DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION		SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COM	PLETED
							С
		345270	B. WING			03/	/05/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT		
					SPRUCE PINE, NC 28777		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE
1/10		,			DEFICIENCY)		
E 039	EP Testing Requirem	ents	F	03	39		4/2/20
SS=F	CFR(s): 483.73(d)(2)		_				.,_,_0
001							
	*[For RNCHI at §403.	748, ASCs at §416.54,					
		ORFs at §485.68, OPO,					
		r §485.727, CMHC at					
	§485.920, RHC/FQH	-					
	Facilities at §494.62]:						
	(2) Testing The Ifesili						
		ity] must conduct exercises / plan annually. The [facility]					
	must do all of the follo						
		a full-scale exercise that is					
	community-based eve						
	-	community-based exercise is					
		ict a facility-based functional					
	exercise every 2	years; or					
		cility] experiences an actual					
		emergency that requires					
	activation of the emer						
		jing in its next required					
	-	individual, facility-based kercise following the onset of					
	the actual event.	cercise following the onset of					
		dditional exercise at least					
		ite the year the full-scale or					
	functional exercise ur						
	this section is conduc	ted, that may include, but is					
	not limited to the follo	wing:					
		d full-scale exercise that is					
		individual, facility-based					
	functional exercise; o						
		disaster drill; or					
	is led by a facilitator a	op exercise or workshop that					
	discussion using a na	•					
		t emergency scenario, and a					
	-	nents, directed messages, or					
	prepared questions	designed to challenge an					
	emergency plan.	5 5					
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed

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

03/27/2020

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
	OUNCEDHON	IDENTIFICATION NOMBER.	A. BUILDI	NG			C
		345270	B. WING				05/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT		
					SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (iii) Analyze maintain documentati exercises, and emerg revise the [facility's] e *[For Hospices at 418 (2) Testing for hospic patient's home. The fexercises to test the e annually. The hospic (i) Participate in community based ever (A) When a e not accessible, condu based functional exer (B) If the hose or man-made emerge of the emergency plate exempt from engaging scale community-based facility- based fut the onset of the emerge (ii) Conduct an a years, opposite the years, opposite the years functional exercise und this section is conduct not limited to the follor (A) A second community-based or a exercise; or (B) A mock (C) A tableto is led by a facilitator and discussion using a nanclinically-relevant 	the [facility's] response to and on of all drills, tabletop ency events, and mergency plan, as needed. a.113(d):] es that provide care in the nospice must conduct emergency plan at least e must do the following: a full-scale exercise that is ery 2 years; or community based exercise is ict an individual facility cise every 2 years; or spice experiences a natural ency that requires activation n, the hospital is g in its next required full ed exercise or individual unctional exercise following gency event. idditional exercise every 2 ear the full-scale or ider paragraph (d) (2)(i) of ted, that may include, but is wing: d full-scale exercise that is a facility based functional disaster drill; or op exercise or workshop that ind includes a group	E	03	9		

Facility ID: 952989

If continuation sheet Page 2 of 46

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345270	B. WING				C 05/2020
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page		E	03	9		
	care directly. The hose exercises to test the exercises to test the exercise in that is community-base (A) When a exercise (A) When a exercise, conduction (B) If the hose or man-made emergers of the emergency plane exempt from engaging full-scale community of functional of the emergency ever (ii) Conduct an a that may include, but following: (A) A secon community-based or a exercise; or (B) A mock (C) A tablete by a facilitator that ind using a narrated, emergency scenario, statements, directed of questions dese emergency plan. (iii) Analyze the	mergency plan twice per ust do the following: an annual full-scale exercise sed; or community-based exercise is act an annual individual al exercise; or spice experiences a natural ency that requires activation in, the hospice is g in its next required based or facility-based exercise following the onset ent. additional annual exercise is not limited to the d full-scale exercise that is a facility based functional disaster drill; or op exercise or workshop led cludes a group discussion clinically-relevant and a set of problem messages, or prepared signed to challenge an hospice's response to and on of all drills, tabletop					
	*[For PRFTs at §441. §482.15(d), CAHs at	ncy plan, as needed. 184(d), Hospitals at					

Facility ID: 952989

If continuation sheet Page 3 of 46

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345270	B. WING				05/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	 (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in that is community-based in that is community-based function (A) When a most accessible, conduct facility-based function (B) If the [PF experiences an actual emergency plan, the engaging in its next rebased or functional exercise for emergency event. (ii) Conduct an [a and that may include, following: (A) A second (C) A tableto is led by a facilitator a discussion, using a na clinically-relevant set of problem statem prepared questions emergency plan. (iii) Analyze the [maintain documentati exercises, and emergency exert. 	F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must an annual full-scale exercise sed; or community-based exercise is act an annual individual, hal exercise; or RTF, Hospital, CAH] I natural or man-made res activation of the facility] is exempt from equired full-scale community individual, facility-based llowing the onset of the additional] annual exercise or but is not limited to the d full-scale exercise that is individual, a facility-based r disaster drill; or op exercise or workshop that and includes a group arrated, t emergency scenario, and a hents, directed messages, or designed to challenge an facility's] response to and on of all drills, tabletop lency events and revise ncy plan, as needed.	E	039			

Facility ID: 952989

If continuation sheet Page 4 of 46

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	3		LETED
		345270	B. WING				C 05/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHAB/SP	BUC			218 LAUREL CREEK COURT		
DRIAN CI	K NEALIN & KENAD/SP	RUC			SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	including unannounce emergency procedure ICF/IID] must do the f (i) Participate in that is community-base (A) When a c not accessible, condu- facility-based function (B) If the [LT an actual natural or m requires activation of the LTC facility is exer required a full-scale c individual, facility following the onset of (ii) Conduct an a that may include, but following: (A) A secon community-based or a functional exercise; of (B) A mock (C) A tableto is led by a facilitator in using a narrated, emergency scenario, statements, directed r questions des emergency plan. (iii) Analyze the response to and main drills, tabletop exercise events, and revise the emergency plan, as n	an at least twice per year, ed staff drills using the es. The [LTC facility, following: an annual full-scale exercise sed; or community-based exercise is tot an annual individual, al exercise. C facility] facility experiences nan-made emergency that the emergency plan, mpt from engaging its next ommunity-based or -based functional exercise the emergency event. additional annual exercise is not limited to the d full-scale exercise that is an individual, facility based r disaster drill; or op exercise or workshop that ncludes a group discussion, clinically-relevant and a set of problem messages, or prepared signed to challenge an [LTC facility] facility's tain documentation of all ses, and emergency e [LTC facility] facility's eeded.	E	03			
	(2) Testing. The ICF/I	ID must conduct exercises					

Facility ID: 952989

If continuation sheet Page 5 of 46

TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CON	NSTRUCTION	(X3) DAT	O. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		CON		
		345270	B. WING			03	C 3/05/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SP	RUC			AUREL CREEK COURT JCE PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
E 039	Continued From page		E	039				
	The ICF/IID must do (i) Participate in a that is community-bas (A) When a not accessible, condu- facility-based function (B) If the ICI natural or man-made activation of the emer is exempt from engag full-scale community- based functional of the emergency ever (ii) Conduct an a	an annual full-scale exercise sed; or community-based exercise is act an annual individual, nal exercise; or. F/IID experiences an actual emergency that requires rgency plan, the ICF/IID jing in its next required based or individual, facility- exercise following the onset ent. dditional annual exercise that						
	(A) A second community-based or functional exercise; o (B) A mock o (C) A tableto is led by a facilitator a discussion, using a n	disaster drill; or op exercise or workshop that and includes a group arrated,						
	set of problem statem prepared questions emergency plan. (iii) Analyze the I	-						
	to test the emergency following: (i) Conduct a par	360] PO must conduct exercises / plan. The OPO must do the per-based, tabletop exercise annually. A tabletop exercise						

Facility ID: 952989

If continuation sheet Page 6 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/02/2020 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345270	B. WING				C / 05/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHAB/SP			2	18 LAUREL CREEK COURT		
DIVIAN				s	SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	emergency scenario, statements, dire questions designed to plan. If the OPO exper- or man-made emerge of the emergency plan engaging in its next following the onset of (ii) Analyze the O maintain documentatia and emergency event and OPO's] emergency This REQUIREMENT by: Based on record revi- facility failed to test the Preparedness (EP) pl participating in a full-se exercise or by conduct facility-based function failure to test their EP affect all residents an Findings included: The facility's EP man 03/05/20. The review information available their EP plan by partic community-based exe individual facility-based	and includes a group arrated, clinically relevant and a set of problem ected messages, or prepared o challenge an emergency eriences an actual natural ency that requires activation in, the OPO is exempt from required testing exercise the emergency event. OPO's response to and ion of all tabletop exercises, its, and revise the [RNHCI's cy plan, as needed. The met as evidenced was and staff interview, the heir Emergency lan in 2019 by either scale, community-based cting an individual nal exercise. The facility's plan had the potential to d staff.	E	039	The facility experienced an actual, non-manmade emergency that require activation of our emergency plan and conducted individual –based functional exercises following the onset of the emergency event in 2019. Prior to sur facility posted an all staff in-service regarding disaster preparedness for 3-10-20 and had previously scheduled and posted notice of a community base table top exercise being conducted at facility on 3-11-20. On 3-10-20 Facility Administrator proveducation to all staff regarding disaste preparedness. Facility prescheduled community base exercise was conducted	has al vey, d sed vided er cted	
	Administrator reveale participate in a comm	0 at 11:03 AM with the d the facility did not unity-based full-scale 19) to test their EP plan and			on 3-11-20 as scheduled. On 3-12-20 facility activated our emergency plan to the actual, non-manmade emergen pandemic COVID-19. Facility administrator is scheduled to	due	

Facility ID: 952989

If continuation sheet Page 7 of 46

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345270	B. WING		C 03/05/2		
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2020	
			218 LAUREL CREEK COURT				
	R HEALTH & REHAB/SI			SPRUCE PINE, NC 28777			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
E 039	September 2018. The tried repeatedly in 20 participation in a full- exercise but was told person that the full-septimized to be done of Administrator stated plan on 10/23/19 who	e 7 in one of these exercises in he Administrator stated she 019 to schedule the facility's scale community-based I by their local EP resource cale exercise was only every other year. The the facility did test their EP en they conducted a tabletop ded group discussion and	E 03	attend Mitchell County Emergen Services Meeting May 12, 2020. Administrator has requested to p in future community based exerc conducted by Mitchell County Er Services and through The Mount Healthcare Preparedness Coaliti Facility will monitor its performan ensure emergency preparedness tested monthly for 4 months ther for 3 quarters with the first month being conducted on or before Ma 2020. The Administrator will rev results of the audits and those fit be reported at the monthly QAPI for 3 months. Then quarterly for quarters until substantial complia been achieved and the committe recommends quarterly oversight District Director of Operations or to maintain continued complianc The Administrator will be respon- the implementation of the accept of correction.	participate cises mergency tain Area ion. tee to s plan is n quarterly hly audit arch 31, iew the ndings will meeting 3 ance has be to by the designee e. sible for table plan		
F 000	INITIAL COMMENTS	3	F 00	Date when corrective action will completed: 4/2/20	De		
F 561 SS=D	survey was conducte There were 8 allegat	complaint investigation ed on 3/2/20 through 3/5/20. ions investigated and they ated. Event ID# OKC111. -(3)(8)	F 56	1	4,	2/20	

