	-	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			Сом	E SURVEY PLETED
		345221	B. WING				C / <b>16/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER H & REHAB WEA	VERV			78 WEAVER BOULEVARD		
BRIAN CE					WEAVERVILLE, NC 28787		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)( §483.10(a) Resident I The resident has a rig self-determination, an access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding the provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The faci resident can exercise	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen		550	DEFICIENCY)	RIATE	4/17/18
	free of interference, c reprisal from the facili rights and to be suppo	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

04/05/2018

					OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		с
		345221	B. WING		_
	ROVIDER OR SUPPLIER	545221		STREET ADDRESS, CITY, STATE, ZIP CODE	03/16/2018
NAME OF PI	ROVIDER OR SUPPLIER				
BRIAN CE	NTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
F 550	Continued From page	e 1	F 550		
	exercise of his or her	rights as required under this			
	subpart.	-			
	This REQUIREMENT	I is not met as evidenced			
	by:				
		ons, record review, resident		Criteria 1	
		the facility failed to ensure		For example #1, on 3/16/18, towel	
	resident showers and	vels were available for		washcloths were provided to linen	
		ailed to provide personal		a par level of 3 washcloths per res and 1 towel per resident per shift t	
		vith removing facial hair of a		ensure resident rights are maintair	
	female (Resident #65	-		usage of appropriate linen. The pro-	-
	reviewed for dignity.	.,		failure that led to this deficiency wa	
				laundry personnel did not monitor	
	The findings included	i:		adequate par levels throughout the For example #2, on 3/16/18, CNA	e day.
	1. Resident #25 was	admitted to the facility		to shave resident #65. Her chin w	
		rly Minimum Data Set (MDS)		shaved of unwanted facial hair. The	he failed
		ated Resident #25 had mild		process that led to this deficiency	
	cognitive impairment	with no behaviors or		nursing staff did not observe close	
	rejection of care.			presence of unwanted facial hair in	n
				between shower days.	
		on 03/15/18 at 3:32 PM,		Criteria 2	
	. ,	stated sometimes on 2nd ney run out of wash clothes		For example #1, par level was obtain	ained
		use pillow cases for bathing		for each linen cart based on numb	
		care. NA #2 also stated she		beds on that hallway and estimatin	
		ry and there would not be		use of 3 washcloths per resident a	-
		e they were being washed or		towel per resident per shift. That p	
	-	stated they had run out of		was supplied to each linen cart by	
		use folded blankets for the		3/19/18. For example #2,a review	
		ted this most recently		current residents was conducted b	-
		NA #2 also stated she had		DON and Unit Managers to detern	
	reported it to the nurs			who has unwanted facial hair. Res	
		short in during NA meetings		care plans were updated and the r	
		make do with what they had.		provide management of facial hair residents who choose to have faci	
	During an interview o	on 03/15/18 at 4:35 PM,		removed was added as a result of	
	-	she had to use a pillow case		review. To prompt and ensure staf	
	for a wash cloth last	-		is now. To prompt and chould star	•

Facility ID: 952991

If continuation sheet Page 2 of 24

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		10. 0938-03 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COL	MPLETED
						С
		345221	B. WING		o	3/16/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIF	CODE	
	NTER H & REHAB WEA			78 WEAVER BOULEVARD		
		VERV		WEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETIO DATE
F 550	Continued From page	e 2	F 5	50		
	· · · · · · · · · · · · · · · · ·	ated they were often out of		and management of facia	l hair (for those	
		vels on 2nd shift on her		who wish to have it remo		
		ent #25 further stated that		added to the task list for a		
		oth or a towel to use and		documentation.	J - ···	
	-	case to bathe with made		For example #1, on or be	fore 4/6/18,	
	her feel like she wasr	n't worth the time or expense		Nursing and Laundry stat	f were	
	and the facility was "s	scraping out of the bottom of		re-educated by the Admir	nistrator that in	
	a barrel."			order to ensure there are	•	
				for provision of care and		
	-	n 03/15/18 at 4:50 PM, NA		resident dignity, par level		
		se towels often when wash		be maintained on linen ca		
	clothes for showers w			they are restocked. Nursi		
		e pillow cases when wash e not available. NA #3		staff members were also it is necessary to commu		
		tly had to use pillow cases		management staff if there		
		week. NA #3 stated he		with maintaining the par I		
		ry to try and find wash		example #2, On or before		
		hen they weren't available on		staff and the Interdisciplir	-	
		halls. NA #3 further stated		re-educated by the DON	•	
	this had only been ha	appening during 2nd shift.		resident rights by ensurin		
				management of facial hai	r.	
		n 03/15/18 at 5:24 PM, a				
		dry stated there had been		Criteria 3		
		he past month when NA's		For example #2, an audit	• •	
		alls to laundry on 2nd shift		levels for towels and was		
		nes and towels. The staff		performed daily at 7 am a		
		A's would get pillow cases e clothing garment) to use for		Housekeeping Manager Housekeeping Manager.		
		othing else was available.		determine if par levels are		
		o stated there was a break		carts are restocked. The		
		n 1st shift laundry workers		done daily for 2 weeks, 3		
		ift laundry workers came in.		4 weeks, and 1 time a we		
		ther stated there had not		The results of these audit		
	been clean wash clot	hes or towels for the 2nd		reported at the monthly G	API meeting	
	shift workers at least	4 or 5 times during the past		until such time substantia	-	
	month.			been achieved and the co		
				recommends quarterly ov		
		n 03/15/18 at 5:36 PM, NA		District Director of House		
	#5 stated numerous t	imes in the last month she		Laundry Services or desi	gnee to maintain	1

