

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

PRINTED: 02/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2013
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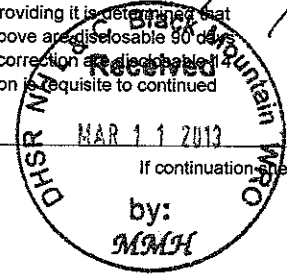
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677
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F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide a resident with activities for 1 of 3 sampled residents (Resident #71).</p> <p>The findings include:</p> <p>Resident #71 was admitted to the facility on 11/13/12 with diagnoses that included dementia and depression. The initial Minimum Data Set (MDS) dated 11/20/12 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident's family reported that it was important for the resident to do his favorite activities and very important for him to listen to music.</p> <p>Resident #71 did not have an individualized Activity care plan.</p> <p>A document titled "Activity Assessment / History" completed by the Activity Director dated 11/20/12 included a section to assess "activity pursuit patterns." Review of the activity pursuit pattern for Resident #71 was left blank.</p>	F 248	<ol style="list-style-type: none"> 1. Corrective action for the alleged deficient practice for resident #71 was accomplished by completing the "Activity Pursuit Patterns" of the Activity Assessment form and initiating an Activity Care Plan. These measures were completed by 2/15/2013. 2. There is a potential for other residents who cannot speak for themselves to be affected by this alleged deficient practice. The Activity Director or designee completed an audit of current 	2/28/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce McGuire TITLE: Administrator (X6) DATE: 2/23/13

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 disseminable 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 disseminable 180 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is a requisite to continued program participation.



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F 248	<p>Continued From page 1</p> <p>Resident #71's room was observed on 01/29/12 at 11:00 AM that revealed he had a television. Resident # 71 did not have books, magazines, radio or any other means for activity in his room. During this observation the resident's window blinds were closed preventing the resident to look outside.</p> <p>Observations made of Resident #36 revealed the following:</p> <ul style="list-style-type: none"> - On 01/29/13 at 2:00 PM Resident #71 was observed in his bed starring at the wall. During this time an activity was occurring for residents in the Activity room. - On 01/30/13 at 9:45 AM Resident #71 was observed positioned in his wheelchair facing the wall of his room. The television was on but Resident #71 was not watching it. Review of the January Activity Calendar revealed a Bible Study group was scheduled at 10:00 AM. Continual observations of Resident #71 revealed he was not invited or assisted to the Bible Study. - On 01/30/13 at 2:30 PM Resident #71 was in his bed not asleep. The television was on but the resident was not watching it. During this observation an activity was occurring in the facility. <p>On 01/31/13 at 8:30 AM nurse aide (NA) #8 assigned to care for Resident #71 was interviewed and reported she wasn't aware if the resident attended group activities provided by the facility. She stated the resident was unable to communicate his likes and dislikes. NA #8 stated Resident #71 stayed in his room most of the day and added she did not know what kind of activities he liked.</p>	F 248	<p>residents' Activity Assessments and Care Plans by 2/28/2013 to verify accuracy and completion. Updates completed as required by 2/28/13.</p> <p>3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Administrator re-educated the Activities Director on the requirements for initial and ongoing assessment and care planning expectations by 2/28/13. The</p>	

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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F 248	Continued From page 2 On 01/31/13 at 8:50 AM the Activity Director was interviewed and reported that she completed initial activity assessments on all residents to determine what their interests were. She stated that in the case of Resident #71 she had to speak with the family to determine what his past activities included because he was unable to communicate his preferences. The Activity Director reported that she spoke with Resident #71's family and learned that the resident enjoyed religious music and fishing. She added that during the month of December the resident was invited to attend religious music activities that he appeared to enjoy. She reported that the resident was recently moved to a new room and had not been attending out of room activities. The Activity Director stated that Resident #71 was not her focus at this time and was unable to offer an explanation why the resident had not been attending these activities. During the interview the Activity Director provided monthly activity logs for Resident #71. She stated that every day one of the activity department employees went to each resident to say good morning which she documented as an activity. She added that in the evening a volunteer came to the facility for 2 hours to offer each resident a piece of candy and this was also considered an activity. Resident #71 did not have a November 2012 activity calendar reflecting that he had attended activities. Resident #71's December activity log was reviewed and revealed that he received activities other than a staff member saying good morning, watching television or receiving a candy from a volunteer 11 out of 31 days in the month. The January 2013 activity	F 248	Activities Director or designee will randomly monitor 10 resident records weekly for 12 to ensure accurate completion of the Activity Assessment and Care plan. The Administrator or designee will randomly observe 10 residents per week for 12 weeks to verify appropriate participation in care planned Activities programs. 4. These measures are to ensure corrections are achieved and sustained: The Activity Director will report the	