Event ID: OKC111

Facility ID: 952989

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
							C
		345270	B. WING			03/	05/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT		
				5	SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	e 8	F	561			
	The resident has the	right to and the facility must					
	promote and facilitate	e resident self-determination					
		sident choice, including but					
	not limited to the right (1) through (11) of this	ts specified in paragraphs (f) s section.					
	C 400 40(f)(4) The survey						
		ident has a right to choose (including sleeping and					
		care and providers of health					
		ent with his or her interests,					
	assessments, and pla	an of care and other					
	applicable provisions	of this part.					
	\$483 10(f)(2) The res	ident has a right to make					
		s of his or her life in the					
	facility that are signific						
	§483.10(f)(3) The res	ident has a right to interact					
		community and participate in					
	•	both inside and outside the					
	facility.						
	§483.10(f)(8) The res	ident has a right to					
	U ()()	ctivities, including social,					
	religious, and commu	inity activities that do not					
	-	ts of other residents in the					
	facility.						
		is not met as evidenced					
	by: Based on record revi	iew, resident and staff			On 3/5/20 the Director of Nursing		
		r failed to provide scheduled			validated that resident #3 and resident		
		sidents (Resident #3 and			#44 did not receive their showers on		
		ed for activities of daily			2/15/20, 2/22/20 and 2/29/20. Resider	nt	
	living.				#3 and resident #44 were both offered		
	The Constant of the test				shower later that same week to make	•	
	The findings included	:			for the missed showers, but declined. was also verified that both residents	IT	
	1 Resident #3 was a	dmitted to the facility on			received a shower on 3/4/20. A 100%		
		es that included hereditary			audit was completed on showers by th		

Event ID: OKC111

Facility ID: 952989

If continuation sheet Page 9 of 46

		MEDICAID SERVICES				<u> </u>	NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	N /	TE SURVEY MPLETED
			A. BUILDING	<u> </u>			С
		345270	B. WING	B. WING			3/05/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/00/2020	
			218 LAUREL CREEK COURT				
BRIAN CT	R HEALTH & REHAB/SP	RUC		SP	PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 561	Continued From page	<u> </u>	F 56	31			
1 001		europathy, muscle weakness	F 30		DON and no other issues were found.		
	and contractures to b				Bort and no other issues were found.		
					On 3/25/20 all nurses and CNAs were		
	The quarterly Minimu	m Data Set (MDS)			educated on completing showers on th	eir	
	assessment dated 2/	5/20 indicated Resident #3			assigned halls. Education included		
		was totally dependent on			instructing CNAs to notify the nurse on		
		assist for bathing and had			their hall that they were unable to		
	impairment to both up	oper extremities.			complete their showers. The nurse on		
	Decident #2's Treatm	ent Administration Record			hall will report this to the RN Superviso		
		020 was not initialed for			on Duty, the Assistant Director of Nursi or the Director of Nursing. The CNA or	-	
		te he received a shower on			the hall will be able to stay over after hi		
	2/15/20, 2/22/20 and				or her shift to complete the resident's	10	
	2, 10,20, 2,22,20 and	2,20,20			shower or other accommodations will b	e	
	On 3/4/20 at 2:40 PM	, an interview with Resident			made that are agreeable with the resid	ent.	
	#3 revealed he had n	ot received his scheduled			C C		
	showers for the past	3 Saturdays. Resident #3			The DON/designee will review random		
	stated he was schedu	led to receive a shower on			shower audits to ensure no showers ar	e	
	Wednesdays and Sat				missed. The audit will consist of five		
		a week on Wednesday for			random residents five times a week for		
	· ·	esident #3 further stated the			four weeks, three random residents five	Э	
		aide (NA) assigned to his			times a week for four weeks and two		
		for the past 3 weeks. He ked this past weekend			random residents five times a week for		
		her shift ended on 3/1/20 in			four weeks starting on 3/23/20.		
		nower since he had not			The DON will review the results of the		
		3 consecutive Saturdays.			random audits and those findings will b	e	
		lid offer to make up his other			reported at the monthly QAPI meeting		
		wers on Tuesdays, but he			three months. Then quarterly for three		
	-	showers on back-to-back			quarters until substantial compliance ha		
	days.				been achieved and the committee		
					recommends quarterly oversight by the	;	
		, a phone interview with NA			District Director of Clinical Services or		
		ed with Resident #3 on			designee to maintain continued		
		during the day shift and did			compliance.		
	-	him his scheduled shower. Id not leave the hall for 45			The DON will be responsible for the		
		esident a shower. NA #5			The DON will be responsible for the implementation of the acceptable plan	of	
		work on 300 hall by herself			correction.	01	

Facility ID: 952989

STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE	<u>). 0938-039</u> E SURVEY PLETED	
	CONTRECTION	IDENTIFICATION NOWIDER.	A. BUILDING			C	
		345270	B. WING			/05/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CI	R HEALTH & REHAB/SP	PRUC		218 LAUREL CREEK COURT SPRUCE PINE, NC 28777			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 561	Continued From pag	e 10	F 56 ⁻	1			
	on 2/15/20 and 2/29/ take care of. NA #5 3/1/20 past the time Resident #3 his sche not received one for further stated the fac for at least a month.	20, and had 26 residents to shared she stayed over on her shift ended to give iduled shower since he had the past 3 Saturdays. NA #5 ility had been understaffed		Date when corrective action wil completed: 4/2/20	l be		
	revealed she worked and worked on 2/15/2 Nurse #3 stated she #3 had missed his so dates (2/15/20, 2/22/ stated Nurse #1 shou could have made up shower on the next d they usually had 1 N the weekends but did	A, an interview with Nurse #3 as the weekend supervisor 20, 2/22/20 and 2/29/20. was unaware that Resident cheduled showers on those 20 and 2/29/20). Nurse #3 uld have notified her so they Resident #3's scheduled lay. Nurse #3 further stated A per hall and a floater NA on a not know that showers not having enough staff.					
	with NA #5 on 2/29/2 worked as the only N Nurse #1 also worke that Resident #3 did shower on 2/22/20 at there was another N/ halls and helped with care, but this NA did showers. Nurse #1 of had notified the week Resident #3 had miss on the past 3 Saturda	e #1 revealed she worked 0 and verified that NA #5 IA on the 300 hall on 2/29/20. d on 2/22/20 and confirmed not get his scheduled nd 2/29/20. Nurse #1 stated A who floated among the meals and incontinence not have time to do resident could not remember if she					

If continuation sheet Page 11 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2020 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345270	B. WING				C 05/2020
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	IR HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	with NA #7 revealed s on 2/15/20 and 2/29/2 and was unaware tha received his schedule NA #7 stated she did shower because she receive them during the Resident #3 never reference showers. On 3/5/20 at 9:23 AM #4 revealed she work and was assigned to stated she had to hell 400 hall as the floater had helped NA #5 on care, passing meal the charting. NA #4 states resident showers with have enough time. N worked on Saturdays have 2 NAs per hall b weeks, they have had hall and a floater NA. On 3/5/20 at 9:30 AM with NA #6 revealed s on 2/22/20 on day shi scheduled shower on worked on 300 hall by time to do all the show the day. NA #6 shares Resident #3 a make-to had been in activities have the opportunity for Director of Nursing (E	she worked with Resident #3 20 during the evening shift t Resident #3 had not ed shower for those days. not give Resident #3 his did not know he did not he day shift. NA #7 shared fused his scheduled , a phone interview with NA ed on 2/15/20 and 2/29/20 be a "floater" NA. NA #4 o on 200 hall, 300 hall and NA. She further stated she 300 hall with incontinence ays, feeding assistance and ed she did not provide any n NA #5 because they did not A #4 shared she only and they were supposed to but during the last 3 to 4 d to work with only 1 NA per , an interview conducted she worked with Resident #3 ift and did not provide his that day. NA #6 stated she y herself and did not have wers that were scheduled for ed she had meant to offer up shower on 2/23/20 but he that day and she did not	F	561			

Facility ID: 952989

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345270	B. WING			C 03/05/2020		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CI	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT SPRUCE PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 561	The DON was unsure offered a make-up sh missed. The DON sta challenges with the st unexpected situations obtain staff to provide On 3/5/20 at 4:40 PM Administrator reveale receive at least 2 sho she was unaware tha his scheduled showed Saturdays, but the ne up or a shower should day if they did not hav done on the day it wa 2. Resident #44 was a 10/5/18 with diagnose intervertebral disc deg weakness. The quarterly Minimu assessment dated 1/3 had intact cognition a from one person in pa Resident #44's Treatr (TAR) for February 20 Resident #44 to indic shower on 2/15/20, 2/ On 3/2/20 at 3:20 PM #44 revealed he was shower on Wednesda not received his Satur past 3 weeks. Reside have enough staff on	 a if Resident #3 had been ower for the showers he ated the facility had taffing due to callouts and so but have been trying to e care for the residents. , an interview with the d all residents should wers a week. She stated t Resident #3 had missed rs during the past 3 xt shift should have made it d have been offered the next ve time to get his shower s scheduled. admitted to the facility on es that included generation and muscle m Data Set (MDS) 3/20 indicated Resident #44 nd required physical help art of bathing activity. ment Administration Record 0/20 was not initialed for ate that he received a 	F	56				