Facility ID: 952991

If continuation sheet Page 3 of 24

				PLE CONSTRUCTION	(X3) DATE SURVE	38-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IG	(X3) DATE SURVE COMPLETED	
					С	
		345221	B. WING		03/16/20	18
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
BRIAN CE	INTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE COM	(X5) IPLETIO DATE
F 550	had to use pillow cass incontinence care ber and towels were not a During an interview o Laundry Supervisor s aware the NA's were pillow cases and tower residents. An observ supplies received sin were a total of 360 to the facility had receiv observation there 120 clothes in storage and Supervisor stated tow wash clothes do and clothes are disposed use. During an interview o Director of Nursing (D been informed the N/ and old clothing prote and showers. The Di was for supplies to be provide adequate car	es for wash clothes and cause clean wash clothes available. In 03/16/18 at 1:29 PM, the stated he had not been using other resources like els to provide care for the ration of the invoices for ce 01/01/18 indicated there wels and 2160 wash clothes red. Upon further D towels and 360 wash d unused. The Laundry vels last much longer than that about 10-12 wash of weekly due to wear from In 03/16/18 at 4:27, the DON) stated she had not A's were using pillow cases ectors for incontinence care ON stated her expectation e available for staff to	F 5	50 compliance when comp Housekeeping and Lau Review. For example #2 random residents who f facial hair will be comple weeks, 3 times a week f time a week for 6 weeks be done by DON or des that each resident is fre facial hair. The results of be reported at the mont until such time substant been achieved and the recommends quarterly of District Director of Clinic designee to maintain co completing Clinical Syst Criteria 4 For example #1, the Ho Manager is responsible the corrective actions. F #2,The DON is respons implementation of the co Criteria 5 The facility will be in full this plan of correction of	ndry Systems 2, an audit of 10 have unwanted eted daily for 2 for 4 weeks and 1 s. The audit will signee to determine e of unwanted of these audits will hly QAPI meeting tial compliance has committee oversight by the cal Services or ompliance when tems Review.	
	use of pillow cases and devices for resident of Administrator also state adequately stocked at (amount of linens in up further stated her exp	and had a good par level use). The Administrator pectation was for the staff to linens available to do what		4/12/18.		

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP			
		345221	B. WING						
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                     </u>			
BRIAN CE	NTER H & REHAB WEA	VERV			78 WEAVER BOULEVARD NEAVERVILLE, NC 28787				
(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 550	Continued From page the resident.	2 4	F	550					
	diagnoses that includ	ependence and stage III							
	onset problem date o self-care deficit due to bound) and decline in was for her to have al assistance. Intervent #65's preferred dress after morning meal ar	ions included Resident ing/grooming routine was							
	02/07/18 coded Resid cognitive impairment The MDS indicated R extensive to total assi	for daily decision making. esident #65 required istance of 1 to 2 staff s of Daily Living (ADL) which							
	used by nurse aides t needs of residents) in	Aide (NA) care guide (tool to know the individual care idicated the shower days for uesday and Thursday on							
	10:16 AM revealed he	sident #65 on 03/12/18 at er lying in the bed with in hairs approximately a half							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/18/2018 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION			LETED
		345221	B. WING		_		C 16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BRIAN CE	NTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 287	787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	<ul> <li>5:10 PM revealed her several noticeable chinch long.</li> <li>An observation of Revealed her noticeable chin hairs long.</li> <li>An observation of Revealed her noticeable chin hairs long.</li> <li>An observation of Revealed her noticeable chin hairs long.</li> <li>During an interview of #6 confirmed resident days and when needed not noticed Resident she provided assistar NA #6 confirmed Resent and the bathing routine shaved when needed Resident #65 had several noticeable chin hairs whet an observation and ir on 03/16/18 at 1:55 P bed, drinking fortified several noticeable chinch long. Resident #chin hairs and used to the set of the set of the set of the set of the hairs whet an observation and ir on 03/16/18 at 1:55 P bed, drinking fortified several noticeable chinch long. Resident #chin hairs and used to the set of the set o</li></ul>	sident #65 on 03/13/18 at sitting up in bed with in hairs approximately a half sident #65 on 03/15/18 at er lying in bed with several approximately a half inch sident #65 on 03/16/18 at er lying in bed with several approximately a half inch n 03/16/18 at 10:41 AM NA ts were shaved on shower ed. NA #6 indicated she had #65 with any chin hair when nce earlier in the morning. ident #65 had several that needed shaved. n 03/16/18 at 11:24 AM onal hygiene care was part and residents should be . Nurse #2 was not aware veral chin hairs that had not onfirmed NAs were expected n noticed. terview with Resident #65 'M revealed her sitting up in soup through a straw, with in hairs approximately a half t65 confirmed she didn't like o shave them herself when ent #65 stated she would	F 550				

