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
	345304	A. BUILDING ______ B. WING ______	C 09/13/2013

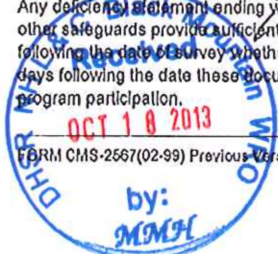
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F281 1. Resident #39 expired on 6/26/13.	
	The services provided or arranged by the facility must meet professional standards of quality.		2. Members of nursing management, DON, ADON, SDC, and Health Information Coordinator conducted an audit of current residents' charts to determine if an order for a palliative care consult was written and if so, if prompt service was provided. No further delays were identified. The audit was completed by October 5, 2013.	10/5/13
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow a physician's order for 1 of 7 sampled residents. An ordered consult for palliative care for Resident #39 was not completed timely.		3. The Facility Social Services Director developed a Provider Services Communication System to streamline communication and ensure timely response to service requests. The system includes a form that will be used to track service requests.	9/16/13
	The findings included: Resident #39 was admitted to the facility on 06/10/13. The resident's diagnoses included urosepsis, atrial fibrillation, dysphasia, advanced dementia with agitated delirium and failure to thrive. The history and physical dated 06/12/13 noted Resident #39 was hospitalized, transferred to Hospice where he was confused but stabilized and then was admitted to the facility.		On September 16, 2013, the DON, ADON, and Staff Developer initiated education of the licensed nursing staff, the Provider Services Communication System. Education was completed by October 1, 2013. Any licensed nurse not receiving this education by October 1, 2013 will be educated prior to the next scheduled shift. Newly hired licensed nurses will receive this education as a part of new hire orientation.	10/1/13
	On 06/12/13 a physician's telephone order, hand written by the physician, included "Consult Palliative care due to end stage dementia." Social Service notes dated 06/14/13 noted Resident #39 was admitted to the facility for short term rehabilitation. He was noted to be alert with confusion and needed assistance with making decisions. There were no social service notes regarding the order for palliative care or any contact with the palliative care agency.		Beginning September 16, 2013 Social Services Director will check the Provider Services Communication System daily Monday - Friday and communicate referral to the appropriate Service Provider. Social Services Director will follow-up with Service Provider to ensure services have been provided or scheduled, and complete a Social Services Note.	9/16/13
	Review of nursing notes revealed he had a productive cough on 06/17/13. On 06/18/13 he		" 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."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/5/13

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.

REVISED 10/16/13



[signature] 10/16/13

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F 281	Continued From page 1 removed his oxygen most of the shift. On 06/19/13 the nursing notes noted he took off his oxygen and was noncompliant keeping it on but went to physical therapy. On 06/21/13 he complained at 9:00 AM about pain when he tried to void. By noon he remained restless and had not voided. At 2:00 PM the facility completed an in and out catheterization and obtained 800 cc of tea colored urine. The physician subsequently ordered an antibiotic for a urinary tract infection. The nursing notes stated that on 06/22/13 the physician changed the antibiotic for the urinary tract infection and the catheter was draining tea colored urine with a lot of sediment. On 06/25/13 Palliative Consultation notes indicated the family was concerned about comfort measures and was agreeable to hospice admission. The note continued that per the social worker, Medicare A benefits were to stop this date and a hospice admission was scheduled to occur the following day. The palliative care plan included transition to hospice as soon as possible. A physician's telephone order dated 06/25/13 noted Hospice consult for admission tomorrow. Resident #39 died in the facility on 06/26/13. On 09/13/13 at 7:36 PM, the Director of Nursing (DON) stated that once an order for palliative or hospice was received, the nurse was to note it and let the social worker know about the order, so that she could get in touch with palliative care and set up the consult. The DON was not sure why the consult ordered on 06/12/13 was not completed until 06/25/13.	F 281	Beginning September 16, 2013, the DON/ADON/SDC/designee will review the 72 Hour Report Resident Condition and Grand Rounds report, and Physician Orders to validate that any new orders for Palliative Services has been recorded on the Provider Services Communication Log for follow-up. In the event that the order was not recorded on the Provider Services Communication Log, re-education and progressive discipline will occur as indicated. This will be an ongoing practice as part of the morning clinical meeting. Health Information Coordinator will audit the charts of five randomly selected residents from the Provider Services Communication System weekly for 4 weeks, then monthly for two additional months to ensure communication to the Provider has been made and services provided or scheduled timely. 4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee. " 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."	9/16/13 9/27/13 10/07/13

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On 09/13/13 at 7:48 PM, the social worker was interviewed. She stated that when she received an order for palliative care, she faxed it over to the palliative agency. She further stated that sometimes, if the palliative nurse was already in the building, the nurse gave the palliative nurse the order in person or even faxed the order to the palliative agency without alerting the social worker. The social worker stated it usually took 1 to 2 days at most for palliative to come to the facility to start services. She stated she did not recall ever getting an order for a palliative consult for Resident #39 and she had no tracking system to ensure the physician's order for palliative care consult was faxed and received by the palliative agency for timely disposition.

Interview with the Assistant Director of Nursing on 09/13 at 7:54 PM revealed she could not recall why there was a delay in obtaining palliative care for Resident #39.

On 09/13/13 at 8:06 AM the Administrator stated that once the order for a palliative consult has been received, the facility faxes it to the palliative agency and it was then up to the palliative agency to contact the family and set up evaluation dates and the facility was not really involved after the fax.