Facility ID: 952989

If continuation sheet Page 13 of 46

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/02/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345270	B. WING				03/	C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SP	RUC			18 LAUREL CREEK COURT PRUCE PINE, NC 28777			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 561	give him his schedule On 3/4/20 at 4:03 PM #5 revealed she work 2/15/20 and 2/29/20 or not have time to give NA #5 stated she cour minutes to give any re had been assigned to on 2/15/20 and 2/29/2 take care of. NA #5 s 3/1/20 past the time h Resident #44 his show the facility had been u month. On 3/4/20 at 4:16 PM revealed she worked and worked on 2/15/2 Nurse #3 was unawat missed his scheduled (2/15/20, 2/22/20 and Nurse #1 should have have made up his sho #3 further stated they and a floater NA on th know that showers we having enough staff. On 3/4/20 at 4:42 PM	d not have enough time to d shower on Saturdays. , a phone interview with NA ed with Resident #44 on during the day shift and did him his scheduled shower. Id not leave the hall for 45 esident a shower. NA #5 work on 300 hall by herself 20, and had 26 residents to shared she stayed over on her shift ended to give wer. NA #5 further stated understaffed for at least a , an interview with Nurse #3 as the weekend supervisor 20, 2/22/20 and 2/29/20. re that Resident #44 had showers on those dates 2/29/20). Nurse #3 stated e notified her so they could ower on the next day. Nurse usually had 1 NA per hall he weekends but did not ere missed due to not	F	561				
	with NA #5 on 2/29/20 worked as the only N/ Nurse #1 also worked that Resident #44 did shower on 2/22/20 an there was another NA	# #1 revealed she worked 0 and verified that NA #5 A on the 300 hall on 2/29/20. I on 2/22/20 and confirmed not get his scheduled of 2/29/20. Nurse #1 stated who floated among the meals and incontinence						

Facility ID: 952989

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2020 MAPPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION			LETED
		345270	B. WING		_		C 05/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BRIAN CI	R HEALTH & REHAB/SP	RUC		218 LAUREL CREEK COUF SPRUCE PINE, NC 2877			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Nurse #1 could not re the weekend supervis missed his showers of On 3/4/20 at 5:34 PM with NA #7 revealed s #44 on 2/15/20 and 2 was unaware that Re his scheduled shower stated she did not giv because she did not f during the day shift. On 3/5/20 at 9:23 AM #4 revealed she work and was assigned to stated she had to hely 400 hall as a floater. helped NA #5 on 300 passing meal trays, fe charting. NA #4 stated resident showers with have enough time. N worked on Saturdays have 2 NAs per hall b weeks, they have had hall and a floater NA. On 3/5/20 at 9:30 AM with NA #6 revealed s #44 on 2/22/20 during provide his scheduled stated she worked on not have time to do al scheduled for the day	have time to do showers. member if she had notified sor that Resident #44 had in the past 3 Saturdays. , an interview conducted she worked with Resident /29/20 on evening shift and sident #44 had not received r for those days. NA #7 e Resident #44 his shower (now he did not get them , a phone interview with NA ed on 2/15/20 and 2/29/20 be a "floater" NA. NA #4 o on 200 hall, 300 hall and She further stated she had hall with incontinence care, eeding assistance and d she did not provide any n NA #5 because they did not A #4 shared she only and they were supposed to but during the last 3 to 4 d to work with only 1 NA per , an interview conducted she worked with Resident g the day shift and did not d shower on that day. NA #6 300 hall by herself and did II the showers that were	F 561				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/02/2020 MAPPROVED D. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345270	B. WING _				C 05/2020
NAME OF PR	OVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC		21	18 LAUREL CREEK COURT		
				S	PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 SS=E	should have received The DON was unsure offered a make-up sho missed. The DON sta challenges with the st unexpected situations obtain staff to provide On 3/5/20 at 4:40 PM. Administrator revealed receive at least 2 show she was unaware that his scheduled shower Saturdays, but the nei- up or a shower should day if they did not hav done on the day it was Accuracy of Assessme CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on observation resident and staff inte accurately code Minin assessments in the ar (Residents #16 and # #16), influenza immur #56, #22, #42 and #33	an interview with the ON) revealed Resident #44 his showers as scheduled. if Resident #44 had been ower for the showers he ted the facility had affing due to callouts and but have been trying to care for the residents. , an interview with the d all residents should wers a week. She stated : Resident #44 had missed s during the past 3 kt shift should have made it have been offered the next re time to get his shower s scheduled. ents of Assessments. t accurately reflect the is not met as evidenced hs, record review and rviews, the facility failed to hum Data Set (MDS) reas of behaviors 17), oxygen use (Resident hization (Residents #50, 3) and prognosis (Resident ed residents reviewed for		561	Resident #16's quarterly MDS dated 2/21/20 will be re- opened to correct accurate coding of oxygen therapy in us This correction will occur on or before 4-1-20. Resident #17's quarterly MDS dated 2/23/20 was currently open and was completed and transmitted with accurate coding of rejection of care. This correct will occur on or before 4-1-20.	te	4/2/20

Event ID: OKC111

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				PRINTED: 04/02/2 FORM APPROV	VED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	1391
	345270	B. WING		C 03/05/2020	
ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD		
			218 LAUREL CREEK COURT		ſ
R HEALTH & REHAB/SP	PRUC		SPRUCE PINE, NC 28777		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLETIN APPROPRIATE DATE	
Continued From page	e 16	F 64	11		
 1. a. Resident #16 was admitted to the facility on 2/5/18 and readmitted on 5/14/19 with diagnosis which included respiratory failure. Resident #16's Treatment Administration Record (TAR) dated February 2020 revealed she refused her continuous positive airway pressure (CPAP) treatments on the following dates: 2/4/20, 2/5/20, 2/6/20, 2/71/20, 2/11/20, 2/17/20, 2/19/20, 2/21/20, 2/25/20, 2/26/20 and 2/27/20. Resident #16's quarterly Minimum Data Set (MDS) assessment dated 2/21/20 coded the resident as being cognitively intact. Resident #16 was coded under behaviors for no rejection of care. An interview was conducted on 3/2/20 at 8:24 AM with Resident #16. She stated she wore a continuous positive CPAP at night, but had been refusing it for the past month because of the mask bothering her. The interview revealed staff had attempted to changer her mask to better fit her face however she fell like it was suffocating her and had continued to refuse the machine. An interview was conducted on 3/3/20 at 4:42 PM with Nurse #4. Nurse #4 stated Resident #16 had refused to wear her CPAP on a nightly basis. She stated a staff member from the CPAP company had came in the week prior to assist in finding a solution to the mask fitting however the resident had continued to refuse the machine. An interview was conducted on 3/03/20 at 4:35 pm with MDS Coordinator #1. During the 			 1/8/20, Resident #56's quarter dated 1/15/20, Resident # 22 MDS dated 12/6/19, Residen annual MDS date 1/2/20, and #33's quarterly MDS dated 12 be modified no later than 4/1/ accurate coding of date resid influenza vaccination. Resident # 88's Significant C dated 12/7/19 was modified t accurate coding of prognosi disease that may result in a lie expectancy of less than 6 modified to accurate 12 dates than 6 modified to accurate 12 dates than 6 modified to accurate 12 dates than 6 modified to accurate coding of less th	erly MDS 's quarterly t #42's I Resident 2/24/19 will '20 to correct ent received hange MDS o correct s or chronic fe unths. This	
			 Director, (RCMD) or designed current residents having an M completed in the last 14 days accurate coding of oxygen us of care, Influenza Vaccine a prognosis is accurately coded Corrections will be made by F identified per the RAI manual Initial audit will be completed 3-31-20. On 3-27-20 Resident Care M Director, educated the MDS on accurate coding of the ME O0100C, O0250A, O0250B, J1400 and educated the MDS coordinators and Social Serv on coding of the MDS section 	e will audit all MDS to verify se, rejection nd resident d. RCMD as guidelines. no later than anagement coordinators DS sections O0250C and S ice Director h E0800 sment	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER R HEALTH & REHAB/SF SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page 1. a. Resident #16 wa 2/5/18 and readmitted which included respir Resident #16's Treath (TAR) dated February her continuous positive treatments on the foll 2/6/20, 2/7/20, 2/11/2 2//25/20, 2/26/20 and Resident #16's quarted (MDS) assessment d resident as being cog was coded under ber care. An interview was con with Resident #16. Si continuous positive C refusing it for the pass mask bothering her. had attempted to cha her face however she her and had continued An interview was con with Nurse #4. Nurse refused to wear her C stated a staff membe had came in the weel solution to the mask f had continued to refu	IDENTIFICATION NUMBER: 345270 ROVIDER OR SUPPLIER RHEALTH & REHAB/SPRUC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 1. a. Resident #16 was admitted to the facility on 2/5/18 and readmitted on 5/14/19 with diagnosis which included respiratory failure. Resident #16's Treatment Administration Record (TAR) dated February 2020 revealed she refused her continuous positive airway pressure (CPAP) treatments on the following dates: 2/4/20, 2/5/20, 2/6/20, 2/7/20, 2/11/20, 2/17/20, 2/19/20, 2/21/20, 2//25/20, 2/26/20 and 2/27/20. Resident #16's quarterly Minimum Data Set (MDS) assessment dated 2/21/20 coded the resident as being cognitively intact. Resident #16 was coded under behaviors for no rejection of care. An interview was conducted on 3/2/20 at 8:24 AM with Resident #16. She stated she wore a continuous positive CPAP at night, but had been refusing it for the past month because of the mask bothering her. The interview revealed staff had attempted to changer her mask to better fit her face however she felt like it was suffocating her and had continued to refuse the machine. An interview was conducted on 3/3/20 at 4:42 PM with Nurse #4. Nurse #4 stated Resident #16 had refused to wear her CPAP on a nightly basis. She stated a staff member from the CPAP company had came in the week prior to assist in finding a solution to the mask fitting however the resident had continued to refuse the machine.	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345270 B. WING	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDERSUPPLERCUN IDENTIFICATION NUMBER A BUILDING A BUILDING B. WING R HEALTH & REHAB/SPRUC STREET ADDRESS. CITY. STATE. 2P COC 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDDED Y FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREEX TAS Continued From page 16 F 641 1. a. Resident #16 was admitted to the facility on 25/18 and readmitted on 5/14/19 with diagnosis which included respiratory failure. F 641 Resident #16's Treatment Administration Record (TAR) dated February 2020 revealed she refused her continuous positive airway pressure (CPAP) treatments on the following dates: 2/4/20, 2/5/20, 2/2/5/20 and 2/27/20. F 641 Resident #16's quarterly Minimum Data Set (mDS) assessment dated 2/21/20, coded the care. Resident #80's squarterly MS dated 12/19 was modified t accurate coding of for prognosi disease that may result in a li expectancy of less than 6 mc correction will occur on or be care. An interview was conducted on 3/2/20 at 8:24 AM with Nurse #4. Nurse #4 stated Resident #16 ba resident #16's quarterly Minimum Data Set (mDS) assessment dated 2/21/20 coded the correction will occur on or be care. The facility Resident Care Ma Director, (RCMD) or designee correction will occur on or be correction will be made by f identified per the RAI manual Initial audit will be completed astate a st	MENT OF HEALTH AND HUMAN SERVICES FORM APPRO2 S FOR MEDICARE & MEDICARD SERVICES OMB NO. 03936 S FOR MEDICARE & MEDICARD SERVICES OMB NO. 03936 S FOR MEDICARE & MEDICARD SERVICES STREET ADRESS, CITY, STATE, 2P CODE STREET ADRESS, CITY, STATE, 2P CODE 3165270 R HEALTH & REHAB/SPRUC STREET ADRESS, CITY, STATE, 2P CODE SUMMARY STATEMENT OF DEFICIENCIES IN MIG ILCH DEFICIENCY MUST BE PRECEDED BY FULL PRECINC SUMMARY STATEMENT OF DEFICIENCIES IP RETIX ILCH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER 3P LIVA C CORRECTION 0,000 ILCH DEFICIENCY WILST BE PRECEDED BY FULL PRECINC CROUGH AND

