| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 SS=B | 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS<br><br>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.<br><br>The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)<br><br>The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br><br>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br><br>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br><br>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.<br><br>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the | F 159 | F159<br><br>Residents #10, #27, and #35 quarterly statements were issued on 12/5/13 by Business Office Manager, also resident trust fund was replenished on 11/8/13 by Activity Assistant.<br><br>Quarterly statements (July/August/September) were mailed to responsible party for each resident on 11/5/13. On 11/12/13 quarterly statements (July/August/September) were received at the building and issued to residents by Business Office Manager by 12/5/13. Resident trust fund was replenished on 11/8/13 by Activity Assistant and has been maintained (kept above 1/3 monies) since then. The quarterly statements are issued the month after the quarter ends; Oct/Nov/Dec will be issued in Jan.<br><br>Activity Assistant and business office manager were provided re-education on the expectations of their role in dispersing cash to residents. This includes, but is not limited to understanding the system of replenishing the cash box when it reaches 1/3 of the designated on hand amount. Disbursements are tracked on tickets, which are then given to the business office and entered into the system. When disbursements reach 2/3 of the on hand amount the Business office manager issues | 12/5 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Heather Scott — Admin — 12/10/13

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 1<br>SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews, the facility failed to issue quarterly statements to 3 of 3 residents (Residents # 10, #27 and # 35) as well as failed to maintain enough cash in the resident trust fund account during posted business hours, to issue withdrawals without a lengthy delay.<br><br>The findings included:<br><br>The facility's policy on Patient Trust Regulations was reviewed. It read, "All bank statements and cancelled checks must be kept in the facility for at least 7 years. The resident or legal representative must be provided with an individual accounting of all transactions on a quarterly basis, or upon request."<br><br>1. A financial statement, produced by the Business Office Manager on 11/7/13, revealed that Resident #10 opened up a Resident Trust Fund account on 12/28/04.<br><br>Resident #10 was re-admitted to the facility on 1/10/13. On a quarterly Minimum Data Set (MDS) assessment completed on 10/2/13, Resident #10 was noted to be cognitively intact.<br><br>During an interview with Resident #10 on 11/4/13 | F 159 | a check which is taken to the bank by the activity assistant, cashed, and the amount placed in the cash box<br>Weekly meetings times four, then monthly thereafter, will be held with Business Manager, Activity Assistant and Administrator to ensure when money reaches one third. The balance needed to be kept on hand was determined by reviewing and averaging past daily disbursements. Transactions will be recorded on an audit tool and provided for Administrators weekly review<br>Quarterly statements will be mailed by the 12th of the month following the end of the quarter. It will be mailed to the legal representative as well as given to the residents and will show each months month end account balance by the business office manager.<br><br>The facility Administrator will report findings to Quality Improvement Committee weekly times four and bi- monthly times one. Changes will be made to the plan of correction if any discrepancies found. | 1/5 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 2<br>at 4:28 pm, he stated that he could not get his money out when he needed it because sometimes he had to wait a couple of days, so that the facility could write the check from the trust account to be cashed. He shared that last Wednesday, 10/30/13, he wanted 25 one dollar bills and he couldn't get the money right away because they didn't have a check written to get the money.<br><br>On 11/7/13 at 5:10 pm, the Business Office Manager was interviewed. She stated that she was hired over the summer and had received on going training on policies and procedures for the resident trust fund. When asked to produce a copy of Resident #10's most current quarterly statement and she offered to print it from her computer. She shared that the new quarter began on 10/1/13. When asked if she had a retained copy in his file, she searched and concluded that she did not.<br><br>The Business Office Manager was questioned further about the balance maintained in the trust fund cash box for daily withdrawals. She mentioned that the account was set up so that every resident with an account can take out up to $30 a day for use, so $600 is maintained in the box. She mentioned that she didn't personally hand out the money, the activities assistant did that. However, she was responsible for keying in transactions before 11 am, then after 2 pm, she wrote a check, giving it to the assistant who cashed it at the bank. She shared that their experience was funds were lower at the beginning of the month, after income checks were deposited and residents made frequent withdrawals. | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 3<br>The Business Office Manager commented that she wasn't sure how much was in the box today. The activities assistant normally went to the bank 3 days a week but she was not sure the last time she cashed a check for the resident trust fund nor did she have a receipt for the last transaction. The Business Office Manager secured the cash box and counted 1 ten dollar bill and 1 twenty dollar and estimated that she had about $10 in change.