Per the DON on 09/13/13 at 8:11 PM, nursing was supposed to check with the social worker about a palliative care referral. A further interview on 09/13/13 at 8:25PM, the DON stated that she would have gotten the duplicate physician's order and in morning meeting it would have been discussed with the social worker to ensure she was aware of the referral. The DON could not recall if this referral was discussed at

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F 281	Continued From page 3 the morning meeting. On 09/13/13 at 9:35 PM Nurse #1, who took the 06/12/13 order for the palliative care consult during second shift, stated she made a copy of the referral for the social worker and if the social worker already left for the day, she put it in her box. She then showed the surveyor the 72 hour sheet where she communicated the new order for palliative care on the sheet for the oncoming nurse to follow up the next morning.	F 281		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to comprehensively assess a change in condition for 3 of 3 sampled residents. Resident # 39 was not assessed upon death. Resident #43 was not assessed for a bruise and edema. Resident #6 was not reassessed for decreased blood pressure and pulse. The findings included: 1. Resident #43 was admitted to the facility on 04/15/13 with dementia, hemiplegia, osteoarthrosis, dysphagia, diabetes,	F 309	F309 1. Resident #39 expired on 6/26/13. Resident #43 discharged from the facility on 5/5/13. Resident #6 currently resides in the facility, and had a change of condition in the last 30 days on 9/16/13. That COC Assessment was properly documented.	10/5/13
			2. A review of the September 72 Hour Report Resident Condition and Grand Rounds was conducted by members of nursing management, DON/ADON/SDC/designee to identify residents who had a change of condition to determine if an assessment of the Change of Condition was documented in the medical record. If complete documentation of the assessment was not located, an interview with the licensed nurse responsible was conducted by the DON and/or Administrator and the assessment was documented as a late entry if determined to be appropriate per documentation guidelines. This was completed by 10/5/13. " 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."	10/5/13

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F 309	Continued From page 4 hyperlipidemia, a history of peripheral vascular disease, renal failure, cardiovascular accident and psychosis. The admission Minimum Data Assessment dated 04/22/13 coded him with long and short term cognitive impairment with moderately impaired decision making skills, having physical abusive behaviors 1 to 3 days in the previous 7, having other behaviors 1 to 3 days in the previous 7, and needing extensive assistance with bed mobility, transfers, dressing, toileting, and needing limited assistance with ambulation. No skin issues were noted. Review of nursing notes revealed ongoing behaviors of undressing, severe confusion and being hard to redirect. The last nursing note dated 04/30/13 at 10:00 PM stated he was very confused, stood and urinated all over the floor and his closet. He showed no signs of pain or discomfort. There were no nursing notes related to any skin issues, edema or bruising. There were no nursing notes from 05/01/13 through 05/04/13. A Head to Toe Skin Check dated 05/01/13 was totally blank except for the date. A Change of Condition communication and progress note dated 05/05/13 noted Resident #43's left leg swollen and painful with bruise. This was noted as starting yesterday (05/04/13). The form noted he had pain in his left leg especially when pressure was applied. This form was signed as completed on 05/05/13 at 3:00 PM and the form was noted as faxed to the physician on 05/05/13 at 3:30 PM. The reverse side of this form included a nursing note which stated he was	F 309	3. The Licensed Nurse involved in the alleged deficient practice is no longer employed. On September 16, 2013, the DON, ADON, and SDC initiated education of the licensed nursing staff, regarding the complete and accurate assessment and documentation of a Change of Condition. Education will be completed by October 1, 2013. Any licensed nurse not receiving this education by October 1, 2013 will be educated prior to the next scheduled shift. Newly hired licensed nurses will receive this education as a part of new hire orientation. Beginning September 16, 2013, the DON/ADON/SDC/designee will review the 72 Hour Report Resident Condition and Grand Rounds report, Stop & Watch Forms, and Physician Orders and Incident and Accident reports for Changes of Condition Monday through Friday during Clinical Meeting to identify residents who have had a Change of Condition. The medical record will be reviewed to ensure an assessment and complete and accurate documentation has occurred. Re-education and progressive discipline will occur as indicated. This will be an ongoing practice as part of the morning clinical meeting. 4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee. " 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."	10/1/13 9/16/13 10/7/13

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awake, in bed, verbally responsive but confused. The resident was noted to keep standing up and removing his clothes. The note continued "the swelling of his left leg started yesterday. The CNA (nurse aide) saw it while she was bathing the resident. It started as a bruise. It appears bigger today than yesterday. Vital signs assessed and were within normal limits. Tried to elevate his leg but he didn't want it to (sic). Further care endorsed."

An Incident/Accident Report about this bruise and edema was reviewed. The form stated the date of incident as "assessed (05/04/13)" at 8:30 AM. There was a notation that the injury was assessed in the shower room. The notes indicated the nurse aide noticed a bruise on his left leg that was a "bit swollen" and painful. There was no description of the bruise or swelling , i.e. color, size, warmth. The action taken was "assessed vital signs/tried to elevate leg." The form was signed as being completed 05/05/13.

A physician's order dated 05/05/13 (no time) was to send Resident #43 "to (name of hospital) ER (emergency room) for evaluation of left and right lower extremities due to (symbol for increased) edema."

Review of the Resident Transfer Form dated 05/05/13 listed vitals of blood pressure 106/72, pulse 81, respirations 18, temperature 99.1 degrees and finger stick glucose 204 at 4:30 PM. The reason for transfer was "Resident lower bilateral extremities noted to have increased in size (symbol for with) red discolored multiple large areas noted to lt (left) calf - rt (right) tibia noted to have x 3 open areas (symbol for with) blood drainage noted."

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F 309	Continued From page 6 On 09/13/13 at 1:14 PM the Assistant Director of Nursing (ADON) stated that there were no more nursing notes and explained that nurses chart by exception. She could not explain how the change in condition report noted edema and bruising was first noted on 05/04/13 and no nursing note was in the medical record regarding findings on 05/04/13. On 09/13/13 at 3:00 PM Interview with Nurse Aide (NA) #1 (who worked 05/04/13 and 05/05/13) stated she worked 200 hall but just started the first of May and couldn't recall this resident. On 09/13/13 at 3:25 PM and at 6:13 PM messages were left and not returned for Nurse #2 (who completed the incident report and change in condition report both dated 05/05/13). On 09/13/13 at 5:25 PM, NA #2 (who worked both 05/04/13 and 05/05/13 and signed off as giving Resident #43 a bed bath on 05/04/13 and a shower 05/05/13) remembered this resident. NA #2 stated she recalled only giving him one shower and did not recall any skin issues with him. On 09/13/13 at 4:51 PM a message was left with NA #3 who worked with Resident #43 on 05/04/13 and 05/05/13, but he did not return the call. NA #4 signed off as giving Resident #43 an "other" type shower on 05/04/13. NA #4 stated on 09/13/13 at 7:00 PM that she recalled Resident #43. She stated he had very good skin, no open areas and she could not recall any edema in his legs. She further stated she did not bathe him but provided pericare to him.	F 309		

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Another phone message with no return call was made on 09/13/13 at 7:10 PM to NA #5 who signed off as giving him a bed bath on 05/05/13.

