#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
		345312	B. WNG			06/2013		
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHAB/HENDERSONVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE  1870 PISGAH DRIVE  HENDERSONVILLE, NC 28791					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	N SHOULD BE E APPROPRIATE			
F 312 SS=B	Noile were		F 312	1. Residents #3, 2 & 4 received nail care on day of survey. Nails were		9/6/13		
				to carry out activities of daily living have potential to be affected by this alleged deficient practice.  The Director of Nursing/designee & U		9/27/13		
			n 9/7/13					
	_	esident # 3, 2, and 4). The		3. Education of all Licensed Nurses & Resident Care Specialists was completed by the Director of Nursing/designee regarding the expectation of providing nail care for residents who require assistance to maintain clean fingernails on shower days & PRN. Any refusal of nail care by resident will be reported to the charge nurse or a member of Nurse Management for documentation & resolution. This will be completed by 9/27/13. Any Resident Care		9/27/13		
	07/30/12 with diagnos aspiration pneumonia anemia, intracranial h obstructive pulmonary feeding tube, and hyp annual Minimum Data	n, right lung mass, cancer, semorrhage, chronic by disease, tracheotomy, sertension. The most recent a Set (MDS) dated 07/19/13 was severely cognitively						
	assistance with all activities of daily living (ADL)  including total dependence for bathing and  Specialist not receiving will receive education		Specialist not receiving education by t will receive education prior to their ne scheduled shift. This info will be include future orientation.	ĸt				
	revealed a requireme Her needs were care with two persons for a care plans were deve	olan review dated 07/18/13 Int for assistance with ADL. Int planned for total assistance In ADL and hygiene. No Illoped for interventions for		The Director of Nursing/Unit Manager conduct weekly audits to monitor residependent on grooming to ensure fing are clean & trimmed. This will be comweekly for 3 months.	nitor residents nsure fingernails			
	On 09/06/13 at 9:35 A	AM Resident #3 was				(VA) DATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is getermined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 20 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

OCT 0 8 2013

Facility ID: 922985

program participation.

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345312		B. WNG			C 09/06/2013		
				TREET ADDRESS, CITY, STATE, ZIP CODE	09/	06/2013	
NAME OF PROVIDER OR SUPPLIER							
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				870 PISGAH DRIVE IENDERSONVILLE, NG 28791			
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Continued From page 1 observed lying in bed. The Resident had untrimmed fingernails approximately ½ " long with ragged edges and a brownish tan substance		F 312	the QAPI Committee for 3 months or un Substantial Compliance has been achie maintained as determined by The Comm		9/27/13		
	observed lying in bed. The Resident had untrimmed fingernails approximately ½ " long			This facility alleges compliance of F312 9/27/13. Compliance as outlined in the POC will be monitored monthly by the CAssurance Performance Improvement Committee.	b;y above	9/27/13	
	_	n 09/06/13 at 11:45 AM with g (DON) stated that her					

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NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHAB/HENDERSONVILLE				18	TREET ADDRESS, CITY, STATE, ZIP CODE 870 PISGAH DRIVE ENDERSONVILLE, NC 28791	08/	06/2013
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F 312	ROVIDER OR SUPPLIER  TR HEALTH & REHAB/HENDERSONVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F.	312			

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F 312	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	312		

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