PRINTED: 03/22/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345208	B. WING _			C 02/14/2019
	ROVIDER OR SUPPLIER US HEALTH AT BREVA	RD		STREET ADDRESS, CITY, STATE, ZIP C 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	CODE	02/14/2013
(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 ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	000		
F 600 SS=D		3.73, Emergency t ID E7ED11. d Neglect	F 6	500		3/14/19
	Exploitation The resident has the neglect, misappropri and exploitation as cincludes but is not lincorporal punishment	om Abuse, Neglect, and e right to be free from abuse, ation of resident property, defined in this subpart. This mited to freedom from it, involuntary seclusion and mical restraint not required to medical symptoms.				
	physical abuse, corp involuntary seclusion This REQUIREMEN by: Based on record ref Medical Director and implement effective to protect residents a a cognitively impaire 1 of 1 resident review Findings included: Resident #17 was an 04/24/13 with diagno	se verbal, mental, sexual, or coral punishment, or n; T is not met as evidenced view and interviews with the distaff, the facility failed to measures and interventions in the facility from being hit by ad resident (Resident #17) for		The Plan of correction is no construed as an admission doing or liability. The facility rights to contest the survey through informal dispute reappeal proceedings or any or legal proceedings. This correction is not meant to estandard of care, contract of position and the facility resto raise all possible contendefenses in any type of civ	of any wrong y reserves the r findings esolution, formal administrative plan of establish any obligation or erves all rights tions and	
I ARORATORY I	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

03/09/2019

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345208	B. WING		02	C 2/ 14/2019
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	./14/2013
				115 N COUNTRY CLUB ROAD		
ACCORDI	US HEALTH AT BREVAR	RD		BREVARD, NC 28712		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 1	F 60	00		
		c disorder with delusions, lessness and agitation, and tion deficit.		claim, action or proceeding. No contained in this plan of correct be considered as a waiver of a potentially applicable Peer Rev	tion should ny	
	dated 12/12/18 indica moderate impairment make self-understood understand others. F revealed Resident #1	urther review of the MDS 7 displayed no psychosis or		assurance or self-critical exami privilege which the facility does and reserves the right to assert administrative, civil or criminal action or proceeding. The facili response, credible allegations of	nation not waive t in any claim, ty offers its of	
	period. Review of Resident #	g the 7-day assessment		compliance and plan of correct of its ongoing efforts to provide care to residents.		
	following entries: 06/17/18 read in part staff Nurse Aide (NA) hitting another reside other resident was try so he yelled at him an	nurse received report from regarding Resident #17 nt. Resident #17 stated the ring to come into his room, and hit him. Staff removed nt from Resident #17's		F 600 Free from Abuse and Ne 1. The plan for correcting the deficiency " The alleged deficiency occ the facility failed to implement of measures and interventions to residents in the facility from bei cognitively impaired resident. F	specific curred when effective protect ing hit by a Resident	
	with his fist. Staff red without incident. On- Practitioner notified. 15-minute checks wit at this time.	other resident in the face lirected Resident #17 away call nurse and Nurse Resident started on h no signs of injuries noted		psychiatric services. "Licensed, and un licensed staff, dietary staff, activity staff, housekeeping staff, rehabilitatic social services staff were re-ed the staff development coordina on protocol regarding monitorin behaviors of cognitively impaired.	nursing on staff and lucated by tor (SDC) ig	
	#17 striking another r closed fist. Resident because the other res house. Residents we	staff observed Resident resident multiple times with a #17 stated he was upset sident stated it was his re separated and assessed . Resident #17 sent to ent for evaluation.		residents and examples of interthat can be utilized should behamanifest. This education also in that all staff are responsible to Director of Nursing or Supervis cognitively impaired resident demonstrates behaviors toward	aviors ncluded alert the or if a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						(С
		345208	B. WING _			02/	14/2019
NAME OF PR	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				11	15 N COUNTRY CLUB ROAD		
ACCORDI	US HEALTH AT BREVA	RD		В	REVARD, NC 28712		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B)		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	DATE
F 600	Continued From pag	e 2	F	300			
					resident.		
	Review of Resident #	#17's care plans, with a			" The Director of nursing or supervis	or	
		f 12/31/18, revealed the			will visually observe resident #17 daily		
	following problem are				5 days, then 3x week for 3 weeks and		
		e potential to be physically			weekly for 8 weeks to ensure behaviors	3	
		dementia, poor impulse			are addressed timely and interventions		
		ession as evidenced by			are put into place immediately.		
		lent. Interventions included			How the facility will identify other		
	~	5-minute checks, stop sign			residents having the potential to be		
		revent other resident's from			affected		
		ency Department (ED)			" An audit of current residents with		
	evaluation.	endy Department (LD)			cognitive impairments indicating a BIM	S	
		e potential to be verbally and			of 10 or lower were reviewed by the	_	
		e related to mental/emotional			Director of Nursing and unit managers	to	
		ulse control. Interventions			determine if interventions were in place		
		idminister medications as			for those that show behaviors.		
		d document side effect and			Measures put into place		
		ications, and intervene when			" Licensed, and un licensed nursing		
		es agitated and before			staff, dietary staff, activity staff,		
		_				and	
	-	guide away from source of			housekeeping staff, rehabilitation staff		
	distress and carrily e	engage in conversation.			social services staff were re-educated the staff development coordinator (SD0		
	Review of the facility	's abuse investigations			on protocol regarding interventions for		
	completed for the pe	riod June 2018 to February			behaviors of cognitively impaired		
	2019 revealed no wr	itten documentation of the			residents. This education also included		
	incidents or evidence	e a 24-hour initial or 5-day			that all staff are responsible to alert the		
	investigative reports	were submitted to the State			Director of Nursing or Supervisor if a		
	Agency (SA) related	to the resident-to-resident			cognitively impaired resident		
	altercations involving	Resident #17.			demonstrates behaviors towards anoth	er	
	J				resident. Education began 3/11/19 an	d	
	Review of the ED pro	ogress note dated 12/31/18			will be on-going. Current staff will be		
	· ·	nt #17 does display some			re-educated prior to working next shift	and	
		re difficulties. He was able to			this education has been added to the n		
		which precipitated him			hire orientation.		