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F 248	<p>Continued From page 3</p> <p>calendar specified Resident #71 had not received activity therapy from 01/10/13 to 01/31/13 other than having his television turned on, a staff member saying good morning and receiving a piece of candy from a volunteer. The Activity Director was present during the review of Resident #71's activity calendars and stated the resident should have received more activities since his admission to the facility. The Activity Director explained that the facility offered small group activities for residents with advanced dementia. She stated that Resident #71 would benefit from this small group but offered no explanation why he had not been invited to attend the small group sessions.</p> <p>On 01/31/13 at 11:00 AM nurse aide #9 was interviewed and stated she had helped with activities and recalled seeing Resident #71 in afternoon activities and reported he appeared to enjoy them. She added the resident especially enjoyed church services and music events. NA #9 reported that the Resident had not been attending activities recently and she was unaware of the reason.</p> <p>On 01/31/13 at 4:00 PM the Administrator was interviewed and reported that she expected residents to be invited and encouraged to attend out of room activities. She stated very little was known about Resident #71 because he was unable to communicate to staff and added his family was not involved in his care. And added Resident #71 needed activity services provided by the facility.</p>	F 248	<p>results of these audits and observations during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendation as indicated.</p> <p>5. Date of compliance: 2/28/13</p>	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	<p>Continued From page 4</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep 1 of 4 residential hallways free from clutter and maintain resident rooms in good repair for 8 of 40 rooms observed.</p> <p>The findings are:</p> <p>1. On 01/28/13 at 1:05 PM and at 4:35 PM observations revealed an approximately 25 foot long section of residential hallway extending from Resident Room 142, past the Central Supply Room and ending at an emergency exit. On the right side of the hallway when facing the exit and in vicinity of Central Supply Room were 14 cardboard boxes of incontinence pads stacked 2 and 3 boxes high. On the left side of the hallway across from Resident Room 142 was an approximately 6 inch high by 2 feet wide by 3 feet long stack of flattened boxes. Next to the flattened boxes was an oxygen concentrator labeled as broken.</p> <p>On 01/29/13 at 8:22 AM was observed this same section of residential hallway. When facing the emergency exit, the hallway on the right side was cleared of cardboard boxes. On the left side of the hallway across from Resident Room 142 was an approximately 8 inch high by 2 feet wide by 3 feet long stack of flattened cardboard boxes. Next to the stack of flattened cardboard boxes was an approximately 1 foot high by 2 feet wide</p>	F 253	<p>Corrective action for the alleged deficiency included the following:</p> <p>a..Cleared the cited hallway on 1-31-2013</p> <p>b.In room 301 removed wallpaper and painted the wall.</p> <p>c.In room 308 replaced the section of drywall, replaced the missing privacy curtain hooks, replaced the loose floor tile.</p> <p>d.In room 309 sanded and painted the bathroom door frame, repaired the cable box outlet.</p> <p>e.In room 310 cleaned the wall above the bed, replaced the tray table, replaced the missing curtain hooks, sanded and painted the bathroom door, replaced the stained caulking around the commode.</p>	2/28/13

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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F 253	<p>Continued From page 5</p> <p>by 3 feet long empty box. Continuing down the left side of the hallway was an oxygen concentrator labeled as broken.</p> <p>On 01/29/13 at 11:38 AM and at 3:00 PM was observed this same section of residential hallway. When facing the emergency exit, the hallway on the right side was cleared of items. On the left side of the hallway across from Resident Room 142 was an approximately 10 inch high by 2 feet wide by 3 feet long stack of flattened cardboard boxes. Continuing down the left side of the hallway was an oxygen concentrator labeled as broken.</p> <p>On 01/30/13 at 8:00 AM was observed this same section of residential hallway. When facing the emergency exit, the hallway on the right side was cleared of items. On the left side of the hallway across from Resident Room 142 was an approximately 10 inch high by 2 feet wide by 3 feet long stack of flattened cardboard boxes. Next to this stack of boxes was observed an upholstered wooden chair. Continuing down the left side of the hallway was an oxygen concentrator labeled as broken. At the end of the hallway and to the immediate left of the emergency exit was observed a blue push-type wet vacuum. A staff member with a black flat push cart was observed in this section of residential hallway entering and leaving the Central Supply Room.</p> <p>On 01/30/12 at 9:28 AM and 12:40 PM was observed this same section of residential hallway. When facing the emergency exit, the hallway on the right side was cleared of items. On the left side of the hallway across from Resident Room</p>	F 253	<p>f. In room 311 removed wallpaper and painted the walls, repaired and restained the bathroom door, replaced cove base and damaged drywall, replaced electrical outlet and the faceplate.</p> <p>g. In room 400 replaced bathroom tiles and commode grout, replaced damaged drywall, removed wallpaper and painted walls, replaced hooks for privacy curtain.</p> <p>h. In room 404, replaced nightstand, sanded and painted the bathroom door.</p> <p>i. In room 408 replaced the bed tray table. Sanded and painted the bathroom doorframe, replaced cove base.</p>		

