	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CONTRECTION	DENTIFICATION NOMBER.	A. BUILDING		C	
		345393	B. WING		02/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	IANOR HEALTH CARE	CENTER		104 HOLCOMBE COVE ROAD		
FISGAILIN		GENTER		CANDLER, NC 28715		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
E 000	Initial Comments		E 000			
	conducted on 02/25/ facility was found in requiredment CFR 4	83.73, Emergency				
F 641	Preparedness. Even Accuracy of Assessr		F 64 ²	1	3/21/19	
SS=D	CFR(s): 483.20(g)	nems	F 04		5/21/19	
	resident's status. This REQUIREMEN by: Based on record rev facility failed to accu residents reviewed fu utilizing the Minimun active diagnosis and (Resident #20). Findings included:	st accurately reflect the T is not met as evidenced view and staff interviews the rately assess 1 of 5 sampled or unnecessary medication n Data Set (MDS) to reflect medication received		F000 Disclaimer Pisgah Manor Health Care Center submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alle deficiency cited. The Provider submits PoC with the intention that it be inadmissible by any third party in any	e ged this civil	
	06/20/17.	dmitted to the facility on ician's orders from 12/01/18		or criminal action against the Provider any employee, agent, officer, director, shareholder of the Provider. The Prov hereby reserves the right to challenge	or ider	
	indicated Resident # and was receiving m	e signed by the physician 20 had diagnosis of anxiety redication to treat anxiety and sident #20 to receive an		findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adverse influence or serve as a basis, in any w for the selection and/or imposition of	ely	
	(MAR) from 12/01/18 staff documentation	cation administration record 3 to 12/31/18 indicated per on the MAR that Resident pam (antianxiety medication)		future remedies, or for any increase in future remedies, whether such remedi are imposed by the Centers for Medic and Medicaid Services (CMS), the Sta of North Carolina or any other entity; o serve, in any way, to facilitate or prom	es are tte or (2)	

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.

03/22/2019

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · · ·	ATE SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	<u> </u>		
		245202	B WINC			С
		345393	B. WING			02/28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
PISGAH N	ANOR HEALTH CARE	CENTER		104 HOLCOMBE COVE ROAD		
				CANDLER, NC 28715		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 641	Continued From page	e 1	F 64	.1		
		and did not receive an		action by any third party ag	ainst the	
	antibiotic from 12/01/			Provider. Any changes to P		
				or procedures should be co		
	A review of a care pla	an dated 12/14/18 to		subsequent remedial meas		
		esident #20 had a problem		concept is employed in Rule		
	of receiving antianxie	-		Federal Rules of Evidence		
	interventions were im	plemented to address the		inadmissible in any proceed	ling on that	
	problem.			basis.		
	A review of Resident	20's quarterly Minimum Data		F641		
		ent dated 12/21/18 indicated		Resident #20. Resident Mir		
		en coded under Section I		Set (MDS) assessment (Qu	• ·	
		not having a diagnoses of		Assessment Reference Dat	· · ·	
	-	was coded under Section N		12/21/2018) was modified v		
		d as receiving an antibiotic		Corrective Attestation Date		
	times 7 days.			The assessment was subm state QIES system on 2/26/		
	On 02/26/19 at 5:47	PM an interview was		accepted on 2/26/2019. Sul		
		Coordinator who stated he		16336323.		
		e Diagnoses and Section N		All current residents with Q	uarterly	
	Medications Receive			Minimum Data Set (MDS) a	•	
	quarterly MDS dated			due have the potential to be		
		esident #20 had a diagnosis		the alleged practice. On 3/1		
		nd should have been coded		through 3/21/2019, an audit		
	as having an anxiety			completed by the MDS Nur		
		t received an antibiotic		to review the most recent N		
		period from 12/15/18 to		Set (MDS) in the last 6 mor		
		not have been coded as		ensured that all residents w		
		ntibiotic during the look back		diagnosis of Anxiety Disord		
		ordinator stated he would dification to Resident #20's		accurately in Section I5700 Disorder) and to ensure that		
		12/21/17 to reflect active		N0410F (Medication Receiv		
	diagnoses of anxiety			Antibiotic) was coded accur	-	
		receive an antibiotic during		the 108 current residents, 0	-	
	the 7 day look back p	•		not have their quarterly ass		
	,			coded accurately for Sectio		
	On 02/26/19 at 6:05	PM an interview was		residents did not have their		
		Director of Nursing (DON)		assessments coded accura		
		ctation was that Resident		N0410F. The audit showed	•	

