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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING ______ B. WING ______	C 06/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVE PLACE NW HICKORY, NC 28601

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F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident review, and resident and staff interviews the facility failed to provide privacy for 1 of 2 residents observed during provision of care.	F 164	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **F 164 Personal Privacy/confidentiality of Records** ***Criteria I*** The Privacy Curtain Track in Room 217 was repaired to allow the curtain to move freely on the track and to allow the door to be closed completely in order to provide privacy during personal care	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 7/17/13

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 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.

Original Signature Date: 7/01/13

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F 164	Continued From page 1 The findings included: Resident #5 was admitted to the facility 04/05/13 with diagnoses which included diabetes and benign prostatic hypertrophy. The most recent Admission Minimum Data Set (MDS) dated 05/16/13 assessed Resident #5 as being able to be understood and able to understand. The MDS assessed Resident #5 as having moderate cognitive impairment and needing extensive assistance with personal hygiene and bathing. An observation was made on 06/13/13 at 3:55 PM. The door to Resident #5's room was open and the curtain partially pulled as it had been on earlier observations that day. Upon knocking and entering the room it was observed that Resident #5 was receiving incontinence care provided by Nursing Assistant (NA) #1. There was a large gap in the curtain leaving Resident #5 in full view of anyone in the room. Resident #5's room contained three beds. The curtain to the second bed was not pulled and the curtain to the third bed was only partially pulled. There was a family member visiting the resident in bed #3. No one was in bed #2 at the time. On 06/13/13 at 4:00 PM an interview was conducted with NA #1. NA #1 stated he had been providing incontinence care for Resident #5 as he had a bowel movement. NA #1 further stated he was "in a rush" and did not take the time to close the door or fully pull the curtains around Resident #5's bed. He stated he should have fully pulled the curtains and closed the door to provide privacy for Resident #5. On 06/13/13 at 4:05 PM an interview was	F 164	***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice. An audit of Privacy Curtains maintained throughout the facility will be conducted by the Administrator or Designee to verify proper function and repair as required. These audits will be completed by July 11, 2013. ***Criteria 3*** The Director of Nursing or Designee will re-educate Nursing Staff on Privacy requirements, to include the use of privacy curtains when providing personal care. This education will be completed by July 11, 2013. The Director of Nursing or Designee will randomly monitor 5	

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F 164	Continued From page 2 conducted with Resident #5. Resident #5 stated he would have like for NA #1 to have pulled the curtain and closed the door during his care. He further stated he was not upset with NA #1 because he knows he stays very busy and when he asks this NA for something he always does it for him. On 06/13/13 at 4:20 PM an interview was conducted with Nurse #1 who worked the hall in which Resident #5 lived. Nurse #1 stated NA #1 should have provided fro privacy by closing the door and pulling the curtains. An interview was conducted on 06/13/13 with the Director of Nursing (DON). The DON stated it was her expectation that NA #1 should have provided privacy by pulling the curtains and closing the door prior to providing care for Resident #5.	F 164	Resident Care Specialists while providing personal care weekly for 4 weeks and monthly for 2 months to ensure compliance with privacy requirements. Opportunities will be corrected as identified. ***Criteria 4*** The results of the audits will be reported in monthly Quality Assurance Performance Improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on facility documents, record review, and staff and resident interviews the facility failed to honor choices regarding frequency of bathing and food choices for 2 of 3 residents reviewed for	F 242	Date of Compliance: July 11, 2013	

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F 242	Continued From page 3 choices. (Residents #5 and #8) The Findings included: 1. Resident #5 was admitted to the facility 04/05/13 with diagnoses which included diabetes and benign prostatic hypertrophy. The most recent Admission Minimum Data Set (MDS) dated 05/16/13 assessed Resident #5 as able to be understood and able to understand. The MDS assessed Resident #5 as having moderate cognitive impairment and needing extensive assistance with personal hygiene and bathing. Further review of the MDS indicated there had been no refusals of care. An interview was conducted on 06/13/13 at 10:40 AM with Resident #5. Resident #5 stated he gets two showers per week. He pointed to the card posted on the bulletin board above his bed which read, "Wednesday and Sunday, 3:00 - 11:00 shift." Resident #5 stated when he came to the facility staff did not ask him how often he would like to have a shower. He stated he would like to have a shower everyday. Resident #5 further explained he would like to have a shower everyday because of the issues he has been having with his urine makes him smell bad. On 06/13/13 at 12:55 PM an interview was conducted with the Activity Director. She stated when residents are admitted she completes the MDS section regarding customary routine and preferences. She stated she does not assess residents' frequency of bathing preference. She stated nursing would assess frequency of bathing. She went on to say that routinely residents are scheduled two showers per week.	F 242	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **F 242 Self Determinatin-Right to make Choices** *Criteria I* Resident # 5 was interviewed regarding his preference for bathing and his schedule was changed to meet his preferences *Criteria 2* All residents have the potential to be affected by this alleged deficient practice. An audit of residents has been conducted by the Director of Nursing or Designee to verify their preferences with regards to	