		Resident #17 states he is			" The director of nursing, Assistant		
	-	ehavior, regrets hitting the			Director of Nursing, Unit		
		he had to do it all over he			Coordinator/Supervisor, facility consult	ant	
		Given his history of TBI, he is			and/or minimum data set nurse will	۸۰۱۱,	
		Isive behaviors and even			visually audit and interview 5 residents		
	intoly at hisk for impu	ioivo politaviolo alla evell			Trouding additional interview of residents		1

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NAME OF P	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	02/14/2019
				115 N COUNTRY CLUB ROAD	
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F 600	Continued From page	e 3	F 60	0	
	aggression when pro An interview was con AM with Resident #1' to recall any details re had with other reside concerns with other r An interview was con PM with Nurse #2. N working on 12/31/18 another resident but of Nurse #2 explained F mad because the oth he did not like so he I residents were imme Resident #17 was se department for a psyc Nurse #2 who worked	ducted on 02/12/19 at 10:50 7. Resident #17 was unable elated to the altercations he nts and voiced having no esidents in the facility. ducted on 02/13/19 at 12:45 turse #2 confirmed she was when Resident #17 hit did not witness the incident. Resident #17 told staff he got er resident said something nit him. Nurse #2 added the diately separated and nt to the emergency		weekly for 4 weeks, then 3 resident week 8 weeks to ensure intervention in place for cognitively impaired residual that show behaviors. 4. Monitoring the plan: "The director of nursing will reprindings of the audits and reviews to Quality Assurance and Performance Committee for any additional monitor modification of this plan monthly months. The Quality Assurance and Performance Improvement Committee and modify this plan to ensure the form the plan in compliance. 5. Title of the person responsible implementing the plan: "The director of nursing is responsible implementing the plan.	ons are sidents ort the o the se soring for 3 d ttee facility for
	A joint interview was 1:20 PM with the Adn Nursing (DON). The and the DON started in October of 2018 ar incident that occurred Administrator and DO the resident-to-reside Resident #17 on 11/1 Administrator added altercation on 12/31/2 Resident #17 to the epsychiatric evaluation magistrate's office to paperwork. The DON	18 he instructed staff to send emergency department for a name while he went to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COMPLETED	
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	ROVIDER OR SUPPLIER US HEALTH AT BREVA	ARD		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	02/14/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 600	#17 was internally in discussions with sta and determine the midentify triggers that The DON added the care planned and misch as 15-minute vine referral and Medical ongoing medication and Administrator standard to this cognitive control related to TE Administrator furthed did not meet the def why they did not repersident to repersident to require to require to repersident to resident to resident to resident to resident to resident. The facility psychiat telephone interview. A telephone interview. A telephone interview. A telephone interview. A telephone interview. The facility psychiat telephone interview. A telephone interview. A telephone interview. The facility psychiat telephone interview. A telephone interview. A telephone interview. A telephone interview. The facility psychiat telephone interview. A telephone interview.	incident involving Resident investigated through off and morning meetings to try oot cause of his behavior and contributed to his aggression. In interventions identified were deasures were put into place visual checks, psychiatric of Director (MD) review for management. Both the DON stated they felt his actions were ever responses to the situation deficit and poor impulse of the stated they felt his actions finition of abuse which was port the altercations to the SA. Indeed the was not aware they for incidents of abuse to the SA.	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLETED	
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	ROVIDER OR SUPPLIER US HEALTH AT BREVA	RD		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	02/14/2013
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F 607 SS=D	AM with NA #3. NA altercation on 12/31 but stated she did n stated staff do a lot #17 and his aggress since his admission it was difficult to det precipitated his beh short-tempered and NA #3 added whene at others, he was at quickly apologized f Develop/Implement CFR(s): 483.12(b)(1) \$483.12(b)(1) Prohi neglect, and exploit misappropriation of \$483.12(b)(2) Estable to investigate any su \$483.12(b)(3) Include paragraph §483.95, This REQUIREMEN by: Based on record reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures by not reinterviews with the Macility failed to imple procedures with	#3 was familiar with the #3 was familiar with the #3 involving Resident #17 of witness the incident. NA #3 of one-on-one with Resident sive outbursts have improved to the facility. She explained ermine the triggers that avior as he could be very impulsive with his actions. ever Resident #17 lashed out ble to tell you why and then or his behavior. Abuse/Neglect Policies)-(3) lity must develop and olicies and procedures that: bit and prevent abuse, ation of residents and resident property, which policies and procedures uch allegations, and the training as required at	F 60	0	ic
	procedures by not re of resident-to-reside	eporting 3 separate incidents		deficiency:	no

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345208	B. WING			C 02/14/2019	
NAME OF P	ROVIDER OR SUPPLIER	1 1 11		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u>	02/14/2019	
	10115211 011 001 1 21211			115 N COUNTRY CLUB ROAD	-		
ACCORDI	US HEALTH AT BREVAR	RD					
				BREVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607	Continued From page	e 6	F 60	07			
	Findings included:			potential to be affected:			
	i manigo moladoa.			" A review was completed by	ov the facilit	v	
	A review of the facility	policy and procedure titled		interim administrator and interi	-	.,	
		and Reporting", with a		of nursing of the previous 30 d			
		mber 2016, read in part:		resident to resident altercation	•		
				No other resident to resident a			
	Policy Statement: All	reports of resident abuse,		reports were found to be out of			
	_	misappropriation of resident		compliance with reporting requ	uirement.		
		nt and/or injuries of unknown					
	source ("abuse") shal	Il be promptly reported to		Measure put into place			
	local, state and federa	al agencies (as defined by		" The regional nurse consul	Itant		
	current regulations) a	nd thoroughly investigated		re-educated the interim admin	istrator and		
	by facility manageme			interim Director of nursing (DC			
	investigations will also	o be reported.		facility policy regarding reporting			
				allegations and the time frame	required o	n	
	Reporting: 2). Suspec			2/28/19.			
		atment (including injuries of		" SDC re-educated current	licensed		
		misappropriation of resident		and un licensed nursing staff,	•		
		rted within two hours. 3).		housekeeping staff, dietary sta			
	Alleged abuse, negle	· ·		rehabilitation staff, activity staf		_	
		ng injuries of unknown		leadership staff on facility polic			
		priation of resident property) n two hours if the alleged		reporting allegations to include resident altercations and the ti)	
		in serious bodily injury; or if		required. Education began on		4	
		the allegation do not		will be on-going. Current staff		u	
		resulted in serious bodily		re-educated prior to working n		d l	
		t be made within twenty-four		this education has been added			
	hours.			hire orientation.			
				" A log will be maintained b	v the		
	Resident #17 was ad	mitted to the facility on		administrator that documents a	-		
		ses that included traumatic		notifications to the State Surve			
	brain injury, dementia			including Resident name, fax of		.,	
		c disorder with delusions,		confirmation page, allegation,			
		lessness and agitation, and		of discovery and time of notific			
	cognitive communica			will be placed in binder mainta	_		
				Administrator.			