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F 253	<p>Continued From page 6</p> <p>142 the stack of flattened cardboard boxes was gone but an upholstered wooden chair was observed. An oxygen concentrator labeled as broken and a blue push-type wet vacuum was observed along the left side of the hallway.</p> <p>On 01/30/13 at 5:30 PM was observed this same section of residential hallway. When facing the emergency exit, the hallway on the right side was cleared of items. On the left side of the hallway across from Central Supply Room were observed three oxygen concentrators, one of these labeled as broken. To the immediate left of the emergency exit was observed a blue push-type wet vacuum.</p> <p>On 01/31/13 at 8:00 AM and 11:40 AM was observed this same section of residential hallway. When facing the emergency exit, the hallway on the right side was cleared of items. On the left side of the hallway across from Central Supply Room remained three oxygen concentrators, one of these labeled as broken. To the immediate left of the emergency exit was observed a blue push-type wet vacuum.</p> <p>On 01/31/13 at 11:40 AM the Maintenance Director was interviewed. He stated this section of hallway is considered residential and a path to the emergency exit and for these reasons should have been clear of equipment and supplies at all times. The Maintenance Director further stated any supplies received by Central Supply may come through the emergency exit and be placed along the hallway but only remained in this location temporarily before stocking in Central Supply. He stated any flattened cardboard boxes after stocking should be removed to the dumpster</p>	F 253	<p>All residents have the potential to be affected by the alleged deficient practice. Therefore all non-service hallways were observed for clutter and this was removed by 2/28/2013. All resident rooms were audited for needed repairs and maintenance and a prioritized repair schedule was developed by the Maintenance Director by 2/28/ 2013.</p>	

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F 253	<p>Continued From page 7</p> <p>immediately. The Maintenance Director stated oxygen concentrators would have been placed in the hallway by Central Supply and the blue push-type wet vacuum by Housekeeping.</p> <p>On 01/31/13 at 11:40 AM the Central Supply staff member was interviewed. He stated he placed oxygen concentrators in the hallway for pick-up by the medical supply company every Monday and they are normally left in his office until such time. The Central Supply staff member stated oxygen concentrators should not have been left in the hallway for the time period observed and flattened cardboard boxes should have been removed immediately after stocking.</p> <p>On 01/31/13 at 1:00 PM the Housekeeping Supervisor was interviewed. He stated he was the person responsible for placing the wet vacuum to the immediate left of the emergency exit after floor work in Therapy on the evening of 01/29/13. The Housekeeping Supervisor stated he placed the wet vacuum there for an intended temporary period but forgot about it. He stated long-term storage of equipment in residential hallways is not permitted.</p> <p>On 01/31/12 at 4:21 PM the Administrator was interviewed. She stated her expectation that residential hallways were to be free of items not in active use for resident care. The Administrator stated Central Supply staff would unload boxes of supplies temporarily received in this location, but flattened boxes and equipment should not have been left there for days.</p> <p>2. On 01/31/13 at 11:10 AM during a tour of the facility with the Maintenance Director, the</p>	F 253	<p>Measures put into place to ensure that the alleged deficient practices do not recur are as follows: All staff will be re-educated by the Maintenance Director or his designee on recognizing and reporting a Maintenance request for needed repairs. The Maintenance Director or his designee will monitor 10 rooms weekly for 12 weeks to identify needed repairs and maintenance.</p>	