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F 242	Continued From page 4 An Interview was conducted on 06/13/13 at 1:05 PM with Nurse #1 who works the hall where Resident #5 lives. She stated shower schedules are set by room and bed numbers and assigned per shift as well. Further more, she reported if a resident would like to have more than two showers per week they would provide them but the resident would have to ask. She stated frequency of bathing is not assessed and residents are not asked how often they would like to have a shower. An interview was conducted on 06/13/13 at 10:51 PM with the Unit Coordinator (UC). The UC stated unless a resident requests more than two showers per week they do not get more. The UC went on to say that if a resident requests a shower on a day that the shower has not previously been scheduled the nursing assistants try to get it done. On 06/13/13 at 4:30 PM an interview was conducted with the Director of Nursing (DON). The DON stated the Activity Director completes the MDS assessment regarding preference of either a shower, tub or bed bath. When a resident is admitted they are plugged into the bath schedule as to their room number. This schedule has been predetermined. She went on to explain that after a resident has been in the facility a few days if they express a preference regarding morning or evening showers then that they will accommodate that request. She stated if a resident requests more than two showers they give them but residents are not asked how often they would like to have a shower or a bath.	F 242	bathing and bathing schedules were adjusted as required based on results of these interviews. The audit will be completed by July 11, 2013 ***Criteria 3*** The Director of Nursing has developed an additional interview tool for use during the admission process to identify resident preferences related to bathing schedules. Licensed Nursing Staff will be educated by the Director of Nursing or Designee on completion of the interview regarding bathing preferences upon admission. Nursing Staff has been re-educated by the Director of Nursing or Designee on adhering to resident preferences regarding bathing schedules and communicating a resident's request for change in bathing schedules to the Director of Nursing or Unit Manager. The education will be completed by July 11, 2013. The Director of Nursing or Designee will randomly interview 5 residents	

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F 242	Continued From page 5 2. On 06/13/13 at approximately 11:45 AM observations were made of food on the lunch tray line. Food items prepared for the lunch meal included puree tuna, puree potato salad and puree peaches. Food was observed plated for Resident #8 with a diet order for puree food. Food items served to Resident #8 included puree tuna. Review of the tray card of Resident #8 included a dislike of tuna. Dietary notes dated 05/31/13 in the medical record of Resident #8 also included tuna as a dislike. Observations were made of Resident #8 being assisted with the lunch meal in the main dining room. Resident #8 did not eat the tuna and reported he did not like tuna. Staff assisting Resident #8 requested an alternate to the tuna after it was brought to their attention. On 06/13/13 at 12:50 PM the Food Service Director (FSD) stated Resident #8 should not have received the puree tuna. The FSD stated pimento cheese or cream soup should have been served to Resident #8 as a substitue for the tuna. The FSD could not explain why puree tuna had been served to Resident #8.	F 242	weekly for 4 weeks and then monthly for 2 months to verify bathing preferences are being followed. Opportunities will be corrected as identified. ***Criteria 4*** The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 11, 2013 F 242 CONTINUED	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer routine medications on two shifts, and administered seven doses of a	F 333	**Resident # 8 and Releted Food Preference Concern** ***Criteria I*** Issue for resident # 8 was resolved on date of survey by providing appropriate substitute for the tuna. Additionally a new Dietary History / Food Preference form was completed	

