PRINTED: 03/16/2016 FORM APPROVED OMB NO. 0938-0391

F 278 SS=D  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifles a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement in a resident assessment does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is a penaltic place of the civil in the penaltic of the civil		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		10.000	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY IPLETED
STREET ADDRESS, CITY, STATE, 2IP CODE 78 WEAVER ROULEVARD WEAVERVILLE, NO. 2887  SUMMAY STREAMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FPRIENT TAG  F 278  483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment is completed.  Each individual who completes a portion of the assessment is completed.  Each individual who completes a portion of the assessment is subject to a cliff money penalty of not more than \$1,000 for each assessment in a resident assessment is subject to a cliff money penalty of not more than \$1,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement in a resident assessment is subject to a cliff money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement in a resident assessment is subject to a cliff money benalty of not more than \$5,000 for each assessment is subject to a cliff money benalty of not more than \$5,000 for each assessment and the statement in a resident assessment and the statement in a resident assessment and the statement in a resident full subject to a cliff money benalty of not more than \$5,000 for each assessment and the statement in a resident according only. Not as smelting only the stateme			345221	B. WING				
PRIAN CENTER H & REHAB WEAVERY  TO SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRICEDED BY PLLL  TAG  ARE SEGULATORY OR LSC IDENTIFYING INFORMATION)  F 278  483.20(g) - (i) ASSESSMENT  ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$1,000 for each assessment, assessment is subject to a civil money penalty of not more than \$1,000 for each assessment.  Clinical disagreement does not constitute a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement in a resident subject to a civil money penalty of not more than \$5,000 for each assessment.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interviews the facility falled to accurately code 3 of 24 sampled residents utilizing the Minimum Data Set (MDS) to reflect the Level II Predmission Screening and Rosidant Review (PASRR) determination for (Resident #15), hospice care for (Resident #90)	NAME OF P	ROVIDER OR SUPPLIER	040221		7		1 03	3/03/2016
SHANCENTER H & REHAB WEAVERY  SUMMARY STRETEMENT OF DEFICIENCIES  PRICE PROPERTY AND OF CORRECTION  SUMMARY STRETEMENT OF DEFICIENCIES  (EACH DEPOCIENCY MUST BE PRECEDED BY PULL  REGULATORY OR LASC DEPHYMING BE ORIMATION)  F 278  483.20(g) - (i) ASSESSMENT  A registered nurse must conduct or coordinate each assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment is completed.  Each individual who completes a portion of the assessment lis subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowlingly causes another individual to contrig a material and false statement in a resident assessment. Can individual who willfully and knowlingly causes another individual to contrig a material and false statement in a resident assessment. Can individual who willfully and knowlingly causes another individual to contrig a material and false statement in a resident assessment. Can individual who willfully and knowlingly causes another individual who willfully and knowlingly causes another individual to contrig a material and false statement in a resident assessment. Can individual who willfully and knowlingly causes another individual who willfully and knowlingly causes another individual to contrig a material and false statement in a resident assessment. Can individual who willfully and knowlingly causes another individual who willfully and knowlingly causes ano								
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION SS=D  A32.20(g) - (j) ASSESSMENT F 278 SS=D ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment, or an individual who willfully and knowingly causes another individual to cortify a material and false statement in a resident assessment, or an individual who willfully and knowingly causes another individual to cortify a material and false statement in a resident assessment of cortical material and false statement in a resident assessment of cortical more penalty of not more than \$1,000 for each assessment, or an individual who willfully and knowingly causes another individual to cortify a material and false statement in a resident assessment of cortical more penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement in a resident assessment of the post of the complete of the cortical practice for necurate coding of Lavel II PASRRs will be identified through audit or currently adhited resident and material and false statement.  Clinical disagreement does not constitute a material and false statement in a resident assessment of the control of the c	BRIAN CE	NTER H & REHAB WEA	VERV		١,	WEAVERVILLE, NC 28787		