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If continuation sheet Page 2 of 15

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
				3	с	_
		345393	B. WING		02/28/201	9
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PISGAH I	IANOR HEALTH CARE (CENTER		104 HOLCOMBE COVE ROAD CANDLER, NC 28715		
(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 SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPL	ETIO
F 641	#20's quarterly MDS would have been acc I Active Diagnoses to anxiety disorder and Received as not rece 7 day look back perio expectation was that assessment dated 12 and submitted to acc diagnoses of anxiety Resident #20 did not 7 day look back perio On 02/26/19 at 6:15 conducted with the A expectation was that assessment dated 12 accurately coded to r anxiety disorder and receive antibiotic mer period. The Administ was the quarterly MD would be modified ar reflect active diagnos	assessment dated 12/21/18 curately coded under Section oreflect active diagnoses of under Section N Medications eiving an antibiotic during the od. The DON stated her the quarterly MDS 2/21/18 would be modified curately reflect active disorder and indicate receive antibiotic during the od. PM an interview was dministrator who stated her the quarterly MDS 2/21/18 would have been reflect active diagnoses of reflect Resident #20 did not dication during the look back rator stated her expectation DS assessment 12/21/18 nd submitted to accurately sis of anxiety disorder and had not received antibiotic	F 64		se (RN) ators m DS ed sultant. The essment tatus. incility or by a tant, or e under days ne , ; oring or back which back review record ent ments, otes, if a y cian ure to the last reventry	

Event ID: 1GLP11

Facility ID: 923409

If continuation sheet Page 3 of 15

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/01/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMF	
		345393	B. WING				28/2019
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	IANOR HEALTH CARE C			OLCOMBE COVE ROAD			
FISGAN	ANOR HEALTH CARE C	ENTER		CAN	DLER, NC 28715		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 641	Continued From page	2.3	F 6	d sre re g s M a w n c ir tr re w P b T N N m (l o C D e D (l w o fc R C a to a b A	ocumentation from other health car ettings where the resident may hav eceived any of these medications w esident of the nursing home (e.g., v iven in the emergency room). This is ervice was completed by 3/18/2019 IDS nurse (full time, part time, and nd member of the interdisciplinary to the did not receive in-service training ot be allowed to work until training is ompleted. This information has been thegrated into the standard orientati aining and in the required in-service effesher courses for all employees a vill be reviewed by the Quality Assur- erocess to verify that the change has een sustained. to ensure compliance, The Director lursing and/or Assistant Director of lursing will review 5 resident electron full assessment this could be eith ne of the following assessments that comprehensive/ Quarterly / PPS Min bata Set (Assessments) per week to nsure that Section 15700 (Anxiety Disorder) and Section N0410F Medication Received: Days Antibiot vas coded accurately. This will be do n weekly basis to include the week or 4 weeks then monthly for 3 month teports will be presented to the mor the committee by the Director of Nur ind/or Mini Data Set (MDS) Coordin to ensure corrective action initiated a ppropriate. Any immediate concern e brought to the Director of Nur diministrator for appropriate action. compliance will be monitored and	e hile a alium n . Any PRN) eam g will s n con e and conce s of nic her at is hi for the second statistical s s s will s s s will	

Event ID: 1GLP11

Facility ID: 923409

If continuation sheet Page 4 of 15

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/01/2019 RM APPROVED	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C	
		345393	B. WING		02/28/2019		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
PISGAH N	IANOR HEALTH CARE C	ENTER		04 HOLCOMBE COVE ROAD CANDLER, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 641 F 656			F 641	ongoing auditing program review monthly QA Committee meeting. Administrator, Director of Nursing Coordinator, Assistant Director of Staff Development Coordinator a members of the interdisciplinary attend the monthly QA meeting.	g, MDS f Nursing, ind other	3/21/19	
SS=D	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, include treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's if mental and psychosocial ied in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the					