On 09/13/13 at 9:20 PM, the DON provided the 72 hour reports. These reports indicated documentation on 05/04/13 by all three shifts yet nothing about his edema or skin was documented. On 5/5/13 the report revealed: 1st shift documented his left leg was swollen and painful when pressure was applied to the bruise; 2nd shift sent to emergency room due to bilateral extremity swelling with red discolored areas to left calf and right tibia x 3 open areas with blood drainage. The DON stated her expectation was there should have been documentation of the bruise including how it looks and documented description of swelling. She stated there was no documentation of the assessment. The regional nurse, present at this interview stated the nurse did not assess Resident #43 well.

2. Resident #39 was admitted to the facility on 06/10/13. The resident's diagnoses included urosepsis, atrial fibrillation, dysphasia, advanced dementia with agitated delirium and failure to thrive.

Review of nursing notes revealed:
*06/17/13 he had a productive cough.
*06/18/13 he removed his oxygen most of the shift.
*06/19/13 the nursing notes noted he took off his oxygen and was noncompliant keeping it on but went to physical therapy.
*06/21/13 he complained at 9:00 AM about pain when he tried to void. By noon he remained restless and had not voided. At 2:00 PM the

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facility completed an in and out catheterization and obtained 800 cc of tea colored urine. The physician subsequently ordered an antibiotic for a urinary tract infection.
*06/22/13 the physician changed the antibiotic for the urinary tract infection and the catheter was draining tea colored urine with a lot of sediment.
*06/23/13 he was awake and verbally responsive. His catheter contained light tea colored urine with only a few sediments. Pain medication was given twice during this second shift.
*06/24/13 he was awake and verbally responsive. He received pain medication several times at family's request. He removed his gown and oxygen. His urine remained tea colored with sediments.

On 06/25/13 Palliative care made an initial visit and stated Resident #39's family noted a significant change in the past 3 days including a decline in function, cognition, alertness, increase in agitation and spasms. They also noted no by mouth intake in 2 days and unresponsiveness for one day. The palliative nurse noted the resident was apneic (absence of spontaneous breathing) for 45 seconds.

The last nursing note in the medical record was dated 06/25/13 during the 3 to 11 PM shift. This note stated Resident #39 was not responding verbally, was noted to be twitching and jerking his whole body and the palliative nurse was made aware per family's request. It was noted staff made frequent rounds on him and kept him comfortable. his vital signs were listed as blood pressure 148/97, pulse 120, respirations 21, oxygen sats 90% and temp 98.0 degrees.

Resident #39 died in the facility on 06/26/13. A

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physician's order dated 06/26/13 at 4:50 AM gave permission to pronounce him deceased and release the body. There was no assessment regarding when staff found Resident #39, at what time, or any assessment between 11 PM and the time of his death.

On 09/13/13 at 4:43 PM the Director of Nursing (DON) stated nursing staff were expected to chart by exception. By exception, the DON explained anything that needed medical attention. She further stated that when a resident died, the nurse should do and chart the assessment at the time of death.

On 09/13/13 at 7:36 PM interview with DON and the Administrator stated that nursing should have documented their assessment of Resident #39 at the time they noted him deceased.

3. Resident #6 was re-admitted to the facility on 07/29/13 with diagnoses that included chronic kidney disease, diabetes type II, high blood pressure, circulatory disease in lower legs and heart disease.

The most recent re-admission Minimum Data Set (MDS) dated 08/13/13 indicated Resident #6 was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living.

A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/19/13 on 7:00 AM to 3:00 PM shift Resident #6 had a blood pressure documented as 102/87, pulse 70, temperature 99 degrees Fahrenheit by mouth. The notes further

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F 309	Continued From page 10 indicated Resident #6 complained of an upset stomach and was nauseated. The notes revealed a Phenergan 25 milligram injection was given for nausea and an enema was given at 12:30 PM. There were no initials or staff signature regarding who documented the information. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds " indicated on 07/20/13 on 7:00 AM to 3:00 PM shift Resident #6 had a blood pressure documented as 120/50, pulse 60 and a temperature of 99.2 degrees Fahrenheit by mouth. The notes further indicated Resident #6's oxygen saturation was 87 percent and oxygen was placed on Resident #6 at 2 liters per minute. The notes revealed Resident #6's oxygen saturation increased to 93 percent at 9:10 AM and to 100 percent at 9:20 AM and oxygen continued at 2 liters per minute. The notes also indicated Resident #6 refused to go to dialysis for treatment on 07/20/13. There were no initials or staff signature regarding who documented the information. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/21/13 in a section for the 3:00 PM to 11:00 PM shift a blood pressure of 105/79, pulse 63, and temperature 99.1 degrees Fahrenheit. There were no initials or staff signature regarding who documented the information. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/21/13 in a section for the 11:00 PM to 7:00 AM shift a blood pressure of 94/75,	F 309		

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F 309	Continued From page 11	F 309		

pulse 52, temperature 98.5 degrees Fahrenheit, respiration's 18 with an oxygen saturation of 98 percent on 2 liters of oxygen per minute. There were no initials or staff signature regarding who documented the information.

A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/22/13 in a section for the 7:00 AM to 3:00 PM shift Resident #6 was sent to the hospital at 2:30 PM for altered mental status. There were no initials or staff signature regarding who documented the information.

A review of a physician's progress note dated 07/22/13 with no time documented indicated Resident #6 complained of nausea, had a pulse of 54 that was slightly irregular and had been sick for 3 days. The notes indicated Resident #6 was sleepy and hard to arouse and stated she didn't feel good. A section labeled assessment and plan indicated Resident #6 had altered mental status, felt warm, rule out sepsis (a serious blood infection in which the body has a severe response to bacteria or other germs); had nausea, a slow heart rate, rule out heart attack and may need urgent dialysis.

A review of a physician's order dated 07/22/13 indicated to transfer Resident #6 to the emergency room for evaluation.

During an interview on 09/11/13 at 4:43 PM the facility Medical Director who was also Resident #6's physician explained it was his expectation for nursing staff to assess a resident when a resident had a change in condition.

During an interview on 09/12/13 at 2:47 PM the

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Director of Nursing (DON) stated nurses were expected to assess residents and complete a change of condition form or document in the nurses notes when a resident had a change in condition. She further explained she considered a change in condition to be any change that was different from the resident's usual condition. She stated nurses could document their assessments and vital signs on the change in condition form but if it that form was not completed there should be documentation in the nurse's notes.