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F 253	Continued From page 8 following concerns were observed: a. In Room 301, wallpaper was missing off the drywall around the heater/air conditioning unit. b. In Room 308, a section of oblong drywall approximately 12 inches by 3 inches at the widest point was noted missing by the lower left corner of the heater/air conditioning unit, exposing yellow fiberglass insulation. In the vicinity of this hole was loose vinyl floor tile. At the bed closest to the door was a privacy curtain missing approximately half of its hanging hooks resulting in a drooping privacy curtain. c. In Room 309, the bathroom door frame was chipped and rusty. On the wall opposite the beds, a cable box was observed hanging loose from the drywall by a black cable. d. In Room 310, on the wall above the bed closest to the door was brown crusty debris in scattered pattern. A bed tray table was noted with chipped and missing laminate along the edge, exposing wood particleboard. A privacy curtain was noted sagging from the ceiling track due to a lack of hooks holding it in a suspended fashion from the ceiling. The bathroom door frame was chipped and rusty. Around the base of the commode was noted brown stained caulking e. In Room 311, wallpaper was ripped on the wall between the doors to the room and the bathroom, to the right of the bathroom door and on a corner edge where the wall turned at a 90 degree angle toward the first bed in the room. The bottom section of the bathroom door frame was chipped and rusty. Under the heater/air conditioning unit,	F 253	To ensure that corrections are achieved and are sustained the Maintenance Director will report the results of these audits and observations during the Quality Assessment and Process Improvement meeting monthly for 3 months and then quarterly. The QAPI team will evaluate and make further recommendations as indicated. Date of compliance: 2/28/2013		

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F 253	<p>Continued From page 9</p> <p>there was missing wallpaper and approximately four feet of vinyl baseboard was missing. Behind the headboard of the bed closest to the window, drywall measuring approximately 8 inches long by 2 inches wide was crushed with a 2 inch diameter hole noted in this affected section. Upon asking the Maintenance Director to move the bed to better inspect the wall, to the right of this section of crushed drywall was noted an electrical outlet missing its faceplate. An approximately 1/4 inch diameter jagged piece of faceplate was held in place by the faceplate screw to this electrical outlet. The bottom outlet was cracked in half with a piece of the outlet missing.</p> <p>f. In Room 400, the base of the commode had pulled away from grout along the floor with loose vinyl tile in the vicinity. Drywall around the heater/air conditioning unit had an unfinished appearance (no paint, primer or wallpaper) with brown stains. A black dusty substance on the ends of this drywall section was observed in the vicinity of existing wallpaper near the lower corners of the heater/air conditioning unit. The wallpaper in this vicinity was peeling away from the wall exposing an older layer of paper black dusty substance between the layers. The privacy curtain by the bed closest to the door was noted with an approximately 6 inch diameter brown stain.</p> <p>g. In Room 404, a bed nightstand located across from the bed closest to the door had an unlevelled top drawer due to a broken drawer track and loose vinyl trim around edge of the bottom door. The bathroom door frame was noted with peeling paint.</p>	F 253			

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F 253	<p>Continued From page 10</p> <p>h. In Room 408, a bed tray table was noted with chipped laminate. The bathroom door frame was chipped. Vinyl baseboard under the heater/air conditioning unit was noted peeling away from the wall.</p> <p>On 01/31/13 at 12:15 PM the Maintenance Director was interviewed. He stated each nursing station has a maintenance request book where staff may find blank work request slips for maintenance concerns. The Maintenance Director's expectation was staff should complete a work request slip if they find maintenance concerns and the maintenance request books were checked hourly during the day shift. He stated staff was trained in using the slips and if the concern posed a harmful situation they were to call for an immediate response. The Maintenance Director revealed all chipped and broken furniture is repaired or replaced as necessary. He stated that at morning meetings of facility leadership he is informed of discharged residents which presented an opportunity to perform repairs not easily done when the room is occupied, such as repairs to wallpaper. The Maintenance Director stated that each day 5 rooms are randomly checked by an assistant for concerns with lights, electric outlets and hazardous conditions, but equipment, furniture and wall condition was not a part of this check. He stated that the broken electrical outlet in Room 311 will be replaced immediately. The Maintenance Director stated privacy curtains are cleaned and monitored by the Housekeeping Supervisor.</p> <p>On 01/31/12 at 4:21 PM the Administrator was interviewed. She stated her expectation of staff</p>	F 253			

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F 253	Continued From page 11 to report obvious maintenance findings such as drywall holes, peeling wallpaper, water damage and missing baseboard. On 01/31/13 at 4:46 PM the Housekeeping Supervisor was interviewed. He stated the facility's deep cleaning schedule addressed 3 rooms per day and those rooms available after a resident was discharged. He further stated privacy curtains were evaluated for cleanliness and proper hanging during this deep cleaning. The Housekeeping Supervisor stated for quality control purposes he entered each deep cleaned room and checked for cleanliness, including an evaluation of privacy curtains. He stated the Maintenance Director informed him of privacy curtain concerns in Rooms 308, 310 and 400, he evaluated their condition and stated their condition was not acceptable.	F 253			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	Corrective action for this alleged deficient practice was satisfied by completing a Significant Change Assessment for the identified changes of condition for resident. #54 by 2/28/13.	2/28/13	

