference and potential for facilities must document ent's desire to return to the essessed and any referrals to incies and/or other appropriate entryose. In sin the comprehensive care te, in accordance with the forth in paragraph (c) of this entry is not met as evidenced entry in the facility failed to ive medications in an entry plan for 1 of 6 residents cessary medications (Resident ded: Is admitted to the facility on gnoses including history of its dysfunctions, gait abnormality demission Minimum Data Set	F2	F279 (D) Develop Compre Plans How will corrective action b accomplished for those resi have been affected by the correctice: The process that lead to de practice: The MDS coordinate have reviewed all the carepall CAA striggered were a careplanned. On 9/21/17, the comprehend	e idents found to deficient ficiency ator should blans to assure ddressed and		
	'	nt dated 06/27/17 revealed he		for resident #165 was upda			

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 279		e 2 ring verbal behavior towards ng care for 1 to 3 days of the	Fí	279	psychoactive medications. On 9/21/17 MDS coordinators #1 and #2 received		
	assessment period w others. The MDS not	ith no risk to the resident or ted the resident with a ut injury before his admission			Teachable Moment on the requirement inclusion of psychoactive medications of the comprehensive care plan.	for	
		receiving both antipsychotic nedications for the full 7 day			How will corrective action be accomplished for those residents having	ıg	
		e Area Assessment (CAA) evealed the resident to have			the potential to be affected by the same deficient practice:	Э	
	vascular dementia with known psychosis. Behaviors noted included rejection of care and wandering. The care area of falls was triggered				On 9/22/17, comprehensive care plans for other residents receiving psychoact medications were reviewed by the		
	due to weakness, abrocoordination. Psycho	normal gait and a lack of otropic medication used at			Resident Care Management Director (RCMD) to ensure care plans reflect		
	antipsychotic medicat antidepressant), with	sment included Geodon (an tion) and Trazodone (an documentation that the this in the resident's care			psychoactive medications as necessar Any identified issues were corrected immediately.	y.	
	to psychotropic medic				What measures will be put into place o systemic changes made to ensure that the deficient practice will not recur:		
		s of resistance to care			On 9/21/17 + 10/4/17 , licensed staff w	as	
	dementia, a new envi	to nursing home care, fronment and wandering, nedication interventions			re-educated by the Director of Nursing and/or Staff Development Coordinator the requirements for compliance with	on	
	noted but no mention use. The problem of	of psychoactive medication			F279 with emphasis on the inclusion of psychoactive medications on the comprehensive care plan.	•	
		effects and effectiveness.			How the corrective action(s) will be		
	Resident #165 as tak	A Progress Note date 06/20/17 documented Resident #165 as taking scheduled and		monitored to ensure the practice will recur, i.e., what quality assurance		ot	
	with the resident calling	e for agitation and anxiety, ng aloud to go home to see			program will be put into place:		
		jects, with staff able to calm t of the time. A Pharmacy			The RCMD will randomly monitor corrective actions to ensure the		

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F 279	Continued From page	e 3	F 2	279				
	Geodon.	d 06/24/17 consult lual dose reduction of some note for Resident #165			effectiveness of these actions by randomly monitoring 3 different resident s individualized care plans for inclusion of psychoactive medications 3x/week X 4 weeks, then monthly X 2	r		
	lethargic compared to	the resident as overall very when he arrived to the ger walking. A Palliative			months or until compliance has been determined. Findings will be reported at the monthly	,		
	compared to a previo	us visit two weeks prior, the g more care with activities of most of the time and not			QAPI meeting until such time as substantial compliance has been achieved and the committee recomme quarterly oversight by the District Direct	nds		
	documented a decrea milligrams (mg) to 10	ase in Geodon from 40 mg. Review of a Psychiatric revealed Remeron (an			of Care Management to maintain compliance when completing facility reviews.	itoi		
	depression to help wi and his evening dose decreased. Another	th his mood and appetite of Trazodone as Psychiatric note dated at due to sedation Geodon			Date of Compliance: 10/20/2017			
	revealed that since hi slightly more energy p was discontinued and							
	0.25mg twice daily, R to be given every nigl was discontinued. Ar note dated 09/11/17 r	c medication) started at the meron 15mg was started and scheduled Trazodone mother Nurse Practitioner revealed the resident was Risperidone that Geodon.						
	Review of Resident # orders dated 09/15/17 Risperidone 0.25mg to giving it once a day a	165's current medication 7 included discontinuing wice a day and instead t bedtime at the 0.25mg er dated 09/15/17 was to						

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F 279	Continued From pageneeded for anxiety of the computerized record CAA to determine with to continued From pageneeded for anxiety of the continued for anxiety of t	e 4 r behavior. ident #165 on 09/19/17 and m to be awake in his calm affect with no bally non-responsive. on 09/20/17 at 9:33 AM with Resident #165's revealed that in stopped and since then he gragitated. arse Practitioner on 09/21/17 at that due to sedation done order for Resident as changed from twice a day time. dent #165 on 09/21/17 at m in his wheelchair and member, awake, having a conding to a greeting with a see and a handshake. Coordinators #1 and #2 on revealed the nurse admitting eleted an initial care plan at the final one in the care plan.		2279		NE -		
	triggered on the CAA along with pertinent of medication use, side psychiatric services in reviews and other reinterdisciplinary team #165 was due for a control of the cap along the control of the cap along the ca	otropic medications were a it would be care planned, diagnoses related to the effects to monitor, f needed, medication views as indicated by the a. They stated Resident care plan review and had an progress. They stated that						

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F 279	computer program us consider updating the psychotropic care plat the ordered and pertitiould break them out Resident #165 should care plan problem in that if Remeron was estimulant this would be problem or to a nutrition that nurses would enterproblem or the stated Resident care plan problem in Geodon then show a Risperidone. They stated Resident care plan problem in Geodon then show a Risperidone. They stated the ord stimulation as well. 483.21(b)(3)(i) SERV PROFESSIONAL STATE (b)(3) Comprehensive as outlined by the compust-	sment was completed the ed would prompt them to a care plan. They stated a n problem would catch all of the nent medications or they by drug class. They stated a have had a psychotropic this care plan. They stated ordered for an appetite the added to the psychotropic on problem. They stated there order updates into the and they would be and clinical meeting. Sistant Director of Nursing Nursing (DON) and the sultant on 09/21/17 at 2:15 ropic medications should be colan if triggered by the CAA. #165 should have had this tiated upon admission for revision when he was put on atted the care plan should der for Remeron for appetite ICES PROVIDED MEET ANDARDS Care Plans d or arranged by the facility, imprehensive care plan,	F 2			10/20/17

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F 281	interviews and profailed to process a discontinued an a (Imdur), reduced a sleep aid (Melator administration of a (Risperidone) and in a timely manne of 6 residents revimedications (Resident #165 wa 06/20/17 with diagonal cerebral infarct, dhypertension and A medication order 06/20/17 revealed medication, Imdur	review, family interview, staff by derinterviews, the facility and follow orders that ntihypertensive medication the dosage for a non-narcotic nin), reduced the frequency of an antipsychotic medication I increase vital sign frequency, or and over a 3 day period, for 1 dewed for unnecessary ident #165). I ded: It is admitted to the facility on gnoses including history of a ementia, atherosclerosis,	F 2		F281 (D) Services Provided Meet Professional Standards How will corrective action be accomplished for those residents foun have been affected by the deficient practice: Process that lead to deficiency practic Nurse that should have processed the order was distracted at busy nurses station. Third shift nurses did not chec charts for new orders missed. On 9/18/17, orders for Resident #165 were processed to include the followin discontinuation of Imdur, dose reduction for Melatonin, frequency reduction for Risperdone and increase in vital sign monitoring frequency. On 9/18/17, U Manager #1 received a Teachable Moment on the expectation regarding timely processing of orders.	e: k g; on	
	#165 dated 09/05 hypotension (low be made with a C on Imdur. An ord to make a follow to Cardiologist relate fatigue, and coror An Emergency De 09/14/17 revealed Cardiology clinic f (systolic) over 50s increased somnol	e Practitioner note for Resident /17 revealed that due to blood pressure), follow up would ardiologist as the resident was er dated 09/05/17 directed staff up appointment with the ed to Imdur, hypotension, harry artery disease. Expartment (ED) report dated If Resident #165 arrived from a for low blood pressure in the 70s is (diastolic) with family noting ence for several days. The reported to have concerns with			How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/18/17, an audit was completed by 2nd shift supervisor, to ensure no other orders were missed and/or outstanding No other issues were identified. What measures will be put into place of systemic changes made to ensure that the deficient practice will not recur: On 10/4/17, licensed nurses were re-educated by the Director of Nursing	e py, er g. or t	