The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment must sign and certify the accuracy of that portion of the assessment must sign and certify the accuracy of that portion of the assessment assessment and deficient practice with regard to resident #19. The assessment dated 11/2/15 was modified to show busined #19. The significant change assessment dated 12/23/16 was modified to solve under the subject to a civil money penalty of not more than \$1,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment is subject to a civil money penalty of not more than \$5,000 for each assessment assessment is subject to a civil money penalty of not more than \$5,000 for each assessment does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interviews the facility falled to accurately code 3 of 24 sampled residents utilizing the Minimum Data Set (MDS) to reffect the Level II PASRR will be provided by social worker. All stort Level II PASRR will be provided by social worker and maintained in a separate binder in the MDS office to ensure MDS is aware of all Level II PASRR were identified with Level II PASRR were identified with Level II PASRR were identified with Level II PASRR see identifie	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	) BE	(X5) COMPLETION DATE
(Resident #15), hospice care for (Resident #90)  RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  (X6) DATE	SS=D	ACCURACY/COORD  The assessment must resident's status.  A registered nurse must each assessment with participation of health  A registered nurse must assessment is completed. A registered nurse must sign that portion of the assessment must sign that portion of the assessment must sign that portion of the assessment in a resubject to a civil money \$1,000 for each assesswillfully and knowingly to certify a material and resident assessment.  Clinical disagreement of the assessment.  Clinical disagreement of the assessment.  Clinical disagreement of the assessment and false states.  This REQUIREMENT is by:  Based on record review acility failed to accurate esidents utilizing the M	INATION/CERTIFIED  It accurately reflect the  ast conduct or coordinate the appropriate professionals.  It sign and certify that the ted.  It the accuracy of the and certify that the ted.  The and certify	F	278	F278 SS=D  Alleged deficient practice in Assessa Accuracy/Coordination/Certified  Criteria #1  Corrective action has been accomplifor the alleged deficient practice with to resident #15, resident #90, and res #182. The assessments dated 11/12/1 modified to show Level II PASIR 03 and accepted by CMS on 03/01/16. T significant change assessment dated 12/23/16 was modified on 03/01/16 to show the Hospice services were initiated. To care plan for resident #182 was modified on 03/01/16 to reflect choice of wearing used for reading only. Next assessment 04/4/16 will be completed according to guidelines and reviewed by RN MDS Coordinator.  Criteria #2  Facility residents who have the potent be affected by the same alleged deficipractice for accurate coding of Level PASRRs will be identified through aucurently admitted residents by the soworker. A list of Level II PASRRs will provided by social worker and maintain a separate binder in the MDS office to ensure MDS is aware of all Level II PASRRs wire for accurate coding. Only I MDS out identified with Level II PASRRs were	by: SKH  by: SKH  ent  shed regard ident 5 was /01/16 he he of and v that he he he led on glasses nt due o RAI  lit of hial l be ncd in ASRR of 3	5
the section of the reflect and the region of the section of the se	(1	Resident #15), hospice	care for (Resident #90)					
1 Des ( con) () 11 month to 3-21-10	AIORY DIR	^			1	\ \		

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.

FORM CMS-2567(02-99) Praylous Versions Obsolete

Event ID; RNK311

Facility ID: 952991

If continuation sheet Page 1 of 12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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AND TO STORY (1982)				78 WEAVER BOULEVARD			
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	and vision for (Reside Findings included:  1. Resident #15 was 03/08/2011 with diagr schizophrenia, non-A anxiety disorder.  A review of Resident Set (MDS) dated 11/1 was not considered by Preadmission Screen (PASRR) process to hand/or intellectual disacreening and review determination of need appropriate care settling recommendations for individual's plan of care A review of the facility residents revealed that included among the retained among the retained the MDS coordinator 03/01/16 at 3:12 PM, I Resident #15's annual revealed the MDS did PASRR determination Coordinator #1 stated coded to reflect Reside PASRR and was missed on 03/01/16 at 4:07 PI (DON) was interviewed her expectation that the determination would have resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit a modified annual PASRR for Resident #15's MDS are expectation that the submit and part expectation that the submit and part expectation that the submit and p	admitted to the facility on noses including Izheimer's dementia, and #15's annual Minimum Data 2/15 indicated the resident by the state Level