<br><br>The Activities Assistant was interviewed on 11/7/13 at 6:10 pm regarding the trust fund account. She mentioned that she went to the bank the day before yesterday, 11/5/13, to get money for the trust fund but can't remember how much she cashed or deposited in the box because she was told she didn't have to keep the bank receipts.<br><br>On 11/8/13 at 10:09 am, the Activities Assistant was again interviewed. She shared that she has been handling the financial transactions for the resident trust fund account weekdays, for the past year. She commented that residents with opened accounts approach her to withdraw funds. She gave them the cash upon request and wrote out a receipt for them. She mentioned that she did not issue any kind of statement or balance on their receipts, but had a statement with the balance for all residents with accounts.<br><br>She went on to say that she was informed that there was a $30 cap per day for each resident to withdraw money; however some residents would approach the former administrator in order to get additional daily funds. She stated that she goes to the bank, when she runs out of money and does not have a pre-determined amount to determine | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 4<br>when she needed to replenish the cash, to keep the funds available for resident's use. She stated that it was difficult to maintain $600 in the box everyday, if she was always withdrawing it for residents. Yesterday, she believed that she had $50 in the box. This morning she went to the bank and cashed checks totaling around $400. She explained that many times the delay in getting checks to cash was due to waiting for the corporate office to approve the balances and key in the transactions.<br><br>On 11/8/13 at 10:26 am, the Administrator, who was newly assigned to the facility, was interviewed. He commented that he was unaware of problems with the business office, but would make sure the issues were resolved.<br><br>On 11/15/13 the Administrator presented additional information to reflect the facility s Quality Assessment and Assurance Committee Action Plan/Performance Improvement Plan. It revealed that the Business Office Manager was initially trained on her duties on 6/17/13 with follow up training on 7/15/13. During the scope of the review, it found that resident trust fund balances and closures were not done timely and that weekly visits or calls would be offered to review trail balances and resident trust. On 8/2/13, an audit and interview revealed that the resident trust did not always have enough cash for resident requests. The Business Office Manager and Activities Assistant were re-educated on theh process. On 8/27/13, a follow up visit was made and concluded that the process had improved. On 9/12/13, the regional collection manager was notified of multiple issues related to trial balance and work performance issues. The Business Office Manager was | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 5<br>re-educated. On 10/17/13, the regional collection manager provided direct inservicing regarding resident trust and cash collections."<br><br>2. A financial statement, produced by the Business Office Manager on 11/7/13, revealed that Resident #27 opened a resident trust fund account on 5/3/05.<br><br>Resident #27 was re-admitted to the facility on 6/15/11. A quarterly MDS assessment completed on 8/5/13 indicated that she was cognitively intact.<br><br>During an interview with Resident #27 on 11/5/13 at 2:30 pm, she commented that sometimes the facility doesn't have cash available in the trust fund account until after 2 pm and sometimes it's still not available.<br><br>On 11/7/13 at 5:10 pm, the Business Office Manager was interviewed. She stated that she was hired over the summer and had received on going training on policies and procedures for the resident trust fund. When asked to produce a copy of Resident #27's most current quarterly statement and she offered to print it from her computer. She shared that the new quarter began on 10/1/13. When asked if she had a retained copy in his file, she searched and concluded that she did not.<br><br>The Business Office Manager was questioned further about the balance maintained in the trust fund cash box for daily withdrawals. She mentioned that the account was set up so that every resident with an account can take out up to $30 a day for use, so $600 is maintained in the box. She mentioned that she didn't personally | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 6<br>hand out the money, the activities assistant did that. However, she was responsible for keying in transactions before 11 am, then after 2 pm, she wrote a check, giving it to the assistant who cashed it at the bank. She shared that their experience was funds were lower at the beginning of the month, after income checks were deposited and residents made frequent withdrawals.<br><br>The Business Office Manager commented that she wasn't sure how much was in the box today. The activities assistant normally went to the bank 3 days a week but she was not sure the last time she cashed a check for the resident trust fund nor did she have a receipt for the last transaction. The Business Office Manager secured the cash box and counted 1 ten dollar bill and 1 twenty dollar and estimated that she had about $10 in change.<br><br>The Activities Assistant was interviewed on 11/7/13 at 6:10 pm regarding the trust fund account. She mentioned that she went to the bank the day before yesterday, 11/5/13, to get money for the trust fund but can't remember how much she cashed or deposited in the box because she was told she didn't have to keep the bank receipts.