Facility ID: 923409

If continuation sheet Page 5 of 15

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/01/2 FORM APPROV OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	
		345393	B. WING		02/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PISGAH N	IANOR HEALTH CARE O	ENTER		04 HOLCOMBE COVE ROAD		
				CANDLER, NC 28715	Ι	
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI	
F 656	Continued From page	e 5	F 656			
	(A) The resident's go desired outcomes.					
	future discharge. Fac	eference and potential for ilities must document s desire to return to the				
		ssed and any referrals to s and/or other appropriate ose				
	(C) Discharge plans i plan, as appropriate,	n the comprehensive care in accordance with the h in paragraph (c) of this				
	section. This REQUIREMENT by:	is not met as evidenced				
	facility failed to implein residents reviewed for #96) and failed to dev	iew and staff interviews the ment the care plan for 1 of 2 or catheter care (Resident velop a comprehensive care		F656 Resident #96's care plan was rev and updated on 3/18/2019 to ens it was accurate for catheter care a	ure that and	
	daily living (Resident			activities of daily living. Resident a care plan was reviewed and upda 3/18/2019 to ensure that it was ac	ated on ccurate	
	The findings included			catheter care and activities of dai All current residents with requiring	g	
	01/22/19 with diagnos	The admission 5-day		catheter care and activities of dai have the potential to be affected I alleged practice. On 3/15/2019 th 3/20/2019, an audit was complete	by the rough	
	revealed Resident #9 impairment and requi with bed mobility, toil	6 had some cognitive red extensive assistance eting and hygiene. The MDS dent #96 had an indwelling		Minimum Data Set (MDS) Nurse Consultant and MDS Coordinator ensure that a care plan was imple for current residents requiring cat	rs, to emented	
	catheter.	-		care and activities of daily living. current residents who require cat	All heter	
	admission 5-day MDS	rea Assessment from the S revealed Resident #96 had r due to neuromuscular		care and activities of daily living h updated care plans. This was cor on 3/20/2019.		
		adder (when the bladder is		On 3/18/2019 The Registered Nu Minimum Data Set (MDS) Coordi and any other Interdisciplinary tea	nators	

Facility ID: 923409

If continuation sheet Page 6 of 15

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TID	LE CONSTRUCTION	OMB NO. (X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPL	
					c	
		345393	B. WING		02/2	8/2019
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
	ANOR HEALTH CARE (NENTED		104 HOLCOMBE COVE ROAD		
FIGGAIL				CANDLER, NC 28715		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 656	Continued From page	e 6	F 65	6		
		Plan dated 01/23/19 revealed		member that participates in	the MDS	
		ntion: "Position catheter bag		assessment process was in		
		level of the bladder and		/educated by the MDS Nurs		
	away from entrance r	room door."		The education focused on t		
				areas: The facility must dev		
	During an interview w			implement a comprehensive		
		she stated that she currently		person-centered care plan		
		on and was unsure what they		resident, consistent with the		
		catheter. An observation of ealed it was seen with a		rights set forth and that incl measurable objectives and		
	-	anging on the bed frame with		meet a resident's medical, i		
		nd bag off the floor with		mental psychosocial needs	•	
	-	aining from the tubing into		identified in the comprehen		
	the catheter bag.	5 5		assessment. The comprehe		
				plan must describe the follo		
	During an observatio	n of incontinence care on		services that are to be furni	shed to attain	
		, Nursing Assistant (NA) #4		or maintain the resident's h	0	
		ove the catheter bag from		practicable physical, menta		
		sident #96 and lay it on top of		psychosocial wellbeing; and	2	
		Resident #96 was laying		that would otherwise be req	-	
		A #4 proceeded to provide		not provided due to the resi		
		Resident #96 while the ed on the mattress with		exercise of rights , including refuse treatment ; and any	-	
	-	resent in the tubing. NA #5		services or specialized reha	-	
		d catheter care for Resident		services the nursing facility		
		observed placing the catheter		a result of PASARR recomm		
		e at 12:15PM. At this time,		and after consultation with t	the resident	
	-	ed to both NA's why the		and the resident's represen		
		he bed during incontinence		residents goals for admission		
	-	ed it was to prevent the		outcomes, the resident's pr		
	-	pulling when Resident #96		potential for future discharg		
	was rolled side to sid	e for her incontinence care.		discharge plans. A compreh centered care plan must be		
	During an interview w	vith NA #4 on 02/27/19 at		for all residents requiring ca	-	
	-	ed she had been trained that		and must be developed for		
		not supposed to go above		receiving activities of daily I		
	the bladder, but she			identifies the type of care no		
				activities of daily living. This		
	During an interview w	vith the Director of Nursing		was completed by 3/18/201		