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F 274	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to comprehensively assess a change in condition for 1 of 1 sampled residents with significant changes in condition. Resident #54's changes included cognition, continency, functional range of motion, pain, and weight.</p> <p>The findings include:</p> <p>Resident #54 was admitted with diagnoses including pneumonia, pleural effusion, dysphagia, atrial fibrillation, respiratory failure, chronic obstructive pulmonary disease, depression and anxiety.</p> <p>The annual Minimum Data Set (MDS) dated 10/09/12 coded him as being cognitively intact, requiring extensive assistance with all activity of daily living skills (ADLS), except he was able to feed himself after set up, frequently incontinent of urine, always continent of bowel, no limitation in range of motion, no splints in use, receiving therapies, having no pain, receiving no pain medications, and weighing 210 pounds.</p> <p>The quarterly MDS dated 12/29/12 coded Resident #54 with long and short term memory impairment, moderately impaired decision making skills, requiring extensive assistance with ADLS except eating, always incontinent of bowel and bladder, having functional range in motion on the lower extremities on both sides, having moderate pain, and weighing 195 pounds.</p> <p>No changes were made to the toileting plan</p>	F 274	<p>All residents who have had a change of condition are at risk for the same alleged deficient practice. The Resident Care Management Director or designee will complete an audit of all residents with an identified change of condition during the last 90 days to verify the appropriate Significant Change Assessment has been completed by 2/28/13.</p>	

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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F 274	<p>Continued From page 13</p> <p>updated 12/29/12 which included to assist Resident #54 to the toilet upon rising, before and after meals and before bed. A new care plan was developed on 01/03/13 for behaviors and resisting care. New care plans were developed 01/07/13 related to the new splint for his left hand and restorative services for range of motion.</p> <p>Resident #54 was observed on 01/30/13 at 9:50 AM in his bed, asleep wearing a left wrist splint. On 01/30/13 at 10:35 AM, he was observed during a transfer and had difficulty following staff cueing. After the transfer, Resident #54's incontinent brief was changed. On 01/30/13 at 10:48 AM, nurse aide (NA) #1 stated she offered Resident #54 the urinal only when he asked for it. She reported he was slightly incontinent of urine.</p> <p>On 01/30/13 at 12:18 PM, NA # 2 brought in his tray and proceeded to feed Resident #54 his meal. NA # 2 stated on 01/30/13 at 1:05 PM that Resident #54 was no longer taken to the commode or offered a urinal.</p> <p>On 01/31/13 at 10:56 AM, NA #3 stated that Resident #54 had changes in behaviors, communication, and continency since being hospitalized in the previous month. She further stated that he was no longer feeding himself.</p> <p>On 01/31/13 at 11:03 AM, NA #4 stated he has had a change over the past couple of months. She revealed Resident #54 no longer ate independently, slept a lot, did not always swallow, used to tell staff when he needed to use the bathroom and no longer did so.</p>	F 274	<p>Measures put into place to prevent future deficient practice include: The Director of Nursing or designee will re-educate all Licensed Nurses completing the MDS on the requirements for completion of a Significant Change Assessment by 2/28/13. The Resident Care Management Director will randomly review 10 residents with a change in condition, weekly for 12 weeks, to verify the appropriate Significant Change Assessment has been completed.</p>		

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F 274	Continued From page 14 On 01/31/13 at 11:09 AM, Nurse #1 stated that Resident #54 used to tell staff when he needed to toilet, his declines included the use of a splint for contractures on his left hand, difficulty feeding himself, and no longer wanting to go to the dining room. She stated that since his last hospitalization, he had deteriorated and was much quieter. On 01/31/13 at 11:51 AM the Unit Manager #1 stated Resident #54 has had an overall decline with worse breathing and no longer getting up to use the toilet. She further stated he had recently quit feeding himself. On 01/31/13 at 3:46 PM, the MDS nurse stated that for a significant change, she looked for changes in two ADLS, or a change in one ADL and another area such as cognition or weight loss. She stated that they had been considering a change in condition for Resident #54 this month. She stated that they were watching for improvements since his hospitalization because in the past he usually returned to his baseline of functioning after a hospitalization. She further stated that when he did not show improvement after 14 days, she should have completed a significant change assessment.	F 274	These measures are to monitor and sustain compliance: The Resident Care Management Director will report the results of these audits and monitoring during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendation as indicated. Date of compliance: 2/28/13	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279	1. Corrective action for the alleged deficient practice was accomplished by developing a comprehensive Activity care plan for Res. #71.	2/28/13