<br><br>On 11/8/13 at 10:09 am, the Activities Assistant was again interviewed. She shared that she has been handling the financial transactions for the resident trust fund account weekdays, for the past year. She commented that residents with opened accounts approach her to withdraw funds. She gave them the cash upon request and wrote out a receipt for them. She mentioned that she did not issue any kind of statement or balance on their | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 7<br>receipts, but had a statement with the balance for all residents with accounts.<br><br>She went on to say that she was informed that there was a $30 cap per day for each resident to withdraw money; however some residents would approach the former administrator in order to get additional daily funds. She stated that she goes to the bank, when she runs out of money and does not have a pre-determined amount to determine when she needed to replenish the cash, to keep the funds available for resident ' s use. She stated that it was difficult to maintain $600 in the box everyday, if she was always withdrawing it for residents. Yesterday, she believed that she had $50 in the box. This morning she went to the bank and cashed checks totaling around $400. She explained that many times the delay in getting checks to cash was due to waiting for the corporate office to approve the balances and key in the transactions.<br><br>On 11/8/13 at 10:26 am, the Administrator, who was newly assigned to the facility, was interviewed. He commented that he was unaware of problems with the business office, but would make sure the issues were resolved.<br><br>On 11/15/13 the Administrator presented additional information to reflect the facility s Quality Assessment and Assurance Committee Action Plan/Performance Improvement Plan. It revealed that the Business Office Manager was initially trained on her duties on 6/17/13 with follow up training on 7/15/13. During the scope of the review, it found that resident trust fund balances and closures were not done timely and that weekly visits or calls would be offered to review trail balances and resident trust. On | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 8<br>8/2/13, an audit and interview revealed that the resident trust did not always have enough cash for resident requests. The Business Office Manager and Activities Assistant were re-educated on theh process. On 8/27/13, a follow up visit was made and concluded that the process had improved. On 9/12/13, the regional collection manager was notified of multiple issues related to trial balance and work performance issues. The Business Office Manager was re-educated. On 10/17/13, the regional collection manager provided direct inservicing regarding resident trust and cash collections."<br><br>3. A financial statement, provided by the Business Office Manager on 11/7/13, revealed that Resident #35 opened his Resident Trust Funds account on 11/1/12.<br><br>Resident # 35 was admitted to the facility on 10/31/12 and then readmitted on 8/18/13.The quarterly MDS, completed on 7/8/13, revealed that he was cognitively intact.<br><br>During an interview with Resident #35 on 11/8/13 at 8:32 am, he stated that when he received money from the Activities Assistant, he only received a pink slip of the transaction. He was not given any written information with account balances. However, he shared that he's most frustrated because he was usually told by the Activities Assistant that he must come back after 2 pm to get money. He stated that even when he arrived at 10 am, he was told to come back after 2 pm. He shared that he was told that he could not request more then $50 in one day and that he withdrew his money daily when his balance was higher. | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 9<br>He stated that he has spoken to the Business Office Manager before about these problems and became aware that she hadn't gotten the checks back from the Activities Assistant to get funds and the Activities Assistant won't go to the bank until usually after her lunch break.<br><br>On 11/7/13 at 5:10 pm, the Business Office Manager was interviewed. She stated that she was hired over the summer and had received on going training on policies and procedures for the resident trust fund. When asked to produce a copy of Resident #35's most current quarterly statement and she offered to print it from her computer. She shared that the new quarter began on 10/1/13. When asked if she had a retained copy in his file, she searched and concluded that she did not.<br><br>The Business Office Manager was questioned further about the balance maintained in the trust fund cash box for daily withdrawals. She mentioned that the account was set up so that every resident with an account can take out up to $30 a day for use, so $600 is maintained in the box. She mentioned that she didn't personally hand out the money, the activities assistant did that. However, she was responsible for keying in transactions before 11 am, then after 2 pm, she wrote a check, giving it to the assistant who cashed it at the bank. She shared that their experience was funds were lower at the beginning of the month, after income checks were deposited and residents made frequent withdrawals.<br><br>The Business Office Manager commented that she wasn't sure how much was in the cash box today. The activities assistant normally went to | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 10 | F 159 | | |

the bank 3 days a week but she was not sure the last time she cashed a check for the resident trust fund nor did she have a receipt for the last transaction. The Business Office Manager secured the cash box and counted 1 ten dollar bill and 1 twenty dollar and estimated that she had about $10 in change.

