	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345312	B. WING		C 08/22/2019			
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COL	•			
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				1870 PISGAH DRIVE HENDERSONVILLE, NC 28791				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE			
E 000	Initial Comments		E 000					
F 000		8.73, Emergency t ID# D4LP11.	F 000					
	investigation survey w through 08/22/19. Or	ertification and complaint vas conducted on 08/19/19 ne allegation was ubstantiated. Event ID#						
F 576 SS=C	Right to Forms of Con CFR(s): 483.10(g)(6)	mmunication w/ Privacy -(9)	F 576		9/8/19			
	reasonable access to including TTY and TE the facility where calls	sident has the right to have the use of a telephone, D services, and a place in s can be made without being des the right to retain and at the resident's own						
	individuals and entitie facility, including reas (i) A telephone, includ (ii) The internet, to the facility; and	's right to communicate with s within and external to the onable access to: ling TTY and TDD services; e extent available to the ge, writing implements and						
	and receive mail, and and other materials d	sident has the right to send to receive letters, packages elivered to the facility for the eans other than a postal						

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/17/2019 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/22/2019	
		345312	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE			870 PISGAH DRIVE		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			п	ENDERSONVILLE, NC 28791 PROVIDER'S PLAN OF CORRECTION		0(5)
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 576	with this section; and (ii) Access to stationed implements at the rest §483.10(g)(9) The rest reasonable access to electronic communication (i) If the access is ava (ii) At the resident's electronic communication (ii) At the resident's electronic communication (iii) At the resident's electronic communication (iii) Such use must contain (iii) Such use must contain (iiii) Such use must contain (iii) Such use must contain	right to: mmunications consistent ery, postage, and writing sident's own expense. sident has the right to have and privacy in their use of ations such as email and s and for internet research. ailable to the facility xpense, if any additional by the facility to provide such t. omply with State and Federal - is not met as evidenced and staff interviews, the le residents with the right to livered on Saturdays.	F	576	How will corrective action be accomplished for those residents havin the potential to be affected by the defice practice? Resident #14 received his mail with no adverse outcome. How will corrective action be	cient	
	residents received un through Friday but no	opened mail Monday			How will corrective action be accomplished for those residents havin the potential to be affected by the sam deficient practice:	-	
	who was the Acting A at 1:53 PM revealed a delivered mail to the Friday. The Activity D Weekend Nurse Supe delivered mail to the Interview with the We	ctivity Director on 08/21/19 the activity department staff residents Monday through irector explained the ervisor on duty Saturday			The Receptionist was educated on 8/23/19 on the facility process of delive of mail to the resident's by the LNHA. Audit was conducted by the LNHA on delivery with no other residents identifie to have been affected by the same deficient practice.	An mail ied	

Facility ID: 922985

If continuation sheet Page 2 of 21

		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0 (X3) DATE SUF		
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLET		
					C		
		345312	B. WING		08/22/	2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
BRIAN CT	R HEALTH & REHAB/HE	NDERSONVILLE		1870 PISGAH DRIVE			
				HENDERSONVILLE, NC 2879)1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE C	(X5) OMPLETIO DATE	
F 576	Continued From page	e 2	F 57	76			
	Weekend Nurse Supe	ervisor every Saturday. The ervisor explained the mail v was set aside for the		systematic changes mad deficient practice does r			
	delivered on Saturday was set aside for the Receptionist to sort on Monday before delivery to the residents. Residents did not receive mail delivered on Saturday.			The Receptionist and th Team was educated by facilities mail delivery pr residents on 8/23/19. Or	the LNHA on the ocess of the		
	2:15 PM revealed she Friday and received t	ceptionist on 08/21/19 at e worked Monday through he mail for the facility. She		resident mail will be dist Weekend Supervisor or	ributed by the Manager on Duty.		
	mail to the Activity De residents. The Recep mail delivered on Sat	ted the mail delivered nd gave all the residents' epartment for delivery to the itionist stated the weekend urday was placed on her it on Monday and gave it to		The Weekend Supervise by the LNHA on 8/23/19 mail on the weekend an the residents in the abse Manger on Duty. Manag obtain and deliver reside	on obtaining the d distributing to ence of the er on Duty will		
	the Activity Director.			absence of the weekend	l supervisor.		
		ninistrator on 08/21/19 at sidents should receive mail was delivered.		The LNHA/Business Off assume role of mail collo absence of the Receptic weekdays.	ection in the		
				How the corrective actio monitored to ensure the recur, i.e. what Quality assurance progr place:	practice will not		
				To ensure ongoing comp LNHA/designee will con audits on 10 resident's r weekly for twelve (12) w mail delivery.	duct random nail delivery		
				The results of these aud reported at the monthly until such time substanti been achieved.	QAPI meeting		