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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F 279	<p>Continued From page 15</p> <p>medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop an activity care plan for 1 of 3 sampled residents reviewed for activities (Resident #71).</p> <p>The findings include:</p> <p>Resident #71 was admitted to the facility on 11/13/12 with diagnoses that included dementia and depression. The initial Minimum Data Set (MDS) dated 11/20/12 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident's family reported that it was important for the resident to do his favorite activities and very important for him to listen to music.</p> <p>Resident #71 did not have an individualized Activity care plan.</p>	F 279	<p>2. All residents are at risk for the same alleged deficient practice. The Activity Director or designee completed an audit of all current residents' Activity Care Plans to verify development of a comprehensive Activity care plan by 2/28/13.</p> <p>3. To ensure that this alleged deficient practice does not recur the Administrator re-educated the Activity Director on care planning requirements for Activities. The Activity Director or designee will randomly monitor 10 residents weekly to verify care planning is complete.</p>	

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F 279	Continued From page 16 A document titled "Activity Assessment / History" completed by the Activity Director dated 11/20/12 included a section to assess "activity pursuit patterns." Review of the activity pursuit pattern for Resident #71 was left blank. On 01/31/13 at 8:50 AM the Activity Director was interviewed and stated that she develops an activity care plan for all residents. She stated that Resident #71 would have been care planned for activities based on his diagnoses of dementia, depression and agitation and his inability to propel himself. The Activity Director reviewed Resident #71's comprehensive care plan and stated it was an oversight that the resident did not have an activity related care plan.	F 279	4. These measures are to ensure corrections are achieved and sustained: The Activity Director will report the results of these audits during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendation as indicated. Date of compliance: 2/28/13	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the plan of care to prevent injuries from a fall by placing fall mats on the floor beside each side of the bed for 1 of 4 sampled residents with fall interventions. (Resident #28) The findings include: Resident #28's diagnoses included Alzheimer's Disease, major depression, failure to thrive,	F 282	1. Corrective action for the alleged deficient practice for Resident #28 was completed by updating the current care plan with clear instructions on floor mat usage related to bed placement. Floor mats were placed according to the care plan by 1/31/13.	2/28/13

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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F 282	<p>Continued From page 17</p> <p>hypertension and peripheral vascular disease.</p> <p>The annual Minimum Data Set (MDS) dated 09/11/12 coded her with long and short memory impairment with severely impaired decision making skills, requiring extensive assistance with most activities of daily living skills, having no behaviors, being nonambulatory, and having no falls.</p> <p>A care plan was developed on 09/17/12 for fall risk with a goal to be free from fall related injuries. The last review this care plan was on 11/30/12 which included the use of a low bed and floor mats on both sides of the bed.</p> <p>Resident #28 was observed in bed on 01/30/13 at 3:50 PM in a low bed, two half rails, a floor mat on the right side of the bed and no floor mat on the left side of the bed (between her bed and the roommate's bed).</p> <p>On 01/31/13 at 10:32 AM interview with Nurse #2 revealed, per the nurse aide care guide, Resident #28 only required one fall mat on the floor. Nurse #2 could not say which side of the bed the floor mat should be on. She did not recall Resident #28 having a fall mat on both sides of the bed.</p> <p>On 01/31/13 at 11:50 AM, the Unit Manager #1 stated a floor mat should be on both sides of the bed when Resident #28 was in bed.</p> <p>On 01/31/13 at 4:22 PM nurse aide (NA) #5 stated she could only recall only utilizing one floor mat for Resident #28 and usually placed it on the right side since the left side was closest to the roommate's bed.</p>	F 282	<p>2. There is a potential for other residents utilizing floor mats as care planned interventions to be affected by this alleged deficient practice. The Director of Nursing or designee will complete an audit of all residents utilizing floor mats as care planned interventions to verify clear instructions for placement are provided by 2/28/13.</p> <p>3. The Director of Nursing or designee will re-educate all Nursing staff on appropriate placement of care planned interventions including the placement of floor mats by 2/28/13. The Director of Nursing will randomly monitor 10 residents weekly for 12 weeks to verify care planned interventions are in place.</p>		