Facility ID: 952989

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION	OMB NO. (X3) DATE SI COMPLE	URVEY
		345270	B. WING	WING		5/2020
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN C	IR HEALTH & REHAB/SP	RUC		218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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	(X5) COMPLETIO DATE
F 641	assessment along wi He confirmed rejectio on the MDS assessm stated the MDS was the TAR provided. He thousands of MDS as residents in the facilit An interview was con Nursing (DON) on 3/0 indicated the MDS as accurate and corresp needs or what she wa she also understood error not by intention. b. A physician's order Resident #16 had a co liters via nasal cannu saturation greater tha Resident #16's quarte (MDS) assessment d resident as being cog was coded for no oxy A MDS note dated 2/2 wore oxygen at 2 liter continuous positive a night but had been re because of the mask	th her February 2020 TAR. In of care was marked "no" lent. MDS Coordinator #1 coded inaccurately based on a stated he answered assessment questions for y and mistakes happen. ducted with the Director of 05/20 at 3:46 pm who assessment should be ond with the residents as doing. The DON stated it was missed out of human a dated 6/5/18 revealed order for oxygen therapy a 2 la as needed to keep oxygen in 90%. erly Minimum Data Set ated 2/21/20 coded the initively intact. Resident #16 rgen therapy use. 21/20 stated Resident #16 rs especially at night with a irway pressure (CPAP). ducted on 3/2/20 at 8:24 AM he stated she wore a irway pressure (CPAP) at fusing it for the past month bothering her. She stated e CPAP she wore oxygen via	F 64	 Beginning no later than 4-1-20, R Care Management Director, or de will audit a minimum of 3 MDS's v ensure accurate coding of O1000 Oxygen use while a resident, E08 Rejection of care, O0250 Influenz Vaccine, and J1400 Prognosis to the resident's status weekly X 6 v then 3 residents per month X 4 m ensure compliance is achieved at maintained. The Resident Care Management will review the results of the rando audits and those findings will be r at the monthly QAPI meeting for t months. Then quarterly for two q until substantial compliance has t achieved and the committee reco quarterly oversight by the District of Care Management or designee maintain continued compliance. Date when corrective action will to completed: 4/2/20 	esignee weekly to 22 000 a reflect weeks, onths to nd Director om eported wo uarters been mmends Director eto	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		345270	B. WING				/05/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
BRIAN CI	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	marked no. The MDS MDS was coded inact the resident wore oxy An interview was con Nursing (DON) on 3/0 indicated the MDS as accurate and corresp needs or what she was she also understood if error not by intention. 2. Resident #17 was 12/5/17 with diagnosid depression, cerebrow hyperlipidemia. Resident #17's care p on 1/10/20, revealed he was resistive to car often refused to let stathis nightstand drawer Resident #17 to coop cleaning through the Interventions listed in education to the resid resident to make his of plan did not include in resident #17's shower revealed he had refus following dates: 2/1/2 2/22/20 and 2/29/20.	hator #1. During the coordinator reviewed 20 quarterly MDS irmed oxygen therapy was Coordinator #1 stated the curately because he knew gen. ducted with the Director of 05/20 at 3:46 pm who sessment should be ond with the residents as doing. The DON stated t was missed out of human readmitted to the facility on s which included hemiplegia, ascular accident and blan, most recently reviewed a focus area which stated ire such as therapy and aff clean out old food from s. The goal was for erate with care and room next review date. cluded occupational therapy, lent and allowing the own decisions. The care nformation regarding the howers.	F	641			

Facility ID: 952989

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2020 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345270	B. WING		_		C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SP	RUC		218 LAUREL CREEK COU SPRUCE PINE, NC 287			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page February 2020.	19	F 641				
	(MDS) assessment da resident as being cog	rly Minimum Data Set ated 2/23/20 coded the nitively intact. Resident #17 aviors for no rejection of					
	AM of Resident #17. / observation Resident Urinals were observer black debris around th	#17 was laying in bed. d on the side of his bed with ne inside of the urinal. debris on his shirt and					
	AM with Resident #17 his showers due to no						
	with Nurse #4. Nurse refused all care incluc matter how many time	ducted on 3/3/20 at 4:52 PM #4 stated Resident #17 had ling showers. She stated no es nursing staff asked the refuse to take a shower.					
	pm with MDS Coordir interview, the MDS Co Resident #17's 2/23/2 assessment along wit log. He confirmed rej "no" on the quarterly I stated the MDS was co	oordinator reviewed 0 quarterly MDS h his February 2020 shower ection of care was marked MDS. MDS Coordinator #1 coded inaccurately based on ed, however said the care					

Facility ID: 952989

If continuation sheet Page 20 of 46

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE		
		345270	B. WING_				C 05/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
		BUC		2	18 LAUREL CREEK COURT			
BRIANCI	R HEALTH & REHAB/SP	NOC .		S	PRUCE PINE, NC 28777	NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	≥ 20	F	641				
	Nursing (DON) on 3/0 indicated the MDS as accurate and corresponeeds or what he was she also understood i error not by intention. 3. Resident #50 was a 3/20/15 with diagnosis failure and non-Alzhe The resident vaccinat Resident #50 receive in the facility on the da Resident #50's quarte (MDS) assessment da resident as being sev Resident #50 was con influenza vaccination An interview was com PM with MDS Coordin interview, the MDS Co Resident #50's 1/8/20 and the vaccination re date coded on the ME Coordinator #1 stated with the resident vacc to look in the residents re stated from now on he vaccination log.	sessment should be ond with the residents a doing. The DON stated t was missed out of human admitted to the facility on s which included heart imer's dementia. ion log for 2019 revealed d her influenza vaccination ate of 11/5/19. erly Minimum Data Set ated 1/8/20 coded the erely cognitively impaired. ded as receiving her on 10/23/2018. ducted on 3/04/20 at 1:10 nator #1. During the oordinator reviewed 0 quarterly MDS assessment ecord. He confirmed the DS was inaccurate. MDS I he had not been provided cination log and was having a charts to verify the date of eceived the vaccination. He e would ask to see the						
	An interview was con Nursing (DON) on 3/0 indicated the MDS as							

If continuation sheet Page 21 of 46

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345270	B. WING _				C 05/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CI	R HEALTH & REHAB/SP	RUC			8 LAUREL CREEK COURT PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	accurate and corresp needs and immunizat they had discussed th and incorrect dates. S Coordinator had thou system was automatic however that was not 4. Resident #56 was a 12/24/18 with diagnos mellitus and depressi The resident vaccinat Resident #56 receive in the facility on the d Resident #56's quarte (MDS) assessment da resident as being cog was coded as not elig vaccination. An interview was con PM with MDS Coordin interview, the MDS C Resident #56's 1/15/2 assessment and the v confirmed the informat inaccurate. MDS Coor not been provided wit log and was having to to verify the date of w the vaccination. He st ask to see the vaccina An interview was con Nursing (DON) on 3/0 indicated the MDS as	ond with the residents ion record. The DON stated he MDS vaccination issue She stated the MDS ght the point click care cally pulling the dates over the case. admitted to the facility on sis which included diabetes on. ion log for 2019 revealed d her influenza vaccination ate of 11/6/19. erly Minimum Data Set ated 1/15/20 coded the nitively intact. Resident #56 gible to receive the influenza ducted on 3/04/20 at 1:10 nator #1. During the oordinator reviewed 20 quarterly MDS vaccination record. He ation coded on the MDS was rdinator #1 stated he had th the resident vaccination to look in the resident charts hen the residents received tated from now on he would ation log.	F 6	341			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING	3		C
		345270	B. WING				05/2020
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT		
BRIAR					SPRUCE PINE, NC 28777		
(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)		(X5) COMPLETION DATE
F 641	they had discussed the and incorrect dates. S Coordinator had thous system was automatic however that was not 5. Resident #22 was not 11/30/19 with diagnos anxiety and depression The resident vaccinat Resident #22 received the facility on the date Resident #22's quarter (MDS) assessment data resident as being cog was coded as receivin outside of the facility. An interview was com- PM with MDS Coordin interview, the MDS Co- Resident #22's 12/6/1 assessment and the v confirmed the date co- inaccurate. MDS Coo- not been provided wit log and was having to to verify the date of w the vaccination. He st ask to see the vaccina- An interview was com- Nursing (DON) on 3/0 indicated the MDS as accurate and correspondent	ion record. The DON stated be MDS vaccination issue She stated the MDS ght the point click care cally pulling the dates over the case. readmitted to the facility on sis which included anemia, on. ion log for 2019 revealed d his influenza vaccination in e of 11/5/19. erly Minimum Data Set ated 12/6/19 coded the nitively intact. Resident #22 ng his influenza vaccination ducted on 3/04/20 at 1:10 nator #1. During the oordinator reviewed 19 quarterly MDS vaccination record. He oded on the MDS was rdinator #1 stated he had h the resident vaccination o look in the resident charts hen the residents received tated from now on he would ation log.	F	64			

Facility ID: 952989

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345270	B. WING				C / 05/2020
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 641	and incorrect dates. S Coordinator had thou system was automatic however that was not 6. Resident #42 was 3/1/18 with diagnosis Alzheimer's dementia diabetes mellitus. The resident vaccinat Resident #42 receive in the facility on the d Resident #42's annua assessment dated 1/2 being severely cognit was coded as receivin on 10/23/2018. An interview was con PM with MDS Coordin interview, the MDS C Resident #42's 1/2/20 and the vaccination re date coded on the MI Coordinator #1 stated with the residents re stated from now on he vaccination log. An interview was con Nursing (DON) on 3/0 indicated the MDS as accurate and corresp	he MDS vaccination issue She stated the MDS ght the point click care cally pulling the dates over the case. admitted to the facility on which included non- , Parkinson's disease and ion log for 2019 revealed d her influenza vaccination ate of 11/6/19. Al Minimum Data Set (MDS) 2/20 coded the resident as ively impaired. Resident #42 ng her influenza vaccination ducted on 3/04/20 at 1:10 nator #1. During the oordinator reviewed 0 annual MDS assessment ecord. He confirmed the DS was inaccurate. MDS I he had not been provided cination log and was having a charts to verify the date of beceived the vaccination. He e would ask to see the ducted with the Director of 05/20 at 8:57 AM who	F	641			