Facility ID: 922985

If continuation sheet Page 3 of 21

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 09/17/201 MAPPROVE 0. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345312	B. WING		08	C 8/22/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				1870 PISGAH DRIVE		
BRIANCI	R HEALTH & REHAB/HE	ENDERSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 576	Continued From page	e 3	F 57	5		
				The LNHA will be responsible implementation of the accept correction.		
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)		F 65			9/8/19
	 be- (i) Developed within T the comprehensive a (ii) Prepared by an inincludes but is not liminal (A) The attending phy (B) A registered nurser resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and their of the and their resident reproduces the resident of the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii) Reviewed and revite an after each asses comprehensive and or as result. 	orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that hited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the				
	Based on record rev	iew and staff interviews, the v and/or revise the care plan		How will corrective action be accomplished for those resid		

Facility ID: 922985

If continuation sheet Page 4 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 09/17/2019 // APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345312	B. WING				C 22/2019
NAME OF PF	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
	R HEALTH & REHAB/HE		1870 PISGAH DRIVE				
BRIANCI				Н	ENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 657	residents reviewed for (Resident #46). Findings Included: Resident #46 was ad 10/24/17 and readmit diagnoses which included dementia. Review of the care pl revised date of 4/18/1 which included using that sets off an alarm Review of the quarter dated 7/05/19 indicate cognitive impairment. Review of physician's wanderguard for Res discontinued on 7/22/	al care needs for 1 of 5 or unnecessary medications mitted to the facility on tted on 11/19/18 with uded non-Alzheimer's an for Resident #46 with a 19 revealed interventions a wanderguard (bracelet at exit doors) as ordered. rly Minimum Data Set (MDS) ed Resident #46 had severe s orders revealed the ident #46 had been /19.	F	657	 the potential to be affected by the defipractice: Resident #46 wander guard bracelet ware removed off the care plan by the MDS nurse on 8/21/19 with no adverse outcome. How will corrective action be accomplished for those residents have the potential to be affected by the same deficient practice: An Audit was conducted on 8/28/19 by the Director of Nursing on residents wave wander guards that had been discontinued to ensure the resident's or plan have been updated. No other residents were affected by the same deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: 	vas ng ne y ith care or	
	11:13 AM revealed th should have been rer when the physician d She further stated she been missed but that daily order printouts. care plans should be reflect accurate reside Resident #46's care p updated when the wa discontinued.	DS Coordinator on 8/21/19 at the wanderguard interventions moved from the care plan iscontinued it, but it was not. the did not know how it had it did not show up on her The MDS Coordinator stated updated when needed to the tare information and blan should have been anderguard was			The Nursing Administrative Team to include the Assistant Director Nursing the Unit Manager were educated on 8/26/19 by DON on ensuring when wander guard orders have been discontinued that it is removed from the residents care plan. How the corrective actions will be monitored to ensure the practice will recur, i.e. what Quality assurance program will be put place:	ie ot	
	3:03 PM indicated sh	e expected the care plans to			To ensure ongoing compliance, the		