Facility ID: 923409

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · /	G	· · · ·	OMPLETED
						С
		345393	B. WING			02/28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PISGAH N	IANOR HEALTH CARE (CENTER		104 HOLCOMBE COVE ROAD CANDLER, NC 28715		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 7	E 6F	56		
F 030	on 02/27/19 she state the NAs to follow Res keeping the resident' below the level of his 2. Resident #98 was 08/24/2017. Her diag dementia and non-Al A review of the quarte (MDS) dated 02/11/2 #98 was oriented to s assistance for activiti bed mobility, transfer hygiene, bathing, and Resident #98 was ab assistance from one A review of Resident no care plan was initi ADL. An interview with Nur 02/26/2019 at 03:32 computer for providin to NAs) gives a summaries to ADL and any spection An interview with the 02/26/2019 at 05:25 does not trigger ADL Assessment section care plan.	ed her expectations were for sident #96's care plan by s catheter bag and tubing a bladder. a admitted to the facility on gnoses included Alzheimer's zheimer's dementia. erly Minimum Data Set 019 revealed that Resident self and required extensive les of daily living (ADL) with s, toileting, dressing, d locomotion on/off the unit. ble to eat with limited person. #98's care plans revealed iated for assistance with rsing Assistant (NA) #1 on PM revealed the kiosk (wall ng resident care information mary of what care the A #1 explained the kiosk or all the residents pertaining ial requirements. MDS Coordinator on PM revealed if the MDS in the Care Area then he would not develop a	F 65	 nurse (full time, part time, member of the interdiscipli did not receive in-service the be allowed to work until tracompleted. This informatic integrated into the standar training and in the required refresher courses for all envill be reviewed by the Que Process to verify that the obeen sustained. To ensure compliance, The Nursing and/or Assistant E Nursing will observe five rerequiring catheter care to oplan is implemented and wiresidents electronic medic ensure that a comprehens developed for activities of will be done on weekly bas weekend for 4 weeks them months. The Director of Nursing or Administrator for action. Compliance will be brought to Nursing or Administrator for action. Compliance will be ongoing auditing program monthly QA Committee medication for the interdiscipling attend the monthly QA medication. 	inary team who training will not aining is on has been of orientation d in-service mployees and hality Assurance change has e Director of Director of esidents ensure that care will review five al record to hive care plan is daily living. This sis to include the monthly for 3 ursing will othly QA ta Set (MDS) rrective action my immediate of the Director of or appropriate monitored and reviewed at the eeting. Nursing, MDS ector of Nursing, nator and other olinary team,	
	AM revealed Resider	#2 on 02/27/2019 at 07:50 nt #98 required extensive le for most of her ADL.				

Facility ID: 923409

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/01/20 ⁷ 1 APPROVE 0. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345393	B. WING			C 02/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PISGAH N	IANOR HEALTH CARE O	CENTER			4 HOLCOMBE COVE ROAD ANDLER, NC 28715		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 8	F	656			
	02/27/2019 at 10:38 /	Director of Nursing on AM revealed her expectation should have an ADL care					
	at 11:19 AM revealed the residents should l identifies the type of staff is required to pe	care needed and how much					
F 684 SS=D	Quality of Care CFR(s): 483.25		F	684			3/21/19
	applies to all treatment facility residents. Base assessment of a resident that residents received accordance with profe- practice, the compre- care plan, and the resident	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered					
	Based on observatio and staff interview the a call light timely to p	ns, record review, resident e facility failed to respond to rovide medicine for 1 of 3 or providing care to maintain #22).			On 2/25/19, the facility nurse and nurse aide responded to (Resident #22) the request for assistance and met the nee for ADL care. On 2/25/19, the Administrator complete 100% audit of call light wait times for all	ds :d	
	12/29/16. The annua dated 12/27/18 revea	mitted to the facility on I Minimum Data Set (MDS) Iled Resident #22 was e MDS also indicated			residents. The findings of the audit were that all lights were answered in compliance with the facility's policy. No additional concerns were identified. On 2/25/19 the facility Assistant Director of Nursing and Staff Development Coordinator began educating facility sta	e vr	