Facility ID: 952991

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345221	B. WING			C / <b>16/2018</b>
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	9 6	F 55	50		
	Director of Nursing (December 2017) Director of Nursing (December 2017)	n 03/16/18 at 2:00 PM the OON) confirmed it was her Id provide residents with e on shower days or when				
F 584 SS=D	Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(	ble/Homelike Environment (7)	F 58	34		4/16/18
	§483.10(i) Safe Envir The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, a homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall ex the protection of the r or theft.	onment. ght to a safe, clean, elike environment, including iving treatment and ng safely.				
	services necessary to and comfortable inter §483.10(i)(3) Clean b	maintain a sanitary, orderly,				
	in good condition; §483.10(i)(4) Private resident room, as spe	closet space in each cified in §483.90 (e)(2)(iv);				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345221	B. WING				C 16/2018
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				78	8 WEAVER BOULEVARD		
BRIAN CE	NTER H & REHAB WEA	VERV		W	VEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 584	levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation and staff interviews th wash clothes and tow reviewed for providing homelike environmen The findings included Resident #25 was add with diagnoses includ disorder among other Data Set (MDS) dated Resident #25 had mill was interviewable and rejection of care. During an interview of Resident #25 also stat case as a wash cloth dry off with. During an interview of Nurse Aide (NA #2) stated of Nurse Ai	te and comfortable lighting table and safe temperature lly certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced is, record review, resident te facility failed to provide rels to 1 of 1 resident g a safe, clean, comfortable t (Resident # 25). : mitted to the facility 04/28/17 ing major depressive s. The quarterly Minimum d 01/09/18 indicated d cognitive impairment but d had no behaviors or n 03/12/18 at 1:32 PM, on a regular basis the facility clothes and towels. ted she had to use a pillow last week and a blanket to n 03/15/18 at 3:32 PM, tated sometimes on 2nd	F	584	Criteria 1 On 3/16/18, washcloths and towels we provided to linen cart at a par level of 3 washcloths per resident and 1 towel per resident per shift to ensure a homelike environment is maintained by usage of appropriate linen. The process failure t led to this deficiency was that laundry personnel did not monitor for adequate par levels throughout the day. Criteria 2 A par level was obtained for each linen cart based on number of beds on that hallway and estimating the use of 3 washcloths per resident and 1 towel per resident per shift. That par level was supplied to each linen cart by 3/19/18. On or before 4/6/18, Nursing and Laun staff were re-educated by the Administrator that in order to ensure th are adequate linens for provision of ca and assurance of a homelike environment, par levels of linen must b maintained on linen carts each time the are restocked. Nursing and Laundry st	a hat er dry ere re ee ey	
	Nurse Aide (NA #2) st shift (3pm - 11PM) the					-	

Facility ID: 952991

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STATEMENT C	S FOR MEDICARE & F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY MPLETED
				i		С
		345221	B. WING		0	3/16/2018
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NTER H & REHAB WEA	WEDV		78 WEAVER BOULEVARD		
DRIANCE				WEAVERVILLE, NC 28787		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 584	would check in laund any available becaus dried. NA #2 further bed pads and would residents. NA #2 sta occurred last week. reported it to the nurs complained of being towels during NA me make do with what th During a 2nd intervie Resident #25 stated a pillow case for a wa week. Resident #25 out of wash clothes a her shower days. Re that not having a was having to use a pillow her feel like she was and the facility was "s a barrel." During an interview of #3 stated he had to us clothes or towels wer stated he most recent for care the previous shift. NA #3 stated he try and find wash clot	care. NA #2 also stated she lay and there would not be se they were being washed or stated they had run out of use folded blankets for the ted this most recently NA #2 also stated she had se and the NA's had short of wash clothes and etings but had been told to ney had. w on 03/15/18 at 4:35 PM, the last time she had to use ash cloth was the previous also stated they were often and towels on 2nd shift on esident #25 further stated sh cloth or a towel to use and w case to bathe with made n't worth the time or expense scraping out of the bottom of on 03/15/18 at 4:50 PM, NA use towels often when wash weren't available and te pillow cases when wash re not available. NA #3 ttly had to use pillow cases week when working on 2nd the always went to laundry to thes and towels when they the linen carts on the halls. this had only been	F 58		g the or ormed eeping ng if par e daily for eks, and sults of ime nmends Director vices or when undry	
		on 03/15/18 at 5:00 PM, NA 2 weeks she had to use				

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM	D: 04/18/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345221	B. WING			C /16/2018
NAME OF PROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP COI		
BRIAN CENTER H & REHAB W	EAVERV		WEAVER BOULEVARD EAVERVILLE, NC 28787		
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
care. NA #4 stated about it because the already aware it was buring an interview staff member in law several instances in came from different looking for wash of member stated the or old bibs (protect the residents when The staff member at in time between will left and when 2nd The staff member at been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member been clean wash of shift workers at lear month. The staff member and they came in to worker hear the shift workers aware the NA's we pillow cases and p provide care for the the invoices for sup indicated there we	sh clothes and for incontinence d she had not told anyone he laundry personnel were as an issue. W on 03/15/18 at 5:24 PM, a undry stated there had been in the past month when NA's at halls to laundry on 2nd shift lothes and towels. The staff e NA's would get pillow cases tive clothing garment) to use for n nothing else was available. also stated there was a break hen 1st shift laundry workers shift laundry workers came in. further stated there had not clothes or towels for the 2nd ast 4 or 5 times during the past nember added the 2nd shift her the dirty linen barrels when ork and wash, dry, fold, and linen carts on the hall as well es for residents as well. W on 03/15/18 at 5:36 PM, NA is times in the last month she cases for wash clothes and because clean wash clothes	F 584			