Facility ID: 922985

If continuation sheet Page 5 of 21

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		D. 0938-03 E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	СОМ	PLETED	
						С	
		345312	B. WING			/22/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 657	Continued From page	- F					
F 657		care for each resident and necessary to accurately	F 65	Director of Nursing or Unit conduct random audits on that have been discontinu twelve (12) weeks to ensu guard has been removed residents care plan. The results of these audits reported at the monthly Q until such time substantial been achieved.	wander guards ed weekly for ire the wander from the s will be API meeting		
F 658 SS=D		eet Professional Standards (i)	F 65	The Director of Nursing wiresponsible for the implem acceptable plan of correct	nentation of the	9/8/19	
	as outlined by the com must- (i) Meet professional This REQUIREMENT by: Based on record rev Manager, family and failed to follow physic (earwax) removal for who had impaired he The findings included Resident #15 was ad	d or arranged by the facility, mprehensive care plan, standards of quality. T is not met as evidenced iew and Audiologist Office staff interviews, the facility cian's orders for cerumen 1 of 1 resident reviewed aring (Resident #15). I: mitted to the facility on e diagnoses that included		How will corrective action accomplished for those re the potential to be affected practice: An order was received on resident #15 for Debrox as by the outside provider (at Resident # 15 has been so 10/9/19 for a follow up app Audiologist.	sidents having d by the deficient 9/5/19 for s recommended udiologist). cheduled on		
	Review of Resident #			How will corrective action accomplished for those re			

Event ID: D4LP11

Facility ID: 922985

If continuation sheet Page 6 of 21

		MEDICAID SERVICES				IO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			E SURVEY	
			A. BUILDIN	IG		с	
		345312	B. WING		0	B/22/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		5/22/2015	
				1870 PISGAH DRIVE			
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				HENDERSONVILLE, NC 28791			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLETIO DATE	
-				DEFICIENCY	⁽)		
E 050							
F 658	Continued From page		F 6				
		jist consult note dated		the potential to be affected I	y the same		
		Otoscopic (visual exam of lighted instrument) exam		deficient practice:			
		f cerumen (earwax) in the		An Audit was conducted on	9/5/19 by the		
		near impaction of cerumen		Director of Nursing on resid			
	-	Cerumen must be removed		received consultations for th			
		earing evaluation can be		to ensure the resident's reco	•		
		schedule hearing evaluation		from the outside providers v	vere followed		
	after cerumen is rem	oved."		thru with as recommended.	No other		
				residents were affected by t	ne same		
		#15's physician telephone		deficient practice.			
		rder dated 04/23/19 which					
	read, "Cerumen/earw	vax removal both ear		What measures will be put i			
	canals."			systematic changes made to			
				deficient practice does not r	ecur:		
		rly Minimum Data Set (MDS) ated Resident #15 had		The Assistant Director Nurs	ng and tha		
				The Assistant Director Nurs Unit Managers were educat			
	impairment in hearing	cognition and minimal		by DON on ensuring outside			
		y.		recommendations were follo	•		
	A telenhone interview	v on 08/19/19 at 2:34 PM		with by the physician as rec			
	with Resident #15's F						
		15 was hard of hearing and		How the corrective actions v	vill be		
		ently at home, Resident #15		monitored to ensure the pra			
		her ears due to earwax		recur, i.e. what			
	-	ded Resident #15 was		Quality assurance program	will be put into		
		r ears cleaned at the facility		place:	·		
	but was not sure if it	had been done.					
				To ensure ongoing compliar			
		v was conducted on 08/21/19		Director of Nursing/Designe			
		Audiologist Office Manager		random audits on resident's			
				-	y for twelve		
		-			····		
					wed thru with		
				as recommended.			
		-			vill bo		
	(AOM). The AOM co seen on 04/23/19 but to complete the heari earwax buildup in bot added Resident #15 with orders for earwa reschedule the hearing	the Audiologist was unable ing examination due to th of her ears. The AOM was sent back to the facility ax removal and instructions to ng examination once the d. The AOM verified until the		with outside providers week (12) weeks to ensure the recommendations were follo as recommended. The results of these audits were reported at the monthly QAF until such time substantial c	y for twelve wed thru with vill be 1 meeting		