	Review of Resident #	17's medical record for the		" The log maintained by the)		
	period June 2018 to F	ebruary 2019 revealed the		administrator will be reviewed	by the		
	following entries:			regional nurse upon visits to e	nsure timel	v	

Facility ID: 922995

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345208	B. WING			C 02/14/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/14/2013	
ACCOPD!	US HEALTH AT BREVAR	חים		115 N COUNTRY CLUB ROAD			
ACCORDI	US REALIN AT BREVAR			BREVARD, NC 28712			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	staff Nurse Aide (NA) hitting another reside other resident was try so he yelled at him ar the wandering reside room. 11/17/18 read in part, witnessed striking and with his fist. Staff red without incident. On-Practitioner notified. 15-minute checks wit at this time. 12/31/18 read in part, #17 striking another relosed fist. Resident because the other reshouse. Residents we with no injuries noted emergency department. Review of the facility's completed for the per 2019 revealed no 24-investigative reports of Agency (SA) related the altercations involving. Review of the quarter dated 12/12/18 indicated moderate impairment make self-understood understand others. Frevealed Resident #1	nurse received report from regarding Resident #17 nt. Resident #17 stated the ring to come into his room, and hit him. Staff removed nt from Resident #17's Resident #17 was other resident in the face lirected Resident #17 away call nurse and Nurse Resident started on h no signs of injuries noted in the stated it was his ere separated and assessed and assessed and resident #17 sent to ent for evaluation. Is abuse investigations find June 2018 to February shour initial or 5-day were submitted to the State to the resident #17. Ity Minimum Data Set (MDS) atted Resident #17 had in cognition, could usually	F 60	reporting. The regional nurse consulta audit all resident to resident alleg weekly for 4 weeks and monthly months ensure timely reporting. 4. Monitoring the plan: The administrator will report findings of the audits and reviews Quality Assurance and Performa Committee for any additional mo or modification of this plan month months. The Quality Assurance a Performance Improvement Commican modify this plan to ensure the remains in compliance. 5. Title of person responsible for implementing the plan The administrator is responsimplementing this plan	the s to the nce nitoring and mittee e facility		

AND DUAN OF CODDECTION DEPOSITION NUMBER.		1 ' '	PLE CONSTRUCTION G	COMPLETED	
		345208	B. WING		C 02/44/2040
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	02/14/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 607	PM with Nurse #2. of the facility's policiabuse. Nurse #2 of 12/31/18 when Result but did not witness explained Resident because the other mot like so he hit hir residents were immediated Resident #17 was supported by the factor of 2018 incident that occurred Administrator and Explained for the resident #17 on 11 Administrator addealtercation on 12/31 Resident #17 to the psychiatric evaluation magistrate's office to paperwork. The DC was internally invest the root cause of hit triggers that contrib DON added the interplanned and measure.	onducted on 02/13/19 at 12:45 Nurse #2 voiced knowledge y regarding reporting alleged onfirmed she was working on ident #17 hit another resident the incident. Nurse #2 #17 told staff he got mad esident said something he did in. Nurse #2 added the ediately separated and eent to the emergency cychiatric evaluation. Is conducted on 02/13/19 at deministrator and Director of e Administrator stated both he d employment with the facility and were not aware of the ed in June of 2018. Both the DON confirmed knowledge of dent altercations involving /17/18 and 12/31/18. The d when informed of the /18 he instructed staff to send emergency department for a on while he went to the ofile the necessary ON explained each incident tigated to try and determine s behavior and identify uted to his aggression. The erventions identified were care ures were put into place such checks, psychiatric referral	F 60	07	
	medication manage	or (MD) review for ongoing ement. Both the DON and d they felt his actions were			

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		345208	B. WING		C 02/14/2019
	ROVIDER OR SUPPLIER US HEALTH AT BREVAR	D.		STREET ADDRESS, CITY, STATE, ZIP CODE I15 N COUNTRY CLUB ROAD BREVARD, NC 28712	32/14/2313
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	due to his cognitive de control related to trau DON and Administrate actions did not meet was why they did not SA. The Administrate they were required to resident-to-resident at A telephone interview 2:10 PM revealed the aware of Resident #1 residents and had se management. The Mad poor short-term rabout his behaviors hany details of the incipoor recollection mad determine what could the added Resident # he was doing when rewas not aware of the caused. Accuracy of Assessm	e responses to the situation eficit and poor impulse matic brain injury. Both the or further stated they felt his the definition of abuse which report the altercations to the or added he was not aware report incidents of buse to the SA. The conducted on 02/13/19 at the Medical Director (MD) was 7's outbursts toward other en him regularly for behavior ID explained Resident #17 memory and when asked the usually was unable to give dent. The MD added his the it difficult when trying to a situation and consequences his actions	F 641		3/14/19
SS=D	resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) to re residents reviewed fo of 5 sampled residen	of Assessments. It accurately reflect the Is not met as evidenced liew and staff interviews the lately code the Minimum flect a fall for 1 of 3 sampled or falls (Resident #171) and 1 lts reviewed for unnecessary le diagnosis (Resident #23).		F641 Accuracy of Assessments 1. How corrective action will be accomplished for those residents affect by deficient practice: " On 2/12/19 MDS Nurse corrected error on assessment and sent to CMS	

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				115 N COUNTRY				
ACCORDI	US HEALTH AT BREVAR	RD		BREVARD, NC				
							I	
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F 641	Continued From page	e 10	F 6	11 11				
	Findings included:			validation;	validation was accepted.			
	i indings included.			2 How core	rective action will be			
	1 Resident #171 was	admitted to the facility on			ned for other residents havin	ıa		
	01/28/19 with diagnos				al to be affected by the defic	•		
	non-Alzheimer's dem			practice:	an to ac amoutou ay the dome			
		sed blood pressure when		·	established by facility to revie	ew		
	standing).	·			nents prior to transmission t			
				ensure falls	s are accurately coded. Dai	ly		
		an with an initiation date of			neeting agenda item			
	02/06/19 indicated Re				ed as a checklist. (effective			
	· ·	being at risk for falls related		date of 2/12	2/19).			