Event ID: 1GLP11

Facility ID: 923409

If continuation sheet Page 9 of 15

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>		(X3) DATE SURVEY COMPLETED	
		345393	B. WING		C 02/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PISGAH N	IANOR HEALTH CARE (CENTER				
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLE	
F 684	Continued From page	e 9	F 68	4		
	activities of daily livin	g.		on importance of answering call	bells	
				timely to ensure that the quality		
		physician progress note vealed Resident #22 was		principles are provided to facility		
		n for an acute cough and		residents. This was completed of with 85 staff members.	011 3/20/19	
		ordered an as needed		On 3/18/19 the Administrator wil	ll begin a	
	cough suppressant.			QA audit of timely answering ca	ll bells	
	5 · · · · ·			timely to ensure that the quality		
	During an interview w	she stated she had to wait a		principles are provided to facility by using the QA tool for Call bel		
		sing her call light. Resident		Administrator will audit five resid		
		have a flat pad call light that		randomly throughout the building		
	was attached to her s	shirt.		and then monthly as listed below		
				This audit will be completed wee	-	
	÷	n on 02/26/19 at 4:40PM, the		then monthly x 3. QA Reports w		
	-	system was on in the hallway lent #22. Resident #22		presented in the weekly QA meet the Director of Nursing/designee		
		ated her call light 30 minutes		ensure that the corrective action		
		vaiting on someone to assist		or ongoing concerns is initiated		
	•	as observed attached to		appropriate for compliance with	C	
		Resident #22 further stated		requirements. Administrator, Dir		
		suppressant and was wice during the interview.		Nursing, MDS Coordinator, Assi Director of Nursing, Staff Develo		
		where during the interview.		Coordinator and other members		
	On 02/26/19 at 5:17F	PM, Nursing Assistant (NA)		interdisciplinary team, attend the		
		enter the room of Resident		QA meeting.		
		sident #22 told NA #3 she				
	needed some cough	medication.				
	During an interview w	vith NA #3 on 02/26/19 at				
	5:59PM, NA #3 state	d she had not been				
		day but had been called in				
		M. NA #3 further stated that				
		ave to wait more than 5 light to be answered. NA #3				
		dent #22 requested cough				
		had informed the nurse when				
	she left the room of F	Resident #22				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345393	B. WING				C /28/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PISGAH N	IANOR HEALTH CARE C	ENTER			104 HOLCOMBE COVE ROAD CANDLER, NC 28715		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	During an interview w 6:09PM, Nurse #3 sta all the time. Nurse #3 should have to wait m their call light answerd During an interview w Nursing (ADON) on 0 ADON stated that 15- reasonable time for N they should not go ov A review of the facility report revealed Resid time of one hour, eigh on 02/26/19 between During an interview w 6:51PM, Nurse #3 ve know that Resident # medicine, and this ha at 6:22PM. During an interview w 02/27/19 at 4:20PM, s patient with the staff to other residents to atter frustrated having to w Resident #22 also sta times each month wh she is unable to do ar #22 specifically referr request something to night and in this insta During an interview w (DON) on 02/27/19 at all staff to answer call	with Nurse #3 on 02/26/19 at ated he answered call lights 3 further stated no resident hore than 5 minutes to have ed. with the Assistant Director of 2/26/19 at 6:25PM, the 20 minutes was a A's to answer call lights, but er 30 minutes. 's call bell response time lent #22 had a response at minutes and six seconds 4:00PM and 6:00PM. with Nurse #3 on 02/26/19 at rified that NA #3 had let him 22 had requested cough d been administered to her with Resident #22 on she stated she tried to be because she knew they have and to, but she does become	F	684			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				PRINTED: 04/01/2019 FORM APPROVED OMB NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE COMF	SURVEY	