Facility ID: 922985

If continuation sheet Page 7 of 21

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	A. BUILDING		`´co∧	PLETED
		0.15040	B. WING		С	
	ROVIDER OR SUPPLIER	345312	STREET ADDRESS, CITY, STATE, ZIP C		08	/22/2019
NAME OF P	RUVIDER OR SUPPLIER			1870 PISGAH DRIVE		
BRIAN CI	R HEALTH & REHAB/HI	ENDERSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 658	F 658 Continued From page 7 earwax was removed from both of Resident #19 ear canals, a hearing evaluation could not be completed.		F 658	been achieved.		
F 712 SS=C	An interview was cor Nursing (DON) on 08 DON explained wher received, the nurse to responsible for enter electronic medical re The DON reviewed to physician order dated and confirmed the ph Resident #15's media entered into the syste staff. The DON was physician's order for her medical chart wit DON stated she wou follow the physician's and reschedule Resi once the order was of Physician Visits-Free CFR(s): 483.30(c)(1) §483.30(c) Frequence §483.30(c)(1) The re physician at least on	ing it into the resident's cord for it to be followed. he consult note and d 04/23/19 for Resident #15 hysician's order was filed in cal chart without being em or completed by facility unsure who received the Resident #15 and filed it into hout being completed. The Id have expected for staff to s order for earwax removal dent #15's hearing exam completed. uency/Timeliness/Alt NPP -(4)	F 712	The Director of Nursing will be responsible for the implementation acceptable plan of correction.	n of the	9/8/19
	date the visit was rec §483.30(c)(3) Except (c)(4) and (f) of this s	later than 10 days after the quired. t as provided in paragraphs section, all required physician by the physician personally.				

Facility ID: 922985

If continuation sheet Page 8 of 21

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI			
		A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345312	B. WING		C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			1870 PISGAH DRIVE		
			HENDERSONVILLE, NC 28791		
		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC	
F 712 Continued From page	8	F 71	2		
alternate between pers and visits by a physicia practitioner or clinical a accordance with parage This REQUIREMENT by: Based on record revise facility failed to ensure alternated with the Phy every 60 days after the for 5 of 26 residents re- restorative, unnecessa and nutrition (Residen #63). The Findings Included 1. Resident #15 was a 05/12/17 with multiple dementia, hypertensio heartbeat), and depres Review of Resident #1 revealed she was seen (PA) on 03/22/19, 05/1 07/25/19 and 08/07/19 she was seen by the F acute (sudden onset of There was no other do she was seen by the p prior to 08/06/19.	s, after the initial visit, may sonal visits by the physician an assistant, nurse nurse specialist in graph (e) of this section. is not met as evidenced ew and staff interviews, the Physician visits were ysician Assistant visits e first 90 days of admission eviewed for rehab and ary medications, accidents, ts #15, #29, #51, #61, and : admitted to the facility on diagnoses that included n, atrial fibrillation (irregular ssion. 15's medical record n by the Physician Assistant 13/19, 06/05/19, 06/24/19, b. Further review revealed Physician on 08/06/19 for an or of short duration) visit. boumentation that indicated ohysician after 03/22/19 or		 How will corrective action be accomplished for those residents hat the potential to be affected by the depractice: Resident #61 was seen by the phys Dr. Holl on 8/22/19. Resident #61 hadverse outcome. Resident #63 was seen by the phys Dr. Holl on 8/22/19. Resident #63 hadverse outcome. Resident #51 was seen by the phys Dr. Holl on 8/27/19. Resident #51 hadverse outcome. Resident #29 was seen by the phys Dr. Holl on 9/77/19. Resident #29 had adverse outcome. Resident #15 was seen by the phys Dr. Holl on 9/7/19. Resident #29 had adverse outcome. Resident #15 was seen by the phys Dr. Holl on 9/7/19. Resident #15 had adverse outcome. Resident #15 was seen by the phys Dr. Holl on 8/6/19. Resident #15 had adverse outcome. Resident #15 was seen by the phys Dr. Holl on 8/6/19. Resident #15 had adverse outcome. Resident #15 was seen by the phys Dr. Holl on 8/6/19. Resident #15 had adverse outcome. Resident #15 was seen by the phys Dr. Holl on 8/6/19. Resident #15 had adverse outcome. An audit was conducted by the Head Information Manager and DON on 8 of current resident's physician visits 	eficient sician ad no sician ad no sician ad no sician d no sician d no sician d no	