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F 281	no other signs or symhis blood pressure im the hospitalist teams of a recommendation where the hospitalist team is a recommendation where the follow up as needed. A Nurse Practitioner of 09/15/17 revealed the the resident's ED evanote documented the hypotension and as a from the Cardiologist [systolic]." The note Cardiologist had called an update and the As (ADON) also as being documented that per was to be discontinued twice a day for a weet to also be on Risperion of the resident of the following decrease the Risperion of the following decrease Melatonin the discontinue Risperidone 0.2 vital signs twice a day the Nurse Practitione hypotension on 9/14/10.	the resident presented with aproms. The report stated aproved since his arrival with peaking to the Cardiologist. as made to hold Imdur and ed. Inote for Resident #165 dated to visit was a follow up after alluation on 09/14/17. The president as having the periodic with "BP in 70s for for the Nurse Practitioner with the ed the Nurse Practitioner with the ed the Nurse Practitioner with the ed and vital signs checked the Cardiologist, the Imdured and vital signs checked the Nesident was noted done twice a day and made to the Psychiatrist to done. #165 dated 09/15/17 g: discontinue Imdur, to 5mg dose at bedtime, one 0.25mg twice a day and so 5mg at bedtime and obtain and for one week then to have review them, related to	F	281	and/or Staff Development Coordinator the requirements for compliance with F281 with emphasis on the protocol for the timely processing of physician and nurse practitioner orders. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Assistant Director of Nursing will randomly monitor corrective actions to ensure the effectiveness of these action by randomly monitoring 3 different resident should be charted to ensure the timely complete processing of orders 3x/week 4 weeks, then monthly X 2 months or uncompliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recomment quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	ns and c X until	
	Resident #165 for Se Imdur extended relea documented as admi	ptember 2017 revealed use 24 hour, 15mg was nistered at 8:00 PM during 7 through 09/17/17. This					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	•	9/22/2017	
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F 281	the period of 09/15/1 MAR also revealed F day was documented and 8:00 PM during through 09/17/17. The vital signs ordered dostarted until 4:00 PM Another Nurse Pract #165 dated 09/18/17 follow up after medic 09/15/17. The note of and Melatonin were weekend after she weekend after she weekend after she weekend after she wresponse to low blood visit on 09/14/17. The the resident appeared with no change report further documented the hall nurse as being medications as held. Telephone interview Resident #165 on 09 the resident saw the week and one of his but she could not rerunterview with the Nuat 11:20 AM revealed the Cardiologist on 0 report lethargy and herecommendation to see the commendation to see the commendation to see the commendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report lethargy and herecommendation to see the cardiologist on 0 report letha	Inistered at 8:00 PM during 7 through 09/19/17. This Risperidone 0.25mg twice a d as administered at 8:00 AM the period of 09/15/17 his MAR also revealed that one twice a day were not on 09/18/17. Itioner note for Resident revealed the visit was a ations were decreased on documented that Risperidone to be decreased over the rote an order on 09/15/17 in d pressure and a hospital he note further documented d'just as lethargic on exam' the day nursing staff. The inted she went to review ound the entire page of 15/17 were not in "the athey were signed off. The athey were signed off.	F 2	81			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 281	the report that the redifferent from the last Cardiologist four more resident returned to 09/14/17 and she of 09/15/17. She state there was no hospit went ahead and wro an order to take the the morning and an She stated she chec 09/20/17 and staff s Melatonin, which the would do. She state Imdur could have set the hospital and the blood pressure was stated that was the vital signs twice a dathe medication chart stated she expected in a timely manner acomplications, but the orders. She stated dementia he was ur following vital signs stated she brought to 09/18/17 because s also informed the Di 09/19/17. She state put them on a cart at Manger if before 3:00 with the Evening Su stated she could not stated she could n	stolic blood pressure], with esident looked so much st time he was seen by the onths prior. She stated the the facility the evening of necked on him on Friday and she was told by a nurse all order to stop Imdur, so she are the order, as well as wrote resident off Risperidone in order to decrease Melatonin. Each on the resident on till had not decreased at Unit Manager said she eat that continuing to take the the resident sent back to Cardiologist thought the so low due to Imdur. She reason why she also ordered any for a week to make sure ages were working. She is staff to follow provider orders and to call her if there were the that with the resident having hable to report symptoms so was very important. She had to come to the ADON on the would take action and she are concerns to the ADON on the would take action and she are concerns to the ADON on the would bring them to a Unit 100 PM, or would leave them pervisor if after 3:00 PM. She reders would be flipped over in the resident's chart. She are member if the orders and 165 were left with a specific	F	281				

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F 281	Continued From pag	e 10	F	281				
	revealed that when propertioners wrote not gave them to one of main nursing station them to her directly, put these orders in the physician or nurse properties they might verbalize she would not put the until they were writtensometimes she would with reviewing orders processing newly additioned they would bring orders if they wanted that once the orders the Pharmacy would after 15 minutes, and "STAT" she would can see if they had the moderation room. Show the medication room. Show there were any new of when she assumed the off-going nurse moders office that Toldid not recall anythin them mentioning her she stated she did no problems with low blow would know about as	ew orders they sometimes the Unit Managers at the or they sometimes gave She stated she sometimes he computer. She stated if a factitioner saw a resident orders to her at that time, but he orders into the computer h down. She stated help the Unit Managers his if they were busy mitted residents, at which her to do this. She stated her to do this order was written orders for processing higher the order was written						
	medication, and she low that particular we	did not remember it being eek. She stated if an order yould be indicated as such in						