	to confusion, gait/bala							
		on. The care plan indicated			es that will be put in place to			
		fall on 02/02/19 while			icient practice will not recur: OS assessments completed t			
	walking without assis	tance.			vill be reviewed and checked			
	A review of an incide	nt accident report dated			ssessment Coordinator and	-		
	02/02/19 indicated Re				Rehab daily for 4 weeks			
		valking to the doorway of his			biweekly checks for 4 weel	KS		
	room and did not sus				y a monthly check for 2 mon			
	A review of a nurse's	note dated 02/02/19		4. How the	facility plans to monitor its			
	indicated Resident #1	171 had a witness fall while		performand	ce to ensure solutions are			
	walking to his doorwa	y and fell on his bottom and		sustained:				
	did not sustain an inju	ıry.			istrator and DON to review			
				"	y standup meeting Monda	y to		
	A review of the 5 day			Friday				
		2/04/19 indicated Resident			esident Assessment			
		under Section J1900 as			or will report the findings of the	те		
	_	e admission/entry or reentry			reviews to the Quality	20		
	or prior assessment.				and Performance Committed	; C		
	On 02/12/19 at 9:18 A	AM an interview was			n of this plan monthly for 3			
		DS Coordinator who stated			ne Quality Assurance and			
		or coding Section J1900 of			ce Improvement Committee			
	Resident #171's 5 da	•			this plan to ensure the facil			
	assessment dated 02	=			compliance.	,		
		esident #171 had a fall in the			person responsible for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		(X3) DATE SURVEY COMPLETED	
	345208	B. WING			C 2/14/2019
ROVIDER OR SUPPLIER JS HEALTH AT BREVAR	RD		115 N COUNTRY CLUB ROAD	1 -	2/1-//2013
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
facility on 02/02/19 d from 01/29/19 to 02/0 coded under Section The MDS Coordinate modification to the 5 assessment to accurrhad a fall. On 02/12/19 at 9:29 conducted with the D who stated her expectation MDS assessment to accurrence would have been accurated from 01/29/19 stated her expectation Coordinator would suday admission MDS to indicate Resident at the conducted with the A expectation was that assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to reall during the look be 02/04/19.	uring the look back period 04/19 and should have been J1900 as having had a fall. or stated he would submit a day admission MDS ately reflect Resident #171 AM an interview was irector of Nursing (DON) ctation was that the 5 day essment dated 02/04/18 curately coded to reflect fall during the look back to 02/04/19. The DON in was that the MDS ibmit a modification to the 5 assessment dated 02/04/19 #171 had a fall. AM an interview was dministrator who stated his the 5 day admission MDS 2/04/19 would have been reflect Resident #171 had a fack period 01/29/19 to istrator stated his the MDS Coordinator would into the 5 day admission ted 02/04/19 to indicate fall. Admitted to the facility on the diagnoses that included rease that affects the brain in dementia with behavioral	F 641	implementing the plan: " The Administrator and Resid		
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page facility on 02/02/19 d from 01/29/19 to 02/0 coded under Section The MDS Coordinate modification to the 5 assessment to accurre had a fall. On 02/12/19 at 9:29 conducted with the D who stated her expectation MDS assessment to accurre had a fall. On 02/12/19 at 9:29 conducted with the D who stated her expectation MDS assessment dated from 01/29/19 stated her expectation Coordinator would suday admission MDS to indicate Resident assessment dated 02 accurately coded to refall during the look be 02/04/19. The Admin expectation was that assessment dated 02 accurately coded to refall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to refall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to refall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to refall during the look be 02/04/19. The Admin expectation was that submit a modification MDS assessment dated 02 accurately coded to refall during the look be 02/04/19. The Admin expectation was that submit a modification date of the provided part of the pr	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 facility on 02/02/19 during the look back period from 01/29/19 to 02/04/19 and should have been coded under Section J1900 as having had a fall. The MDS Coordinator stated he would submit a modification to the 5 day admission MDS assessment to accurately reflect Resident #171	A BUILDING 345208 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 facility on 02/02/19 during the look back period from 01/29/19 to 02/04/19 and should have been coded under Section J1900 as having had a fall. The MDS Coordinator stated he would submit a modification to the 5 day admission MDS assessment to accurately reflect Resident #171 had a fall. On 02/12/19 at 9:29 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the 5 day admission MDS assessment dated 02/04/18 would have been accurately coded to reflect Resident #171 had a fall during the look back period from 01/29/19 to 02/04/19. The DON stated her expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. On 02/12/19 at 10:17 AM an interview was conducted with the Administrator who stated his expectation was that the 5 day admission MDS assessment dated 02/04/19 would have been accurately coded to reflect Resident #171 had a fall during the look back period 01/29/19 to 02/04/19. The Administrator stated his expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. 2. Resident #23 was admitted to the facility on 12/14/18 with multiple diagnoses that included encephalopathy (disease that affects the brain structure or function), dementia with behavioral disturbance, chronic obstructive pulmonary	A BUILDING 345208 STREET ADDRESS, CITY, STATE, 2IP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 11 facility on 02/02/19 during the look back period from 01/29/19 to 02/04/19 and should have been coded under Section J 1900 as having had a fall. The MDS Coordinator stated he would submit a modification to the 5 day admission MDS assessment to accurately reflect Resident #171 had a fall. On 02/12/19 at 9:29 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the 5 day admission MDS assessment dated 02/04/18 would have been accurately coded to reflect Resident #171 had a fall during the look back period from 01/29/19 to 02/04/19. The DON stated her expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. On 02/12/19 at 10:17 AM an interview was conducted with the Administrator who stated his expectation was that the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall during the look back period from 01/29/19 to 02/04/19 to indicate Resident #171 had a fall during the look back period from 01/29/19 to 02/04/19 to indicate Resident #171 had a fall. Regulation and the follow admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. Regulation and the follow admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. Regulation and the follow admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. Regulation and the follow administrator who stated his expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. Regulation and the follow administrator who stated his expectation was that the MDS Coordinator would submit a modification	A BUILDING 345208 345208 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 15 N COUNTRY CLUB ROAD REVARD, NC 28712 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SUPPLIER) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SUPPLIER) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SUPPLIER) CONTINUED From page 11 facility on 02/02/19 during the look back period from 01/29/19 to 02/04/19 and should have been coded under Section 1/1900 as having had a fall. The MDS Coordinator stated he would submit a modification to the 5 day admission MDS assessment to accurately coded to reflect Resident #171 had a fall during the look back period from 01/29/19 to 02/04/19. The DON stated her expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/18 would have been accurately coded to reflect Resident #171 had a fall. On 02/12/19 at 10:17 AM an interview was conducted with the Administrator who stated his expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. On 02/12/19 at 10:17 AM an interview was conducted with the Administrator stated his expectation was that the MDS Coordinator would submit a modification to the 5 day admission MDS assessment dated 02/04/19 to indicate Resident #171 had a fall. Resident #23 was admitted to the facility on 12/14/18 with multiple diagnoses that included encephalopathy (disease that affects the brain structure or function), dementia with behavioral disturbance, chronic obstructive pulmonary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345208	B. WING			С	