Facility ID: 922985

If continuation sheet Page 9 of 21

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTR	UCTION	OMB NO (X3) DATE	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B		COM	PLETED
						С	
		345312	B. WING			08	/22/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
	R HEALTH & REHAB/HE			1870 PISG	AH DRIVE		
				HENDER	SONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 712	Continued From page	e 9	F 7'	2			
	_	ian progress notes for			liance of having been seen by t	he	
	Resident #15 and co	nfirmed routine physician		physic			
		5 were not alternated with					
		as required. The DON			measures will be put into place		
	stated the medical re	ding the physician with a list		-	matic changes made to ensure ent practice does not recur:	the	
		ded to be seen for routine		uenci	ent practice does not recur.		
		plained the facility had been		Dr. H	oll was educated on frequency of	of	
		ical records person since			cian visits on 8/23/19 by LNHA		
	November 2018 and	the physician was not			ring that residents are seen by the	he	
		o needed to be seen for a			cians as per regulations. The		
	routine visit.				ng Administrative Team to includ		
	An interview was con	ducted with the			ssistant Director of Nursing and Manger were educated on 8/23/		
		22/19 at 9:49 AM. The			NHA on frequency of physician		
		the physician was required			DON will track physician visits of		
		in 30 days of admission and			ents to ensure continued compli		
		fter. She verified Resident		with fi	requency of physician's visits.		
		physician on 08/06/19 but					
		any additional progress			the corrective actions will be		
		physician's visits were			tored to ensure the practice will	not	
		A visits as required. The the medical records person			, i.e. what ty assurance program will be pu	it into	
		providing the physician with a		place			
		needed to be seen for		Procession of the second secon			
		led the facility had been			sure ongoing compliance, the		
	•	lical records person since			tor of Nursing/Designee will con	duct	
		Administrator stated a system			ly audit on residents required		
	failure was identified				cian visits weekly for twelve (12		
		ing provided with a list of d to be seen for routine			s to ensure the residents receive cian's visits to maintain regulato		
		er the system failure was			liance.	n y	
		developed a method in the					
		cord that would keep track of		The re	esults of these audits will be		
	when physician visits	were due so the physician			ted at the monthly QAPI meeting	-	
	could be notified.				such time substantial compliance achieved.	e has	
	A telephone interview	v was conducted with the		Deen			
		9 at 9:54 AM. The Physician			Director of Nursing will be		

Facility ID: 922985

If continuation sheet Page 10 of 21

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED	
		245242	B. WING _		С	
	ROVIDER OR SUPPLIER	345312	B. WING	STREET ADDRESS, CITY, STATE, ZI	08/22/201	19
	NOVIDEN ON SUIT LIEN			CODE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 2879	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMP TO THE APPROPRIATE DA	X5) PLETIOI ATE
F 712	Continued From page	e 10	F 7	712		
	explained he was req 120 days for a routine the medical records p him when the visits w seeing residents for a were listed in the phy book but had not had residents who were d visit. He indicated he tracking residents in t to be seen by him for Physician verified the 08/21/19 that he had as required and the fa place on 08/21/19 to resident visits were d An interview was con Information Coordina 11:44 AM. The HIC s employment with the not informed at that ti tracking the frequenc HIC confirmed she w she would need to ke required a routine vis provide the physician needing to be seen. 2. Resident #29 was 04/21/10 with multiple	uired to see residents every e visit and stated he relied on person in the facility to inform vere due. He stated he was acute concerns because they riscian's communication I not been receiving a list of lue to be seen for a routine e would do a better job of the facility who were required routine visits. The e facility notified him on not been seeing residents acility had put a system in notify him when required ue.		responsible for the imple acceptable plan of corre		
		cent physician's progress I/18. There was no other medical record that				

Facility ID: 922985

If continuation sheet Page 11 of 21

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	、 <i>,</i>		COMPLETED
				С	
		345312	B. WING		08/22/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLET E APPROPRIATE DATE
F 712	Continued From page	e 11	F 71	2	
		view revealed she was seen			
		istant (PA) on 01/31/19,			
	03/22/19, 06/06/19, 0 08/05/19, and 08/21/)6/07/19, 06/21/19, 07/25/19, 19.			
	An interview was son	ducted with the Director of			
		3/21/19 at 9:31 AM. The			
	DON verified Resider				
		8. She was unable to locate			
		ian progress notes for nfirmed routine physician			
		9 were not alternated with			
		as required. The DON			
	stated the medical re	-			
		ding the physician with a list ded to be seen for routine			
		blained the facility had been			
	•	ical records person since			
		the physician was not			
	notified Resident #29 routine visit.	needed to be seen for a			
	An interview was con	iducted with the 22/19 at 9:49 AM. The			
		the physician was required			
		in 30 days of admission and			
		fter. She verified Resident			
		the physician on 10/11/18 ate any additional progress			
		physician's visits were			
		A visits as required. The			
		the medical records person			
		providing the physician with a needed to be seen for			
		led the facility had been			
	without a steady med	lical records person since			
	failure was identified	Administrator stated a system			