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	ROVIDER OR SUPPLIER	ENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	ΙΕ	30/22/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	DATE	
F 281	Nurse #3 further state documented in the content of they were ordered to order should be put day and evening shis know about it. She the MAR the order whow to get the vital not know about the risperidone either. So review of the vital signs record, they appeared documented as twice no vital signs recorded on each day 20/17 and as bein 09/21/17. She state recorded revealed in the Unit Manager new content with the Unit Manager new content with the Unit Managers. Were entered into the of the printed orders who were expected of the orders. They written and they couthe end of their shift.	e clear that it was ere would be no place in the ving it. Ited that vital signs were computerized record and if to be done twice a day, the on the MAR, timed for the fit, or the nurse would not estated that by being placed on vould "pop" up and staff would signs. She stated she did order change for the She stated that based on her gns in the computerized ed to have been done and e a day only on 09/15/17, with ed on 09/16/17, one set any from 09/17/17 through g done three times on d the vital signs that were ormal blood pressures. Manager #1 and Unit Manager 54 AM revealed physicians ers brought to a particular reders, depending on what resided and as assigned to They stated that once orders e computer, the yellow copy was given to the nurses, to double check the accuracy stated if lots of orders were Id not review them all before , those left remaining for	F 2	281			
	They stated someting them, sometimes the	o the Evening Supervisor. The sorders were handed to be seen the seen were put in the record rack were laid on the desk of the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345312	B. WING				22/2017	
	ROVIDER OR SUPPLIER	ENDERSONVILLE	•	1870	EET ADDRESS, CITY, STATE, ZIP CODE 0 PISGAH DRIVE NDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE	
F 281	nurse practitioners wand bring them to the They stated orders let flagged, as indicated orders up so they wo Unit Manager #1 state orders for Resident # by the Nurse Practitionat which time she saw computer and she put Manager #2 did not wand they stated that on work, the weekend in put them in the compustated that any misses picked up during chawhen they saw hand next to them, they as reviewed and process Evening Supervisors orders, but they could they stated that once	e 12 y stated physicians and ould verbalize "STAT" orders eir attention immediately. If in records on a cart were by turning the page of uld stick out of the record. If it is dealy the state of the record in the state of the	F:	281	DEFICIENCY)			
	verified all orders dur times the Evening Su Supervisor would do for the Unit Managers the current order pro- stated that what they orders was that there of which one sheet w into the computer by stated medication err	ON and the DON on If revealed the Unit Managers ring the week and at other apervisor or Weekend it as well as a second check is. They stated they thought cess was "pretty tight." They knew about Resident #165's is were two sheets of orders, was reviewed and entered the PM supervisor. They for reports were completed.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE S COMPL	ETED
		345312	B. WING _			09/2) 22/2017
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				STREET ADDRESS, CITY, STATE, ZIP C 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	ODE:	, , ,	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 281	would not have a res lay order sheets downursing station. The orders to be transcrift stated it was the resp. Supervisor to make scart by the Nurse Pra. They stated vital sign. Resident #165 as ord. Telephone interview on 09/22/17 at 12:25 started her shift she review orders noted. Managers. She state nurse practitioners or residents and would which she would revithe end of her shift. orders might be writt pages would stick togshe checked for. She physicians and nurse orders, but rather that chart they would inst stated she did not received she did not received her possible. Telephone interview Cardiologist on 09/22 the Cardiologist on 09/22 the Cardiologist on 09/22 the Cardiologist was would notify the Cardiologist was would not be given thypotensive. Review of a signed service of the resident of a signed service.	ident's hard chart and would in at the computer at the sy stated it was important for bed and followed. They consibility of the Evening sure any orders left on the actitioner were reviewed. In should have been done for dered. With the Evening Supervisor PM revealed that when she assumed responsibility to reviewed by the Unit ed some physicians and bould be late to round on write orders on the PM shift, ew before she went home at She stated that sometimes en on two pages and the gether, which was something e stated that other times a practitioners would write an place them in the hard ead hand them to staff. She call taking off any orders for 1/15/17, although it might with the nurse of the 2/17 at 12:55 PM revealed seeing patients but she diologist and get them to write ecord. She stated Imdur	F2	281			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	, ,	OMPLETED
		345312	B. WING _			C 09/22/2017
	ROVIDER OR SUPPLIER	ENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	,	33/22/2311
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Imdur. The stateme medication should be recommend holding blood pressure less of mercury]. If he is hypotension." Interview with the Act 12:56 PM revealed so be processed and for 483.21(b)(3)(ii) SER PERSONS/PER CATC (b)(3) Comprehension The services provide as outlined by the comust- (ii) Be provided by quaccordance with eact care. This REQUIREMEN by: Based on record revinterviews, the facilit interventions for fall fall mats for one (1) (Resident #69). Resident #69 was act	tent hypotension and was on ant further documented "This is held if he is hypotensive. I the medication for systolic than 100 mmHg [millimeters given Imdur, it will aggravate Iministrator on 09/22/17 at the expected new orders to Illowed. VICES BY QUALIFIED RE PLAN The Care Plans and or arranged by the facility, comprehensive care plan,	F 2	F282 (D) Services by Qualified Persons/Per Care Plan How will corrective action be accomplished for those resider have been affected by the deficience:	nts found to	10/20/17
	weakness, anxiety d disorder, abnormaliti muscle wasting with Review of Resident:	isorder, insomnia, bi-polar es of gait and mobility and weakening.		The process that led to the defi practice is as follows: The Care plan reflected the ap measure of 2 fall mats, the RC Manager, and Hall Nurse did no communicate that resident was	propriate S, Unit ot	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG				
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		349312	B. WING_	0.7.0		09	9/22/2017	
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAI	B/HENDERSONVILLE		187	0 PISGAH DRIVE			
				HE	NDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	Continued From p	page 15	F 2	282				
	· ·	resident to be unable to make			matt.			
		ns in his life. Resident #69 was			On 9/22/17 , 2 fall mats were placed a	at		
	· •	t activities of daily living as			Resident #69s bedside. On 9/22/17,			
		e assistance with two person			#1, the hall nurse, the RCS (CNA s)			
		so assessed as always			the unit manager received a Teachabl			
					Moment on the importance of ensuring			
	incontinent of bladder and bowel and he was not on a scheduled toileting program. Record review of Resident #69's care plan dated				fall mats are in place for Resident #1.			
		d a care plan area for fall			How will corrective action be			
	•	ventions included an addition of			accomplished for those residents havi			
		s, fall mats x2, anti-slip surface			the potential to be affected by the san	1е		
	•	it's wheelchair and use of an ent was in bed or in his			deficient practice:			
	wheelchair.	ent was in bed of in this			On 9/22/17 , an audit was completed	hv		
	Wilcolonali.				ADON , to ensure other resident s fa	-		
	Electronic record	review of the entered Nurse's			interventions were in place per the pla			
		vealed multiple documented			care. Any identified issues were			
	instances of resid	ent attempting to transfer out of			immediately corrected.			
		Some attempts resulted in						
	documented falls				What measures will be put into place			
	Observation on O	0/20/47 at 11:22 AM revealed			systemic changes made to ensure the	и		
		9/20/17 at 11:23 AM revealed ag to get out of bed on his own.			the deficient practice will not recur:			
		on revealed only one fall mat on			On 9/22/17 + 10/4/17 , licensed nurse	.0		
		ht of resident's bed (as he is			and C.N.A. □s were re-educated by the			
	lying in it).	in or recidence bed (de no le			Director of Nursing and/or Staff	.0		
	,,g,.				Development Coordinator on the			
	Observation on 0	9/20/17 at 12:41 PM revealed			requirements for compliance with F28	2		
	only one fall mat i	n resident's room.			with emphasis on ensuring fall mats a			
					place per the care planned intervention	n.		
		9/21/17 at 9:3 AM continued to						
	reveal only one fa	ıll mat in resident's room.			How the corrective action(s) will be			
					monitored to ensure the practice will r	ıot		
		sing assistant (NA) #1 on			recur, i.e., what quality assurance			
		PM reported Resident #69 was a			program will be put into place:			
		care planned with interventions						
		with preventing falls. He stated			The Unit Managers will randomly mon	iltor		
	resident had anti-	slip padding on his wheelchair,			corrective actions to ensure the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			1	C / 22/2017		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	122/2011		
DDIAN OT	DUEALTH & DELIADATE	-NDEDOON #1 - E		18	870 PISGAH DRIVE				
BRIANCI	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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 282	Continued From page 16 F 282								
	mattress as a few of place. Interview with the hal PM revealed Resider a diagnosis of demen	bed rails and a scoop the interventions that were in I nurse on 09/21/17 at 1:35 at #69 was a fall risk and had atia with behaviors that were, ards others. She stated			effectiveness of these actions by randomly monitoring 3 different resider to ensure fall interventions are in place per the plan of care 3x/week X 4 week then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly	S,			
	Resident #69 frequer himself from the bed doing so. She contin #69 first was admitted had hired a private si no avail. The nurse i had two fall mats whi but since he moved to mat had been placed	antly attempted to transfer and had frequent falls from ued stating when Resident d to the facility, the family tter to try and prevent falls to informed that the resident le he was on the 100 Hall to the 600 Hall, only one fall in his room. She stated she			QAPI meeting until such time as substantial compliance has been achieved and the committee recommendanterly oversight by the District Direct of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	nds			
	was unsure if someon plan. An interview with NA revealed she was aw risk. She reported the interventions in place others. She stated slinformed daily if chan are made. She state Resident Care Special were provided to all Nesident #69 has onlocated to the right of Review of the Resider Assignment Sheet or revealed under Accid Ulcer Prevention that pressure alarm to be	#2 on 09/21/17 at 2:26 PM are Resident #69 was a fall ere being multiple including a fall mat among he and the other NAs are ages to a resident's care pland she is informed on the falist Assignment Sheet that NAs. She further explained by ever had one fall mat this bed.							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345312	B. WING _				C 22/2017
	ROVIDER OR SUPPLIER R HEALTH & REHAB/HE	ENDERSONVILLE		STREET ADDRESS, CITY, S 1870 PISGAH DRIVE HENDERSONVILLE, N		1 00	22/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page		F	282			
F 309 SS=D	coordinator on 09/21/and two other MDS or responsible for updat reported resident care every fall for possible continued, stating if cadministration, she or coordinators would prochange. She reported had been no requested #69's care plan in regulation of the care plan in regulation of the care plan called formats were placed at I was were placed at I an interview with the 09/21/17 at 3:17 PM or care plans were follow. An interview with the 11:23 PM revealed shower followed as direct 483.24, 483.25(k)(l) FOR HIGHEST WELL 483.24 Quality of life Quality of life is a fundapplies to all care and residents. Each residents. Each residents. Each residents to attain or metal to the care of the care to attain or metal to the care of the care and residents. Each residents to attain or metal to the care of the care and residents.	ing resident care plans. She e plans were reviewed after intervention changes. She hanges were requested by r one of the other MDS rocess the requested d to her knowledge there ed changes to Resident pards to removing a fall mat. Assistant Director of Nursing PM revealed she expected followed as written and if or two fall mats, that two fall Resident #69's bedside. Director of Nursing on revealed she expected that wed as written. Administrator on 09/22/17 at the expected that care plans cted until changed. PROVIDE CARE/SERVICES L BEING damental principle that d services provided to facility then must receive and the he necessary care and maintain the highest mental, and psychosocial	F:	809			10/20/17

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345312	B. WING _		C 09/22/2017
	ROVIDER OR SUPPLIER	ENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	03/22/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 309	483.25 Quality of care Quality of care is a furth applies to all treatment facility residents. Base assessment of a resident residents receive accordance with profession practice, the compression of a resident residents consistent with profession the comprehensive provided to resident residents who require services, consistent residents who require services, consistent resident	e indamental principle that int and care provided to sed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices, including following: t. ure that pain management is who require such services, essional standards of practice, erson-centered care plan, als and preferences. ity must ensure that e dialysis receive such with professional standards rehensive person-centered sidents' goals and it is not met as evidenced on, record review, family lews and provider interviews, inplement for three days	F3	F309 (D) Provide Care/Services for Highest Well Being How will corrective action be accomplished for those residents for have been affected by the deficient practice: Process that lead to deficiency prayurse that should have processed	ound to t actice:

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDIN	<u></u>		С		
		345312	B. WING			9/22/2017		
NAME OF PR	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP COL	· ·	0,22,2011		
				1870 PISGAH DRIVE				
BRIAN CT	R HEALTH & REHAB/HE	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 THE DEFICIENCY)	E APPROPRIATE	COMPLÉTION DATE		
F 309	Continued From page	e 19	F 30	09				
				order was distracted at busy	nurses			
	The findings are:			station. Third shift nurses did				
	-			charts for new orders missed	l.			
	Resident #165 was a	dmitted to the facility on						
	_	ses including history of a						
		entia, atherosclerosis,						
	hypertension and gai	t abnormality.		On 9/18/17, orders for Resid				
	D :	l (D :) / //405		were processed to include th				
		on order for Resident #165		discontinuation of Imdur, dos				
		aled the antihypertensive hour extended release,		for Melatonin, frequency redu Risperdone and increase in v				
	15mg tablet, one table	•		monitoring frequency. On 9	•			
	roning tablet, one tabl	e at beatime.		Manager #1 received a Teac				
	Review of Resident #	t165's admission Minimum		Moment on the expectation r				
	Data Set (MDS) asse	essment dated 06/27/17		timely processing of orders.	3			
		erely cognitively impaired,						
	displaying verbal beh	avior towards others and		How will corrective action be				
		3 days of the assessment		accomplished for those resid				
	•	ted the resident with a		the potential to be affected by	y the same			
	_	ut injury before his admission		deficient practice:				
		receiving both antipsychotic		0.04047				
	·	nedications for the full 7 day		On 9/18/17, an audit was cor	•			
	assessment period.			Unit Managers , to ensure no were missed and/or outstand				
	Review of Resident #	t165's Care Area		issues were identified.	ing. No other			
		evealed the resident to have		leaded Word Identified.				
	, ,	th known psychosis, which		What measures will be put in	ito place or			
		tropic medications and the		systemic changes made to e	•			
		ons would be addressed in		the deficient practice will not				
	the resident's care pl	an.						
				On 9/18/17 + 10/4/17, license				
		165's care plan dated		were re-educated by the Dire				
		e problems of resistive to		Nursing and/or Staff Develop				
	_	ment to nursing home care,		Coordinator on the requirement				
		ironment and wandering,		compliance with F309 with en				
		nedication interventions		the protocol for the timely pro	•			
	use. The problem of	of psychoactive medication		physician and nurse practitio	ner orders.			
		observe ordered medications		How the corrective action(s)	will he			
	accumented stail to t	boon ve oracioa illealeations	1	i low the contective action(s)	***** 00	1		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING			1	C 22/2017
NAME OF P	ROVIDER OR SUPPLIER	2.02.12	 	9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	22/2017
TO THE OT THE	TO VIDER OR OUT FEET						
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			870 PISGAH DRIVE		
				Н	IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 20	F3	309			
	for side effects and ef	ffectiveness.			monitored to ensure the practice will no recur, i.e., what quality assurance	ot	
		r Resident #165 dated additional 240cc of fluids			program will be put into place:		
	with each meal tray in and to hold antihyper Metoprolol and Cozar Another order dated Cozar until Tuesday Practitioner followed Review of a Nurse Pr#165 dated 09/05/17 hypotension (low bloc be discontinued, the lowered and follow up Cardiology as the resof an order dated 09/05 to have made for him with the Cardiologist hypotension, fatigue, disease. Review of an Emerge	n addition to what is served, tensive medications ar due to low blood pressure. 09/03/17 directed holding (09/05/17) until the Nurse up. actitioner note for Resident revealed that due to od pressure) Cozaar would Metoprolol dosage would be o would be made with ident was on Imdur. Review 05/17 directed the resident a follow up appointment related to Imdur,			The Evening Supervisor will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly monitoring 3 different resident s charts to ensure the timely complete processing of orders 3x/week 4 weeks, then monthly X 2 months or use compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommendarterly oversight by the District Direct of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	and c X until	
	from a Cardiology clir the 70s (systolic) ove noting increased som The Cardiologist was with overmedication a with no other signs or stated his blood press arrival with the hospit Cardiologist. A recon hold Imdur and to foll handwritten note by the report documented the the resident returned	nic for low blood pressure in r 50s (diastolic) with family molence for several days. reported to have concerns and the resident presented symptoms. The report sure improved since his alist team speaking to the nmendation was made to ow up as needed. A he Nurse Practitioner on this nat Imdur was not held when					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345312	B. WING			C 09/22/2017	
	ROVIDER OR SUPPLIER	ENDERSONVILLE	•	STREET ADDRESS, CITY, STATE, ZIP (1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	follow up after the recognitive to the recognitive	revealed the visit was a esident's ED evaluation on documented the resident as and as being sent to the rdiologist's office with "BP in note further documented the led the Nurse Practitioner with ssistant Director of Nursing notified. It was documented ogist, the Imdur was to be gns checked twice a day for there was a need to further rolol. The resident was noted idone twice a day and made to the Psychiatrist to idone. Resident #165 dated the following: discontinue latonin to 5mg dose at the Risperidone 0.25mg twice a ridone 0.25mg at bedtime and ce a day for one week then to obtitioner review them, related	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	COME	SURVEY PLETED
		345312	B. WING			1	C / 22/2017
	ROVIDER OR SUPPLIER	HENDERSONVILLE		1870	ET ADDRESS, CITY, STATE, ZIP CODE PISGAH DRIVE DERSONVILLE, NC 28791	, 00.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 309	Resident #165 date was a follow up after decreased on 09/15 that Risperidone and decreased over the order on 09/15/17 in pressure and a hosy note further docume "just as lethargic on reported by nursing documented she we and found the entire 09/15/17 were not in they were signed of ADON, Unit Managenotified and morning Observation of Resident #165 on 0 the saw the Cardiological	Mon 09/18/18. Nurse Practitioner note for d 09/18/17 revealed the visit or medications were if 17. The note documented d Melatonin were to be weekend after she wrote an a response to low blood poital visit on 09/14/17. The ented the resident appeared exam" with no change staff. The note further ent to review blood pressure exame and hall nurse as being g medications as held. Ident #165 dated 09/19/17 at im to be in his wheelchair in stress, having a calm affect thal response to a greeting. In #2 on 09/20/17 at 5:29 AM of familiar with any medication Resident #165 as no assed to him on night shift. In with a family member of 9/20/17 at 9:33 AM revealed ons were stopped, but she	F	309			
	at 11:20 AM revealed	urse Practitioner on 09/21/17 ed Resident #165 had seen 09/14/17, who called her to					

OL: VIEI	O T OTT INLEDIO TITLE OF	· · · · · · · · · · · · · · · · · · ·				C 110	7. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
				_		(С
		345312	B. WING			09/	22/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE			870 PISGAH DRIVE HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Cozaar. The residenthe Cardiologist's offi [systolic blood pressuresident looked so mutime he was seen by prior. She stated the facility the evening of on him on Friday 09/r told by a nurse there stop Imdur, so she worder, as well as wrot resident off Risperido order to decrease Mechecked on the resident off decreased Manager said she woresident continuing to him back to the hospithought the blood pre Imdur. She stated the also ordered vital sign make sure the medic She stated she experorders in a timely mawere complications, to orders. She stated the dementia he was unafollowing vital signs we stated she brought he 09/18/17 because she also informed the Din 09/19/17.		F	309			
	her orders on 09/15/1	17 for Resident #165 and re were any new orders for					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		SURVEY LETED	
		345312	B. WING _			09/:	22/2017
	ROVIDER OR SUPPLIER	ENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 309	morning of 09/15/17 mentioned he went of Thursday 09/14/17, anything specific and mentioning he had gestated she did not reproblems with low be would know about a pressure before giving medication, and she low that particular we was discontinued it of the MAR, it would be discontinued and the MAR to sign off if giving Nurse #3 further stated ocumented in the corder should be put day and evening shi know about it. She is the MAR the order we know to get the vital not know about the crisperidone either. So	the off-going nurse to the doctor's office that but she did not recall d she did recall them gone to the hospital. She emember him having lood pressure, which she is she checked his blood ing him his blood pressure did not remember it being eek. She stated if an order would be indicated as such in eclear that it was ere would be no place in the ving it. Ited that vital signs were computerized record and if to be done twice a day, the on the MAR, timed for the fit, or the nurse would not stated that by being placed on would "pop" up and staff would signs. She stated she did	F3	309			
	documented as twic no vital signs record recorded on each da 9/20/17 and as being 09/21/17. Interview with Unit N #2 on 09/22/17 at 9: Manager #1 stateing	e a day only on 09/15/17, with ed on 09/16/17, one set ay from 09/17/17 through g done three times on Manager #1 and Unit Manager 54 AM revealed Unit g she did not remember #165 coming to her attention					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			09/2) 22/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE			
BRIAN CT	R HEALTH & REHAB/H	ENDERSONVII I E		1870 PISGAH DRIVE				
DIVIANCE	K HEALIN & KEHAD/III	ENDERGONVILLE		HENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 309	at which time she sa computer and she put Manager #2 did not will Unit Manager #1 star should have been pid They stated the PM spicked up the orders was going on. They discontinuation order computer, the order will Interview with the AD 09/22/17 at 11:46 AM about Resident #165 two sheets of orders reviewed and entere PM supervisor. They reports were complete important for orders followed. They state the PM Supervisor to on the cart by the Nu	oner until Monday 09/18/17, we they were not in the at them in the computer (Unit work that particular day). Ited that any missed orders cked up during chart checks. Supervisor should have to be the would not say what stated that once is were put into the would come off the MAR. OON and the DON on if the material was that there were to of which one sheet was do into the computer by the computer by the computer by the computer in the work of the was the responsibility of the make sure any orders left in the practitioner were and vital signs should have	F3	309				
	09/22/17 at 12:25 PM started her shift she review orders noted Managers. She state off any orders for Re although it might hav Telephone interview Cardiologist on 09/22 the Cardiologist was would notify the Card	ed she did not recall taking sident #165 on 09/15/17, e been possible.						