During an interview on 09/13/13 at 6:03 PM the Assistant Director of Nursing (ADON) explained she was aware Resident #6 was sent to the hospital on 07/22/13 but she could not find any nurse's documentation regarding assessments of Resident #6 or documentation of vital signs in the resident's medical record. She confirmed there was no change in condition form or nurses notes from 07/19/13 through 07/22/13. She stated the nurses charted by exception and anything that was not normal for the resident should have been documented in the medical record.

During a follow up interview on 09/13/13 at 8:12 PM the DON confirmed Resident #6's blood pressure and vital signs should have been rechecked on 07/21/13 and 07/22/13 since her blood pressure and pulse were low. She also confirmed there should have been nursing assessments done and documented in the medical record for Resident #6 and since there was no documentation in the medical record she was unsure what nurses had assessed except for the documentation on the 72 hour report. She explained the 72 hour report was a communication tool the nurses used but it was not considered to be a part of the resident's

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F 309	Continued From page 13 medical record.	F 309		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide adequate substitutions for the protein in a sandwich and a tomato salad in one of two meal services observed. The findings included: Review of the planned menu and spread sheets for the noon meal of 09/11/13 revealed residents were to receive an egg salad sandwich consisting of 2 ounces of egg salad and 2 slices of bread, 1/2 cup of marinated tomato salad, 3/4 cup of vegetable soup, 2 saltine crackers, 1/2 cup of vanilla pudding, a pickle spear, 1 cup of a beverage of their choice, 1 cup of milk and 1 green pickle spear. On 09/11/13 at 9:20 AM, dietary staff were observed making preparations for the meal. On 09/11/13 at 11:44 AM the service table was prepared with the planned menu items. On 09/11/13 at 12:13 PM, all food on the service line was uncovered and the food temperatures were checked. At 12:17 PM, the Dietary Manager	F 363	F 363 1. Residents #50, #80, #88, #89 and #109 are receiving adequate protein when requesting substitutes during meals. 2. Residents who receive substitutes from the kitchen have the potential to be affected. 3. On September 17, 2013, the Dietary Manager, and Registered Dietitian initiated education of the Dietary Staff, regarding following portion control and Menu Spreadsheets, when a menu item substitution is regarding. Education was completed on 10/3/13. This information will also be included in new hire orientation. On September 24, 2013, the Dietary Manager/Designee initiated random audits of residents' trays to verify that residents are receiving the nutritional equivalent of the original menu when a substitution is required. The audit schedule is: 5 random Trays 3 times per week for 2 weeks 5 random Trays weekly for 2 weeks 5 random Trays monthly for 2 months 4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee. " 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."	10/3/13 9/24/13 10/7/13

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(DM) made the decision to remove the tomato salad and egg salad due to the temperatures being unsatisfactory. She stated at this time that turkey sandwiches would be prepared instead. The surveyor left the kitchen at this time.

On 09/11/13 at 1:18 PM, observations of the tray line which was in progress resumed. The DM and the Registered Dietician (RD) were overseeing the tray line service. The surveyor watched kitchen aide #3 prepare 7 turkey sandwiches which consisted of 2 thin slices of processed turkey and two pieces of white bread. Staff proceeded to fix lunch trays with soup, sandwich, pickle and pudding. At 1:32 PM, the surveyor asked about the amount of turkey on each sandwich and was informed by kitchen aide #3 that 2 slices of the turkey equaled two ounces. At 1:39 PM, the package label was reviewed with the RD which revealed that 2 ounces of turkey from this package equaled 3 slices (60 calories). The RD confirmed the turkey sandwiches did not contain 2 ounces of turkey.

Interview on 09/11/13 at 1:40 PM with kitchen aide #3 revealed she had been trained to put two slices of meat on each sandwich and that the guide book also instructed 2 slices of turkey equaled 2 ounces. The DM stated staff assumed that 2 slices equaled 2 ounces and corrected this at 1:46 PM after several more sandwiches had already been prepared and plated.

On 09/11/13 at 1:55 PM, the RD stated the guide book did indicate 2 oz equaled 2 slices and the discrepancy was in the actual turkey product that the staff were using.

In addition, as the trays were prepared, there was

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F 363	Continued From page 15 no observation of any replacement salad being plated substituting the tomato salad. Observations made at 09/11/13 starting at 2:00 PM of regular meal trays being served on the hall revealed Residents #50, #80, #88, #89, and #109 all were to receive a regular diet and their meals consisted of pudding, turkey on white bread, soup, saltines and a pickle and beverages consisting of milk, coffee, fruit juice or tea. No one had any tomato product on their trays and no tray card indicated a dislike for tomato. Interview with the DM after this observation on 09/11/13 at 2:15 PM revealed that the substitute for the tomato salad was tomato juice, which was what residents on a pureed diet were having in place of tomato salad per the spread sheet. She offered no explanation as to why the trays did not include tomato juice. On 09/11/13 at 4:44 PM, the RD stated macaroni salad should have been the replacement for tomato salad. When she was informed that no macaroni salad or tomato juice was on the observed trays, she was able to give no explanation.	F 363		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility and medical record reviews the facility	F 367	F 367 1. Resident #6 is receiving diet as indicated on a renal diet. " 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 367	Continued From page 16 failed to provide food as indicated for a renal diet for one (1) of one (1) resident who had physician orders for a therapeutic diet. (Resident #6). The findings included: Resident #6 was re-admitted to the facility on 07/29/13 with diagnoses that included chronic kidney disease, diabetes type II, high blood pressure, circulatory disease in lower legs and heart disease. The most recent re-admission Minimum Data Set (MDS) dated 08/13/13 indicated Resident #6 was moderately impaired in cognition for daily decision making and required supervision and 1 person staff assistance for eating. The MDS further indicated Resident #6 had no swallowing or nutrition issues. A review of a facility document titled "In-House Communicator" dated 08/01/13 indicated to initiate diet of mechanical soft with thin liquids and continue dietary restrictions as indicated. A review of a facility document titled "Nutritional Status Review" and dated 08/16/13 indicated reduced concentrated sweets, liberal renal mechanical soft diet. A review of a care plan titled weight loss/nutrition last updated on 08/16/13 indicated to provide diet as ordered and the responsible disciplines were dietary, nurses and nurse aides. A review of monthly physician's orders from 09/01/13 through 09/30/13 indicated Resident #6 was to receive a liberal renal diet, with reduced concentrated sweets and no added salt.	F 367	2. Residents on a therapeutic diet have had their dietary needs and restrictions reviewed by the facility dietitian. Changes on their dietary tray card have been made as necessary. 3. On September 17, 2013, the Dietary Manager, and Registered Dietitian initiated education of the Dietary Staff, regarding proper reading and following Therapeutic Diets. Education was completed on October 3, 2013. The Facility Dietitian developed and posted therapeutic diet restriction - limitation notice. On September 24, 2013, the Dietary Manager/Designee initiated random audits of residents' trays to verify that residents receive the correct items to meet their therapeutic diet restrictions/limitations. The audit schedule is: 5 Trays 3 times per week for 2 weeks 5 Trays weekly for 2 weeks 5 Trays monthly for 2 months 4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee. " 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."	10/2/13 10/3/13 10/1/13 9/24/13 10/7/13