Facility ID: 952991

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	
		345221	B. WING			- 16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER H & REHAB WEA	/ERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584 F 684 SS=D	Upon further observa and 360 wash clothes The Laundry Supervisi longer than wash clot wash clothes are disp from use. During an interview o Director of Nursing (D been informed the NA and old clothing prote and showers. The DO was for supplies to be provide adequate car During an interview o Administrator stated r use of pillow cases ar devices for resident c Administrator also sta adequately stocked a (amount of linens in u further stated her exp have the appropriate needed to be done fo Administrator stated i staff to do anything le the resident. Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resident	tion there were 120 towels is in storage and unused. sor stated towels last much hes do and that about 10-12 bosed of weekly due to wear in 03/16/18 at 4:27, the DON) stated she had not available for staff to e for the residents. In 03/16/18 at 6:36 PM, the ho one had ever brought the ho old protective clothing are to her attention. The ted the facility was ind had a good par level se). The Administrator ectation was for the staff to linens available to do what if the resident. The twas unacceptable for the ss than what was right for	F 58			4/5/18

Facility ID: 952991

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Event ID: NSBT11

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 04/18/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			LETED
		345221	B. WING			C 16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER H & REHAB WEA	WERV		78 WEAVER BOULEVARD		
BRIANCE				WEAVERVILLE, NC 28787		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pag	e 11	F 684	4		
		hensive person-centered	1 00			
	care plan, and the re					
		T is not met as evidenced				
	by:					
	-	view, resident and staff		Criteria 1		
		y failed to provide pain		Resident #89 was administere		
		r and 30 minutes causing		the 3/13/18. The process failur		
		sleep for 1 of 4 residents		this deficiency was that nursin	•	
	reviewed for pain ma	anagement (Resident #89).		to prioritize administration of P		
	The findings include:	4.		medication over scheduled me	edication	
	The findings included	J.		pass. Criteria 2		
	Resident #89 was ac	mitted to the facility on		A list has been compiled of cu	rrent	
		ses including arthritis among		residents who have an order for		
		day Minimum Data Set (MDS)		medications.	•	
	assessment dated 02	2/16/18 indicated Resident		On or before 4/6/18, nursing s	taff were	
	-	to extensive assistance with		re-educated by the DON on th		
		ily Living (ADL's). The MDS		importance of providing pain n		
	also indicated Reside			as soon as they are aware of t		
		ication but did receive as tion. The MDS further		Included in the education was necessity for other staff to mal		
		89 was cognitively intact and		aware of a request for medical		
	had adequate vision.	<b>c</b>		as it is made. Nursing has bee		
				to pause their scheduled med		
	Record review of the	Medication Administration		complete a request for PRN pa	ain	
	. ,	arch 2018 indicated the		medication. After providing rec		
	•	pain medications were		medication, they can resume s	scheduled	
	available for Resider	nt #89:		medication pass.		
	Hydrocodone / A seter	ninonhon 5/225 milliorama		Criteria 3	vintoniow	
	-	ninophen 5/325 milligrams by mouth as needed every 6		DON or designee will randoml 3 alert and oriented residents		
	hours for severe pair			weeks, 3 x weekly for 4 weeks		
		ninophen 5/325 MG - give 1		weekly for 6 weeks to ensure t		
		eeded every 6 hours for		received requested pain medic		
	moderate pain	-		timely manner. The results of t	these audits	
		th (ES) 500 MG - give 2		will be reported at the monthly		
		needed every 8 hours as		meeting until such time substa		
	needed for pain.			compliance has been achieved		
				committee recommends quarter	eny	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
		IDENTIFICATION NUMBER:		G	COMPLETED	
					С	
		345221	B. WING		03/16/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
BRIAN CE	NTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE	
F 684	Continued From page	ə 12	F 68	84		
	<ul> <li>Record review of administered pain medication for March 2018 indicated Resident #89 had received Hydrocodone-Acetaminophen 5/325mg - 2 tablets on 3 different occasions on 03/04, 03/06 and 03/09.</li> <li>Resident #89 had not received Tylenol in March 2018 according to what was indicated on the MAR.</li> <li>Record review of a note written by the MDS Coordinator on 03/13/18 revealed the following: "he reports having frequent pain in his eye/cheek bone, aches in his legs, and a burning sensation in his thighs that is improvinghe reports that the pain has interfered with sleep he states that he takes Tylenol and it helps."</li> </ul>			oversight by the District Dire Services or designee to ma compliance when completin Systems Review. Criteria 4 The DON is responsible for the corrective actions. Criteria 5 The facility will be in compli- plan of correction on or befor	intain ng Clinical implementing ance with the	
	Resident #89 stated I medication at 12:00A receive it until almost Resident #89 stated I when he asked for his #89 also stated he us Nurse Assistant (NA) told her he needed pa #89 stated he waited call light again and th room and he told her medication. Residen another 30 minutes b	n 03/13/18 at 10:26AM, he had requested pain M on 03/13/18 but did not 1:30AM on 03/13/18. he was watching the clock s pain medication. Resident ed his call light and the came into his room and he ain medication. Resident 30 minutes and used his e same NA came into the again that he needed pain t #89 stated he waited efore using his call light a e was very agitated because				
	he had to wait so long Resident #89 stated to had told the nurse ea again. Resident #89 pain medication about	g and told the NA this. the NA informed him she ch time, but would tell her stated he eventually got his it 1:30AM, but he did not use he had been agitated for				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345221	B. WING				C 16/2018
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	ENTER H & REHAB WEA	VERV					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	having to wait for his During an interview of Nurse #1 acknowledg Tylenol for pain to Re- morning on 03/13/18 documented on the M was about 15 minutes her about Resident #4 before she gave it to stated she went to fol but he was sleeping. During an interview of #1 stated Resident #8 call light and told her The NA stated she to medication on a differ Resident #89 rang for later and again reque NA stated she told Nu #1 continued to be giv another hall. The NA 3rd time and was agit nurse had not come w The NA stated Nurse Resident #89 a few m medication. The NA had waited over an her During an interview of Director of Nursing (E was for any nurse wh having pain, to go and assess their pain leve tells residents if they 15 minutes of asking their medication again		F	684			