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	345312	B. WING _			l	C 22/2017	
ROVIDER OR SUPPLIER R HEALTH & REHAB/HE	NDERSONVILLE		18	70 PISGAH DRIVE		-	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE	
should not be given to hypotensive. Review of a signed state for Resident #165 data resident had intermitted Imdur. The statement medication should be recommend holding to blood pressure less to for mercury]. If he is go hypotension." Interview with the Addr 12:56 PM revealed state processed and foll 483.24(a)(2) ADL CADEPENDENT RESID (a)(2) A resident who activities of daily living services to maintain go personal and oral hygothesis to maintain go personal and oral hygothesis and staff interviewed for activities #166). The findings include: Resident #166 was a 08/09/17 with diagnostic state of the sident #166 was a 08/09/17 with dia	atement by the Cardiologist red 09/22/17 revealed the ent hypotension and was on the further documented "This held if he is hypotensive. If the medication for systolic than 100 mmHg [millimeters given Imdur, it will aggravate ministrator on 09/22/17 at the expected new orders to owed RE PROVIDED FOR ENTS Is unable to carry out the greceives the necessary good nutrition, grooming, and giene. It is not met as evidenced the system of daily living (Resident dimitted to the facility on sees of non-Alzheimer's			have been affected by the deficient practice: Process that lead to deficient practice is as follows: The shower schedule had n	s ot	10/20/17	
Review of the signific	ant change Minimum Data			On 9/22/17 , a shower was offered and			
	CORRECTION ROVIDER OR SUPPLIER R HEALTH & REHAB/HE SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page should not be given to hypotensive. Review of a signed st for Resident #165 dat resident had intermitted Imdur. The statement medication should be recommend holding the blood pressure less the of mercury]. If he is go hypotension." Interview with the Adr 12:56 PM revealed sh be processed and foll 483.24(a)(2) ADL CA DEPENDENT RESID (a)(2) A resident who activities of daily living services to maintain go personal and oral hyg This REQUIREMENT by: Based on observation resident and staff inte provide scheduled sh reviewed for activities #166). The findings include: Resident #166 was ac 08/09/17 with diagnos dementia, history of face	RHEALTH & REHAB/HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 should not be given to someone who is hypotensive. Review of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the resident had intermittent hypotension and was on Imdur. The statement further documented "This medication should be held if he is hypotensive. I recommend holding the medication for systolic blood pressure less than 100 mmHg [millimeters of mercury]. If he is given Imdur, it will aggravate hypotension." Interview with the Administrator on 09/22/17 at 12:56 PM revealed she expected new orders to be processed and followed 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166).	REVIEW Of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the resident holding the medication for systolic blood pressure less than 100 mmHg [millimeters of mercury]. If he is given Imdur, it will aggravate hypotension." Interview with the Administrator on 09/22/17 at 12:56 PM revealed she expected new orders to be processed and followed 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166). The findings include: Resident #166 was admitted to the facility on 08/09/17 with diagnoses of non-Alzheimer's dementia, history of falls and muscle weakness.	A BUILDING	TOURIDER OR SUPPLIER R HEALTH & REHAB/HENDERSONVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION MUST BE PRECIDED DY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 26 Should not be given to someone who is hypotensive. Review of a signed statement by the Cardiologist for Resident had intermittent hypotension and was on Indur. The statement further documented "This medication for yestolic blood pressure less than 100 mmHg [millimeters of mercury]. If he is given imdur, it will aggravate hypotension." Interview with the Administrator on 09/22/17 at 12:56 PM revealed she expected new orders to be processed and followed 483.24(a)(2) ALC CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166). The findings include: Resident #166 was admitted to the facility on 08/09/17 with diagnoses of non-Alzheimer's dementia, history of falls and muscle weakness.	A BUILDING 345312 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISCAND RIVEY BLANDARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 Should not be given to someone who is hypotensive. Review of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the resident modulo the held if he is hypotensive. Review of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the resident had intermittent hypotension and was on Indur. The statement further documented "This medication should be held if he is hypotensive." 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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING			1	C
NAME OF D	ROVIDER OR SUPPLIER			97	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	22/2017
TVAIVIL OF T	NOVIDEIX OIX OOI 1 EIEIX				870 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB	/HENDERSONVILLE					
				П	ENDERSONVILLE, NC 28791		ı
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	age 27	F3	312			
	Set dated 09/07/17	7 revealed Resident #166 was			provided to Resident #166. On 9/22/17		
		and required extensive			NA #1 and NA #2 received a Teachable		
	assistance with ba				Moment on the expectation for comple	tion	
					of showers as scheduled as well as the	;	
		e plan dated 09/20/17 revealed			protocol for communicating incomplete		
		d an activity of daily living (ADL)			tasks their direct supervisor.		
		nce deficit related to extensive					
	'	vith ADL and at risk for further			How will corrective action be	.~	
		chronic diagnoses/disease was for Resident #166 to			accomplished for those residents having the potential to be affected by the same		
	'	evel of function through the			deficient practice:	•	
		nterventions included:			denoism praedees.		
	bathing/showering	2 times per week and as			On 9/23/17, shower schedules were		
	needed, check nai	l length and trim and clean on			reviewed to ensure residents schedule	d to	
	bath day and as no	eeded.			receive showers were offered and		
					provided bathing per preference as		
		lity shower schedules from			scheduled. Any identified issues were		
		09/21/17 revealed Resident			corrected immediately.		
		shower days were Wednesday eschedules revealed Resident			What measures will be put into place o	r	
		wers on the following dates:			systemic changes made to ensure that		
		sday, 08/15/17 - Tuesday,			the deficient practice will not recur:		
		sday, 08/30/17 - Wednesday,			and demonstrating the second		
		sday, and 09/20/17 -			On 10/4/17, direct care and licensed		
	Wednesday.				nursing staff was re-educated by the		
					Director of Nursing and/or Staff		
		ucted on 09/18/17 at 11:25 AM			Development Coordinator on the		
		6 revealed he was not receiving			requirements for compliance with F312		
		. He stated he had only been			with emphasis on ensuring showers ar		
		week and some weeks only a vanted 2 showers a week.			being offered and are provided per faci shower schedule and PRN.	шу	
	Deu Dain and ne W	anteu 2 Showers a Week.			SHOWER SCHEUUIE AHU FRIN.		
	An interview condu	ucted on 09/20/17 at 10:56 AM			How the corrective action(s) will be		
		IA) #1 revealed she works on			monitored to ensure the practice will no	ot	
	,	Resident #166 on the 7:00 AM			recur, i.e., what quality assurance		
		She stated there were many			program will be put into place:		
		get all of the scheduled					
		ause she was the only NA on			The Unit Managers will randomly moni	tor	
	the hall. She state	d there is only 1 NA scheduled			corrective actions to ensure the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345312	B. WING		1	C / 22/2017	
NAME OF PE	ROVIDER OR SUPPLIER	0.00.12	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	09	12212017	
				1870 PISGAH DRIVE			
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE		HENDERSONVILLE, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 312	Continued From page	: 28	F 3	12			
	provide care and show	nd it makes it very difficult to wers for residents. ed on 09/21/17 at 9:47 AM		effectiveness of these actions by randomly monitoring 3 resident schedules to ensure showers are provided as scheduled 3x/week	s shower e being		
	all 3 shifts. He stated the 100 hall because	ne works all of the halls and the hardest hall to work was you were the only NA on the		weeks, then monthly X 2 months compliance has been determined	d.		
		de sure residents were not always get the showers		Findings will be reported at the r QAPI meeting until such time as substantial compliance has beer achieved and the committee rec	1		
	with the Director of No depending on the resi 2 NAs scheduled to w	ed on 09/22/17 at 8:43 AM cursing (DON) revealed ident census there were 1 to cork the 100 hall. She stated		quarterly oversight by the District of Care Management to maintain compliance when completing fact reviews.	า		
	to be given the NA sh shift so they can give	of for all showers to be led and if they weren't able ould report to the oncoming them. She stated she was naving problems getting		Date of Compliance: 10/20/2017			
F 333 SS=D	with the Administrator	nts to receive their showers	F 33	33		10/20/17	
33 2	483.45(f) Medication	Errors.					
	The facility must ensu	ire that its-					
	by:	ee of any significant is not met as evidenced n, record review, family		F333 (D) Residents Free of Sign	nificant		
	Dadda dii obdei vallo	ii, rocora rovion, lairiiiy		. 555 (B) Residents i rec of olgi	mount		