Facility ID: 922985

If continuation sheet Page 12 of 21

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-03 E SURVEY	
ND PLAN OF	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		CON	COMPLETED	
			D. MINO			С	
		345312	B. WING			8/22/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE			
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 712	Continued From page	o 10	F 74				
F / 12	Continued From page		F 712	2			
		d to be seen for routine					
		ter the system failure was developed a method in the					
	electronic medical record that would keep track of when physician visits were due so the physician						
	could be notified.						
		v was conducted with the					
	-	9 at 9:54 AM. The Physician					
	-	uired to see residents every					
		e visit and stated he relied on person in the facility to inform					
		vere due. He stated he was					
		acute concerns because they					
	-	/sician's communication					
	book but had not had	I not been receiving a list of					
		due to be seen for a routine					
		e would do a better job of					
	to be seen by him for	the facility who were required					
	•	e facility notified him on					
	-	not been seeing residents					
		acility had put a system in					
		notify him when required					
	resident visits were d	lue.					
		nducted with the Health					
		ator (HIC) on 08/22/19 at					
	11:44 AM. The HIC s						
		facility on 08/08/19 but was ime she was responsible for					
		cy of physician visits. The					
		vas informed on 08/21/19 that					
		eep track of residents who					
		it from the physician and					
		n with a list of residents					
	needing to be seen.						

Facility ID: 922985

If continuation sheet Page 13 of 21

		MEDICAID SERVICES				<u>10. 0938-03</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · ·	(X3) DATE SURVEY COMPLETED	
	345312 NAME OF PROVIDER OR SUPPLIER		The Bolebill		с		
			B. WING		0	8/22/2019	
NAME OF P			•	STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE HENDERSONVILLE, NC 28791			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	PRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO DATE	
F 712	Continued From page	e 13	F 71	12			
		e diagnoses that included					
	Alzheimer's disease, diabetes, hypertension, atrial fibrillation, and depression.						
	Review of Resident #						
		cent physician's progress 9/19. There was no other					
	documentation in the						
		en by a physician after					
		view revealed she was seen					
		istant (PA) on 06/17/19,)7/26/19, and 08/12/19.					
	Nursing (DON) on 08	ducted with the Director of /21/19 at 9:31 AM. The					
	DON verified Resider						
		9. She was unable to locate ian progress notes for					
		nfirmed routine physician					
		1 were not alternated with					
	the PA every 60 days stated the medical re	as required. The DON					
		ding the physician with a list					
	of residents who nee	ded to be seen for routine					
		plained the facility had been ical records person since					
		the physician was not					
		needed to be seen for a					
	routine visit.						
	An interview was con						
		22/19 at 9:49 AM. The the physician was required					
		n 30 days of admission and					
	every 60 days therea	fter. She verified Resident					
		the physician on 04/09/19					
		ate any additional progress physician's visits were					
		A visits as required. The					

Facility ID: 922985

If continuation sheet Page 14 of 21

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 09/17/20 FORM APPROVE OMB NO. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312		B. WING		C 08/22/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE	
				HENDERSONVILLE, NC 28791	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 712	Continued From page	e 14	F 71	2	
	Administrator stated	the medical records person			
		providing the physician with a			
		needed to be seen for led the facility had been			
		dical records person since			
	October 2018. The Administrator stated a system				
	failure was identified				
		ing provided with a list of d to be seen for routine			
		er the system failure was			
		developed a method in the			
		cord that would keep track of			
	when physician visits could be notified.	s were due so the physician			
		v was conducted with the			
	-	9 at 9:54 AM. The Physician			
		quired to see residents every e visit and stated he relied on			
	-	person in the facility to inform			
	him when the visits w	vere due. He stated he was			
	•	acute concerns because they			
		vsician's communication I not been receiving a list of			
		due to be seen for a routine			
		e would do a better job of			
	-	the facility who were required			
	to be seen by him for				
	-	e facility notified him on not been seeing residents			
		acility had put a system in			
	place on 08/21/19 to	notify him when required			
	resident visits were d	lue.			
		nducted with the Health			
		tor (HIC) on 08/22/19 at			
	11:44 AM. The HIC s	stated she began facility on 08/08/19 but was			
		ime she was responsible for			