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<u>CENTER</u>	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	M APPROVE D. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SUR COMPLETE		
		345221	B. WING				C / <b>16/2018</b>	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER H & REHAB WEA	VERV		78	WEAVER BOULEVARD			
			1	W	EAVERVILLE, NC 28787		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 684	Continued From page	e 14	F	684				
	pain medication."							
F 865 SS=D			F	865			4/16/18	
	§483.75(a) Quality as improvement (QAPI)	ssurance and performance program.						
		nt its QAPI plan to the State ter than 1 year after the regulation;						
	except in so far as su	ary may not require ords of such committee ich disclosure is related to ch committee with the						
	and correct quality de a basis for sanctions. This REQUIREMENT	by the committee to identify efficiencies will not be used as						
	interview, the facility Assurance (QA) Com implemented procedu interventions that the the 02/10/17 recertifie deficiencies originally and again cited in the deficiencies were in t environment for resid assistance from staff continued failure of th	facility put in place following cation survey. This is for two cited in the 02/10/17 survey 03/16/18 survey. The he areas of dignity and lents who required			Criteria 1 Corrective action has been taken for the alleged deficient QAPI practice by implementing the above POC for F550 and F584. For example #1, on 3/16/18 washcloths and towels were provided linen cart at a par level of 3 washcloths per resident and 1 towel per resident p shift to ensure resident rights are maintained by usage of appropriate line For example #2, on 3/16/18, CNA offee to shave resident #65. Her chin was shaved of unwanted facial hair. The	) 3, to s per en.		

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	-	ID HUMAN SERVICES					APPROVED	
		MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ECONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILD	ING _				
		345221	B. WING					
	ROVIDER OR SUPPLIER	040221			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	16/2018	
	NOVIDER OR SOLT EIER				78 WEAVER BOULEVARD			
BRIAN CE	NTER H & REHAB WEA	VERV			WEAVER BOOLEVARD			
					·			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF				(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE	
					DEFICIENCY)			
			1					
F 865	Continued From page	e 15	F	865				
	Assessment and Ass	urance Program.			QAPI committee to sustain compliance	;		
					through ongoing monitoring of previous	sly		
	The findings included	:			cited deficiencies for F550 Resident			
	<b>T</b> I. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.				Rights/Dignity and F584 Resident			
	This tag is cross refer	renced to: F 550 and F 584.			Rights/Environment.			
	1 E 550 Resident Ri	ghts/Dignity: Based on			Criteria 2			
		review, resident and staff			For F550 example #1 and F584,a par			
		failed to ensure wash			level was obtained for each linen cart			
	· · · ·	ere available for resident			based on number of beds on that hallw	/ay		
	showers and incontin	ence care and failed to			and estimating the use of 3 washcloths	\$		
	provide personal hygi				per resident and 1 towel per resident p			
		f a female resident reviewed			shift. That par level was supplied to ea	ch		
	for dignity.				linen cart by 3/19/18.			
	2 E EQ4 Desident Di	abte/Environmente Deced			For F550 example #2,a review of curre			
		ghts/Environment: Based ord review, resident and staff			residents was conducted by the DON a Unit Managers to determine who has	DIR		
		failed to provide wash			unwanted facial hair. Resident care pla	ans		
	-	a resident reviewed for			were updated and the need to provide			
		n, comfortable homelike			management of facial hair for residents			
	environment.				who choose to have facial hair remove			
					was added as a result of this review. T			
	-	n 03/16/18 at 6:36 PM the			prompt and ensure staff attention to th			
	Administrator acknow	-			care area, observation and manageme			
		inication between staff and			of facial hair (for those who wish to have			
		he Administrator stated the be proactive with concerns			removed) was also added to the task li for daily CNA documentation. On or	SI		
		nd would develop a plan to			before 4/6/18, nursing staff and the			
		and continue with follow-up			Interdisciplinary Team were re-educate	ed		
		months to assure the issue			by the DON about promoting resident			
	-	dministrator also stated if			rights by ensuring appropriate			
		ng in their clinical meeting			management of facial hair.			
	-	ely start a process to fix it.			To prevent the alleged deficient practic			
	The Administrator fur				from reoccurring, Nursing and Laundry			
		staff to do anything less than			staff were re-educated on or by 4/6/18			
	the right thing for the				F550 example #1 and F584 that in ord to ensure there are adequate linens fo			
					provision of care and assurance of			
					resident rights and a homelike			