NAME OF D	DOWNER OF GUIDRUIER	343206	D. WING	_	ATREET ADDRESS SITV STATE ZID SODE	02/	14/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 15 N COUNTRY CLUB ROAD		
ACCORDI	US HEALTH AT BREVAR	RD			BREVARD, NC 28712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 656 SS=D	Atorvastatin Calcium medication) 40 milligr for hyperlipidemia. Review of the admiss (MDS) dated 12/21/18 severe impairment in the MDS revealed hy as an active diagnosis. During an interview o MDS Coordinator exphospital history and p summary and the faci physical when determ code on the MDS. He history and physical in diagnosis of hyperlipide Atorvasatin medication assessment. The ME missed coding hyperlidiagnosis and a modi 12/21/18 would be sure During an interview on Director of Nursing stassessments to be accompanied to the Section of Section 12 (1) Section 13 (1) Section 14 (1) Section 15 (1) Section 16 (1) Section 16 (1) Section 17 (1) Section 17 (1) Section 18 (1	23's medical record sorder dated 12/14/18 for Tablet (cholesterol arms to be given at bedtime dison Minimum Data Set and Cognition. Further review of perlipidemia was not coded so. In 02/13/19 at 3:45 PM, the plained he reviewed the hysical, hospital discharge dility's physician history and hining active diagnoses to be confirmed the hospital endicated Resident #23 had a demia and she received for at the time of the MDS and Coordinator stated he ipidemia as an active fication of the MDS dated dismitted. In 02/13/19 at 4:45 PM, the lated she expected for MDS courately coded. Comprehensive Care Plans collity must develop and densive person-centered sident, consistent with the that §483.10(c)(2) and		641			3/14/19
	_	. , , ,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345208	B. WING		C 02/14/2019		
	ROVIDER OR SUPPLIER US HEALTH AT BREVA			STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	02/14/2015		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 656	medical, nursing, ar needs that are identiassessment. The condescribe the following (i) The services that or maintain the reside physical, mental, and required under §483.24, §480 provided due to the under §483.10, inclustreatment under §483.10, in	frames to meet a resident's and mental and psychosocial tified in the comprehensive omprehensive care plan must are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and to would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 33.10(c)(6). services or specialized the nursing facility will of PASARR for a facility disagrees with the ARR, it must indicate its dent's medical record.	F 656				
	future discharge. Fa whether the residen community was ass local contact agenci entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on observatinterviews, the facili	acilities must document t's desire to return to the essed and any referrals to es and/or other appropriate		F656 Develop/Implement Compreher Care Plans CFR(s) 1. How corrective action will be an	sive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345208	B. WING			C 02/14/2019		
NAME OF D	ROVIDER OR SUPPLIER	343200		- C-	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	/14/2019	
NAME OF FI	NOVIDER OR SUFFLIER				, , ,			
ACCORDI	US HEALTH AT BREVAR	RD			I5 N COUNTRY CLUB ROAD			
				В	REVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(,	EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE		
F 656	Continued From page	e 14	F 6	356				
	#38).				accomplished for those residents affect	ted		
	,				by deficient practice:			
	Findings included:				" On 2/14/19 silverware was taken o	off		
	-				care plan assessments. Call button a	nd		
	Resident #38 was ad	mitted to the facility on			ted hose were put			
	12/31/15 with the follo	owing diagnoses: heart			On and moved to accessible position.			
	failure.				" Ted hose orders have been added	to		
					MAR (effective 2/19/19)			
		al Minimum Data Set (MDS),			" Inservice was provided on			
· · · · · · · · · · · · · · · · · · ·		ated Resident #38 had			expectations for call lights to be within reach of all residents.			
		airment. The MDS also 38 required supervision with			reaction an residents.			
		assistance for dressing and			2. How corrective action will be			
	personal hygiene.	addictarios for discouring diffe			accomplished for other residents havin	a		
	, , , , , , , , , , , , , , , , , , ,				the potential to be affected by the defic			
	A record review of a F	Physician's Order, dated			practice:			
	01/09/19, indicated R				" Audit of all residents conducted or	1		
		se to be applied in the			2/19/19 to identify residents with poten	tial		
	morning and removed	d in the evening for edema.			to require Ted hose.			
	A record review of the	e heart failure care plan,			3. Measures that will be put in place	to		
		ated Resident #38 required			ensure deficient practice will not recur:			
		applied to her bilateral lower			" Director of Nursing to review all Te			
		rning and removed in the			hose orders and compliance weekly fo			
	evening.				weeks followed by biweekly review for			
	During an absentation	o on 02/12/10 of 7:56 AM			weeks followed by monthly review for 2	2		
	_	n on 02/13/19 at 7:56 AM, served in her room, sitting in			months.			
		g away from the bed and			4. How the facility plans to monitor it:			
		ower extremities and was			performance to ensure solutions are	•		
	not wearing knee-hig				sustained:			
		P.F			" The director of nursing will report t	he		
	During an observation	n on 02/13/19 at 9:32 AM,			findings of the audits and reviews to th			
		served in her room, sitting in			Quality Assurance and Performance			
		g away from the bed and			Committee for any additional monitoring	g		
		ower extremities and was			or modification of this plan monthly for			
	not wearing knee-hig	h support hose.			months. The Quality Assurance and			
					Performance Improvement Committee			
	During an interview o	n 02/13/19 at 10:00 AM, a			can modify this plan to ensure the facil	ity		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345208	B. WING		C 02/14/2019	
	ROVIDER OR SUPPLIER US HEALTH AT BREVA	ARD		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	1 02/1-9/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 656	Resident #38 stated hose, but she had not further stated Resid wear the hose becarete, but she did not hose were located in the buring an interview Nurse #1 stated Restreatment orders for not wear knee-high. During an interview MDS Coordinator storder for knee-high The MDS Coordinator storder for knee-high the Medication Adm. Record as it should staff to check for pla Coordinator indicate have been placed owith the care plan at the plane AM, the facility physishould be wearing the stated it was good to lower extremities in down because she disease. The facility would come from Richard was that Resident #200 processor.	IA #1) who regularly cared for a the resident had support not seen them on her. NA #1 tent #38 was supposed to suse she had swelling in her to know where the knee-high in Resident #38's room. On 02/13/19 at 10:27 AM, sident #38 did not have to knee-high hose and she did hose. On 02/13/19 at 1:01 PM, the stated Resident #38 had an hose written in January 2019, tor further stated the order for had not been transcribed on sinistrator or Treatment have been for the nursing accement. The MDS and the knee-high hose should in Resident #38 consistent	F 656	remains in compliance. Title of the person responsible for implementing the plan: " The Director of nursing is resp for implementing the plan	onsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345208	B. WING _			C / 14/2019	
	ROVIDER OR SUPPLIER US HEALTH AT BREVAR	RD		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712		71-72013	
(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 CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 656	During an interview o Administrator stated I Resident #38 should knee-high hose.	n 02/14/19 at 2:03 PM, the nis expectation was that have been wearing the		556			