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	-	ID HUMAN SERVICES				FORM	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:)		PLETED
		345270	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	040210			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	05/2020
					218 LAUREL CREEK COURT		
BRIAN CT	R HEALTH & REHAB/SP	RUC			SPRUCE PINE, NC 28777		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
E 044			_				
F 641	Continued From page		F	64´	1		
	and incorrect dates. S	ne MDS vaccination issue					
		ght the point click care					
	system was automati	cally pulling the dates over					
	however that was not	the case.					
	7 Resident #33 was i	readmitted to the facility on					
		s which included non-					
	Alzheimer's dementia	i, anemia, seizure and					
	psychotic disorder.						
	The resident vaccinat	tion log for 2019 revealed					
		d her influenza vaccination					
	in the facility on the d	ate of 11/5/19.					
	Resident #33's quarte	erly Minimum Data Set					
		ated 12/24/19 coded the					
	resident as being sev	erely cognitively impaired.					
	Resident #33 was co	0					
	influenza vaccination	on 11/1/2018.					
	An interview was con	ducted on 3/04/20 at 1:10					
	PM with MDS Coordin	0					
	interview, the MDS C						
	Resident #33's 12/24	vaccination record. He					
		oded on the MDS was					
		ordinator #1 stated he had					
	-	th the resident vaccination					
		o look in the resident charts hen the residents received					
	-	tated from now on he would					
	ask to see the vaccin	ation log.					
	An interview was con	ducted with the Director of					
	Nursing (DON) on 3/0						
	indicated the MDS as						
		ond with the residents					
	needs and immunizat	tion record. The DON stated					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/02/2020 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345270	B. WING					C 105/2020
NAME OF P	ROVIDER OR SUPPLIER		-	5	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
	R HEALTH & REHAB/SP	PUC		2	218 LAUREL CREEK COURT			
DIVIAN	R HEALTH & REHAD/SP			5	SPRUCE PINE, NC 28777			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD B HE APPROPRI		(X5) COMPLETION DATE
F 641	Continued From page they had discussed th and incorrect dates. S Coordinator had thous system was automatic however that was not 8. Resident #88 was a 11/03/19 with diagnos vascular accident (CV disease and dementia in her health over the Resident #88 was add 11/27/19 and had a H 11/27/19, with a docu six months or less sig Director. The resident's Signific Set (MDS) dated 12/0 was coded for the are having a condition or result in a life expecta The resident was cod Hospice Care while a An interview was comp m with MDS Coordir interview, the MDS C Resident #88's 12/07/ assessment and her f 11/27/19. He confirm inaccurately on the 12 based on the Hospice stated he answered th	e 25 he MDS vaccination issue She stated the MDS ght the point click care cally pulling the dates over the case. admitted to the facility on see which included cerebral (A), diabetes, Alzheimer's a with a noted rapid decline past six months. mitted to Hospice on ospice Certificate dated mented life expectancy of ned by the Hospice Medical cant Change Minimum Data 07/19 revealed the resident a of Prognosis as not chronic disease that may ancy of less than 6 months. ed as having received resident. ducted on 3/03/20 at 4:35 hator #1. During the oordinator reviewed (19 Significant Change MDS Hospice Certificate dated ed Prognosis was coded 2/07/19 MDS assessment e Certificate provided. He housands of MDS is for residents in the facility		641	DEFICIENC			
	The resident's Signific Set (MDS) dated 12/0 was coded for the are having a condition or result in a life expecta The resident was cod Hospice Care while a An interview was com pm with MDS Coordir interview, the MDS Co Resident #88's 12/07, assessment and her I 11/27/19. He confirm inaccurately on the 12 based on the Hospice stated he answered the assessment questions and mistakes happen	97/19 revealed the resident a of Prognosis as not chronic disease that may ancy of less than 6 months. ed as having received resident. ducted on 3/03/20 at 4:35 hator #1. During the oordinator reviewed /19 Significant Change MDS Hospice Certificate dated ed Prognosis was coded 2/07/19 MDS assessment e Certificate provided. He housands of MDS s for residents in the facility						

Facility ID: 952989

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/02/2020 MAPPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345270	B. WING			03	C 6/05/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHAB/SF			218	LAUREL CREEK COURT		
BRIAN CT	R HEALTH & REHAD/SF			SPF	RUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 641	Continued From page	<u>- 26</u>	E I	641			
1 011		05/20 at 3:46 pm who		541			
	indicated the MDS as						
		ond with the residents'					
		ims. The DON stated she					
	not by intention.	is missed out of human error					
F 656		Comprehensive Care Plan	F	656			4/2/20
SS=D	CFR(s): 483.21(b)(1)						1/2/20
	implement a compret care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and	cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's i mental and psychosocial					
	assessment. The cor describe the following (i) The services that a	ied in the comprehensive nprehensive care plan must g - are to be furnished to attain ent's highest practicable					
	required under §483. (ii) Any services that under §483.24, §483 provided due to the re	I 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					
	treatment under §483 (iii) Any specialized s rehabilitative services	3.10(c)(6). ervices or specialized s the nursing facility will					
	findings of the PASA	a facility disagrees with the RR, it must indicate its					
	resident's representa	h the resident and the tive(s)-					
	(A) The resident's go	als for admission and					

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					APPROVED 0938-0391
CENTERS FOR MEDICARE & MEI STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION (X1	I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY
	345270	B. WING		C 03/0	5/2020
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
			218 LAUREL CREEK COURT		
BRIAN CTR HEALTH & REHAB/SPRU	C		SPRUCE PINE, NC 28777		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 656 Continued From page 27 desired outcomes. (B) The resident's prefere future discharge. Facilitie whether the resident's de community was assessed local contact agencies ar entities, for this purpose. (C) Discharge plans in th plan, as appropriate, in a requirements set forth in section. This REQUIREMENT is by: Based on record review, interviews, the facility fail plan with goals and inter- who rejected treatments reviewed for behaviors (F The finding included: Resident #16 was readm 5/14/19 with diagnosis w failure. Review of a physician or revealed Resident #16 w nighttime per home settir obstructive sleep apnea. Review of Resident #16's revealed no focus area re care. Resident #16's Treatment (TAR) dated February 20 refused her continuous p (CPAP) treatments on the 2/5/20, 2/6/20, 2/7/20, 2/ 	rence and potential for es must document esire to return to the ed and any referrals to ind/or other appropriate to accordance with the paragraph (c) of this a not met as evidenced ar, and resident and staff led to develop a care eventions for a resident for 1 of 2 residents Resident #16). hitted to the facility on which included respiratory and resident and staff led to develop a care eventions for a resident for 1 of 2 residents Resident #16). and resident and staff led to develop a care eventions for a resident for 1 of 2 residents Resident #16).	F 65	 On 3/3/20 The Resident Care Management Director, (RCMD) updat resident #16 careplan to reflect refuse CPAP. An audit of all current residents with a MDS completed in the past 14 days w be completed by 3-31-20 by the RCM designee to ensure any resident with E0800 rejection of care coded on the MDS will have a current care plan initi or updated to reflect the rejection of care educated all members of the IDT team 3/27/20 on implementing and updating residents care plan according to the Resident Assessment Instrument, (RA Manual guidelines. Beginning no later than 4/1/20 Reside Care Management Director, (RCMD) designee will audit a minimum of 3 random residents care plan weekly fo accurate care planning of rejection of X 6 weeks, then 3 residents per monticare the set of the team of team of the team of the team of the team of team of team of the team of team of	I of n rill D or ated are. n on g the N) nt or	

Facility ID: 952989

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TATEMENT (F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE C	CONSTRUCTION	(X3) D	NO. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G			OMPLETED
		345270	B WING				С
	ROVIDER OR SUPPLIER	545270			REET ADDRESS, CITY, STATE, ZIP CODE		03/05/2020
					B LAUREL CREEK COURT		
BRIAN CT	R HEALTH & REHAB/SF	PRUC			PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	a 28	F 65	56			
	2/21/20, 2/25/20, 2/2		1 00		months to ensure compliance is achiev	hav	
	212 1120, 2123120, 212	$\psi/2\psi$ and $z/21/2\psi$.			months to ensure compliance is achiev and maintained.	eu	
	Resident #16's quarte	erly Minimum Data Set					
		ated 2/21/20 coded the			The Resident Care Management Direc	tor	
	. ,	nitively intact. Resident #16			will review the results of the random		
	was coded under beh	naviors for no rejection of			audits and those findings will be report	ed	
	care.				at the monthly QAPI meeting for two		
					months. Then quarterly for two quarter	rs	
		ducted on 3/2/20 at 8:24 AM			until substantial compliance has been		
	with Resident #16. S				achieved and the committee recommen		
		irway pressure (CPAP) at			quarterly oversight by the District Direct	tor	
	-	efusing it for the past month			of Care Management or designee to		
		bothering her. The interview cempted to changer her			maintain continued compliance.		
		face however she felt like it			Date when corrective action will be		
		and had continued to refuse			completed: 4/2/20		
	the machine.						
	An interview was con	ducted on 3/3/20 at 4:42 PM					
	with Nurse #4. Nurse	#4 stated Resident #16 had					
		CPAP on a nightly basis. She					
		r from the CPAP company					
		k prior to assist in finding a					
	had continued to refu	fitting however the resident ise the machine.					
	An interview was con	ducted on 3/03/20 at 4:35					
	pm with MDS Coordin						
	interview, the MDS C	-					
	Resident #16's 2/21/2						
		th her February 2020 TAR					
		onfirmed rejection of care					
		the resident's 2/21/20					
		sment and the resident did					
		a on her care plan for $\frac{2}{2}$					
		r to 3/3/20 when the surveyor ne resident's care plan. MDS					
		d resident should have had a					
	care plan reflecting h						

	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SUR\ COMPLETE C		
		345270	B. WING			/05/2020	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SP	RUC		218 LAUREL CREEK COURT SPRUCE PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	treatments. An interview was con Nursing (DON) on 3/0 indicated the care pla correspond with the r	ducted with the Director of	F 6	56			
F 657 SS=D	it was missed out of h Care Plan Timing and	uman error not by intention. Revision i)-(iii)	F 65	57		4/2/20	
	 be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lime (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the resident and the resident and the resident report for the resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determion as requested by th (iii)Reviewed and revi 	erdisciplinary team, that ited to 'sician. e with responsibility for the responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). to included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary ssment, including both the					