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		D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/201 FORM APPROVEI OMB NO. 0938-039
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345221	B. WING		03/16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•
BRIAN CE	NTER H & REHAB WEA	/ERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 865	Continued From page	2.16	F 86	<ul> <li>environment, par levels of lin maintained on linen carts ead are restocked. During the edd Nursing and Laundry staff me also re-educated that it is near communicate to management there is a problem with maint par levels.</li> <li>For F550 example #2,Nursin the Interdisciplinary Team we re-educated by the DON and Managers on or by 4/6/18 with promoting resident rights by premoval of unwanted facial had notation in POC that alerts notation in POC that alerts not observe for unwanted facial fit the resident needs to have the to shave or be shaved.</li> <li>Criteria 3</li> <li>For F550 example #1 and F5 of necessary par levels for to washcloths will be performed and 4pm by Housekeeping Maraudit will determine if par levels week for 4 weeks, and 1 time weeks.</li> <li>For F550 example #2, an aud random residents who have or be shave or be that each resident with resident had the second the second</li></ul>	ch time they ucation, embers were cessary to ht staff if taining the g staff and ere I Nurse th regards to providing hair. The ir have a ursing staff to hair and that he opportunity 584, an audit wels and d daily at 7 am Manager or hager. The els are met ed. The audit s, 3 times a e a week for 6 dit of 10 unwanted daily for 2 weeks and 1 le audit will e to determine

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				FOF	ED: 04/18/2018 RM APPROVED O. 0938-0391
CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		(X3) DAT	E SURVEY IPLETED
	345221	B. WING		0:	C 3/16/2018
SUPPLIER			STREET ADDRESS, CITY, STATE,		
REHAB WEA	VERV		78 WEAVER BOULEVARD		
			-		
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	E ACTION SHOULD BE	(X5) COMPLETION DATE
Prevention & 183.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	& Control (2)(4)(e)(f) htrol blish and maintain an ind control program a safe, sanitary and hent and to help prevent the hsmission of communicable		A monthly summary of will be presented at QA months. The committe changes to the POC if Criteria 4 The DON is responsible corrective action for F5 Rights/Dignity regardin Housekeeping Manage implementing the corre F550 Resident Rights/I appropriate linen. The I Manager is also respor implementing the corre F584 Resident Rights/I The Administrator will b oversight and assurand actions are implemente summaries of findings a QAPI meetings for 6 m Administrator will also e changes in the POC ar QAPI committee if nece of ongoing monitoring. Criteria 5 The facility will be in co of corrections on or bef	API monthly for 6 re will recommend necessary. e for implementing 50 Resident g facial hair, and er is responsible for active actions for Dignity regarding Housekeeping housekeeping housekeeping housekeeping totive actions for Environment. be responsible for active actions for Environment. be responsible for act that corrective ed and monthly are reported at onths. The ensure that re made by the essary as a result	4/5/18
	EDICARE & CIES SUPPLIER REHAB WEA SUMMARY ST. ACH DEFICIENC GULATORY OR I ad From page Prevention & 483.80(a)(1) Infection Con ity must esta prevention a ble environm nent and trar	IDENTIFICATION NUMBER: 345221	EDICARE & MEDICAID SERVICES         CIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIF         JDENTIFICATION NUMBER:       A. BUILDING         345221       B. WING	EDICARE & MEDICAID SERVICES         CIES       (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         34521       STREET ADDRESS, CITY, STATE, 78 WEAVER BOLLEVARD WEAVER VILLE, NC 28787         SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLA (EACH CORRECTW) CROSS-REFERENCED DEFIC         dd From page 17       F 865       A monthly summary of will be presented at QA months. The committe changes to the POC if Criteria 4         dd From page 17       F 865         A monthly summary of will be presented at QA months. The committe changes to the POC if Criteria 4         The DON is responsibil corrective action for F5         Readed and the presented at QA months. The committe changes to the POC if Criteria 4         The DON is responsibil corrective action for F5         Rights/Dignity regardin Housekeeping Manager inplementing the corre F550 Resident Rights/I appropriate linen. The Manager is also respon implementing the corre F584 Resident Rights/I appropriate linen. The Manager is also respon implementing the corre F684 Resident Rights/I appropriate linen. The Manager is also respon implementing the corre F584 Resident Rights/I appropriate linen. The Manager is also respon implementing the corre F684 Resident Rights/I appropriate linen. The Manager is also respon implementing the corre F684 Resident Rights/I appropriate linen. The Manager is also respon implementing the corre f684 Resident Rights/I appropriate linen. The Manager is also respon occur appropriate linen. The Manager is also respon implementi	HEALTH AND HUMAN SERVICES     FOR EDICARE & MEDICAID SERVICES     OMB N       DICIS     (x1) PROVIDER/SUPPLIERCLIA DENTIFICATION NUMBER:     (x2) MULTIPLE CONSTRUCTION     (x3) CONSTRUCTION       345221     B. WING     CON       SUPPLIER     345221     B. WING     00       REHAB WEAVERV     TREETADDRESS, CITY, STATE, ZIP CODE     00       SUMMARY STATEMENT OF DEFICIENCIES GULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX     PREVUENCE AND PREVENCE AND CORRECTLO AND HOLD BE CROSS-REFERENCED TO THE APPORTANTE DEFICIENCY     00       d From page 17     F 865     A monthly summary of the audit results will be presented at QAPI monthly for 6 months. The committee will recommend changes to the POC if necessary. Criteria 4     A monthly summary of the audit results will be presented at QAPI monthly for 6 months. The committee will recommend changes to the POC if necessary. Criteria 4       The DON is responsible for implementing corrective actions for F550 Resident Rights/Dinylty regarding appropriate linen. The Housekeeping Manager is also responsible for implementing the corrective actions for F584 Resident Rights/Environment. The Administrator will are responsible for oversight and assurance that corrective actions are implemented at corrective actions for F584 Resident Rights/Environment. The Administrator will are responsible for oversight and assurance that corrective actions are implemented at corrective actions for F584 Resident Rights/Environment. The Administrator will are responsible for oversight and assurance that corrective actions are implemented at corrective actions for F584 Resident Rights/Environment.       Prevention & Control Manager is the POC