The Activities Assistant was interviewed on 11/7/13 at 6:10 pm regarding the trust fund account. She mentioned that she went to the bank the day before yesterday, 11/5/13, to get money for the trust fund but can't remember how much she cashed or deposited in the box because she was told she didn't have to keep the bank receipts.

On 11/8/13 at 10:09 am, the Activities Assistant was again interviewed. She shared that she has been handling the financial transactions for the resident trust fund account weekdays, for the past year. She commented that residents with opened accounts approach her to withdraw funds. She gave them the cash upon request and wrote out a receipt for them. She mentioned that she did not issue any kind of statement or balance on their receipts, but had a statement with the balance for all residents with accounts.

She went on to say that she was informed that there was a $30 cap per day for each resident to withdraw money; however some residents would approach the former administrator in order to get additional daily funds. She stated that she goes to the bank, when she runs out of money and does not have a pre-determined amount to determine when she needed to replenish the cash, to keep the funds available for resident ' s use. She stated that it was difficult to maintain $600 in the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 159 | Continued From page 11<br>box everyday, if she was always withdrawing it for residents. Yesterday, she believed that she had $50 in the box. This morning she went to the bank and cashed checks totaling around $400. She explained that many times the delay in getting checks to cash was due to waiting for the corporate office to approve the balances and key in the transactions.<br><br>On 11/8/13 at 10:26 am, the Administrator, who was newly assigned to the facility, was interviewed. He commented that he was unaware of problems with the business office, but would make sure the issues were resolved.<br><br>On 11/15/13 the Administrator presented additional information to reflect the facility s Quality Assessment and Assurance Committee Action Plan/Performance Improvement Plan. It revealed that the Business Office Manager was initially trained on her duties on 6/17/13 with follow up training on 7/15/13. During the scope of the review, it found that resident trust fund balances and closures were not done timely and that weekly visits or calls would be offered to review trail balances and resident trust. On 8/2/13, an audit and interview revealed that the resident trust did not always have enough cash for resident requests. The Business Office Manager and Activities Assistant were re-educated on theh process. On 8/27/13, a follow up visit was made and concluded that the process had improved. On 9/12/13, the regional collection manager was notified of multiple issues related to trial balance and work performance issues. The Business Office Manager was re-educated. On 10/17/13, the regional collection manager provided direct inservicing regarding resident trust and cash collections. | F 159 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 520 | Continued From page 23<br>assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to maintain effective monitoring practices through their quality assessment and assurance committee over the calendar year, to prevent unacceptable accounting practices with the resident trust fund account. The findings included:<br><br>On 11/7/13 at 5:10 pm, the resident trust fund account was reviewed with the Business Office Manager. She stated that she was new to her position, hired over the summer and had received on-going training from the corporate office regarding policy and procedures of the resident | F 520 | An audit of closed accounts was completed 12/3/13 by the Business Office Manager and refund checks sent to corresponding representative payee/estate.<br><br>The facility business office manager was provided re-education regarding procedure for closing resident trust fund when discharged or expired, to ensure proper time frame followed on 11/12/13 by regional manager of collections.<br><br>The facility administrator will review residents who have discharged or expired from the previous week to ensure that resident trust had been closed within 30 days weekly times four and bi- monthly times one.<br><br>The facility Administrator will report findings to Quality Improvement Committee weekly times four and bi- monthly times one.<br>Changes will be made to the plan of correction if any discrepancies found | 12/5 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 520 | Continued From page 24<br>trust fund account.