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F 367	Continued From page 17 A review of the diet spreadsheet for the lunch meal on 09/11/13 indicated the menu for a liberal renal diet was as follows: Egg salad sandwich 2 ounces with 2 slices of bread 2 bean salad ½ cup Pineapple cube ½ cup Beverage choice 1 cup Pepper 1 each Parsley Sprig 1 each During an observation on 09/11/13 at 1:46 PM Meal Resident #6 was sitting up in bed with an overbed table in front of her with her lunch meal tray on top of it. She had 1 cup of cranberry juice and a small bowl of vanilla pudding. She also had a divided plate that contained a chopped turkey sandwich and a pickle spear. A tray card was lying beside her plate and indicated Resident #6's diet was reduced concentrated sweets, no added salt, liberal renal and the texture was mechanical soft. Resident #6 was observed eating all food on her plate. During an interview on 09/13/13 at 11:34 AM Nurse #6 explained Resident #6 had a good appetite and normally ate most of her dinner and lunch. She further explained Resident #6 went to dialysis on Tuesday, Thursday and Saturday each week early in the morning and got back to the facility around lunch time. During an interview on 09/13/13 at 12:40 PM Nurse Aide (NA) #10 stated she routinely provided care to Resident #6. She explained Resident #6 usually cleaned her plate after she came back from dialysis because she was hungry but at other times she ate about 50 percent of her	F 367		

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meals. NA #10 stated Resident #6 was on a renal diet and was not supposed to have certain foods such as potatoes or tomatoes. She stated if dietary sent something Resident #6 was not supposed to have, she would return it and ask dietary staff to send the resident something else that was approved for her diet.

A review of the diet spreadsheet for the lunch meal on 09/13/13 indicated the menu for a liberal renal diet was as follows:
Baked chicken 2 ounces
Green Beans ½ cup
Dinner roll 1 each
Margarine 1 pat
Fruit cocktail ½ cup
Beverage choice 1 cup
Pepper 1 each
Parsley sprig 1 each

During an observation on 09/13/13 at 1:08 PM Resident #6 was sitting up in bed and had her meal tray on her overbed table in front of her. She had 1 cup of cranberry juice (1) cup and a small bowl of mandarin oranges. She had a divided plate that contained a roll, yellow rice, collard greens, and baked chicken cut in small pieces. Resident #6 was observed eating all food on her plate except for rice.

During an interview on 09/13/13 at 7:13 PM the Dietary Manager explained the initial diet order for a renal diet came from the hospital when the resident was admitted. She further explained she did an initial dietary assessment for the resident and then the Registered Dietician reviewed it within the month. She stated she put the resident's diet in the computer system and it printed out the tray card. She explained it was

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F 367	Continued From page 19 the usual process when meal trays were prepared for the cook to check the tray card and start placing food on the plate, then the dietary aide put condiments on the plate and lastly the bread and desert was placed on the plate. She further explained when the tray went to the halls the NA's passed the meal trays and they were expected to check the resident's name, check the food on the plate to see if it matched the tray card and if it didn't they were supposed to bring it back to the kitchen. The Dietary Manager verified Resident #6 was on a liberal renal, mechanical soft, no added salt diet and on 09/11/13 they had to change the menus at the last minute for the lunch meal service. She stated Resident #6 should have received a pasta salad with her turkey sandwich and was not sure why Resident #6 should have gotten pineapple instead of vanilla pudding but she would call the Registered Dietician to find out. She also stated Resident #6 should have gotten chopped chicken, rice, green beans and mandarin oranges on 09/13/13. She further stated the pickle spear and collard greens were not supposed to be on Resident #6's plate because they were not part of the liberal renal diet. During a follow up interview on 09/13/13 at 8:28 PM the Dietary Manager stated she called the Registered Dietician and found out that vanilla pudding had phosphorus in it and should not be served to residents on a renal diet. She stated she was aware Resident #6 did not like fruit so they probably sent the pudding as a substitute for fruit and didn't realize pudding was not an acceptable substitute.	F 367		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observations, staff and family interviews and medical record reviews the facility failed to properly label, date and store items brought in by family for 1 of 1 (Resident #83), maintain a clean ceiling in the kitchen and maintain the paint of the kitchen and breaker metal doors to prevent rust.

The findings included:

1. The facility had no policy for the storage of foods brought in by family members. Resident #83 was admitted to the facility on 11/23/11 with diagnoses which included chronic pain, altered mental status, diabetes, chronic kidney disease, muscle weakness, and anxiety state. The most recent annual Minimum Data Set (MDS) dated 02/26/13 indicated Resident #83 was severely cognitively impaired for daily decision making and had problems with short and long term memory. The MDS indicated Resident #83 was assessed to receive extensive assistance with all Activities of Daily Living (ADL) which included eating.

During an observation on 09/11/13 at 1:22 PM

F 371 (Plan of Correction)

F371
1. The strawberries and cooler were removed from the room of Resident #83. — 9/11/13

The kitchen door and breaker box covers were painted. — 9/12/13

The ceiling and light fixture in the dish washing area were cleaned. — 9/12/13

2. Residents who receive food from the facility kitchen or have food brought in by family members have the potential to be affected by the alleged deficient practice.