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP		
		345221	B. WING				_ 16/2018	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
BRIAN CE	NTER H & REHAB WEA	/ERV			78 WEAVER BOULEVARD NEAVERVILLE, NC 28787			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CORRECTIVE ACTION SHOULD BE CO EFERENCED TO THE APPROPRIATE		
F 880	<ul> <li>§483.80(a) Infection program.</li> <li>The facility must estat and control program (a minimum, the follow</li> <li>§483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visite providing services uncertain accepted national states are not limited to:</li> <li>(i) A system of surveil possible communicable diseases reported;</li> <li>(ii) When and to whom communicable diseases reported;</li> <li>(iii) Standard and trant to be followed to prev (iv)When and how isom resident; including but (A) The type and durate depending upon the init involved, and</li> <li>(B) A requirement that least restrictive possible circumstances.</li> <li>(v) The circumstances</li> </ul>	brevention and control blish an infection prevention IPCP) that must include, at ring elements: Im for preventing, identifying, g, and controlling infections seases for all residents, brs, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and bgram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of the or infections should be semission-based precautions ent spread of infections; lation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable	F	880				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO.	APPROVED	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345221	B. WING		_	6/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
BRIAN CE	NTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	contact will transmit t (vi)The hand hygiene by staff involved in di §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on observation interviews the facility glucometer (blood glu sugar monitoring) acc recommendations for sugar (FSBS) observ Findings included: A review of a facility p Cleaning and Disinfe on 12/2017 indicated needed to be cleanse manufacturer's instru the monitor needed to glucometer with wipe entire time instructed A review of the manu	s or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. Ile, store, process, and s to prevent the spread of view. Int an annual review of its ir program, as necessary. T is not met as evidenced ons, record review, and staff failed to disinfect a ucose meter used for blood cording to manufacturer's t 1 of 1 finger stick blood ed (Resident #97). Dolicy for Glucometer ction dated 2012 and revised (in part) the glucometer ed according to ctions for the length of time to remain wet (may wrap in order to ensure wet for	F 8	Criteria 1 The nurse was immediately acceptable infection contro regarding glucometer clear necessity of following the m guidelines on 3 minute wet The nurse was also immed with a watch to ensure abili minute wet contact. The pro- that led to this deficiency w nurse failed to follow specif provided on glucometer sto not accurately timing wet co Criteria 2 On 3/14/18, a glucometer w for each resident who need blood glucose levels monito glucometer and container w with the resident's name ar on the medication cart for m	I practices hing and the nanufactures c contact time. liately provided ity to time 3 ocess failure vas that the fic directions orage box by ontact time. was provided ds to have ored. Each were labeled hd are located		