II Ing and Resident Review nave a serious mental illness ability. The results of this were used for formulating a determination of an ing and a set of services to help develop an ite. Is list of Level II PASRR it Resident #15 was insidents named on the list. #1 was interviewed on regarding the accuracy of MDS. When it was not reflect the Level II for this resident, the MDS the MDS should have been ent #15 was Level II and for coding. We the DON stated it was the Level II PASRR are been coded accurately in the DON stated it was a MDS Coordinator would all MDS to reflect Level II	F2	residents with level II PASRR a in the RAI Manual Section A15 DHHS PASRR Provider Manual preadmission screens and Level requirements. The Social Works maintain a copy of all PASRR separate list of residents and adresidents with PASRR Level II copy of list and updated list of P Level II residents to be placed in the MDS office. The Resident C Management Director will audit admission/annual/significant cha assessments per month by no late last day of the month to ensure a coding of PASRR Level for a per months. The Resident Care Ma Director educated MDS Coording Section O of the RAI Manual on accurate coding of the MDS assesensure this practice does not occu RCMD will pull weekly census directions are ceiving Hospice service review completed MDS assessmentransmission to ensure no further will be affected for a period of 3 n. The Resident Care Management Leducated the MDS coordinators 3/ Section B regarding assessments fiper RAI guidelines on use of eyegl adjusting lighting to identify problevision and to ensure adequate	in the property of the propert	g R a n	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T (Va) MI		CONTRIBUTION		VO. 0930-039	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	William Or Helican		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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prilition	*N****				8 WEAVER BOULEVARD			
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	expectation that the L determination would h on Resident #15's ME  2. Resident #90 was a 12/23/14 with diagnos disease, dementia, de disorder.  The physician's order Resident #90 was acc A review of the medica #90 began receiving h A review of the facility' revealed that Resident the residents on the lis A review of Resident # Minimum Data Set (ME indicate Resident #90 l The MDS Coordinator #1 Soldent #90's significate MDS Coordinator #1 st MDS should have been #90 received hospice c Dn 03/01/16 at 9:18 AM conducted with the MDS detated she coded the signed seceived hospice care. Dn 03/01/16 at 10:45 AM Resident #90 and forgo deceived hospice care.	sinistrator stated it was her evel II PASRR have been coded accurately DS.  admitted to the facility on ses including Alzheimer's expression, and anxiety  dated 12/15/15 revealed septed for hospice care.  al record revealed Resident cospice care on 12/16/15.  Is list of hospice residents at #90 was included among it.  90's significant change DS) dated 12/23/15 did not had received hospice care.  #1 was interviewed on egarding the accuracy of ant change MDS. The sated the significant change in coded to reflect Resident are.  M an interview was S Coordinator #2 who gnificant change MDS for it to code Resident #90  M, the Director of Nursing	F	278	documentation as verified by RN MDS Coordinator. To ensure this practice do not occur again, the RCMD will audit a assessments completed by LPN MDS Coordinator for verified documentation RN of assessment in progress notes for days, initiated with all assessments completed 3/1 through 3/31, and for an additional 2 months, RCMD will audit 1 assessments completed by LPN MDS Coordinator to ensure ongoing practice. audits will be completed  Criteria #4  The Resident Care Management Directo will review data obtained during assessa audits, analyze the data and report patte trends to the QAPI committee every mor x 3 months. The QAPI committee will evaluate the effectiveness of the above p and will add interventions based on identified trends/ outcomes to ensure continued compliance.	II by 0  All r nent rns/	March 31 <sup>31</sup> 2016	
s F ri	stated she coded the signesident #90 and forgo eceived hospice care.	gnificant change MDS for t to code Resident #90						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DA	(X3) DATE SURVEY COMPLETED	
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	her expectation that it would have been code Resident #90 received On 03/01/16 at 10:50 Director (DCD) was in she completed quarte that Resident #90's signot coded for hospice On 03/01/16 at 11:16 interviewed. The Admi expectation that significate have been coded accut #90 received hospice of 3. Resident #182 was 10/07/15 with diagnost dementia, hypertension A review of Resident #10/13/15 revealed a prelated to wears glasses Interventions included: Resident #182 had the available as necessary glasses were within ear #182.  A review of Resident #182.  Resident #182's quarte Coordinator #3 stated the glasses for reading and have Resident #182 stated Resi	ne significant change MDS and accurately to reflect if hospice care.  