		345393	B. WING _				C 02/28/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CI 104 HOLCOMBE CO CANDLER, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E EFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684 F 690 SS=D	answer the light and a as they can get to it. response time to call Bowel/Bladder Incont	address the issue as soon The DON further stated lights was very important. tinence, Catheter, UTI	F 6				3/21/19	
	resident who is contir admission receives s maintain continence of condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive asses ensure that- (i) A resident who ent indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who en- indwelling catheter or is assessed for remo- as possible unless the demonstrates that ca and (iii) A resident who is receives appropriate prevent urinary tract if continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive asses ensure that a residen	cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical ness such that continence is ain. esident with urinary on the resident's assment, the facility must ters the facility without an not catheterized unless the udition demonstrates that necessary; ters the facility with an r subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345393		(X2) MULTII	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		B. WING			C 02/28/2019			
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
PISGAH MANOR HEALTH CARE CENTER				10	4 HOLCOMBE COVE ROAD			
				CA	ANDLER, NC 28715			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE	
F 690	Continued From page	e 12	F 6	90				
	restore as much normal bowel function as							
	possible.							
		T is not met as evidenced						
	by:							
	Based on observation			F690				
	interviews the facility			On 2/27/19, the Assistant Director of				
	catheter below the le			Nursing and Staff Development				
	residents review for o	catheter care (Resident #96).			Coordinator assessed resident #96's			
					catheter function, catheter tubing			
	The findings included	d:			placement, and resident general			
	Desident #00 was ad				condition, and no concerns were noted	d.		
	Resident #96 was ad			On 2/27/19, the Assistant Director of				
	01/22/19 with diagno neurogenic bladder.			Nursing and Staff Development Coordinator assessed 100% of other				
	Minimum Data Set (N			residents with indwelling catheters. Th	ere			
	revealed Resident #96 had some cognitive				were five residents with indwelling			
	impairment and requ			catheters at this time and no concerns	;			
		eting and hygiene. The MDS			were identified.			
	further revealed Resi	ident #96 had an indwelling			On 3/13/19, the Staff Development			
	catheter.				Coordinator and Assistant Director of			
					Nursing began in-servicing facility nurs	sing		
		Area Assessment from the			assistants on catheter care, peri-care,			
		S revealed Resident #96 had			which included training on maintaining	a		
		er due to neuromuscular			catheter bag below the level of the			
	unable to completely	adder (when the bladder is			bladder when providing personal care Assistants were also in-serviced in a	•		
		empty out unne).			meeting 3/20/19. This has been			
	Review of the Care F	Plan dated 01/23/19 revealed			completed with 26 assistants as of			
		ntion: "Position catheter bag			3/20/19. In-serving will continue to ens	sure		
		level of the bladder and			all that assistants have been trained.	-		
	away from entrance				Nurses were also provided additional			
					education on catheter care, peri-care,			
		progress notes dated 2/21/19			which included training on maintaining	а		
		of gross hematuria (blood in			catheter bag below the level of the			
	-	ent #96 began an antibiotic			bladder when providing personal care	on		
	for a urinary tract infe	ection on 02/22/19.			3-13-19 in the monthly meeting.			
					On 3/13/19, the Assistant Director of			
	-							
	During an interview v 02/26/19 at 8:56AM s	vith Resident #96 on she stated that she currently			Nursing and Staff Development Coordinator will begin a QA audit of			