3. Facility Ambassadors were in-serviced by the Administrator on September 24, 2013 regarding the expectation to ensure food is not improperly stored in residents' rooms. Food found not properly stored will be thrown away as indicated. Ambassadors will report their findings daily Monday-Friday at Morning Meeting. — 9/24/13

Administrator/DON or Designee will complete rounds daily Monday–Friday in randomly selected rooms to ensure food is not improperly stored in resident rooms. Food found not properly stored will be thrown away as indicated. — 9/25/13

On September 17, 2013, the Dietary Manager, and Registered Dietitian initiated education for the Dietary staff on proper cleaning techniques, following cleaning schedule, communication of required Maintenance issues in the kitchen. This education was completed by October 3, 2013. Any Dietary Staff not receiving this education by October 3, 2013, will be educated prior to their — 10/3/13

" 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 371	Continued From page 21	F 371	next scheduled shift. This will be included in new hire orientations.	

Nurse #4 was assisting Resident #83 with her lunch tray. Observed Nurse #4 arousing the resident and asked Nurse #5 who came into the room with her to hand her a plate of strawberries from the other side of the bed on top of the cooler. Nurse #4 was observed about to place a strawberry in Resident ' s mouth when the surveyor stopped and asked if she really wanted to feed her those berries. Nurse #4 looked at the strawberries and stated she did not. Nurse # 4 and Nurse #5 both confirmed the strawberries looked bad with a grey white substance on them. Nurse #4 then instructed Nurse #5 to put them back on top of the cooler. The nurses and the surveyor observed a tupperware container on top of the cooler which contained some wilted mixed green salad with a runny white liquid. Nurse #5 opened the cooler at the residents ' bedside. The cooler was observed to contain water, pink in color, half full, with no ice, a jello container containing jello with a white furry ring around the outside of the jello container and a floating plastic milk carton. The surveyor asked the nurse what she normally would do about these items the husband brought in. Nurse #4 stated she would let the family member know because he brings food in daily. She further stated the Resident ' s family member cleaned the cooler daily. Nurse #4 confirmed the cooler looked like it was not cleaned yesterday or today.

On 09/11/13 at 1:26 PM Nursing Assistant (NA) #8 also came into the Resident ' s room. He observed the cooler and its contents and the food items on top of the cooler. He stated this was an infection control hazard for this resident and other residents if another would have gotten into it. He stated he would take it away and clean it and report it to the administrator. All three staff

The Administrator will complete Sanitation and Maintenance Environmental rounds in the kitchen weekly for 3 months. Identified issues will be addressed as indicated. — 9/26/13

4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee. — 10/7/13

" 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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	345304	A. BUILDING ______ B. WING ______	C 09/13/2013

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BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 present in this room confirmed the observation of bad food as described above and the potential of food borne illness. On 09/11/13 at 1:35 PM ADON and NA #8 stated the strawberries and other food items in the Resident #83 ' s room were brought by her family member yesterday. On 09/11/13 at 5:11 PM Resident #83 was observed in bed with eyes closed and the cooler at the bedside was empty and clean. During an interview conducted on 09/11/13 at 5:20 PM with Resident #83 ' s family member, he stated he brought the strawberries and a lettuce salad with tuna on Monday (09/09/13) in the evening and left them on the tray table for his wife to eat. He further stated that if she hadn't eaten them he had expected the staff to have thrown them away. He stated he normally cleaned the cooler each day and added fresh water and ice. He further stated he missed his visit on Tuesday (09/10/13). During an interview conducted on 09/13/2013 at 10:32 AM the social worker (SW) confirmed the family member did have the cooler in the room and he was responsible for maintaining it. The SW revealed the facility allowed him to use their ice. During an interview on 09/13/13 at 5:59 PM NA #4 stated he was familiar with Resident #83 ' s care and was aware that the family member brought in food. NA #4 revealed the Resident ' s family member brought in the cooler and usually cleaned it and placed ice in it. NA #4 further revealed the family member did not come in on	F 371		

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F 371	Continued From page 23	F 371		

Tuesday and had not cleaned the cooler. NA #4 further revealed that she had placed the strawberries on top of the cooler and covered them with a napkin on Tuesday on the evening shift. NA #4 stated the normal practice for food brought in by families was the food was labeled, dated and placed in the nutrition room refrigerator or disposed of if not eaten.

During an interview on 09/13/13 at 6:07 PM NA #9 stated he was familiar with Resident #83 ' s care and was aware that the family member brought in food. NA #9 stated the standard procedure was all leftover foods brought in by family members were labeled, dated and stored in nutrition refrigerator and disposed of afterwards if not eaten.

During an interview on 09/13/13 at 09:40 PM the DON stated staff were aware that all left over foods brought in by family members were to be labeled, dated and placed in the refrigerator in the nutrition room. The DON further stated all food labels should be checked and the food thrown away if out of the date range for safety. The DON confirmed that the food in Resident #83 ' s room was not labeled or dated and not been kept at the proper temperature. The DON confirmed the strawberries were not labeled and the cooler was not cleaned.

2. On 09/11/13 at 11:45 AM, observations in the kitchen revealed that the metal door used to deliver the carts of food trays to the floors was scraped and rusty on the inside of the kitchen, where the top and middle of the food carts met with the door. In addition to the right of this door were two large breaker panels that were covered in rusty bubbly paint. Just below these breaker

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F 371	Continued From page 24 panels were clean glasses, tea dispensers and the juice dispenser. On 09/12/13 at 8:52 AM, the scraped and rusty door and the bubbly rusty paint on the breaker doors remained in the kitchen. The Dietary Manger (DM) stated at this time that the breaker doors had been painted in the past and that the maintenance man had a schedule for painting the doors. Regarding the main metal door, the DM stated that the food carts scraped the door and metal panels had been placed on the door to keep the paint from scrapping off the doors. However, since then, the door was flipped around so that it opened inward towards the kitchen to avoid the scraps. This caused the metal panels to be on the outside of the door and the scraps from the outside were now inside the kitchen. She further stated that she had not put a work order in for the metal doors to be painted. On 09/12/13 at 9:05 AM the maintenance man was interviewed. He stated he floated between 2 facilities full time, spending 2 days at one facility and 3 days at the other. He stated that on the days he came to this facility, he checked the maintenance book to see what needed to be fixed. A review of this book on 09/12/13 at 9:10 AM revealed there were no painting requests in the kitchen since the book started 07/23/13. The maintenance man stated he would paint any time there was a request in the book. 3. During the initial tour of the kitchen on 09/09/13 at 1:23 PM, the ceiling and fluorescent light fixture above the dish washing area was observed to be splattered with a reddish brown substance, covering several feet.	F 371		