AM, the District Clinical terviewed, The DCD stated fry MDS audits and missed gnificant change MDS was care.  AM, the Administrator was inistrator stated it was her cant change MDS would trately to reflect Resident care.  admitted to the facility on as including anemia, in, and diabetes mellitus.  182's care plan dated oblem of sensory deficit as for reading.  Staff were to assure appropriate visual aide. Staff were to assure appropriate visual aide. Staff were to assure appropriate visual aide as yreach for Resident  182's quarterly Minimum D1/11/16 revealed corrective lenses. If a was interviewed on garding the accuracy of the MDS and Resident II-182 were she did not attempt to ar his glasses during the	F	278			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	W. 11/42 5/50 (23-20)	TIPLE CONSTRUCTION	V	(X3) DATE SURVEY COMPLETED	
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F 281 SS=D	On 03/01/16 at 9:59 A conducted with the MI stated she signed the #182 and did not reali: glasses during the visit Coordinator #2 stated Date (ARD) and the quality of 1/11/16 and she wou perform another vision with his glasses on. On 03/01/16 at 10:54 / (DON) was interviewed her expectation that the assessment would have Resident #182 wearing stated it was her expectation that the MDS Coordinator #1 MDS for Resident #182 on 03/01/16 at 11:22 A interviewed. The Admir expectation that the quassessment would have Resident #182 wearing stated it was her expectation that the quassessment would have Resident #182 wearing stated it was her expectation that the quassessment conducted #3 would have been act the MDS Coordinator #5 MDS for Resident #182 483.20(k)(3)(I) SERVIC PROFESSIONAL STAN	M an interview was DS Coordinator #2 who quarterly MDS for Resident ze that he had not worn ion exam. The MDS the Assessment Reference warterly MDS date were ld not have had time to exam for Resident #182  AM, the Director of Nursing d. The DON stated it was e quarterly MDS vision we been conducted with ghis glasses. The DON station that the vision by the MDS Coordinator courately completed prior to #2 signing the quarterly 22.  AM, the Administrator was histrator stated it was her arterly MDS vision be been conducted with his glasses. The DON tation that the vision by the MDS Coordinator curately completed prior to 22 signing the quarterly .  ES PROVIDED MEET IDARDS	F 28	278			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Para Barana and	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 28	This REQUIREMENT by:  Based on medical recinterviews the facility of 1 of 6 residents with medical recinterviews the facility of 1 of 6 residents with medical recinterviews the facility of 1 of 6 residents with medical record of 6 resident #199)  The findings included:  Resident #199 was addoc/02/16 after hospital which included enterord gout, chronic kidney of back pain, hypertensic disease, atrial fibrillatic cardiomyopathy and medical record of 6 record o	cord review and staff called to obtain lab work for nedications reviewed.  mitted to the facility ization with diagnoses coccus, sepsis, chronic sease, hypokalemia, low in, atherosclerotic heart in, ischemic yperlipidemia.  n orders for Resident #199 blood thinner) .5 milligrams ext Prothrombin time (PT) ad Ratlo (INR) due NR of 2-3. The PT/INR is Coumadin dosage. A ocated from 02/03/16 in tesident #199.  M the interim Director of ed the facility system for Coumadin. The interim din was entered on the on Record (MAR) and through the day before the interim DON stated the orted to the physician to hanges needed for The interim DON stated to be restarted until the eck and new orders were	F28	· · · · · · · · · · · · · · · · · · ·	the solution in the solution i	

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	stated when the first Pobtained it triggered the Anticoagulant Therapy individual resident. The Anticoagulant Therapy track Coumadin dosing each resident on Courstated because the initidone for Resident #19 Therapy Flow Sheet winterim DON stated, if Flow Sheet had been it should have triggered PT/INR.  Review of the February noted the Coumadin wadministered again unt Anticoagulant Therapy #199 noted the first recifrom 02/29/16 with test 12.9/1.0.  On 03/02/16 at 11:35 A the PT/INR ordered on done as ordered. The course to Coumadin the end of was obtained and the Courrent DON could not of PT/INR had not been do The current DON stated process of making chan system to prevent issue future.  