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F 333	Continued From page 6 discontinued "as needed" narcotic pain medication (Percoset), for 1 of 3 residents reviewed for unnecessary medications (Resident #2). The findings include: Resident #2 was originally admitted to the facility on 1/31/13 and readmitted on 4/26/13. Resident #2' s diagnoses included anemia, history of gastrointestinal bleeding, history of deep vain thrombosis, chronic pain and acute renal failure. A review of the medication orders dated 4/26/13 included: · Bupropion XL 300 mg (milligram) once daily · Vitamin D3 1000 IU (international units) once daily · Synthroid 175 mcg (microgram) once daily · Multivitamin once daily · Vitamin B-6 100 mg once daily · Xarelto 15 mg once daily to start on 4/26/13 · Carafate 1 G (gram) (in liquid form) three times daily before meals and at bedtime · Fibercon 1250 mg two times daily · Calcium 600 mg once daily · Atorvastatin 40 mg once daily · Protonix 40 mg once daily · Oxycodone with Acetaminophen (5 mg/325 mg) tablet as needed and not continued on 4/26/13 A further review of the Medication Administration Record (MAR) for the month of May 2013 revealed that none of these medications were documented to have been given on 5/6/13 during the first and second shift medication administration. Resident #2 was sent to the hospital on 5/7/13 for an evaluation and no	F 333	F242 CONTINUED to assure future accuracy of his preferences on same date as survey. ***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice. A Dietary History / Food Preference form will be completed for each resident by the FSM or designee. All tray cards will be updated to assure their accuracy for each resident by July 3, 2013 again completed by the FSM or designee. All food service staff and additional staff involved in feeding or food delivery will be educated on reviewing tray card against actual tray for accuracy and assurance that food preferences are met. Education will be completed by July 3, 2013. ***Criteria 3*** The food service director or designee will complete audits comparing the tray card preferences against actual food plated and served. This will be completed both in the kitchen as	

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F 333	Continued From page 7 explanation was found why these doses of medications were not administered on 5/6/13. Further review of the narcotic log for Oxycodone with Acetaminophen (5/325 mg) (Percocet) revealed that seven doses of this narcotic 'as needed for pain' medication was administered after it was discontinued on 4/26/13. Further, the administration of Percocet was not documented in the MAR. No explanation or no other documentation of these medication errors was available in the medical records. An interview with Nurse #2 on 6/13/13 at 6:20 PM revealed that Nurse #2 had administered five of the seven doses of Percocet and did not remember why he had administered the doses without a proper physician order and also could not explain why nurse #2 did not have any documentation in the May 20013 MAR. Nurse #2 also had no explanation related to the medications not administered for Resident #2 on 5/6/13 during the second shift. A telephone interview with Nurse #3 on 6/13/13 at 6:30 PM responsible for morning medications had no explanation why medications were not administered to Resident #2 during the morning medication administration on 5/6/13 prior to her discharge to the hospital the following day. An interview with the Director of Nursing (DON) on 6/13/13 at 5:15 PM revealed that it was her expectation to document all medication administrations and if there was no initial in MAR, they were not administered. DON had no explanation for these medication errors and all nurses were expected to bring medication errors to her attention. DON also stated that all	F 333	F242 - CONTINUED well as in feeding areas to assure all staff is aware and checking for food preferences (likes & dislikes). This will be completed on a minimum of 10 residents each week for 8 weeks and then monthly for an additional 2 months. ***Criteria 4*** The results of the audits will be reported in the Quality Assurance Performance Improvement meeting for 4 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 11, 2013	

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F 333	Continued From page 8 discontinued medications should have been removed from the medication cart and should have been returned to the pharmacy for credit. The DON was not sure why Resident #2' s Percocet was not sent back to pharmacy after it was discontinued and how it was accessible to Nurse #2 for administration.	F 333	F333 POC Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **F 333 Residents Free of Significant Med Errors** ***Criteria I*** Medication Variance Reports were completed for ordered medications with missing signatures related to Resident #2. The Physician was notified as required	

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F 333	Continued From page 9	F 333	***Criteria 2*** All residents receiving medications have the potential to be affected by this alleged deficient practice. An audit of current resident's Medication Administration Records from the last 30 days will be completed by July 11, 2013 and Medication Variance Reports completed as required. ***Criteria 3*** The Director of Nursing or Designee will re-educate Licensed Nurses and Certified Medication Aides on Medication Administration and Documentation, including accurately signing the Medication Administration Record following medication	

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F 333	Continued From page 10	F 333	administration. The education will be completed by July 11, 2013. The Director of Nursing or Designee will perform 5 random audits of Medication Administration Records 3 times a week for 4 weeks, then weekly for 8 weeks, to verify accurate medication administration and documentation. Opportunities will be corrected as identified. ***Criteria 4*** The results of the audits will be reported in the Quality Assurance Performance Improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 11, 2013	