Event ID: OKC111

Facility ID: 952989

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						<u>10. 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
						С
		345270	B. WING		o	3/05/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CI	R HEALTH & REHAB/S	PRUC		218 LAUREL CREEK COURT		
BRIANO				SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 657	Continued From pag	ie 30	F 65	57		
		T is not met as evidenced				
	by:					
		view, observations and erviews, the facility failed to		On 3/4/20 Resident Care M Director updated resident #1	•	
		ith interventions and goals for		to reflect rejection of care to		
	a resident who rejec	ted showers for 1 of 2 or rejection of care. (Resident		refusal of shower.	molado	
	#17)			An audit will be completed b	y 3-31-2020	
				by the RCMD or designee for		
	The finding included	:		resident's with an MDS com		
	Regident #17 was re	admitted to the facility on		last 14 days to ensure any re E0800 coded related to refus		
		admitted to the facility on sis which included hemiplegia		care plan will be reviewed to	-	
		ide), depression, and		accurate timely and revision		
	cerebrovascular acc			plan to include refusal of sho		
	Resident #17's care	plan, most recently reviewed		Resident Care Management	Director	
		a focus area indicating he		educated all members of the		
		such as therapy and often		3-27-20 on timely revision ar		
		ean out old food from his		the resident's care plan acco		
		The goal was to cooperate cleaning through the next		Resident Assessment Instru	ment, (RAI)	
	review date. Interver			Manual guidelines.		
		/, education to the resident		Resident Care Management	Director.	
		ident to make his own		(RCMD) or designee will aud		
	decisions. The care			of 3 random residents care p		
	information regarding	g the refusal of showers.		for accurate care planning of		
				showers X 6 weeks, then 3		
		ver log dated February 2020 used 6 of his 9 scheduled		month x 4 months to ensure is achieved and maintained		
	shower days for the			later than 4-1-20.		
	Resident #17's quar	terly Minimum Data Set		The Resident Care Manager	nent Director	
		dated 2/23/20 indicated he		will review the results of the		
		t. No rejection of care was		audits and those findings wil		
	noted.	-		at the monthly QAPI meeting		
				months. Then quarterly for t	wo quarters	
		conducted on 3/2/20 at 10:12		until substantial compliance		
	AM of Resident #17.	At the time of the		achieved and the committee	recommends	

Facility ID: 952989

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		CON	C
		345270	B. WING		0	3/05/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	PRUC		218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 657	Continued From page	e 31	F 65	7		
		t #17 smelled of a foul odor, had tan debris on his shirt		quarterly oversight by the Distric of Care Management or designed maintain continued compliance.		
	AM with Resident #1 his showers due to n	-		Date when corrective action will completed: 4/2/20	be	
	An interview was conducted on 3/3/20 at 4:52 PM with Nurse #4. Nurse #4 stated Resident #17 had refused all care including showers. She stated no matter how many times nursing staff asked the resident he still would refuse to take a shower.					
	pm with MDS Coordi interview, the MDS C Resident #17's show resident's care plan o take showers. He fur the shower log provid	Coordinator reviewed				
F 690	Nursing (DON) on 3/ indicated the MDS as should be accurate a residents needs. The understood it was mi	nducted with the Director of 05/20 at 3:46 pm who ssessment and care plan and correspond with the e DON stated she also ssed. tinence, Catheter, UTI	F 690			4/2/20
SS=D	CFR(s): 483.25(e)(1) §483.25(e) Incontine §483.25(e)(1) The fa					

If continuation sheet Page 32 of 46

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345270	B. WING				C 05/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			18 LAUREL CREEK COURT PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 690	resident who is contir admission receives se maintain continence u condition is or becom not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter is resident's clinical con catheterization was n (ii) A resident who ent indwelling catheter or is assessed for remov as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate for prevent urinary tract i continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen receives appropriate for restore as much norm possible. This REQUIREMENT by: Based on record revia and staff interviews, t urinary catheter bag for	ent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's esment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nefections and to restore ent possible. esident with fecal on the resident's esment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as f is not met as evidenced ew, observations, resident the facility failed to prevent a rom touching the shower esidents (Resident #3)	F	690	On 3/5/20 the DON validated that resident #3s catheter bag was laying o the floor of the shower room during the resident's shower and that even though resident insisted that the CNA	;	

Facility ID: 952989

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345270	B. WING				C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC			8 LAUREL CREEK COURT PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 690	uropathy and neuroge Resident #3's care pla last revised on 3/26/1 a urinary catheter rela- uropathy. The goals to be/remain free from and for Resident #3 to symptoms of urinary i interventions were list and tubing below the handwashing before a anchor catheter to pre observe/record/report symptoms of UTI (urin perineal care as indic The quarterly Minimu assessment dated 2/8 was cognitively intact urinary catheter. A review of a Physicia indicated Meropenem (intravenously) every On 3/2/20 at 3:32 PM #3 revealed him sittin fluid running through observation, an interv revealed he was curre for UTI. Resident #3	 inited to the facility on est that included obstructive enic bladder. an initiated on 5/24/18 and 9 indicated Resident #3 had ated to obstructive and reflux listed were for Resident #3 in catheter-related trauma to show no signs and infection. The following ted: position catheter bag level of the bladder, and after delivery of care, event excess tension, it to the doctor signs and hary tract infection) and ated. m Data Set (MDS) 5/20 indicated Resident #3 and had an indwelling an Order dated 2/24/20 indicated Resident #3 and had an indwelling an Order dated 2/24/20 indicated Resident #3 and had an indwelling an observation of Resident g inside his room with an IV his right arm. During this riew with Resident #3 ently receiving IV antibiotics stated it was common for 	F	590	not hang the catheter bag on the show chair the CNA should have placed it in wash basin or put it down in a plastic b On 3/6/20 all residents with catheters were identified so residents could be monitored to ensure that catheter bags are not touching the floor. On 3/5/20 100% education was completed with all nursing staff on prop placement of catheter bags during showers as well as when the resident if a wheelchair or the bed. Nursing staff was instructed to hang catheter bags of the shower chair or place the catheter in a basin or plastic bag during the shower. Nursing staff was also educat on making sure that catheter bags are touching the floor when residents are in their wheelchairs or beds. The DON/designee will document rand audits of residents with catheters to ensure that catheter bags are not touching the floor beginning 3/23/20. Taudit will consist of five random residents times a week for four weeks, three random residents five times a week for four weeks, and two random residents times a week for four weeks. The DON will review the results of the random audits and those findings will b reported at monthly QAPI meeting for three months. Then quarterly for three quarters until substantial compliance h been achieved and the committee recommends quarterly oversight by the	a ag. oer s in bag ed not n fom fhe nts five	
	revealed he was curre for UTI. Resident #3	ently receiving IV antibiotics			quarters until substantial compliance h	as	

Facility ID: 952989

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		MEDICAID SERVICES	(X2) MI II TIPI	E CONSTRUCTION		10. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · ·	MPLETED	
					с		
		345270	B. WING		0	3/05/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
BRIAN CT	R HEALTH & REHAB/SF			218 LAUREL CREEK COURT			
BRIANOI	R HEALTH & REHAD/OF			SPRUCE PINE, NC 28777			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE	
F 690	Continued From page	e 34	F 69				
	On 3/4/20 at 10:35 A Resident #3 in the sh	M, an observation of nower room revealed him		designee to maintain continu compliance.	ed		
	sitting in the shower chair with the curtain pulled in the first shower stall. Resident #3's urinary catheter bag was observed laying flat on the floor, under the curtain, outside the shower stall and under the sink. There were two trash barrels and			The DON will be responsible implementation of the accept correction.	able plan of		
	urinary catheter bag the shower room floo assisting Resident #3	s right next to where the was observed laying flat on or. Nurse aide (NA) #2 was 3 with his shower and both were also present in the		Date when corrective action completed: 4/2/20	will be		
	revealed this was here #3 a shower and here his urinary catheter be corner under the sink his shower. NA #2 si upset Resident #3 if a NA #2 further stated a request to place his floor, she would have	M, an interview with NA #2 r first time to give Resident had requested her to place bag on the floor around the s so it won't get wet during tated she did not want to she did not do as he asked. if Resident #3 had not made s urinary catheter bag on the e hung it on the shower chair so that it did not touch the					
	#2 revealed she did r urinary catheter bag floor. Nurse #2 state urinary catheter inser attention to where his Nurse #2 stated that Resident #3's urinary	M, an interview with Nurse not notice Resident #3's being on the shower room id she was focused on his rtion site and had not paid is catheter bag was placed. it was unacceptable for catheter bag to be laying on or and would change it right					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 04/02/2020 MAPPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				(X3) DATE SURVEY COMPLETED	
		345270	B. WING _					C 05/2020
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
	R HEALTH & REHAB/SP	RUC		2	18 LAUREL CREEK COURT			
BRIANCT	R HEALTH & REHAD/SP			S	PRUCE PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 690	before and she usuall bag on the shower ch the floor. NA #1 state his urinary catheter bas and she tried her bess placed it flat on the sh On 3/4/20 at 1:09 PM Resident #3 revealed hung his urinary cathe gets a shower. Resid NA #2 to place the ca morning and admitted do so before sometim getting on the bag. On 3/5/20 at 3:46 PM with the Director of Ne #2 had placed Reside on the floor because I let her hang it on the sunacceptable to place stated she could have or put a bag around it the floor. On 3/5/20 at 4:40 PM Administrator reveale followed the standard regarding urinary cath Administrator stated s what Resident #3 war found another solution	en Resident #3 a shower y hung his urinary catheter air so that it did not touch ed Resident #3 did not want ag to get wet during showers t for it not to, but she never nower room floor. , a follow-up interview with the nurse aides usually eter bag on the side while he lent #3 stated he had asked theter bag on the floor this the had requested them to the sto keep water from , an interview conducted ursing (DON) revealed NA ent #3's urinary catheter bag he was upset and would not shower chair but it was e it on the floor. The DON e placed it on a wash basin to prevent it from touching , an interview with the d NA #2 should have s of clinical practice	F	690				
F 693 SS=D	practice. Tube Feeding Mgmt/F CFR(s): 483.25(g)(4)(F	693				4/2/20