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SENTERS I SIT MEDIO TILE SITUATION								
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
VIAD LEWIN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _				
						۱ '	С	
		345312	B. WING			09/	22/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIAN CT	R HEALTH & REHAB/HE	ENDEDSONVII I E		18	870 PISGAH DRIVE			
BRIANCI	N HEALIN & NEHAB/HE	ENDERSONVILLE		Н	ENDERSONVILLE, NC 28791			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI		COMPLETION DATE	
TAG	REGULATORT OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16		
F 333	Continued From page	<u> </u>	F	333				
			'	555	Med Errors			
		ews and provider interviews,)discontinue as ordered an			Wed Errors			
		dication, reduce the dosage			How will corrective action be			
		ep aid and reduce the			accomplished for those residents found	l to		
		tration of an antipsychotic			have been affected by the deficient			
		s for Resident #165 with			practice: Process that lead to deficient			
		low blood pressure and (2)			practice is as follows:			
	failed to discontinue a	as ordered and for 11 days			For #1. Nurse that should have			
	for Resident #30 a na	arcotic pain medication, for 2			processed the order was distracted at			
	of 6 residents review	ed for unnecessary			busy nurses station. Third shift nurses			
	medications.				not check charts for new orders missed			
					#2. Nurse failed to clarify order with the)		
	The findings are:				potential for error and or			
	1 Decident #105	a advetted to the facility on			miscommunication due to ambiguity.			
		s admitted to the facility on ses including history of a			1 On 0/19/17 orders for Resident #	165		
		entia, atherosclerosis,			 On 9/18/17, orders for Resident # were processed to include the following 			
	hypertension and gai				discontinuation of Imdur, dose reductio	-		
	Trypertension and gar	t abriormanty.			for Melatonin, frequency reduction for			
	Review of a medication	on order for Resident #165			Risperdone and increase in vital sign			
	dated 06/20/17 revea	aled the antihypertensive			monitoring frequency. On 9/18/17, Un	it		
	medication Imdur 24	hour extended release,			Manager #1 received a Teachable			
	15mg tablet, one tabl	e at bedtime.			Moment on the expectation regarding			
					timely processing of orders.			
		165's admission Minimum			2. On 9/22/17, Resident #30s narcoti	С		
		essment dated 06/27/17			pain medication was discontinued as			
		erely cognitively impaired,			ordered. On 9/22/17, Nurse #1 and Uni	τ		
		without injury before his			Managers #1 and #2 received a	£.,		
		ity and as receiving both tidepressant medications for			Teachable Moment on the need to clari orders with the potential for error and/o	•		
	the full 7 day MDS as				miscommunication due to ambiguity.	ı		
	ano idii 7 day MDO as	boooment period.			missorimanioation due to ambiguity.			
	Review of Resident #	165's Care Area			How will corrective action be			
		evealed the resident to have			accomplished for those residents havin	g		
		th known psychosis, which			the potential to be affected by the same	-		
	due to use of psychol	tropic medications and the			deficient practice:			
		ons would be addressed in						
	the resident's care pla	an.			On 9/22/17, an audit was completed by	',		
					DON, ADON, and Unit Managers to			