Facility ID: 922985

If continuation sheet Page 15 of 21

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	O. 0938-039 E SURVEY PLETED
				NG		С
		345312	B. WING	STREET ADDRESS, CITY, STATE, ZIP COL		/22/2019
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				1870 PISGAH DRIVE HENDERSONVILLE, NC 28791	JE	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE APPROPRIATE	(X5) COMPLETIOI DATE
F 712	HIC confirmed she w she would need to ke required a routine vis provide the physician needing to be seen. 4. Resident #63 was 10/17/14 with multiple Parkinson's disease, Review of Resident # revealed the most rea note was dated 03/11 documentation in the indicated she was se 03/11/19. Further rev by the Physician Assi 06/05/19 and 08/12/1 An interview was con Nursing (DON) on 08 DON verified Residen physician on 03/11/19 any additional physic Resident #63 and con visits for Resident #6 the PA every 60 days stated the medical re responsible for provid of residents who nee visits. The DON exp without a stable medi November 2018 and	ey of physician visits. The ras informed on 08/21/19 that eep track of residents who sit from the physician and a with a list of residents a admitted to the facility on e diagnoses that included dementia and depression. 463's medical record cent physician's progress 1/19. There was no other e medical record that een by a physician after view revealed she was seen istant (PA) on 05/13/19, 19. aducted with the Director of 8/21/19 at 9:31 AM. The nt #63 was seen by a 9. She was unable to locate istan progress notes for nfirmed routine physician 3 were not alternated with as a required. The DON	F 7	712		
	notified Resident #63 routine visit. An interview was con	B needed to be seen for a needed to be seen for a needed with the 22/19 at 9:49 AM. The	P11	Equility 10: 022025	lf og skanstige och	et Dana 4

Facility ID: 922985

If continuation sheet Page 16 of 21

			0.00			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
			A. BOILDING	J		С
		345312	B. WING		01	B/22/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				1870 PISGAH DRIVE		
BRIAN CT	R HEALTH & REHAB/HI	ENDERSONVILLE		HENDERSONVILLE, NC 28791		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION DATE
F 712	Continued From page	e 16	F 71	12		
	-	the physician was required		-		
		in 30 days of admission and				
	every 60 days therea	fter. She verified Resident				
		the physician on 03/11/19				
		cate any additional progress				
		physician's visits were				
		A visits as required. The the medical records person				
		providing the physician with a				
		needed to be seen for				
	routine visits and add	led the facility had been				
	without a steady med	lical records person since				
		Administrator stated a system				
		on 08/21/19 where the				
		ing provided with a list of				
		d to be seen for routine ter the system failure was				
		developed a method in the				
		cord that would keep track of				
		s were due so the physician				
	could be notified.					
	A telephone interview	v was conducted with the				
	-	9 at 9:54 AM. The Physician				
	-	quired to see residents every				
		e visit and stated he relied on				
	-	person in the facility to inform				
		vere due. He stated he was				
		acute concerns because they				
		sician's communication				
		I not been receiving a list of due to be seen for a routine				
		e would do a better job of				
		the facility who were required				
	to be seen by him for					
	Physician verified the	e facility notified him on				
		not been seeing residents				
	as required and the f	acility had put a system in				
		notify him when required				