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F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interview and staff interviews, the facility failed to firmly affix siderails against the mattress and tighten siderails to avoid excessive movement when in use for 3 of 41 sampled residents. (Residents #28, #70 and #127).</p> <p>The findings were:</p> <p>1. Resident #127's diagnosis included infection of the left chest wall abscess, uncontrolled diabetes, hypertension, anxiety, and depression.</p> <p>The admission Minimum Data Set dated 12/06/12 coded him as having moderately impaired cognitive skills, needing limited assistance with bed mobility, and requiring supervision with transfers and ambulation.</p> <p>On 01/30/13 at 5:20 PM, Resident #127 was observed in bed with the left top half siderails in the upright position. The surveyor's fist could be easily placed between the mattress and the left siderail. The right side of the bed was against the wall. The left siderail was observed very loose,</p>	F 323	<p><i>F282 Con't</i></p> <p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of these audits and observations during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendation as indicated. Date of compliance: 2/28/13</p>	
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F 323	<p>Continued From page 19</p> <p>wobbling inward and outward and end to end as Resident #127 grabbed it and repositioned himself. Resident #127 stated he used the half siderails to reposition himself and the left siderail had been very wobbly and sometimes fell down during use.</p> <p>The left siderail was observed down when Resident #127 was observed sleeping in bed on 01/31/13 at 7:49 AM.</p> <p>The left siderail was again observed down on 01/31/13 at 8:47 AM while the resident was in bed. Resident #127 again stated at this time that he used his siderails to turn and the left upper siderail fell down sometimes during use. He stated he told a nurse but could not recall the name the nurse he told about the siderail.</p> <p>On 01/31/13 at 9:12 AM, Nurse Aide (NA) #11 stated Resident #127 was noncompliant with keeping personal alarms turned on and attached and that he got up without assistance or without calling for assistance. She further stated she was unaware of any problems with the siderail being loose or falling down out of place.</p> <p>On 01/31/13 at 9:25 AM, the Unit Manager #2 stated Resident #127 was noncompliant with allowing the alarms on his bed and that he got out of bed unassisted.</p> <p>On 01/31/13 at 10:09 AM, Nurse #3 stated she had never noticed any problems with the loose siderail for Resident #127 nor had she been told about any problems. Nurse #3 went into the room at this time and verified the left upper siderail did not lock in place consistently and was</p>	F 323	<p>Corrective action for the alleged deficiency was taken by repairing the side rails for residents #28, #70, and #127</p> <p>Residents who use side rails have the potential to be affected by the same alleged deficient practice. Therefore, the Maintenance Director has performed an audit of all bed rails and repaired as required by 2/28/13.</p> <p>Measures put into place to ensure that the alleged practice does not recur include: All Nursing have been re-educated by the Maintenance Director or designee on recognizing and reporting a Maintenance request for needed repairs including</p>	2/28/13	

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F 323	<p>Continued From page 20</p> <p>loose. She stated she would write a note in the maintenance book for it to be repaired.</p> <p>On 01/31/13 at 5:18 PM, the Administrator stated she expected staff to recognize when siderails were loose. She further stated that maintenance staff were responsible for making rounds and thought maintenance staff had checked the siderails for proper fit and tightness at least twice in past 2 years. Further interview at 6:00 PM revealed that all siderails in the building had been checked on 09/11/12 to ensure they were secure and it against the mattress. There were no scheduled routine checks to check siderails.</p> <p>2. Resident #70's diagnoses included dementia, reactive confusion, obstructive hydrocephalus, depression, anxiety, syncope and collapse, Rheumatoid arthritis and muscle weakness.</p> <p>The annual Minimum Data Set (MDS) dated 01/3/13 coded her with long and short term memory impairment and moderately impaired decision making abilities, requiring extensive assistance with most activities of daily living skills and having balance problems.</p> <p>Resident #70 was observed in bed on 01/28/13 at 2:57 PM with both top half siderails upright. Both siderails were loose and wobbling, inward and outward and end to end.</p> <p>On 01/30/12 at 10:21 AM and at 11:23 AM, Resident #70 was in bed with both top half rails upright and loose.</p> <p>On 01/30/13 at 11:28 AM, Nurse Aide (NA) #10 assisted Resident #70 out of bed with the</p>	F 323	<p>appropriately fitted bed rails by 2/28/13 The Maintenance Director or designee will randomly monitor 10 bed rails weekly for 12 weeks to ensure appropriate fit and repair as identified.</p> <p>These measures are to ensure that corrections are achieved and sustained: These measures are to ensure corrections are achieved and sustained: The Maintenance Director will report the results of these audits and observations during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendation as indicated. Date of compliance: 2/28/13</p>		