Facility ID: 922985

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING _			1	22/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	
				18	870 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page	e 30	F3	333			
F 333	Review of Resident # 07/06/17 included the care related to adjust dementia, a new enviwith numerous non-moted but no mention use. The problem of documented staff to of for side effects and effects a	165's care plan dated problems of resistive to ment to nursing home care, ronment and wandering, redication interventions of psychoactive medication being at risk for falls observe ordered medications fectiveness. actitioner note for Resident revealed that due to od pressure) Cozaar would Metoprolol dosage would be o would be made with ident was on Imdur. Review 05/17 directed the resident a follow up appointment related to Imdur,		333	ensure no other orders were missed and/or outstanding. No other issues we identified. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/4/17, licensed nurses were re-educated by the Director of Nursing and/or Staff Development Coordinator the requirements for compliance with F333 with emphasis on the protocol for the timely processing of physician and nurse practitioner orders. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Staff Development Coordinator will randomly monitor corrective actions to ensure the effectiveness of these action by randomly monitoring 3 different resident scharts to ensure the timely complete processing of orders 3x/week 4 weeks, then monthly X 2 months or use compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as	on ot Il ns and c X until	
	hold Imdur and to foll handwritten note by t report documented th the resident returned Review of a Nurse Pr	ow up as needed. A ne Nurse Practitioner on this at Imdur was not held when			QAPI meeting until such time as substantial compliance has been achieved and the committee recommer quarterly oversight by the District Direct of Clinical Services to maintain compliance when completing facility reviews.		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		345312	B. WING _			1	C 22/2017
	ROVIDER OR SUPPLIER	NDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			22/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 333	follow up after the res 09/14/17. The note of having hypotension a hospital from the Card 70s [systolic]." The note of an update and the As (ADON) also being not that per the Cardiolog discontinued, vital sig a week and to see if the decrease the Metoproto also be on Risperion notification would be decrease the Risperion Review of orders for 109/15/17 included the Imdur, decrease Melabedtime, discontinued ay and start Risperion obtain vital signs twice have the Nurse Pract to hypotension on 9/1 Review of the Medica (MAR) for Resident #revealed Imdur exten was documented as admitted the period of 09/15/17 MAR also revealed R day was documented and 8:00 PM during the through 09/17/17. The	sident's ED evaluation on locumented the resident as and as being sent to the diologist's office with "BP in lote further documented the ed the Nurse Practitioner with sistant Director of Nursing office. It was documented gist, the Imdur was to be an schecked twice a day for there was a need to further colol. The resident was noted done twice a day and made to the Psychiatrist to done. Resident #165 dated a following: discontinue atonin to 5mg dose at Risperidone 0.25mg twice a done 0.25mg at bedtime and the aday for one week then to ditioner review them, related 14/17. Attion Administration Record 165 for September, 2017 ded release 24 hour, 15mg administered at 8:00 PM 19/15/17 through 09/17/17. Ited Melatonin 10mg was an instered at 8:00 PM during 7 through 09/19/17. This insperidone 0.25mg twice a las administered at 8:00 AM the period of 09/15/17 his MAR also revealed that one twice a day were not	F	3333	Date of Compliance: 10/20/2017		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345312	B. WING		C 09/22/2017
	ROVIDER OR SUPPLIER	HENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	1 03/22/2017
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 333	Continued From pa	age 32	F 33	3	
	Resident #165 date was a follow up after decreased on 09/1 that Risperidone and decreased over the order on 09/15/17 in pressure and a host note further docum "just as lethargic or reported by nursing documented she wand found the entir 09/15/17 were not they were signed of ADON, Unit Manage notified and morning Observation of Rese 4:19 PM revealed in the hallway in no desired and morning of the signed of the hallway in no desired and morning of the signed of the hallway in no desired and morning of the signed of t	Nurse Practitioner note for ed 09/18/17 revealed the visit er medications were 5/17. The note documented and Melatonin were to be a weekend after she wrote an in response to low blood spital visit on 09/14/17. The ented the resident appeared a exam" with no change g staff. The note further ent to review blood pressure to page of orders written on in "the system" even though off. The note documented the ger and hall nurse as being an medications as held.			
	revealed she was reconcerns regarding medications were purely relephone interview. Resident #165 on the saw the Cardiol one of his medicatic could not remember at 11:20 AM reveal	se #2 on 09/20/17 at 5:29 AM not familiar with any medication g Resident #165 as no passed to him on night shift. W with a family member of 09/20/17 at 9:33 AM revealed ogist the previous week and ons were stopped, but she er which one. Nurse Practitioner on 09/21/17 ed Resident #165 had seen 09/14/17, who called her to			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED		
		345312	B. WING				C 22/2017		
	ROVIDER OR SUPPLIER	ENDERSONVILLE	,	STREET ADDRESS, CI 1870 PISGAH DRIVE HENDERSONVILL	:	<u>,</u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG CROSS-REFERENCED TO THE APPROVIDENCE DEFICIENCY)		BE.	(X5) COMPLETION DATE		
F 333	Cozaar. The reside the Cardiologist's of [systolic blood press resident looked so n time he was seen by prior. She stated the facility the evening con him on Friday 09 told by a nurse there stop Imdur, so she worder, as well as worder, as well as worder to decrease Mochecked on the resident off Risperid order to decrease Mochecked on the resident continuing the blood properties of the hosp thought the blood properties in a timely make sure the medical She stated she experies orders in a timely make sure the medical she stated she experies orders. She stated the dementia he was unfollowing vital signs stated she brought to 09/18/17 because shallowing vital signs stated she did not her orders on 09/15, she did not know the	stop Imdur and to decrease in the was sent to the ED from fice and was "in the 70's" sure], with the report that the much different from the last of the Cardiologist four months is resident returned to the of 09/14/17 and she checked of 15/17. She stated she was as was no hospital order to event ahead and wrote the one in the morning and an elatonin. She stated she dent on 09/20/17 and staff still of which well and the Cardiologist essure was so low due to the otake Imdur could have sent of the otake Imdur could have sent of the was the reason why she gas twice a day for a week to cation changes were working. Sected staff to follow provider anner and to call her if there but they needed to follow the that with the resident having able to report symptoms so was very important. She her concerns to the ADON on the would take action and she rector of Nursing (DON) on the world and the section of the world and the remember anyone handing (17 for Resident #165 and the every more anyone worders for the section of the assumed care the	F	333					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		345312	B. WING _			C 9/22/2017		
	ROVIDER OR SUPPLIER	ENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		3/22/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 333	Thursday 09/14/17, anything specific and mentioning he had g stated she did not reproblems with low bl would know about as pressure before givin medication, and she low that particular wown was discontinued it to the MAR, it would be discontinued and the MAR to sign off if giv Interview with Unit M#2 on 09/22/17 at 9: Manager #1 statings for Resident #165 co Nurse Practitioner of which time she saw computer and she pid Manager #2 did not Unit Manager #1 statishould have been pid They stated the PM picked up the orders was going on. They discontinuation order computer, the order Interview with the AE 09/22/17 at 11:46 AI about Resident #165 two sheets of orders reviewed and entered PM supervisor. The	the off-going nurse of the doctor's office that but she did not recall dishe did recall them one to the hospital. She member him having ood pressure, which she is she checked his blooding him his blood pressure did not remember it being eek. She stated if an order would be indicated as such in exclear that it was ere would be no place in the wing it. Itanager #1 and Unit Manager 54 AM revealed Unit she did not remember orders oming to her attention by the notil Monday 09/18/17, at they were not in the cut them in the computer (Unit work that particular day). Ited that any missed orders cked up during chart checks. Supervisor should have to the doctors of the control of th	F3	33				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345312	B. WING			l	22/2017
	ROVIDER OR SUPPLIER R HEALTH & REHAB/HE	ENDERSONVILLE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 870 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	o9/22/17 at 12:25 PM started her shift she a review orders noted in Managers. She state off any orders for Resalthough it might have Cardiologist on 09/22 the Cardiologist on 09/22 the Cardiologist was a would notify the Cardia statement for the reshould not be given to hypotensive. Review of a signed st for Resident #165 dat resident had intermitted Imdur. The statement medication should be recommend holding to blood pressure less the formercury]. If he is go hypotension." Interview with the Adri 12:56 PM revealed she processed and follows.	with the PM Supervisor on I revealed that when she assumed responsibility to reviewed by the Unit and she did not recall taking sident #165 on 09/15/17, where the possible. With the nurse of the revealed seeing patients but she iologist and get them to write record. She stated Imdure to someone who is the statement by the Cardiologist and the ent hypotension and was on at further documented "This is held if he is hypotensive. I he medication for systolic than 100 mmHg [millimeters given Imdur, it will aggravate ministrator on 09/22/17 at the expected new orders to	F	333			
	Review of the signific	ant change Minimum Data					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345312	B. WING		09/22/2017		
	NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	09/22/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION		
F 333	Set (MDS) dated 02 was cognitively intaknown. Review of the physical revealed an order of Norco, a pain medice exhausted. Review of the Medical from 09/08/17 through the medication card recover every ev	cian orders dated 09/08/17 vas written to discontinue cation, when current supply cation Administration Record 19/08/17 revealed 19/08/17 revealed 19/08/17 revealed 19/08/17 revealed 19/08/17 revealed 19/08/17 revealed 19/08/18/17 revealed 19/08/18/17 revealed 19/08/18/17 revealed 19/08/18/18/18/18/18/18/18/18/18/18/18/18/18	F 33				
	intention for the Northe 2 doses were gispoken to the reside informed her he did Norco to help him sidiscontinued the mestated she was not	The NP stated it was her roo to be discontinued after ven. She stated she had ent about his pain and he not have pain but took the leep and that is why she edication. The NP further aware there was an order at refill of the Norco and had she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345312	B. WING		09/22/2	017
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	US/22/2	.011
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE CO	(X5) MPLETION DATE
F 333	discontinue the Norce given. An interview conduct with Unit Manager #1 revealed they would Resident #30 to be d dose on the card was 09/08/17. They further clearly written and the the order before reor pharmacy on 09/11/11 An interview conduct the Director of Nursing expectation for order She stated the order discontinued Resider been clarified with the last dose from the medication cart was interpreted the order discontinued the order she prescription was interpreted the order discontinued the ord	ed on 09/22/17 at 9:55 AM and Unit Manager #2 have expected the Norco for iscontinued after the last is given per the NP's order on er stated the order was not en urse should have clarified dering the Norco from the 7. ed on 09/22/17 at 12:06 with ag revealed it was her is to be followed as written. written on 09/08/17 to int #30's Norco should have en NP as to discontinue when en current card in the given or discontinue when	F 33	33		
F 353 SS=D	with Nurse #1 reveals #30's Norco on 09/11 order to discontinue to was deleted. She sta reviewed the orders by	pefore reordering the Norco. FICIENT 24-HR NURSING PLANS	F 3	53	10/2	20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING		09	C 9/ 22/2017	
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE			,	STREET ADDRESS, CITY, STATE, ZIF 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 353	the appropriate coprovide nursing an resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the faccordance with that §483.70(e). [As linked to Facilities implemented by (Phase 2)] (a) Sufficient Staff. (a)(1) The facility resufficient numbers of personnel on a surrounding care to all resident care plans (i) Except when we this section, licens (ii) Other nursing plimited to nurse aid (a)(2) Except when this section, the faculty of the section of the faculty of the section of the sec	ave sufficient nursing staff with impetencies and skills sets to did related services to assure did attain or maintain the highest fall, mental, and psychosocial resident, as determined by ents and individual plans of care de number, acuity and acility's resident population in the facility assessment required by Assessment, §483.70(e), will beginning November 28, 2017 and provide services by the following types 24-hour basis to provide residents in accordance with accordance with accordance with the following but not dies. In waived under paragraph (e) of collity must designate a licensed and charge nurse on each tour of the following types are charge nurse on each skill care for residents' needs, as resident assessments, and	F	353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345312	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	0.00.2		STREET ADDRESS, CITY, STATE, ZIP CODE	09/22/2017
IVAIVIL OI II	KOVIDER OR OUT FEER			1870 PISGAH DRIVE	
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE			HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 353	Continued From pag	e 39	F 35	53	
	assessing, evaluating resident care plans a needs. This REQUIREMENT by:	includes but is not limited to g, planning and implementing and responding to resident's T is not met as evidenced ons, record review and		F353 (D) Sufficient 24-HR Nursing	Staff
	resident and staff into provide sufficient nur scheduled showers f	erviews the facility failed to sing staff to complete or 1 of 2 residents reviewed iving (Resident #166).		per Care Plans How will corrective action be accomplished for those residents for have been affected by the deficient	
	The findings include:			practice: Process that lead to deficient practic	ce is
	08/09/17 with diagno dementia, history of the Review of the signific	admitted to the facility on ses of non-Alzheimer's falls and muscle weakness. cant change Minimum Data evealed Resident #166 was		as follows: RCS did not communicate Nurse that shower was not given, not they report to Charge Nurse. Nurse not check to see if shower was give Staffing pattern was not assessed a changed	te with or did did n.
	assistance with bathing Review of the care possible Resident #166 had a self-care performance up to total assist with decline related to chipprocess. The goal was maintain current lever review date. The interprocess and the composition of the composition of the care performance of the care per	lan dated 09/20/17 revealed in activity of daily living (ADL) e deficit related to extensive ADL and at risk for further ronic diagnoses/disease as for Resident #166 to el of function through the erventions included: times per week and as ength and trim and clean on		On 9/22/17, a shower was offered a provided to Resident #166. On 9/22 NA #1 and NA #2 received a Teacha Moment on the expectation for composition of showers as scheduled as well as protocol for communicating incompletasks their direct supervisor. How will corrective action be accomplished for those residents had the potential to be affected by the sadeficient practice:	d/17, able pletion the ete
	08/09/17 through 09/	shower schedules from 21/17 revealed Resident ower days were Wednesday		On 9/23/17, staffing patterns were reviewed for effectiveness and show schedules were reviewed to ensure residents scheduled to receive show	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	A. BUILDING			C	
		345312	B. WING				/22/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIAN OT	DUEALTH & DELIAD	WENDERCONNULLE		18	870 PISGAH DRIVE			
BRIAN CI	R HEALTH & REHAB	HENDERSONVILLE		Н	ENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 353	Continued From page	age 40	F:	353				
. 555	-	schedules revealed Resident	'	333	were offered and provided bathing per			
		wers on the following dates:			preference as scheduled. Any identifie	4		
		day, 08/15/17 - Tuesday,			issues were corrected immediately.	•		
		sday, 08/30/17 - Wednesday,			,			
	09/13/17 - Wednes	sday, and 09/20/17 -			What measures will be put into place o	r		
	Wednesday.				systemic changes made to ensure that			
				the deficient practice will not recur:				
		ucted on 09/18/17 at 11:25 AM						
		S revealed he was not receiving			On 10/4/17, direct care and licensed			
	2 showers a week.			nursing staff was re-educated by the Director of Nursing and/or Staff				
	getting 1 shower a week and some weeks only a bed bath and he wanted 2 showers a week.				Development Coordinator on the			
	bea batti alia ile w	anted 2 showers a week.			requirements for compliance with F353	;		
	An interview condu			with emphasis on effective staffing				
	with Nurse Aide (N			patterns and ensuring showers are bei	ng			
	the 100 Hall with R	desident #166 on the 7:00 AM			offered and are provided per facility			
		he stated there were many			shower schedule and PRN.			
		get all of the scheduled						
		ause she was the only NA on			How the corrective action(s) will be	. 1		
		d there is only 1 NA scheduled Il and it makes it very difficult to			monitored to ensure the practice will no recur, i.e., what quality assurance	Ж		
		howers for residents.			program will be put into place:			
		ucted on 09/21/17 at 9:47 AM			The Director of Nursing will randomly			
		ed he works all of the halls and			monitor corrective actions to ensure the)		
		ed the hardest hall to work was			effectiveness of these actions by			
		se you were the only NA on the			randomly monitoring effectiveness of			
		made sure residents were did not always get the showers			staffing patterns for 3 different resident care to ensure showers are being	⊔5		
	done due to staffin				provided as scheduled 3x/week X 4			
		9			weeks, then monthly X 2 months or un	til		
	An interview condu	ucted on 09/22/17 at 8:43 AM			compliance has been determined.			
	with the Director of	Nursing (DON) revealed						
		resident census there were 1 to						
		o work the 100 hall during the			Findings will be reported at the monthly	1		
		M and 3:00 PM to 11:00 PM			QAPI meeting until such time as			
		he 100 and 600 Hall on the			substantial compliance has been			
		AM shift. She stated it was her showers to be completed as			achieved and the committee recommendately oversight by the District Direct			
	CAPECIALION IOI dil 3	SHOWCIS IO DE COHIPIELEU AS	1		quarterly oversignt by the District Difet	iOI	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345312	B. WING				22/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				18	TREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE ENDERSONVILLE, 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 353 F 520 SS=D	NA should report to the can give them. She is were having a difficult on the 100 hall and fe adequately staffed. An interview conducted with the Administrator expectation for reside as scheduled. She standequately staffed and difficult time completing inform the DON and the 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMB QUARTERLY/PLANS) (g) Quality assessment (1) A facility must main and assurance comminimum of: (ii) The director of number of the condition of the staff, at least three others of the staff, at least one of the comminimum of the comminimum of the comminimum of the staff, at least one of the comminimum of th	weren't able to be given the ne oncoming shift so they tated she was unaware staff time completing showers elt like the building was ed on 09/22/17 at 10:54 AM revealed it was her ents to receive their showers ated the building was ed if staff were having a ng their work they needed to nerself. (i)(ii)(h)(i) QAA ERS/MEET int and assurance. Intain a quality assessment existe consisting at a sing services; etr or his/her designee; etr members of the facility's who must be the a board member or other ship role; and essment and assurance		520	of Care Management to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017		10/20/17