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/02/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345270	B. WING		C 03/05/2020
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE
BRIAN CT	R HEALTH & REHAB/SP	PRUC		218 LAUREL CREEK COURT	
BRIANOT				SPRUCE PINE, NC 28777	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 693	Continued From page	e 36	F 69	93	
	both percutaneous er percutaneous endoso enteral fluids). Based comprehensive asses ensure that a residen §483.25(g)(4) A resid eat enough alone or v enteral methods unle condition demonstrat clinically indicated an resident; and §483.25(g)(5) A resid means receives the a services to restore, if and to prevent compl including but not limit diarrhea, vomiting, de abnormalities, and na This REQUIREMENT by: Based on observatio interviews the facility orders for administeri amounts of tube feed resident reviewed for #69). Findings included: Resident #69 was ad with diagnosis includi	c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and on a resident's ssment, the facility must t- lent who has been able to with assistance is not fed by ss the resident's clinical es that enteral feeding was d consented to by the lent who is fed by enteral appropriate treatment and possible, oral eating skills ications of enteral feeding ed to aspiration pneumonia,		On 3/5/20 the DON validat resident #69s tube feeding 60cc/hour and should have 50cc per hour. A medicatio completed and the Dietician family were notified. The D verified that the Dietician and that the extra 240 cc per dat harmful to the resident. Th also replaced in case of a m to the pump itself. On 3/5/2 with feeding tubes were eva- ensure that the settings on matched the MD orders.	was set at been set at on error was n, MD and ON also nd MD stated ay was not e pump was nalfunction due 20 all residents aluated to

Event ID: OKC111

Facility ID: 952989

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A. BUILDING C 345270 B. WING 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT BRIAN CTR HEALTH & REHAB/SPRUC STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CON	NSTRUCTION	(X3)	3 NO. 0938-039 DATE SURVEY
345270 B.WING 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CON CON STREET ADDRESS, CITY, STATE, ZIP CODE CON STREET ADDRESS, CITY, STATE, ZIP CODE CON CON STREET ADDRESS, CITY, STATE, ZIP CODE CON CO	IND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G			COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CTR HEALTH & REHAB/SPRUC 218 LUREL CREEK COURT OVAIUD PMERIX TVG ISUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY UNIT EREPORTING UNIT OF REFECTED OF YULL REGULTORY OR LSC IDENTIFYING INFORMATION) PROVIDER OF CARE ACTION SHOULD DE CROSS REFERENCED TO THE APPORPTIATE DEFICIENCY) F 693 Continued From page 37 feeding of Osmolite 1.2 at 50 milliliters an hour (milht) via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 total calories in a 24-hour period. F 693 On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the tube feeding settings match the MD orders. Review of the quarterly Minimum Data Set (MDS) dated 01/22/20 revealed Resident #69 had a feeding tube and received 51% or more of her total calories from tube feeding. The Director of Nursing or designee will document random audits of residents with feeding last updated 01/14/20 revealed she was to receive her tube feeding as ordered. The goal was for Resident #69 to receive of sapiration, fever, shortness of breath, tube dysfunction or malfunction. The DON will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for three months feeding services or designee to maintain continued compliance. Review of the Medication Administration Record for March 2020 revealed an order dated 10/10/19 for Resident #69 to receive Osmolite 1.2 at 50 mil/hr via feeding tump with water flushes of 175 mil every 4 hours for a total of 1200 c			345270	B. WING				
BRIAN CTR HEALTH & REHAB/SPRUC SPRUCE PINE, NC 28777 (74) [0] SUMMARY STATEMENT OF DEFICIENCIES (EACH OPEICIENCY MUST BE PRECEDED BY PLL (EACH OPEICIENCY MUST BE PRECEDED BY PLL REGULATORY OR LSC DENTIFYING INFORMATION) ID (EACH OPEICIENCY) PREVIX PRECEDED BY ILL (EACH OPEICIENCY) PREVIX TAG PREVIX TAG OPEICIENCY) F 693 Continued From page 37 feeding of Osmolite 1.2 at 50 milliliters an hour (mil/hr) via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 total calories in a 24-hour period. F 693 On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the ube feeding settings match the MD orders. The Director of Nursing or designee will document random audits of residents with feeding tubes and received 51% or more of her total calories from tube feeding. The Director of Nursing or designee will document random audits of residents with feeding tubes to ensure that the settings on the pump match the MD orders. Review of Resident #69's care plan for tube feeding last updated 01/14/20 revealed she was to receive her tube feeding. The Director of Nursing or designee will document random audits with feeding tubes five times a week for four weeks. Review of the Medication Administration for March 2020 revealed an order dated 10/10/19 for Resident #69 to receive Osmolite 1.2 at 50 mil/m via feeding pump with water flushes of 175 mi levery 4 hours for a total of 1200 calories in a 24-hour period. The MAR revealed the feeding was documented as running at the correct rate. The DON	NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIZIORY OR LSCIDENTIFYING INFORMATION) PREFX TAG (EACH DEFICIENCY) COMPLET TAG F 693 Continued From page 37 feeding of Osmolite 1.2 at 50 milliiters an hour (m/hr) via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 total calories in a 24-hour period. F 693 On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the tube feeding tube and received 51% or more of her total calories from tube feeding. On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the tube feeding settings match the MD orders. Review of Resident #69's care plan for tube feeding last updated 01/14/20 revealed she was to receive her tube feeding. The Director of Nursing or designee will document random audits of residents with feeding tube dotting tubes to receive her tube feeding as ordered. The goal was for Resident #69 to receive Osmolite 1.2 at 50 ml/hr via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 calories in a 24-hour period. The DON will review the results of the random audits and those findings will be reported at the monthy QAPI meeting for three months then quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. The DON will be responsible for the implementation of the acceptable plan of	BRIAN CT	R HEALTH & REHAB/SF	PRUC					
feeding of Osmolite 1.2 at 50 milliliters an hour (m/hr) via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 total calories in a 24-hour period.On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the tube feeding settings match the MD orders.Review of the quarterly Minimum Data Set (MDS) dated 01/22/20 revealed Resident #69 was severely cognitively impaired for decision making. The MDS also stated Resident #69 had a feeding tube and received 51% or more of her total calories from tube feeding.The Director of Nursing or designee will document random audits of residents with feeding tubes to ensure that the settings on the pump match the MD orders.Review of Resident #69's care plan for tube feeding last updated 01/14/20 revealed she was to receive her tube feeding as ordered. The goal was for Resident #69 to remain free of aspiration, fever, shortness of breath, tube dysfunction or malfunction.The DON will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for three months then quarterly for three quarters until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance.Record review from 09/06/19 through 03/05/20 revealed Resident #69 weights were stable withThe DON will be responsible for the implementation of the acceptable plan of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
(ml/hr) via feeding pump with water flushes of 175 ml every 4 hours for a total of 1200 total calories in a 24-hour period.On 3/25/20 100% education was completed with all nurses that included instructing the nurses to check patients with feeding tubes at the beginning of the shift to make sure that the tube feeding settings match the MD orders.Review of the quarterly Minimum Data Set (MDS) dated 01/22/20 revealed Resident #69 was severely cognitively impaired for decision making. The MDS also stated Resident #69 had a feeding tube and received 51% or more of her total calories from tube feeding.The Director of Nursing or designee will document random audits of residents with feeding tubes to ensure that the settings on the pump match the MD orders beginning on 3/23/20. The audits will consist of all residents with feeding tubes to receive her tube feeding as ordered. The goal was for Resident #69 to remain free of aspiration, fever, shortness of breath, tube dysfunction or malfunction.The DON will review the results of the random audits and those findings will be reported at the monthly QAPI meeting for three months then quarterly for three quarters until substantial compliance has been achieved and the committe racommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance.Review of ne weise from 09/06/19 through 03/05/20 revealed Resident #69's weights were stable withThe DON will be responsible for the implementation of the acceptable plan of	F 693	1.0		F 69	93			
An observation of Resident #69 on 03/04/20 at 3:50 PM revealed her tube feeding was infusing at 60 milliliters an hour with flushes of 350 ml every 4 hours. An observation of Resident #69 on 03/05/20 at		 (ml/hr) via feeding pu 175 ml every 4 hours calories in a 24-hour Review of the quarted dated 01/22/20 reveal severely cognitively i The MDS also stated tube and received 51 calories from tube feed Review of Resident # feeding last updated to receive her tube feed was for Resident #69 through the next revia included observation fever, shortness of bin malfunction. Review of the Medica for March 2020 reveal for Resident #69 to re ml/hr via feeding pun ml every 4 hours for 24-hour period. The I was documented as Record review from O revealed Resident #60 no weight loss noted. An observation of Re 3:50 PM revealed he at 60 milliliters an hou- every 4 hours. 	 Imp with water flushes of a for a total of 1200 total period. Inty Minimum Data Set (MDS) aled Resident #69 was mpaired for decision making. I Resident #69 had a feeding % or more of her total eding. #69's care plan for tube 01/14/20 revealed she was beeding as ordered. The goal 0 to remain free of aspiration ew date. Interventions of any signs of aspiration, reath, tube dysfunction or ation Administration Record aled an order dated 10/10/19 eceive Osmolite 1.2 at 50 mp with water flushes of 175 a total of 1200 calories in a MAR revealed the feeding running at the correct rate. 09/06/19 through 03/05/20 69's weights were stable with . esident #69 on 03/04/20 at r tube feeding was infusing ur with flushes of 350 ml 		CCC in W St Sec TI do fe O CCC fiv tir tir TI rate th qu bo cCC TI D do CCC TI D D CCC TI D D CCC TI D D CCC TI TI TI TI TI TI TI TI TI TI TI TI TI	ompleted with all nurses that inclustructing the nurses to check pati ith feeding tubes at the beginning nift to make sure that the tube fee ettings match the MD orders. The Director of Nursing or designed ocument random audits of resider reding tubes to ensure that the se in the pump match the MD orders eginning on 3/23/20. The audits w ponsist of all residents with feeding we times a week for four weeks, and two mes a week for four weeks. The DON will review the results of andom audits and those findings w eported at the monthly QAPI meet warters until substantial compliance ecommends quarterly oversight by istrict Director of Clinical Services esignee to maintain continued ompliance. The DON will be responsible for the porrection. The when corrective action will be	ents of the ding e will tts with ttings vill tubes pree vo the vill be ing for se the se has or the se or	