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F 371	Continued From page 25 On 09/11/13 at 8:33 AM, another observation revealed the ceiling and light fixture remained splattered with the reddish brown substance above the dishwashing area. On 09/11/13 at 9:18 AM, the splattered ceiling and light fixture remained. Interviews with the two dish washers, kitchen aides #1 and #2 and the Dietary Manager all stated they had not noticed the spatters on the ceiling and light fixtures. They further stated they never looked up and could not say how long the splatters had been on the ceiling. On 09/11/13 at 11:26 AM, staff were wiping off the ceiling and light fixture and the splatters were easily removed.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F441 1. No residents identified in the Statement of Deficiency 2. Residents who receive food from the facility kitchen have the potential to be affected by the alleged deficient practice. 3. On September 17, 2013, the Dietary Manager, and Registered Dietitian initiated education of the Dietary Staff, regarding reporting Maintenance related issues to the Maintenance Department. Education was completed October 3, 2013. Dietary Manager/Maintenance Director/Designee will monitor water temperatures: Daily M-F for two weeks Three times per week for one week Weekly for one week Monthly for two months " 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."	10/3/13 9/24/13

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F 441	Continued From page 26	F 441	4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee.	10/7/13

isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to provide warm water for the hand washing sink in the kitchen to prevent the spread of food contamination during food preparation.

The findings included:

On 09/09/13 at 1:23 PM during the initial kitchen inspection, the water in the kitchen's hand washing sink was observed to be cool when running only the hot water.

On 09/11/13 at 8:33 AM and at 9:10 AM, the hot water in the kitchen's hand washing sink was again noted to be cool not warm. During this time, constant observations were made of staff utilizing the dish machine and washing there hands in the hand washing sink in between dirty and clean tasks. At 9:10 AM the Dietary Manager (DM) was asked about the lack of warm water.

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F 441	Continued From page 27 She stated that maintenance had been working on the problem but would not say how long the water was not warm. Staff continued to use the hand washing sink in between dirty and clean tasks at 9:16 AM. On 09/11/13 at 4:44 PM, the hot water in the kitchen's hand washing sink was noted to be slightly warm when used but was noted only cool when used again at 4:55 PM. The sign above the sink instructing users in hand washing skills noted the water should be at least 100 degrees Fahrenheit for good hand sanitation. On 09/12/13 at 8:50 AM, the hot water in the kitchen's hand washing sink was again cool. The DM stated at this time she could not say how long the water was not getting warm and referred the surveyor to the maintenance man. The DM would only say the problem was a "recent" one. The maintenance man was interviewed on 09/12/13 at 9:02 AM with the Administrator. The Administrator stated the facility was between full time maintenance staff and this maintenance man came several times a week to assist with repairs since around June. The maintenance man stated that 3 weeks ago it was brought to his attention that the water was cool in the kitchen. He subsequently adjusted the mixing valve. He further stated he tried to keep the water in the kitchen's hand washing sink to around 115 degrees Fahrenheit. Since he adjusted the mixing valve, he stated he had received no more reports about cool water. He stated he did not go back and recheck the temperature in the kitchen's hand washing sink since the adjustment or routinely when checking other water temperatures. He counted on kitchen staff to	F 441		

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F 441	Continued From page 28 inform him of any problems. At this time, the maintenance man and the surveyor checked the temperature in the kitchen's hand washing sink and noted it to be 79.7 degrees Fahrenheit. The DM, who was there at the time of this temperature check, stated she had not reported to maintenance again that the water remained cool. On 09/12/13 at 9:10 AM, the book where staff write maintenance requests was reviewed and noted that since the initial request to check the water in the kitchen's hand washing sink on 08/12/13, no other reports regarding ongoing concerns about the kitchens' water temperature had been reported.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document vital signs and resident	F 514	F514 1. Resident #6 currently resides in the facility, and has not experienced a change of condition in the past 30 days requiring documentation of an assessment. 2. A review of the September 72 Hour Report Resident Condition and Grand Rounds was conducted by members of nursing management, DON/ADON/SDC/designee to identify residents who had a change of condition to determine if an assessment of the Change of Condition was documented in the medical record. If complete documentation of the assessment was not located, an interview with the licensed nurse responsible was conducted by the DON and/or Administrator and the assessment was documented as a late entry if determined to be appropriate per documentation guidelines. This was completed by 10/5/13. " 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."	10/5/13 10/5/13

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F 514	Continued From page 29 assessments in the medical record for a resident with a change in condition for 1 of 4 sampled residents with incomplete medical record information (Resident #6). The findings included: 1. Resident #6 was re-admitted to the facility on 07/29/13 with diagnoses that included chronic kidney disease, diabetes type II, high blood pressure, circulatory disease in lower legs and heart disease. The most recent re-admission Minimum Data Set (MDS) dated 08/13/13 indicated Resident #6 was moderately impaired in cognition for daily decision making and required extensive assistance from staff for activities of daily living. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/19/13 on 7:00 AM to 3:00 PM shift Resident #6 had a blood pressure documented as 102/87, pulse 70, temperature 99 degrees Fahrenheit by mouth. The notes further indicated Resident #6 complained of an upset stomach and was nauseated. The notes revealed a Phenergan 25 milligram injection was given for nausea and an enema was given at 12:30 PM. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/19/13 on the 3:00 PM to 11:00 PM shift Resident #6 had a pain pill at 8:05 PM and there were no vital signs recorded. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds"	F 514	3. The Licensed Nurse involved in the alleged deficient practice is no longer employed. On September 16, 2013, the DON, ADON, and SDC initiated education of the licensed nursing staff, regarding the complete and accurate assessment and documentation of a Change of Condition. Education will be completed by October 1, 2013. Any licensed nurse not receiving this education by October 1, 2013 will be educated prior to the next scheduled shift. Newly hired licensed nurses will receive this education as a part of new hire orientation. Beginning September 16, 2013, the DON/ADON/SDC/designee will review the 72 Hour Report Resident Condition and Grand Rounds report Stop & Watch Forms, and Physician Orders and Incident and Accident reports for Changes of Condition Monday through Friday during Clinical Meeting to identify residents who have had a Change of Condition. The medical record will be reviewed to ensure an assessment and complete and accurate documentation has occurred. Re-education and progressive discipline will occur as indicated. This will be an ongoing practice as part of the morning clinical meeting. 4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee. " 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."	9/16/13 9/16/13 10/7/13