On 03/02/16 at 1:45 PM	PT/INR results were the nurse to complete an a relative for the the interim DON stated the are interim DON stated the are interim DON stated to g and PT/INR results for madin. The interim DON lial PT/INR had not been 9 the Anticoagulant as not initiated. The the Anticoagulant Therapy initiated for Resident #199 it nursing staff of the missing as given 02/02/16 and not il 02/29/16. Review of the Flow Sheet for Resident sorded PT/INR results were results documented as  M the current DON stated 02/03/16 had not been current DON stated facility sident #199 had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not had not been for Resident #199. It has not had not been for Resident #199. It has not had not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had not been for Resident #199. It has not had n	F 2	book for that hall. The phlebotomist from the hosp comes four days a week and draws the ordered labs. The nurse on the hall draws labs remaining three days or whe the patient has a central line place. The yellow copy of the lab slip is left with the nurse the nurses' station which is picked up by the Unit Manage for that hall. Unit Coordinate created a lab book on March 2016 for each nurses station. Lab orders are printed dally from PCC by the DON and give to the Unit Manager of the hawho verifies that the labs for that day were drawn by picking up the yellow copy of the lab slip left by the phlebotomist of nurse, verifies results have be received, and verifies that results are faxed to the	the n in e at er 7, en II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	10237 100	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345221	B. WNG			l.	C /03/2016	
	PROVIDER OR SUPPLIER	VERV		STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787			700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE	
i t f s c	subtherapeutic for Rehad caused any harm Coumadin taken by the Coumadin term DON no explanation for the Coumadin the Coumadin taken to be done as ordered stated the 02/03/16 Produce as ordered for Register of Coumadin could be obtained for continuation to the Coumadin could be obtained for continuation to the Coumadin the Coumadin term of Coumadin term of Coumadin the Coumadin term of Coumadin te	29/16 PT/INR results were sident #199 he did not feel it is because of the low dose of he resident.  PM the Interim DON stated act with the lab and they the 02/03/16 lab for a celed by someone at the stated the lab could offer cancellation.  AM the Physician Assistant ted she expected lab work is the Physician Assistant Physician Phys	F	attending physicia audits conducted coordinator/ADOI supervisor will con indefinitely. In act lab book at each n we have another k containing the PTI sheets. Each day the Coordinator review sheets and flags the are due the next d verifies each day the completed. The D a daily list of order Each order on the compared to the pon the chart and the copy of each writted order to verify accumulation.	by unit N/unit ntinue ddition to the nurses station book &R flow he Unit ws the flow ne PTI&R that ay and then hat they were DON prints ou s from PCC. list is phone orders ne yellow en doctor	e e ut		

C CCITITION	TO TOT WILDIONIL A	MEDIOVID OF LAIOFO				CIMID IA	0. 0000-0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345221	B, WING			700000	C
		348221	U, WING			03	/03/2016
S	PROVIDER OR SUPPLIER ENTER H & REHAB WEA	/ERV		7	STREET ADDRESS, CITY, STATE, ZIP CODE  (8 WEAVER BOULEVARD  NEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	current DON stated the weekly CBC w/diff, Ct Resident #199 due 02 02/22/16 had not beein no explanation for the DON stated the facility issues with lab work be facility was in the proof the lab work system to work in the future.  Review of lab work in Resident #199 noted to diff, Chemistry 7 and L 02/15/16 and 02/22/16 medical record. On 02 progress note in the mr #199 noted concern wand a Metabolic Packar Comprehensive Metabolic	rey were unaware the nemistry 7 and LFT for 1/08/16, 02/15/16 and in completed and could offer omission. The current is was aware there were eing completed and the ess of making changes to prevent issues with lab.  The medical record of the results of the CBC with a physician's edical record of Resident in the 1/23/16 a physician's edical record of Resident in the 1/23/16 a physician's edical record of Resident in the 1/23/16 a physician's edical record of Resident in the 1/23/16 a physician's edical record of Resident in the 1/23/16 and 1/	F 3	281	4.Measures put in place to assure that the alleged deficie practice does not reoccur include a weekly audit of 100 of the Coumadin flow sheets and an audit of 25% of the all labs each week for 90 days or recommended by the QAPI Committee. A monthly summary of the audit results will be presented to QAPI and the committee will recommen changes to the POC if needed.	% as	Aarch 31" 2016

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 No. 1		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245224			***************************************		С
NAME OF F	PROVIDER OR SUPPLIER	345221	B, WING	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1	03/03/2016
	ENTER H & REHAB WEA	/ERV		7	VEAVER BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	The facility must ensu any significant medical  This REQUIREMENT by: Based on medical recinterview the facility fall which affected anti-coal	re that residents are free of tition errors.  Is not met as evidenced ord review and staff filed to obtain lab work agulant medication being residents with medications 199)  mitted to the facility zation with diagnoses nsion, atherosclerotic rillation, ischemic	F	333	F333  1.Corrective action was taken by the unit coordinator on 2/29/16 for the resident #199 affected by the alleged deficient practice by completing a medication review and restarting the medication based on the lab value received on 2/29/16 per MD order.	on ne	