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FICIENCIES						
RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION	· · ·	OATE SURVEY OMPLETED	
345393		B. WING			C 02/28/2019	
	0-0000				02/28/2019	
BER OR OUT FIER						
OR HEALTH CARE C	ENTER		CANDLER, NC 28715			
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHO		IOULD BE	(X5) COMPLETION DATE	
ntinued From page	13	F 60	00			
During SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 90 Continued From page 13 had a bladder infection and was unsure what they were doing with her catheter. An observation of her catheter bag revealed it was seen with a privacy bag over it, hanging on the bed frame with the catheter tubing and bag off the floor with clear, yellow urine draining from the tubing into the catheter bag. During an observation of incontinence care on 02/27/19 at 12:06PM, Nursing Assistant (NA) #4 was observed to remove the catheter from the bed frame of Resident #96 and lay it on top of the mattress where Resident #96 was laying down. NA #5 and NA #4 proceeded to provide incontinence care to Resident #96 while the catheter bag remained on the mattress with yellow urine visibly present in the tubing. NA #5 and NA #4 completed catheter care for Resident #96 and NA #4 was observed placing the catheter bag on the bed frame at 12:15PM. At this time, the question was asked to both NA's why the catheter was put on the bed during care and NA #5 replied it was to prevent the catheter tubing from pulling when Resident #96 was rolled side to side for incontinence care. During an interview with NA #4 on 02/27/19 at 12:30PM, NA #4 stated she had been trained that the catheter bag was not supposed to go above the bladder, but she must have forgotten. During an interview with the Staff Development Coordinator (SDC) on 02/27/19 at 2:16PM, she stated she goes over peri care and catheter care with the NAs during orientation. The SDC further		F 69	observations of facility nurse aid providing catheter care to ensur a resident in the facility with an catheter receives appropriate tr and services to prevent urinary to infections and to maintain the ca This audit will be observing one and one resident weekly x4 then x 3. QA Reports will be presenter monthly QA meeting by the Direr Nursing/designee to ensure that corrective action for trends or on concerns is initiated as appropria compliance with regulatory requi Administrator, Director of Nursin Coordinator, Assistant Director of Staff Development Coordinator a	te that the indwelling eatment ract assistant monthly d in the ctor of the going ate for irements. g, MDS of Nursing, and other		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L antinued From page d a bladder infectio are doing with her ca r catheter bag revea- vacy bag over it, ha e catheter tubing an ear, yellow urine dra e catheter tubing an ear, yellow urine dra e catheter bag. ring an observation /27/19 at 12:06PM, is observed to remo d frame of Residen attress where Resid a #5 and NA #4 prote- continence care to F theter bag remained low urine visibly pro- d NA #4 completed 6 and NA #4 was o g on the bed frame e question was asket theter was put on th replied it was to pro- m pulling when Res- e for incontinence of signal interview w :30PM, NA #4 states e bladder, but she n ring an interview w iordinator (SDC) on the se goes over h the NAs during of the the goes over h the NAs during of the the goes over h the NAs during of the the secause this of the secause this of the secause this of the secause this of the secause this of the secause this of the secause this of the secause this of the secause this of the secause the sec	DER OR SUPPLIER DER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Antinued From page 13 d a bladder infection and was unsure what they are doing with her catheter. An observation of r catheter bag revealed it was seen with a vacy bag over it, hanging on the bed frame with e catheter tubing and bag off the floor with tar, yellow urine draining from the tubing into e catheter bag. ring an observation of incontinence care on /27/19 at 12:06PM, Nursing Assistant (NA) #4 s observed to remove the catheter from the d frame of Resident #96 and lay it on top of the attress where Resident #96 was laying down. A#5 and NA #4 proceeded to provide iontinence care to Resident #96 was laying down. A#5 and NA #4 proceeded to provide iontinence care to Resident #96 was laying down. A#5 and NA #4 proceeded to provide iontinence care to Resident #96 was laying down. A#5 and NA #4 proceeded to provide iontinence care to Resident #96 was laying down. A#5 and NA #4 proceeded to provide iontinence care to Resident #96 while the theter bag remained on the mattress with low urine visibly present in the tubing. NA #5 d NA #4 completed catheter care for Resident 6 and NA #4 was observed placing the catheter g on the bed frame at 12:15PM. At this time, e question was asked to both NA's why the theter was put on the bed during care and NA replied it was to prevent the catheter tubing m pulling when Resident #96 was rolled side to le for incontinence care. ring an interview with NA #4 on 02/27/19 at :30PM, NA #4 stated she had been trained that e catheter bag was not supposed to go above a bladder, but she must have forgotten. ring an interview with the Staff Development ordinator (SDC) on 02/27/19 at 2:16PM, she ted she goes over peri care and catheter care	DER OR SUPPLIER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Intinued From page 13 F 65 d a bladder infection and was unsure what they re doing with her catheter. An observation of r catheter bag revealed it was seen with a vacy bag over it, hanging on the bed frame with e catheter tubing and bag off the floor with ar, yellow urine draining from the tubing into e catheter bag. F 65 rring an observation