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

PRINTED: 02/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	
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F 323	<p>Continued From page 21</p> <p>assistance of another NA. During this transfer, Resident #70 did not use the siderails. NA #10 stated that Resident #70 followed cues and turned herself in bed utilizing the siderails.</p> <p>The top half siderails remained upright and loose and a hand width away from the mattress during an observation on 01/30/13 at 1:12 PM.</p> <p>Interview with NA #5 on 01/30/13 at 4:06 PM revealed Resident #70 used the siderails to turn herself in bed.</p> <p>On 01/31/13 at 8:53 AM, Resident #70 requested to go to bed. NA #5 answered the call light and assisted her to bed. NA #5 placed the left top siderail upright before the transfer and it was observed loose and wobbly. Resident #70 was observed to use the siderails to turn herself once she was in bed.</p> <p>On 01/31/13 at 9:01 AM, NA #5 stated she did not notice how loose the siderail was for Resident #70 and stated that when she observed a loose siderail, she placed a request for repair in the maintenance book. She further agreed the siderail was loose and wrote a note in the maintenance book.</p> <p>On 01/31/13 at 10:32 AM, interview with Nurse #2 revealed she believed Resident #70 could use the siderails to turn herself but had not actually witnessed her using the siderails. She further stated that if a siderail was noted to be loose or ill-fitting, it was written in the maintenance book which was reviewed 2 to 3 times a day by maintenance staff.</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>On 01/31/13 at 5:18 PM, the Administrator stated she expected staff to recognize when siderails were loose. She further stated that maintenance staff were responsible for making rounds and thought maintenance staff had checked the siderails for proper fit and tightness at least twice in past 2 years. Further interview at 6:00 PM revealed that all siderails in the building had been checked on 09/11/12 to ensure they were secure and it against the mattress. There were no scheduled routine checks to check siderails.</p> <p>3. Resident #28 was admitted to the facility with diagnoses including Alzheimer's Disease, major depression and failure to thrive.</p> <p>The annual Minimum Data Set (MDS) dated 09/11/12 and the quarterly MDS dated 12/02/12 coded her with long and short term memory impairment, severely impaired decision making abilities, requiring extensive assistance with most activities of daily living skills and being nonambulatory.</p> <p>On 01/28/13 at 2:42 PM, Resident #28's bed was observed with the left top half siderail in the up position. Resident #28 was not in bed at the time. The siderail was very loose and moved back and forth at least 6 inches.</p> <p>On 01/30/13 at 8:43 PM the left top half siderail was in the up position, angled out at top and moved back and forth, at least 6 inches. The surveyor's fist could fit in between the mattress and the siderail.</p> <p>On 01/30/13 at 3:50 PM Resident #28 was observed in bed with two half top siderails in the</p>	F 323		

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F 323	<p>Continued From page 23</p> <p>upright position. The upper left half siderail remained loose and away from the mattress.</p> <p>On 01/30/13 at 4:03 PM, Nurse Aide (NA) #5 and NA #6 assisted Resident #28 out of bed. She was very quick in her independent movements to move around in bed. She did not utilized the siderail during this observation. NA #5 stated Resident #28 freely moved around in bed but did not use the siderails when turning.</p> <p>On 01/31/13 at 10:22 PM, NA #7 stated Resident #28 used the siderails to turn at times. The siderails were inspected in the presence of NA #7 and the left upper siderail was observed to be loose and not tight against the mattress. NA #7 stated she did not notice it before and proceeded to write the loose siderail in the maintenance book.</p> <p>On 01/31/13 at 10:32 AM, Nurse #2 stated she had never seen Resident #28 use the siderails, but believed she could if cued. She further stated that If a loose siderail was observed, staff would write about it in the maintenance book for repair, which maintenance staff looked at 2 to 3 times a day.</p> <p>On 01/31/13 at 5:18 PM, the Administrator stated she expected staff to recognize when siderails were loose. She further stated that maintenance staff were responsible for making rounds and thought maintenance staff had checked the siderails for proper fit and tightness at least twice in past 2 years. Further interview at 6:00 PM revealed that all siderails in the building had been checked on 09/11/12 to ensure they were secure and it against the mattress. There were no</p>	F 323			

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F 323	Continued From page 24 scheduled routine checks to check siderails.	F 323			