	С
345312 B. WING (9/22/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	0/22/2011
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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 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 record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification and complaint survey of 09/20/17. The two federal surveys of record show a pattern of the facility's inability to sustain and effective Quality Assurance Program. F520 (D) QAA Committee-Membership/Meet Quarterly/Plans How will corrective action be accomplished for those residents found to have been affected by the deficient practice: On 10/16/17, plans of correction were submitted for repeat citations F279, F282, F309, F312 and F353. On 10/16/17, the facility Administrator received education from the District Director of Clinical Services regarding implementation of a post survey performance improvement plan in order to eliminate and/or reduce the likelihood or repeat citations.	

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		L , IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING			C 09/22/2017		
NAME OF P	ROVIDER OR SUPPLIER	5 100 12	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	22/2017	
	10115211 011 001 1 21211				870 PISGAH DRIVE			
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE		NDERSONVILLE			HENDERSONVILLE, NC 28791			
	OLIMANA DV. OT	ATEMENT OF REFIGIENCIES			T		217	
(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 520	Continued From page	e 43	F 5	520				
	F 279: Comprehensiv observations, record staff interviews, the fa	re care plan: Based on review, family interview and acility failed to include			How will corrective action be accomplished for those residents havin the potential to be affected by the sam deficient practice:	e		
		tions in an individualized			On 10/16/17, audits were completed a			
	care plan for 1 of 6 re				per annual survey plans of correction t	0		
	unnecessary medicat			ensure no other residents were being				
	D	::			affected by the respective deficient			
	During the recertification survey of 08/05/16 the facility was cited at F279 for failing to develop a				practice. Any identified issues were			
	care plan for a foot wound for 1 of 4 residents				corrected immediately.			
	reviewed for wounds				What measures will be put into place of	·r		
	reviewed for woulds	(Resident #156).			systemic changes made to ensure that			
	F 282: Services by au	ualified professional per care			the deficient practice will not recur:	*		
		d review, observation and			the denoish practice will not recar.			
		acility failed to follow care			On 10/16/17, the Administrator was			
	plan interventions for				re-educated by the District Director of			
	-	or one (1) of one (1) fall risk			Operations on the requirements for			
	resident (Resident #6				compliance with F520 and by the Distr	ict		
	,	•			Director of Clinical Services on the pos			
	During the recertificat	tion survey of 08/05/16 the			survey performance improvement proc	ess		
	facility was cited at F2	282 for failing to follow the			with emphasis on implementation of			
	physician's orders as	written for treatments, the			monitoring strategies to reduce and/or			
		to complete wound care			eliminate the likelihood of repeat citation	ins.		
		sampled residents reviewed						
	for dressing changes	and wound care (Resident			How the corrective action(s) will be			
	#56).				monitored to ensure the practice will no	ot		
					recur, i.e., what quality assurance			
		ices: Based on observation,			program will be put into place:			
		interview, staff interviews						
		vs, the facility failed to			The Administrator will randomly monito	4T		
		ays provider order changes			corrective actions to ensure the			
		hypertensive medication,			effectiveness of these actions by	`		
	increase vital signs m				monitoring audit findings of each of the	1		
		of a non-narcotic sleep aid			October 2017 annual survey citations			
		requency of administration			weekly X 4 weeks, monthly X 2 months and quarterly thereafter until compliance			
	of an antipsychotic medication for a resident with known sedation and low blood pressure				has been determined.	<i>,</i> €		

` '	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345312	B. WING		0	C 9/ 22/2017	
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDE	RSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL SENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
Continued From page 44 (Resident #165), who was reviewed for well-being. During the recertification is facility was cited at F282 final pain medication to a reside the knee amputation cause unrelenting pain for 1 of 3 reviewed for pain manage failed to follow a physician and dressing changes for residents reviewed for word #197 and #158). F312: Activities of daily living staff interviews the facility scheduled showers for 1 of for activities of daily living. During the recertification is facility was cited at F282 find care and showers for 4 of residents (Resident #1, #8 F353: Sufficient nursing staff to a showers for 1 of 2 resident activities of daily living (Resident #1) and the recertification is facility was cited at F282 find pain for the recertif	survey of 08/05/16 the or failing to administer ent who had a below ing the resident to have sampled residents ment. The facility also its order for wound care 1 of 4 sampled und care (Resident ing: Based on w and resident and failed to provide of 2 residents reviewed (Resident #166). Survey of 08/05/16 the or failing to provide oral 7 dependent sampled 8, #45, and #109). Faff: Based on w and resident and failed to provide ingiled to provide in w and resident and failed to provide	F 52	Findings will be reported at the QAPI meeting until such time as substantial compliance has bee achieved and the committee requarterly oversight by the Distriof Clinical Services to maintain compliance when completing fareviews. Date of Compliance: 10/20/201	s en commends ct Director acility		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345312	B. WING _			C 0/22/2047
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791		9/22/2017
(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 CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 520	needs of the resident care (Residents #1, # An interview with the 1:18 PM revealed the correction and did all plan and thought they from the citations in C	s' showers and incontinence	F 5	· ·		