of incontinence care on /27/19 at 12:06PM, Nursing Assistant (NA) #4 s observed to remove the catheter from the d frame of Resident #96 and lay it on top of the titress where Resident #96 was laying down. # # # 5 and NA #4 proceeded to provide ontinence care to Resident #96 waile the theter bag remained on the mattress with low urine visibly present in the tubing. NA #5 d NA #4 completed catheter care for Resident 6 and NA #4 was observed placing the catheter g on the bed frame at 12:15PM. At this time, e question was asked to both NA's why the theter was put on the bed during care and NA replied it was to prevent the catheter tubing m pulling when Resident #96 was rolled side to le for incontinence care. rring an interview with NA #4 on 02/27/19 at :30PM, NA #4 stated she had been trained that e catheter bag was not supposed to go above e bladder, but she must have forgotten. rring an interview with the Staff Development ordinator (SDC) on 02/27/19 at 2:16PM, she ted she goes over peri care and catheter care h the NAs during orientation. The SDC further ted that she did not review the need to keep e urinary catheter bag below the level of the dider because this was something they would <td>Der OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE DR HEALTH CARE CENTER 104 HOLCOMBE COVE ROAD CANDLER, NC 28715 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROMDER'S FLAN OF CORR (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ntinued From page 13 F 690 d a bladder infection and was unsure what they re doing with her catheter. An observation of catheter bag revealed it was seen with a vacy bag over it, hanging on the bud frame with catheter bag. F 690 d a bladder infection and was unsure what they re doing with her catheter. An observation of catheter tag. F 690 d a bladder infection and was unsure what they re doing with her catheter from the d frame of Resident #60 and lay it on top of the sobserved to remove the catheter from the d frame of Resident #60 kas laying down. F 690 277/19 at 12:00PM, Nursing Assistant (NA) #4 s observed to remove the catheter from the d frame of Resident #96 was laying down. F 690 W #5 and NA #4 proceeded to provide ontinence care to Resident #96 will the theter was put on the bed furing care and NA repiled to atheter dare for Resident g on the bed frame at 12:15PM. At this time, queustion was asked to both NA's why the theter was put on the bed furing care and NA repiled it was to prevent the catheter tubing m pulling when Resident #96 was rolled side to e for incontinence care. ring an interview with NA #4 on 02/27/19 at :30PM, NA #4 stated she had been trained that catheter bag was not supposed to go above e bladder, but she must have forgotten. ring an interview with</td> <td>DeP or OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE DR HEALTH CARE CENTER 10 PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTORY OR LSC IDENTIFYING INFORMATION) PRETEX TAG Definition of the Catheter Care on catheter bag revealed it was seen with a vacy bag over it, hanging on the bed frame with ar, yellow urine draining from the tubing into to catheter bag. F 690 observations of facility nurse aides providing catheter care to ensure that the catheter bag. 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Condinator, Assistant Condinator and other continence care. ring an interview with NA #4 on 02/27/19 at catheter bag was not supposed to go above b ladder, but she dud not revie</td>	Der OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE DR HEALTH CARE CENTER 104 HOLCOMBE COVE ROAD CANDLER, NC 28715 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROMDER'S FLAN OF CORR (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ntinued From page 13 F 690 d a bladder infection and was unsure what they re doing with her catheter. An observation of catheter bag revealed it was seen with a vacy bag over it, hanging on the bud frame with catheter bag. F 690 d a bladder infection and was unsure what they re doing with her catheter. An observation of catheter tag. F 690 d a bladder infection and was unsure what they re doing with her catheter from the d frame of Resident #60 and lay it on top of the sobserved to remove the catheter from the d frame of Resident #60 kas laying down. F 690 277/19 at 12:00PM, Nursing Assistant (NA) #4 s observed to remove the catheter from the d frame of Resident #96 was laying down. F 690 W #5 and NA #4 proceeded to provide ontinence care to Resident #96 will the theter was put on the bed furing care and NA repiled to atheter dare for Resident g on the bed frame at 12:15PM. 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Condinator, Assistant Condinator and other continence care. ring an interview with NA #4 on 02/27/19 at catheter bag was not supposed to go above b ladder, but she dud not revie	

Facility ID: 923409

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/01/2019 1 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345393		B. WING			C 02/28/2019			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
PISGAH MANOR HEALTH CARE CENTER			104 HOLCOMBE COVE ROAD					
					CANDLER, NC 28715			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 690	Continued From page 14 certification to be an NA.		F	690				
	During an interview w (DON) on 02/27/19 at expectations were for urinary catheter bag a The DON also stated providing the care tha according to proper p cause any type or pro- further stated that ong	with the Director of Nursing t 1:50PM she stated her the NAs to not place the at the level of the bladder. that the NAs should be at the residents need rotocol so that they do not oblem or infection. The DON going staff training should be know the expectations of						

Facility ID: 923409

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