F 657 SS=D	be- (i) Developed within 7 the comprehensive a (ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the range of the resident and the range of the resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii) Reviewed and reviteam after each assecomprehensive and cassessments.	ensive Care Plans brehensive care plan must days after completion of sesessment. terdisciplinary team, that hited to disciolan. with responsibility for the responsibility for the days and nutrition services staff. Sticable, the participation of resident's representative(s), be included in a resident's participation of the resident resentative is determined and evelopment of the staff or professionals in ined by the resident's needs are resident. sised by the interdisciplinary sesment, including both the	F	657		3/14/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345208	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	0.0200	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		02/14/2019	
NAIVIE OF F	ROVIDER OR SUFFLIER			, , ,			
ACCORDI	US HEALTH AT BREVAR	RD.		115 N COUNTRY CLUB ROAD			
				BREVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 657	by:		ND				
	Based on record revinterviews, the facility to accurately reflect a a nutritional suppleme (Resident #67) review update a care plan to resident's Level II Pre Resident Review (PA resident reviewed for Findings included: 1. Resident #26 adm 03/30/18 with multiple neurological disorder abnormal weight loss Review of the physici revealed an order dat (nutritional supplementally that was discontinutricial supplementally su	wed for food and failed to accurately reflect a readmission Screening and SRR) status for 1 of 1 PASRR (Resident #12). whitted to the facility on rediagnoses that included a dementia, depression and redeal of the facility of the ded 06/06/18 for House 2.0 ont) 60 milliliters (ml) twice tinued on 11/28/18. Review		F657 CARE PLAN TIMING AI REVISION 1. How corrective action will accomplished for those resider by deficient practice: " On 2/14/19 Resident Asse Coordinator corrected error and care plan to reflect that residen no longer taking the Med Pass supplement. Resident#12 care updated to reflect correct PASF by Resident Assessment Coord 2. How corrective action will accomplished for other resident the potential to be affected by the practice: " Nutritional Care plans and care plans were reviewed by D Nursing and Resident assessment coordinator to ensure that supplications."	be ints affected ressment d revised int#67 was re plan was RR status dinator. be its having the deficient I PASSR Director of nent plement		
	of the Medication Administration Records (MAR) for December 2018, January 2019 and February 2019 revealed House 2.0 was not administered to Resident #26. Review of the quarterly Minimum Data Set (MDS) dated 01/02/19 indicated Resident #26 was coded with moderate impairment in cognition and required supervision with set-up assistance for eating. Further review of the MDS revealed Resident #26 had no significant weight loss or gain during the assessment period. Review of Resident #26's nutrition care plan, last reviewed on 01/10/19, identified the problem area for potential weight changes related to MS and dementia. Interventions included for staff to			interventions were accurate as PASRR status and intervention other residents found affected at 3. Measures that will be put it ensure deficient practice will not "Physicians orders will be redaily in the morning clinical medirector of Nursing and Reside Assessment Coordinator Mondon Friday to ensure that supplemed been appropriately updated on resident scare plan. PASRR admissions or Resident Review completed for existing resident reviewed as well by the Director Nursing and the Resident Asses	as. No at this time in place to ot recur: reviewed eeting by the ent day to eents have the s for new ws ts will be or of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345208	B. WING				C	
NAME OF B	20/4050 00 011001150	343206	D. WING _	0.	TREET ARRESTS OF STATE 7 TO CORE	02/	14/2019	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ACCORDI	US HEALTH AT BREVAR	D			15 N COUNTRY CLUB ROAD			
		_		В	REVARD, NC 28712			
(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 657	Continued From page	e 18	F6	657				
F 657	administer House 2.0 During an interview o MDS Coordinator confor updating resident Coordinator confirmer Resident #26 was dis should have been renhis care plan. The Milan oversight and the During an interview o Administrator stated in care plans to be accurated by the care plans to the care pl	n 02/13/19 at 3:45 PM the offirmed he was responsible care plans. The MDS defined the order for House 2.0 for continued on 11/28/18 and moved as an intervention on DS Coordinator stated it was care plan would be updated. n 02/13/19 at 4:45 PM the transition that was his expectation for rate and updated as admitted to the facility es which included anxiety, depreciately at Resident #12 was a was coded as requiring with most of her activities of the I Preadmission Screening (PASRR). Dean initiated 1/18/18 for defined the resident had a Level II intal illness.	F6	357	Coordinator in the morning clinical meeting Monday to Friday to ensure the PASRRs and any completed Resident Reviews have been appropriately updated on the resident so care plan. This will be completed daily for 4 weeks followed be biweekly checks for 4 weeks followed to monthly check for 2 months. 4. How the facility plans to monitor its performance to ensure solutions are sustained: "The director of nursing and Reside Assessment Coordinator will report the findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facil remains in compliance. Title of the person responsible for implementing the plan: "The Director of Nursing and Reside Assessment Coordinator are responsible for implementing the plan.	ent e g 3 ent e e g 3		
	error. An interview with the	Director of Nursing (DON)						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345208	B. WING		C 02/14/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT BREVAR	D.		115 N COUNTRY CLUB ROAD		
ACCORDI	US REALIN AT BREVAR	Ь		BREVARD, NC 28712		
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F 657	Continued From page	: 19	F 6	57		
	on 2/13/19 at 4:53 PN expectation that the cresidents.	I revealed it was her are plan was accurate for all				
	4:53 PM revealed it w	Administrator on 2/13/19 at as his expectation that the reflect the needs of the				
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)(et Professional Standards i)	F 6	58	3/14/19	
	as outlined by the cormust- (i) Meet professional s	or arranged by the facility, nprehensive care plan,				
	Based on observation interviews, the facility order regarding kneeresidents reviewed for Findings included: Resident #38 was add 12/31/15 with the following failure.	ns, record review, and staff failed to follow a physician's high support hose for 1 of 2 r edema (Resident #38). mitted to the facility on wing diagnoses: heart		F658 Services Provided Meet Professional Standards CFR(s) 1. How corrective action will be accomplished for those residents a by deficient practice: " On 2/14/19 the order for TED I orders was added to MAR. " TED hose was provided to the resident. " Staff educated on expectation daily HOSE use required for reside	nose	
	dated 01/04/19, indicasevere cognitive impasupervision with one-for dressing and personal A record review of a F 01/09/19, indicated R	person physical assistance onal hygiene. Physician's Order, dated		2. How corrective action will be accomplished for other residents he the potential to be affected by the opractice: " Audit conducted for all residen Director of Nursing and Regional N Consultant to capture any other res	deficient ts by lurse sidents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345208	B. WING		C 02/14/2019	
NAME OF P	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/14/2013	
				115 N COUNTRY CLUB ROAD		
ACCORDI	US HEALTH AT BREVAF	RD		BREVARD, NC 28712		
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F 658	Continued From page	e 20	F 658	3		
	morning and remove	d in the evening for edema.		other residents found affected at this	time.	