Facility ID: 922985

If continuation sheet Page 17 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING				C 22/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE			370 PISGAH DRIVE ENDERSONVILLE, NC 28791		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 712	resident visits were di An interview was con Information Coordinat 11:44 AM. The HIC s employment in the fac not informed at that ti tracking the frequency HIC confirmed she was she would need to ke required a routine visi provide the physician needing to be seen. 5. Resident #61 was 06/09/18. A quarterly Minimum assessment dated 07 #61 was cognitively in included dementia, Pa diabetes mellitus. He assistance with bed n and personal hygiene assistance with dress A review of Resident revealed a physician's 03/15/19 and was sig was no other docume record that indicated seen by the physician Resident #61 was see Assistant on 03/20/19	ue. ducted with the Health tor (HIC) on 08/22/19 at stated she began cility on 08/08/19 but was me she was responsible for y of physician visits. The as informed on 08/21/19 that eep track of residents who it from the physician and with a list of residents admitted to the facility on Data Set (MDS) 7/24/19 indicated Resident mpaired and diagnoses arkinson's disease, and required extensive nobility, transfers, toileting, e and required limited sing. #61's medical record s progress note dated and by the physician. There entation in the medical Resident #61 had been h. en by the Physician 0, 05/30/19, 07/19/19, and	F	712			
	On 08/22/19 at 9:31 A conducted with the D	AM an interview was irector of Nursing (DON)					

Facility ID: 922985

If continuation sheet Page 18 of 21

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		IO. 0938-03 E SURVEY
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:					IPLETED
						С
		345312	B. WING		0	8/22/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE		1870 PISGAH DRIVE		
				HENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 712	Continued From page	e 18	F 71	2		
		ent #61 was seen by the		-		
		9 and had not been seen by				
		onths (over 120 days). The				
		physician had missed				
	•	for the required routine visit.				
		medical records person was				
		ting a list of residents who seen for routine visits to the				
		shared that the facility had				
		e medical records person				
		8 and the physician had not				
	been notified that Res	sident #61 had been				
		or routine visit and was				
		ated that she believed the				
		n to see Resident #61 was having a stable medical				
		vould generate a list of				
	-	equired to be seen by the				
	physician for routine					
	On 08/22/19 at 9:49 /	AM an interview was				
		dministrator who verified the				
		en Resident #61 since				
	03/15/19 (over 120 d	ays). The Administrator				
		was required to see the				
		ys of admission and every 60				
	-	administrator stated the				
		out a steady medical records r 2018. The Administrator				
	stated the medical re					
		ating a list of residents who				
	were required to be s	een by the physician for				
		days of admission and				
		fter. The Administrator				
		system failure had been				
		dical records person had not dents who were required to				
	be seen for routine vi	-				
		sit to the physician The				

Facility ID: 922985

If continuation sheet Page 19 of 21

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED	
			A. DOILDING		С		
		345312	B. WING	08	3/22/2019		
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI			
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				1870 PISGAH DRIVE			
				HENDERSONVILLE, NC 28791			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 712	Continued From pag	e 19	F 712				
		developed a method in the					
	,	cord where the residents that					
		sit would be tracked and the					
	physician would be notified.						
	On 08/22/10 at 0.54	AM a telephone interview					
		the physician who stated he					
		nt #61 since 03/15/19. He					
	stated he relied on th	ne medical records person at					
	-	nim of residents who were					
	•	or routine visits. He stated					
		eiving a list from medical					
		be seen for routine visit.					
	-	ted he had not been doing a					
		ping track of residents in the					
	-	uired to be seen for routine					
		shared that he was required					
		or a routine visit every 120 stated he was seeing					
		oncerns because they were					
		n's communication book. The					
		hat he would do a better job					
	-	in the facility who were					
		by him for routine visit. The					
		facility notified him on not been seeing residents for					
		visits. The physician shared					
		ut in place on 08/21/19 a					
		of residents who were					
	required to be seen b	by him for a routine visit.					
	On 08/22/19 at 11:44	AM an interview was					
	conducted with the ⊢						
	Coordinator (HIC) wh	no stated she began					
		cility on 08/08/19. She					
	shared that she was	cility on 08/08/19. She not informed on hire that she rovide a list of residents who					

Facility ID: 922985

If continuation sheet Page 20 of 21

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 09/17/2019 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345312	B. WING				C 8/22/2019
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/HE	ENDERSONVILLE			870 PISGAH DRIVE IENDERSONVILLE, NC 28791		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 712	stated she was inform would need to track re	ned on 08/21/19 that she esidents who required a physician and provide a list	F	712			

Event ID: D4LP11

Facility ID: 922985

If continuation sheet Page 21 of 21