in the state of th	(mg) every day and nex International Normalizer 02/03/16 with a target II a test used to monitor CA physician's progress rof Resident #199 dated #199 had a diagnosis wibrillation with plans to cOn 03/02/16 at 10:09 AN Nursing (DON) explained nonitoring residents on the Coumac Medication Administration	olood thinner) .5 milligrams at Prothrombin time (PT) d Ratio (INR) due NR of 2-3. The PT/INR is coumadin dosage.  Inote in the medical record 02/04/16 noted Resident hich included atrial continue Coumadin.  If the interim Director of d the facility system for Coumadin. The interim lin was entered on the n Record (MAR) and rough the day before the			2.Facility wide audit of all residents on Coumadin was completed by DON on 2/29/16 to determine potential residents that could be affected by the alleged deficient practice. No additional errors were identified in this audit.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	025 32000000000000	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	340221	J D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/03/2016	
BRIAN CI	ENTER H & REHAB WEA	/ERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	PT/INR results were in determine any dosing residents on Coumadi the Coumadin would in PT/INR results were be obtained from the physistated when the first Pobtained it triggered the Anticoagulant Therapy individual resident. The Anticoagulant Therapy track Coumadin dosing each resident on Counstated because the initiation of the Resident #19 Therapy Flow Sheet winterim DON stated, if I Flow Sheet had been i should have triggered in the PT/INR and Coumadin wadministered again unterimed the Coumadin wadministered again unterimed the Coumadin wadministered again unterimed the first received the properties of the first received the first received the first received the first received the Coumadin wadministered again unterimed the first received the	eported to the physician to changes needed for n. The interim DON stated to be restarted until the ack and new orders were sician. The interim DON T/INR results were e nurse to complete an Flow Sheet for the e interim DON stated the Flow Sheet was used to and PT/INR results for nadin. The interim DON ial PT/INR had not been the Anticoagulant as not initiated. The che Anticoagulant Therapy initiated for Resident #199 it nursing staff of the missing order.  MAR for Resident #199 as given 02/02/16 and not ill 02/29/16. Review of the Flow Sheet for Resident orded PT/INR results were results documented at ult was not located from record of Resident #199.  M the current DON stated	F 33	3.To prevent any further alleged deficient practic the facility has implemented daily order checks completed byuni coordinator/ADON/wee end supervisor to ensure accuracy of order entered. Anticoagulation Flow Sheet is initiated by hall nurse when the medication is ordered by the physician Daily audits of Anticoagulation Flow sheets are done by unit coordinator/ADON/weel end supervisor to insure the appropriate monitoring and follow up in correlation of the order review. The Director of Nursing assures the daily review is completed by nursing	e t k	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBERS		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF C	PROVIDER OR SUPPLIER	345221	B, WNG		03/03/2016	
NAME OF I	-ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	ENTER H & REHAB WEA	VERV		78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
	was unaware Resider Coumadin until 02/29/ stated the facility was changes to the lab wo with lab work in the fu On 03/02/16 at 1:45 P Director stated lab wo residents as ordered, stated though the 02/2 subtherapeutic for Reshad caused any harm Coumadin taken by the On 03/02/16 at 2:52 P she had been in containoted in their records the PT/INR had been cancellab. The interim DON no explanation for the companion of the companion o	at #199 had not received  116. The current DON  in the process of making  ork system to prevent issues  ture.  11 M the facility Medical  rk should be completed for  The Medical Director  129/16 PT/INR results were  sident #199 he did not feel it  because of the low dose of  the resident.  12 M the interim DON stated  ct with the lab and they  the 02/03/16 lab for a  teled by someone at the  stated the lab could offer  cancellation.  13 M the Physician Assistant  and she expected lab work  The Physician Assistant  I/INR should have been  stident #199 so the dosing  reviewed and orders	F 33	management. All starwere educated by AD on 2/29/16 on the importance of accurace of the medication ordered and importance of follup to medication monitoring. The daily medication/Anti-Coagulation Flowshee audit will continue darfor 4 weeks, then will done weekly indefinite.  4. To assure continued compliance with these processes the DON will evaluate audit results a present these results to QAPI on monthly basis. The QAPI committee will recommend any needed changes.	er low / et uily be e.	