	A record review of the dated 01/09/19, indicknee-high hose to be extremities in the mo evening. During an observation Resident #38 was obher wheelchair, facing had swelling to both I not wearing knee-high During an observation Resident #38 was obher wheelchair, facing had swelling to both I not wearing knee-high During an interview on ursing assistant (NA Resident #38 stated those, but she had not further stated Reside wear the hose becauted, but she did not I hose were located in During an interview on Nurse #1 stated Reside treatment orders for I not wear knee-high houring an interview of the During and During an interview of the During and During an interview of the During an interview of the During and During an interview of the During	e heart failure care plan, ated Resident #38 required applied to her bilateral lower rning and removed in the n on 02/13/19 at 7:56 AM, served in her room, sitting in g away from the bed and ower extremities and was h support hose. n on 02/13/19 at 9:32 AM, served in her room, sitting in g away from the bed and ower extremities and was h support hose. n on 02/13/19 at 10:00 AM, (A) #1 who regularly cared for the resident had support at seen them on her. NA #1 nt #38 was supposed to se she had swelling in her know where the knee-high Resident #38's room. n 02/13/19 at 10:27 AM, dent #38 did not have knee-high hose and she did ose. n 02/13/19 at 1:01 PM, the		3. Measures that will be put in place ensure deficient practice will not recommended in the morning clinical meeting Mond Friday to ensure compliance weekly weeks then biweekly for 4 weeks, the monthly for 2 months. "Director of Nursing and Nurse Managers will randomly audit once pweek for 4 weeks, then monthly for 2 months to ensure that TED hose interventions are being utilized as ordered. 4. How the facility plans to monitor performance to ensure solutions are sustained: "The Director of Nursing will report findings of the audits and reviews to Quality Assurance and Performance Committee for any additional monitor or modification of this plan monthly for months. The Quality Assurance and Performance Improvement Committed can modify this plan to ensure the faremains in compliance. Title of the person responsible for implementing the plan: "The Director of nursing and Administrator are responsible for implementing the plan: "The Director of nursing and Administrator are responsible for implementing the plan	ders lay to for 4 en er er the its ort the the ring or 3	
	order for knee-high h The MDS Coordinato	ted Resident #38 had an ose written in January 2019. or further stated the order for ad not been transcribed on				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER US HEALTH AT BREVA	RD		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	02/14/2013	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 658	the Medication Admi Record as it should staff to check for pla Coordinator indicate have been placed or with the care plan ar During a telephone it AM, the facility phys should be wearing the stated it was good to lower extremities in down because she of disease. The facility would come from Re- knee-high hose. During an interview of Director of Nursing (was that Resident #3 the knee-high hose) During an interview of Administrator stated Resident #38 should knee-high hose. Menus Meet Reside CFR(s): 483.60(c)(1	nistrator or Treatment have been for the nursing cement. The MDS d the knee-high hose should n Resident #38 consistent nd physician order. Interview on 02/14/19 at 9:55 ician stated Resident #38 ne knee-high hose. He further o have compression on her order to keep the swelling did have peripheral vascular physician indicated no harm esident #38 not wearing the Interview on 02/14/19 at 1:48 PM, the DON) stated her expectation as should have been wearing over the physician's order. Interview on 02/14/19 at 1:48 PM, the DON) stated her expectation as should have been wearing over the physician's order. Interview on 02/14/19 at 2:03 PM, the his expectation was that I have been wearing the Interview on 02/14/19 at 2:03 PM, the his expectation was that I have been wearing the Interview on 02/14/19 at 2:03 PM, the his expectation was that I have been wearing the Interview on 02/14/19 at 2:03 PM, the his expectation and the wearing the Interview on 02/14/19 at 2:03 PM, the his expectation was that I have been wearing the Interview on 02/14/19 at 2:03 PM, the his expectation and the wearing the high provided the provided that th	F 80		3/14/19	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
		345208	B. WING _			02/14/2019		
	ROVIDER OR SUPPLIER	RD		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712	'	92 2010		
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F 803	reasonable efforts, the thnic needs of the reinput received from regroups; §483.60(c)(5) Be upon served in the se	t, based on a facility's ne religious, cultural and esident population, as well as esidents and resident dated periodically; riewed by the facility's ically qualified nutrition tional adequacy; and g in this paragraph should be resident's right to make ices. T is not met as evidenced ons, record review, resident the facility failed to provide e resident's food preference esident #26) reviewed for ed to the facility on 03/30/18 ses that included neurological depression and abnormal #26's recorded weights for r 2018 to February 2019 g: s (lbs.)	F	F803 Menus Meet Resident Needs/Prep in Advance/Followe 1. The plan for correcting the deficiency: " Resident #26 has been giv portions as requested beginning Meal card for this particular resibeen updated. " Dietary manager and Regis Dietician have agreed to review preferences lists at regularly solvisits by Registered Dietician. 2. How the facility will identify residents having the potential to affected: " On 2/25/19 a 100% audit or resident food preferences was do to ensure accuracy of resident rickets.	ed CFR(s) specific en larger g 2/14/19. ident has stered food heduled other b be if all conducted			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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ACCORDI	US HEALTH AT BREVAR	RD .					
				BREVARD, NC 28712		T	
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F 803	Continued From page	e 23	F 80	3			
	Review of the guarter	ly Minimum Data Set (MDS)		3. Measures put into place:			
		ited Resident #26 was		" Dietary manager to review me	al		
		impairment in cognition and		tickets weekly to safeguard against			
		with set-up assistance for		and improve patient centered care.			
		w of the MDS revealed		" On 3/13/19 education began to)		
		ecorded weight of 153 lbs.		Licensed and non-licensed nursing			
		ight loss or gain during the		by SDC on Documentation and			
	assessment period.			communication to be made when			
	•			appropriate to the dietary manager	if a		
	Review of Resident #	26's medical record		resident preference needs to be up			
	revealed an undated	food preference list signed		Education is on-going and Current			
	by the Registered Die	etician (RD) that indicated		licensed and non-licensed nursing	staff		
	Resident #26 liked all	foods and preferred larger		will be re-educated prior to working	next		
	portions at breakfast,	lunch and dinner.		shift and this education has been a	ded		
				to the new hire orientation. Updated	i		
	During an interview o	n 02/11/19 at 4:10 PM		preferences will be given to Dietary			
		no concerns with the quality,		manager.			
		of the food but indicated he		" Weekly audit form to be given	:O		
	_	h to eat at meals and would		Administrator showing			
	like larger portions.			changes/corrections made to dietar	У		
				preferences for 4 weeks.			