Facility ID: 952991

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	、 <i>′</i>	G		MPLETED
			-			С
		345221	B. WING		0	3/16/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI		
				78 WEAVER BOULEVARD		
BRIAN CE	NTER H & REHAB WEA	VERV		WEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From page	- 20				
F 000	Continued From page		F 88			
		to wipe the surface to be		the resident. On or befor	•	
		ugh wipes for the treated		staff were educated by D		
		ibly wet for the contact time		practice for glucometer r		
	and allowed to air dry	nfecting. Use enough wipes		appropriate infection con Glucometers will only be	-	
		e to remain visibly wet for 3		Clorox wipes when visibl		
	minutes and allowed	3		glucometers will only be		
	minutes and allowed	to all dry.		individual they are assign		
	During a continuous	observation on 03/13/18 at		Criteria 3	neu lo.	
		as observed not wearing a		DON or designee will rar	adomly choose 5	
		is not observed on the 400		residents per day for 1 w		
		urse #1 was observed		and various shifts) to obs		
		eter from a plastic container		procedure for glucomete		
		nent cart. Nurse #1 indicated		DON or designee will the		
		e glucometer had been		residents a day, 3 times		
	disinfected. Nurse #1	-		weeks, and 1 time a wee		
		I wipe from a germicidal		observe proper glucome		
	-	the treatment cart and wiped		The results of these aud	•	
		ides of the glucometer for		reported at the monthly (		
		conds and tossed the wipe		until such time substantia		
		sh receptacle on the cart.		been achieved and the c	ommittee	
	Nurse #1 laid the glue	cometer on top of the		recommends quarterly o	versight by the	
	treatment cart. The to	op surface of the glucometer		District Director of Clinica	al Services or	
		or to 3 minutes. Nurse #1		designee to maintain cor	-	
		athered supplies and the		completing Clinical Syste	ems Review.	
		gloves and was observed		Criteria 4		
		Resident #12. Nurse #1		The DON is responsible	for implementing	
		supplies and gloves in the		the corrective actions.		
	-	eptacle located on the		Criteria 5		
		d the glucometer on top of		The facility will be in com	-	
		urse #1 washed her hands		plan of correction on or b	petore 4/12/18.	
		nd removed a germicidal				
		idal container located on the				
		ped the front, back, and				
	-	ter for approximately 20				
		the wipe and gloves in the				
	trash receptacle on the					
	giucometer on top of	the cart. The top surface of				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/18/2018 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345221	B. WING				C 16/2018
NAME OF PI	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER H & REHAB WEA	/ERV		78	WEAVER BOULEVARD		
				W	EAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	obtain a FSBS on Res the supplies and the g #97's room and laid th #97's bedside table. N #97 that she was read #1 was stopped by the a FSBS on Resident # On 03/13/18 at 4:25 F conducted with Nurse received training on h glucometer when she at the end of January instructions on how to were located on the o glucometer case. Nur the instructions indicat to be wiped off using allowed to sit. Nurse # disinfecting instruction glucometer had to hav to disinfect the glucom did not know that the wet for 3 minutes in o glucometer had to on the glucometer had to do container located on the wet contact time for d there was only one gl	shed her hands and d indicated she was ready to sident #97. Nurse #1 carried glucometer into Resident he glucometer on Resident durse #1 informed Resident durse #1 working in the facility 2018. Nurse #1 verified the o disinfect the glucometer utside cover of the se #1 stated she thought ted that the glucometer was a germicidal wipe and then f1 verified the glucometer is located on the er indicated that the ve wet contact for 3 minutes inteter. Nurse #1 stated she glucometer had to remain rder to disinfect the verified the manufacturer's in the Clorox germicidal he treatment cart indicated o have 3 minutes of visible isinfection. Nurse #1 stated ucometer available for use and she had to continually	F 8	80			
		PM an interview was rector of Nursing (DON) tation was that Nurse #1					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345221	B. WING				C 16/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER H & REHAB WEA	VERV			8 WEAVER BOULEVARD VEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 880	would have followed t the glucometer case t glucometer that indica contact time was requ glucometer. The DON wipe had to maintain contact time to disinfe appropriately. The DO expectation that Nurs the glucometer appro attempted to obtain a The DON stated it wa #1 would have notifie treatment cart did not DON stated Nurse #1 disinfecting the glucon On 03/13/18 at 5:27 F conducted with the Ad expectation was that disinfected the glucon instructions. The Adm had been trained on o On 03/13/18 at 5:33 F was conducted with N the Administrator, DC Clinical Services (DM DMCS. Nurse #1 stat glucometer had rema because she had tapp minutes had gone by. On 03/14/16 at 9:50 A was conducted with th representative for the wipe who stated in or organisms, pathogen	the instructions located on for disinfecting the ated 3 minutes of visibly wet aired to disinfect the a verified the germicidal 3 minutes of visibly wet bet the glucometer ON stated it was her e #1 would have disinfected priately before she FSBS on Resident #97. Is her expectation that Nurse d the DON that the 400 hall have 2 glucometers. The had been trained on meter. PM an interview was diministrator who stated her Nurse #1 would have neter per manufacturer's inistrator stated Nurse #1 disinfecting the glucometer. PM an additional interview Jurse #1 in the presence of IN, and District Manager of CS) at the request of the ed she knew that the ined wet for 3 minutes bed her foot to indicate 3 M a telephone interview he manufacturer Clorox Bleach Germicidal	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/18/2018 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345221	B. WING		_	03/ <sup>,</sup>	) 16/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BRIAN CE	INTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 287			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	minutes. The represe time that the glucome all surfaces for 3 minus stated the glucometer	ntative stated it was best to eter remained visibly wet on utes. The representative r did not need to remain dal wipe if the glucometer	F 8				

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