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F 514	Continued From page 30 indicated on 07/20/13 on 7:00 AM to 3:00 PM shift Resident #6 had a blood pressure documented as 120/50, pulse 60 and a temperature of 99.2 degrees Fahrenheit by mouth. The notes further indicated Resident #6's oxygen saturation was 87 percent on room air and oxygen was placed on Resident #6 at 2 liters per minute. The notes revealed Resident #6's oxygen saturation was 93 percent at 9:10 AM and 100 percent at 9:20 AM with oxygen on at 2 liters per minute. The notes also indicated Resident #6 refused to go to dialysis for treatment on 07/20/13. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/21/13 in a section for the 3:00 PM to 11:00 PM shift a blood pressure of 105/79, pulse 63, and temperature 99.1 degrees Fahrenheit. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/21/13 in a section for the 11:00 PM to 7:00 AM shift a blood pressure of 94/75, pulse 52, temperature 98.5 degrees Fahrenheit, respiration's 18 with an oxygen saturation of 98 percent on 2 liters of oxygen per minute. A review of a facility document titled "72 Hour Report Resident Condition And Grand Rounds" indicated on 07/22/13 in a section for the 7:00 AM to 3:00 PM shift Resident #6 was sent to the hospital at 2:30 PM for altered mental status. A review of a physician's progress note dated 07/22/13 indicated Resident #6 was complaining of nausea, had a pulse of 54 and slightly irregular and had been sick for 3 days. The notes	F 514		

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F 514	Continued From page 31 indicated Resident #6 was hard to arouse and stated she didn't feel good. A review of a physician's order dated 07/22/13 indicated to transfer Resident #6 to the emergency room for evaluation. A review of nurse's notes and assessment documents indicated there was no documentation in Resident #6's medical record on 07/20/13, 07/21/13 or 07/22/13. During an interview on 09/12/13 at 2:47 PM the Director of Nursing (DON) explained she expected nursing staff to document a resident's change of condition on a change of condition form or in the nurse's notes. During an interview on 09/13/13 at 6:03 PM the Assistant Director of Nursing (ADON) explained she was aware Resident #6 was sent to the hospital on 07/22/13 but she could not find any nurse's documentation regarding assessments of Resident #6 or documentation of vital signs in the resident's medical record. During a follow-up interview on 09/13/13 at 8:12 PM the DON stated she would have expected to see documentation in nurse's notes regarding assessments and vital signs for Resident #6. She confirmed the 72 hour reports were not part of the resident's medical record but they were a communication tool among nursing staff. She verified there was no information documented in Resident #6's medical record regarding vital signs or assessments prior to her transfer to the hospital on 07/22/13.	F 514		
F 516	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO,	F 516		

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F 516 SS=D	Continued From page 32 SAFEGUARD CLINICAL RECORDS	F 516	F516 1. The chart for Resident # 141 was found on September 17, 2013	9/17/13
	A facility may not release information that is resident-identifiable to the public.		2. On September 27, 2013, all charts have been confirmed to be secure	9/27/13
	The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.		3. On September 16, 2013, the DON, ADON, and Staff Developer initiated education of the facility staff regarding chart security, and location. Education will be completed by October 5, 2013. Staff not receiving this education by October 5, 2013 will be educated prior to the next scheduled shift. Newly hired staff will receive this education as a part of new hire orientation.	10/5/13
	The facility must safeguard clinical record information against loss, destruction, or unauthorized use.		Facility Nurses' station has been made more secure. The facility installed a combination lock, and ½ doors leading into the Nurses Station as appropriate. A Security Camera was installed to monitor and record the nurse's station.	10/5/13
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to keep safe and provide confidentiality for the medical record for 1 of 31 resident clinical records. (Resident #141)		Weekly the Health Information Coordinator will verify that all chart locations are known, and kept secure.	9/27/13
	The findings included:		4. Results of the audits will be presented to Quality Assurance Performance Improvement Committee monthly for 3 months or until substantial compliance has been achieved and maintained as determined by the QAPI committee.	10/7/13
	Resident #141 was admitted to the facility on 08/09/13 and was discharged to the hospital on 09/03/13.			
	During an interview on 09/12/13 at 11:00 AM with the Health Information Coordinator revealed the medical record for Resident #141 was unable to be located and she had been looking for it since 09/09/13 as Resident #141 was readmitted to the facility on 09/09/13.		Date of Substantial Compliance 10/7/13 "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."	
	During an interview on 09/13/13 at 9:00 AM the Administrator and the Corporate Nurse revealed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING ______ B. WING ______	C 09/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/SHAM	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 516	Continued From page 33 staff had searched for Resident #141's medical record and they were unable to find it. The Administrator stated he had staff in from another facility working in the facility over the weekend and he had calls into them to see if they had seen the chart. During a follow up interview on 09/13/13 at 9:54 AM Health Information Coordinator further revealed Resident #141 was discharged and her chart would have come to medical records until she closed the chart. The Minimum Data Set (MDS) Coordinator used the chart on 09/06/13 to complete Resident #141's MDS assessment. The Health Information Coordinator stated it was her regular routine after a resident had been discharged from the facility for 48 hours was to take the chart to medical records and there it would stay on a cart until she closed out the record. She reported the only staff who had a key to medical records was the Director of Nursing and herself. During a phone interview on 09/13/13 at 5:54 PM with the MDS Coordinator from another facility revealed she had come to the facility to assist with the MDS assessments and had taken Resident #141's medical record on 09/06/13 from a cart at the nurse's station and returned it to the same cart at the nurse's station when she was finished with her MDS about noon on 09/06/13. She also stated this cart was not were the other medical records were kept but on a small cart behind the nurses station. She further stated she returned to the facility on 09/09/13 to assist the facility's MDS Coordinator and needed the medical record for Resident #141 in order to add something to the care plan and could not locate the medical record for the 08/09/13 admission.	F 516		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 516	Continued From page 34 During an interview on 09/13/13 at 7:30 PM with the Administrator revealed the medical record for the 08/09/13 admission for Resident #141 had not been located and it was his expectation that the medical record should not be missing.	F 516		