		n and follow-up interview on		" Dietary Manager will conduct r			
		Resident #26 was sitting up		audit on 4 residents monthly for 2 r			
	in bed finishing break			to ensure that preferences are prov			
		card revealed larger portions		" Checklist added to Weights Me	eting		
		was served one biscuit, one		to review any preference changes.			
	sausage patty, a port			" Preferences of residents to be			
		sident #26 stated he ate all		quarterly by Dietary Manager and u	paatea		
	_	gs which he did not like.		as necessary.			
		ne "was not starving, just He added breakfast was		4 Monitoring the plan:			
		would prefer larger portions		4. Monitoring the plan:Dietary Manager will report the			
	with lunch and dinner			findings of the audits and reviews to			
				Quality Assurance and Performance			
	During an interview o	n 02/13/19 at 9:50 AM the		Committee for any additional monit			
	_	l) stated she was unaware		or modification of this plan monthly			
		ed larger portions at each		months. The Quality Assurance and			
	-	ved the undated food		Performance Improvement Commit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345208	B. WING _			l	C / 14/2019
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT BREVARD				STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712			14/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 803	preference list signed large portions were normeal card. She was date but stated the RI January 2019 and the update all residents' finded the RD must how of Resident #26's requested to update all resident #26's requested to update all resident #26's requested to update his foor Resident #26 requested to update his foor Resident #26 requested and had discuss the RD could not recomplete the expected for larger point and preference list to the During an interview of Administrator stated in residents' dietary preference list to CFR(s): 483.60(d) Food and	Continued From page 24 preference list signed by the RD and confirmed large portions were not currently indicated on his meal card. She was unable to recall the exact late but stated the RD was at the facility in lanuary 2019 and they were working together to update all residents' food preferences. She ladded the RD must have forgotten to inform her of Resident #26's request for larger portions. During a telephone interview on 02/13/19 at 4:29 PM the RD explained she had not been working at the facility for very long and was still trying to samiliarize herself with the residents in the building. She recalled she was at the facility cometime in January 2019 and met with Resident #26 to update his food preferences. She added Resident #26 requested larger portions at each meal and had discussed his request with the DM. The RD could not recall if she indicated Resident #26's request for larger portions in her dietary note but stated at the very least she would have expected for larger portions to have been mplemented for Resident #26 when she gave the lood preference list to the DM. During an interview on 02/13/19 at 4:45 PM the Administrator stated it was his expectation for esidents' dietary preferences to be honored and larger portions implemented when requested. Orinks Avail to Meet Needs/Prefs/Hydration		F 803 can modify this plan to ensure the fremains in compliance. Title of the person responsible for implementing the plan: "The Dietary Manager and Administrator are responsible for implementing the plan F 807		3/14/19	
	liquids consistent with	including water and other resident needs and cient to maintain resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	1.3333		STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	/14/2019		
ACCORDI	US HEALTH AT BRE	VARD		115 N COUNTRY CLUB ROAD BREVARD, NC 28712				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)		
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F 807	Continued From page 25		F 80)7				
	hydration. This REQUIREMI	ENT is not met as evidenced						
	Based on resider	nt and staff interviews the facility		F807 Drinks Available to Mee	et			
	failed to provide d	Irinks consistent with the		Needs/Preferences /Hydration 0	CFR(s)			
		nce for 1 of 1 resident reviewed		The plan for correcting the states.	specific			
	for preferences (F	Resident #44).		deficiency:				
	T. C. I.			" Resident #44 has been pro				
	The findings inclu	aea:		requested buttermilk in portions				
	Docidont #44 was	admitted to the facility on		glass per meal with an effective 2/14/19.	date of			
	Resident #44 was admitted to the facility on 11/25/14 with diagnoses including heart failure,			" Facility will honor preference	es for			
	hypertension, non-Alzheimer's dementia, and			such beverages in accordance				
	chronic obstructive pulmonary disease.			in reasonable portions regardles				
				Facility budget or formulary.				
	The quarterly Min	imum Data Set (MDS) dated						
	1/12/19 revealed	that Resident #44 was severely		2. How the facility will identify				
	cognitively impair	ed.		residents having the potential to affected:	be			
		Resident #44 on 2/13/19 at		" On 2/14/19 a 100% audit of				
		d the facility wrote a letter which		resident food preferences was o				
		o longer provide her buttermilk		to ensure accuracy of resident n	neal			
		facility had talked to her about		tickets.	1.24			
		ot know why she stopped		" On 2/14/19 facility purchase				
	•	milk. She further stated that r preference and that she used		for residents with specific prefer	ences mai			
	to get it.	i preference and that she used		were not being met by current formulary/menu. These items w	/ere			
	to get it.			added to meal tickets to be serv				
		the Dietary Manager on 2/12/19 ed the facility did not order		meal times.	ou ut			
		ore. She stated they used to		3. Measures put into place:				
		but no longer provide it to		" Resident food committee m	ieets			
		ther stated it was on her order		monthly and will review menu/fo				
	sheet and she car	n get it but due to the low		preferences.				
	census at the faci	lity her dietary budget had been		" Resident council meets mo	nthly and			
		ne further stated she was aware		will review menu/food preferenc				
		ement had sent a letter to		" Dietary manager to review				
		ilies about no longer providing		tickets weekly to safeguard again				
	special requests for nourishments but she had			and improve patient centered ca	are.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345208	B. WING				2
			1 2: 11:10 _				14/2019
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ACCORDI	US HEALTH AT BREVAR	D			N COUNTRY CLUB ROAD		
				BREVARD, NC 28712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE
F 807	Continued From page 26 not seen or endorsed this letter. A review of the letter signed by the facility Administrator dated 1/10/19 read in part "We cannot provide special requests. If you wish to purchase specialty items such as buttermilk or certain types of bread not in our formulary you can still purchase these items with your monthly resident funds account." An interview with the Administrator on 2/13/19 at 4:53 PM revealed his expectation was the facility should meet the needs of the residents within reason. He stated he did have a discussion with Resident #44 about food preferences and she didn't care for the facility food and wanted to have more buttermilk than the facility found to be reasonable but he did not discuss buttermilk specifically with Resident #44 nor did he discuss a compromise about the amount of buttermilk she could be provided daily. The Administrator stated he was directed to send out the letter by the corporate office stating resident requests could			DEFICIENCY)		om to this d. ated ee	
	2-3 times per day instreasonable resident r	further revealed buttermilk tead of regular milk was a equest and that buttermilk chased for the resident.		r F C r T i	or modification of this plan monthly for months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Title of the person responsible for mplementing the plan: ' The Dietary Manager and Administrator are responsible for mplementing the plan		