Facility ID: 952989

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 04/02/2020 MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345270	B. WING			_		C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				2	218 LAUREL CREEK COUR	RT		
BRIAN CI	R HEALTH & REHAB/SP	RUC		1	SPRUCE PINE, NC 287	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	e e comme e e com page		F	693				
		tube feeding was infusing Ir with flushes of 175 ml						
	PM revealed Residen infusing at 60 milliliter 175 ml every 4 hours. Physician's order state regarding her tube fee order read for the resi infusing at 50 milliliter 175 ml every 4 hours.	eding Nurse #6 stated the ident to receive tube feeding s an hour with flushes of						
	room to change the se pump from 60 ml/hr to Physician orders. Nur Osmolite bottle read t and administered on 0 Resident #69 to receiv	ettings on the Kangaroo o infuse at 50 ml/hr per se #6 stated the label on the hat Nurse #7 had written 03/05/20 at 12:00 AM for ve tube feeding at 60 ml/hr. nad not checked Resident						
		ttings or compared them						
	PM revealed she had from 2:30 PM to 11:00 stated Resident #69's at 60 ml/hr with flushe	se #4 on 03/05/20 at 2:16 cared for Resident #69 0 PM on 03/04/20. Nurse #4 tube feeding was infusing es of 175 ml/hr every 4 03/04/20. She stated she did						
	not recall the flush rur interview with Nurse # reviewed the Physicia and stated she had no correct on 03/04/20 at	nning at 350 ml. A follow up #4 revealed she had an orders for Resident #69 ot verified the settings were nd had made a mistake.						
	should have been infu not 60 ml/hr. She stat	dent #69's tube feeding using at a rate of 50 ml/hr ed she felt the feeding be feeding was delivered						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 04/02/2020 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	-	(X3) DATE COMP	SURVEY LETED
		345270	B. WING			03/0) 05/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SP	RUC		218 LAUREL CREEK COU			
				SPRUCE PINE, NC 287			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	Continued From page was malfunctioning ar recalculating and wer revealed she determin Physician's order and room to check the pur reported any issues w to 03/05/20 at 2:16 Pl An interview with Nurs PM revealed she had during third shift on th 03/05/20. She stated bottle of Osmolite 1.2 #69 every night at mic had accidentally put th label and infused Res the rate of 60 ml/hr in stated she could not r Resident #69's flushe ml/hr. Nurse #7 stated another resident who been on the same hal two residents confuse in a rush due to a nur 03/05/20 and wasn't p interview revealed Nur malfunctions with the On 03/05/20 at 3:04 P Physician orders to be #69's tube feeding an feeding was not on th	a 39 a the flushes were a not correct. The interview hed this after reviewing the going into Resident #69's mp. She stated she hadn't ith the feeding pump prior M. as #7 on 03/05/20 at 5:39 cared for Resident #69 a dates of 03/04/20 and she administered a new tube feeding for Resident dright. Nurse #7 stated she he wrong setting on the ident #69's tube feeding at stead of 50 ml/hr. She ecall what she had set s at or if it was set to 350 d this happened because received tube feedings had l and she had gotten the d. She stated she had been se calling out on the date of baying attention. The rse #7 did not know of any feeding pump. Director of Nursing (DON) M revealed she expected a followed for Resident d she wasn't sure why the e correct setting so the correct amount of feeding	F 65				
	the incident, notified t family of Resident #69	npleted an assessment of he Physician, Dietitian and 9. The DON stated the he situation as a medication					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		C
		345270	B. WING		03/05/2020
NAME OF P	ROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CT	R HEALTH & REHAB/SP	RUC		18 LAUREL CREEK COURT PRUCE PINE, NC 28777	
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 693	error by Nurse #4 and	e 40 d had replaced the feeding Ilfunction with the pump	F 693		
F 725 SS=D	Sufficient Nursing Sta CFR(s): 483.35(a)(1)		F 725		4/2/20
	the appropriate comp provide nursing and r resident safety and at practicable physical, i well-being of each res resident assessments and considering the n diagnoses of the facil	e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care			
	by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed	sonnel, including but not			
	designate a licensed nurse on each tour of	section, the facility must nurse to serve as a charge		On 3/5/20 the DON validated that	

Event ID: OKC111

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345270	B. WING				C 05/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	18 LAUREL CREEK COURT		
BRIAN CT	R HEALTH & REHAB/SP	RUC		S	PRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page residents (Resident # The findings included This tag was cross-re F-561 - Based on rec staff interviews, the fa scheduled showers fo #3 and Resident #44) daily living. A review of the Daily 3 revealed: 1. 2/15/20 - 1 nurse a floater on day shift 2. 2/22/20 - 1 NA per shift 3. 2/29/20 - 1 NA per shift 4. 3/1/20 - 1 NA per h On 3/2/20 at 3:08 PM with NA #3 revealed s	e 41 3 and Resident #44). : ferenced to F-561: ord review, resident and		725		with in ng by w cy ing e to	
	done that were sched stated she tried to get	t get any of the showers uled for 3/1/20. NA #3 t them on the next day but if , the residents would just next scheduled day.			Indeed, Facebook and work with local community college to recruit staff. The Administrator, DON and scheduler will meet five times a week for four week		
	with NA #8 revealed s for 3 months on the e she had worked by he				three times a week for four weeks and two times a week for four weeks to rev staffing pattern and make adjustments needed beginning on 3/23/20.	as	
					The Administrator and DON will review staffing and will report on staffing issue and new hires in the monthly QAPI Meeting for three months and quarterly	s	

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
		345270	B. WING		C 03/05/2020	0
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
BRIAN CT	R HEALTH & REHAB/SF	PRUC		218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT	ETIO
F 725	Continued From page	e 42	F 72	25		
	asked to make up a s completed on day sh On 3/4/20 at 5:47 PM revealed she had wo evening shift on 2/1/2 remember who the N couldn't get a showed required 2-person as was impossible for th extra showers that di because they had at each evening. On 3/4/20 at 8:33 AM Scheduler revealed t open NA positions w full-time and 1 part-tit full-time positions for positions for night sh positions. The Schee supposed to have at day and evening shif shift. The facility has not having enough st and unexpected situal scheduled staff mem they tried to call othe and called the staffin continued to utilize ag 250-300 hours per w open positions online	<i>A</i> , an interview with Nurse #5 rked with just 1 NA on an 20 but she couldn't IA she worked with. The NA r done because the resident isistance. Nurse #5 shared it he evening shift to pick up id not get done on day shift least five showers to do <i>A</i> , an interview with the he facility currently had 14 which consisted of 2 12-hour me position for day shift, 5 revening shift, 2 full-time ift and 4 prn (as needed) duler stated the facility was least 2 NA per hall on both its and 1 NA per hall on night a had some challenges with taff to work due to callouts ations affecting the bers. The Scheduler stated er staff members to come in g agency for help. She gency staffing who worked eek. They had posted their e and on social media, had hus for new hires and had		three quarters until subs has been achieved and the recommends quarterly of District Director of Clinic designee to maintain con- compliance. The Administrator and Dhe responsible for the imple acceptable plan of correst Date when corrective acc completed: 4/2/20	the committee versight by the al Services or ntinued ON are ementation of the ction.	
	Director of Nursing ([/l, an interview with the DON) revealed the staffing n the census but the facility				

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		DNSTRUCTION		ATE SURVEY
		345270	B. WING				C 03/05/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE	·	
BRIAN CT	R HEALTH & REHAB/SP	PRUC			LAUREL CREEK COURT RUCE PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 725 F 761 SS=D	it was frustrating beca keep good help. The other staff members to callouts and they offer members who worked shared the facility reli- staffing which current positions. On 3/5/20 at 4:40 PM Administrator revealed callouts, but they cov could and tried to get come in. The Admini conducted job fares et social media, advertis and offered sign-on b also improved their o increase new employ Administrator shared colleges and talked to Label/Store Drugs an CFR(s): 483.45(g) Labeling o Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the o applicable. §483.45(h) Storage o §483.45(h)(1) In accordance	s per hall. The DON taffing was an issue and that ause it was hard for them to supervisors tried to call to come in when there were ared a shift bonus for staff d an extra shift. The DON ted heavily on agency dy filled 10 to 11 open NA I, an interview with the ered them as quickly as they other staff members to strator stated they every quarter, shared on sed on papers, put up signs bonuses for new hires. They rientation process to ere retention. The she also went to the local o potential applicants. d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be e with currently accepted is, and include the y and cautionary		725			4/2/20

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	MENT OF HEALTH AN S FOR MEDICARE &	ID HUMAN SERVICES			FOI	RM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345270	B. WING		C	C 3/05/2020
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				218 LAUREL CREEK COURT		
BRIAN C	IR HEALTH & REHAB/SP	RUC		SPRUCE PINE, NC 28777		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 761	biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the package drug distribu- quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to dispos stored in 1 of 3 medic medication cart). The findings included During an observation cart on 03/03/20 at 4: medication was found use: Sodium Chloride table count with 57 tablets an expired date of 01 An interview with the 03/03/20 at 4:45 PM f expired and should ha 300 Hall medication of An interview with the on 03/05/20 at 4:34 F	compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tition systems in which the imal and a missing dose can is not met as evidenced ns and staff interviews, the se of an expired medication carts (300 Hall curve state of an evaluable for an of the 300 Hall medication 39 PM, the following d in the cart and available for ets, 1 gram tablets 100 remaining in the bottle with /2020. Nurse #2 on the 300 Hall on revealed the medication was ave been removed from the	F 7	 61 On 3/5/20 the DON verified expired bottle of Sodium Ch had been left on the 300 ha DON also verified that the n should have been pulled from the cart and discarded by th 3/6/20 an audit of all medical completed and no other expiredications were found. On 3/25/20 100% education completed with all nurses the instruction that all medication be checked every shift for emedications. Nurses were at that any expired medication pulled from the cart and ser pharmacy or properly waster facility. The DON/designee will doc medication cart audits to emergined medications are left 	nloride tablets III cart. The medication form the cart and was taken off ne nurse. On ation carts was bired in was nat included on carts are to expired also instructed as are to be nt back to the ed in the sument random asure that no	

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATI	<u>O. 0938-039</u> E SURVEY PLETED
		345270	B. WING		03	C / 05/2020
	ROVIDER OR SUPPLIER	PRUC		STREET ADDRESS, CITY, STATE, ZIP CODE 218 LAUREL CREEK COURT SPRUCE PINE, NC 28777		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 761	the medication carts checked for expired r nurses. According to representative had re medication carts twic expired medication a An interview with the 5:24 PM revealed sh	rmacy. She went on to say, were supposed to be medications by all the o the DON, the pharmacy ecently gone through the se and had missed the s well. Administrator on 03/05/20 at e expected expired moved from the medication	F 76	1 medication cart. The audit will four medication carts five times four weeks, three times a week weeks and two times a week for weeks. The DON will review the results random audits and those findin reported at the monthly QAPI reported at the monthly QAPI reported at the monthly QAPI reported at the commit recommends quarterly oversigh District Director of Clinical Services designee to maintain continued compliance. The DON will be responsible for implementation of the acceptate correction.	a week for for four or four s of the gs will be neeting for three liance has tee ht by the vices or d	

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