<br><br>She admitted that she had some challenges learning the material and processing the conveyance of funds in a timely manner. She shared that recently, on 10/28/13, she issued a set of checks to clerk of courts for residents who had expired since summer, even though she knew that the expectation was for her to issue a refund within 30 days of their deaths. She commented that her trainer had detected that the checks were not issued timely during an audit. She felt she had captured all of the expired residents, but realized she overlooked issuing a refund check to the estate of Resident #109 who had expired 8/16/13.<br><br>During the review of the resident bank statements, she shared that she did not retain a copy of their quarterly statements at the end of the quarter, September, 2013. She offered that residents get a pink slip (receipt) when they withdraw money from the fund; however, no quarterly had been issued.<br><br>She addressed that some residents had complained that there was not always funds available in the cash box for resident trust fund withdrawals. Ideally, they tried to keep $600 in the box however when she counted the box today, there was approximately $40 in the cash box for resident use.<br><br>In regard to the liability notices, she stated that she gave 48 hours notice before service ended, but did not include appeal contact information or reason for service ending on Medicare non-coverage letters. | F 520 | Preparation and/or execution of this plan of correction does not constitute admission by the provider of the truth of the facts alleged or conclusions set forth is this statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of state and federal law. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 520 | Continued From page 25<br>On 11/8/13 at 10:26 am, the Administrator, who was newly assigned to the facility, was interviewed. He commented that he was unaware of problems with the business office, but would make sure the issues were resolved.<br><br>In a follow up meeting with the Administrator and Administrative Staff #1 on 11/8/13 at 3:15 pm, they offered that each department was responsible for bringing their own information that they had previously gathered to the QAA meeting to determine if the plan of correction should be continued or revised.<br><br>On 11/15/13 the Administrator presented additional information to reflect the facility's Quality Assessment and Assurance (QAA) Committee Action Plan/Performance Improvement Plan. It revealed that the Business Office Manager was initially trained on her duties on 6/17/13 with follow up training on 7/15/13. During the scope of the review, it found that resident trust fund balances and closures were not done timely and that weekly visits or calls would be offered to review trail balances and resident trust. On 9/12/13, the regional collection manager was notified of multiple issues related to trial balance and work performance issues. The Business Office Manager was re-educated. On 10/17/13, the regional collection manager provided direct in servicing regarding resident trust and cash collections. | F 520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 166 SS=E | 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident and staff interviews, the facility failed to promptly resolve grievances for 1 (Resident #183) of 3 residents reviewed with grievances and failed to address grievances for 2 (Resident #10 & #183) of 3 residents reviewed with grievances. The findings included:<br><br>1. Resident # 183 was admitted to the facility on 5/16/13 with the following cumulative diagnoses: muscular disuse atrophy, diabetes mellitus type II and a brain abscess. On a 5/23/13 admission Minimum Data Set (MDS) assessment it indicated that Resident #183 was cognitively intact.<br><br>A record review was conducted and revealed that Resident #183 first filed a grievance on 6/21/13 regarding restorative services. Within the complaint, he alleged that he requested to speak with the Administrative Staff # 1 four times, with no response. On 6/24/13, the Administrative Staff #1 reviewed Resident #183's concerns and spoke with him and noted that he was satisfied with the restorative aide being re-counseled. The grievance indicated that on 7/9/13, Administrative Staff #2 followed up with him regarding resolution. | F 166 | Tag 166<br><br>Resident #183 is no longer a resident at facility.<br><br>Resident #10 was re-interviewed by the social worker and grievances were addressed and corrected to his satisfaction on 11/6/13.<br>Alert and oriented residents were interviewed by the social worker to see if grievances were present and any present were written up on concern forms and given to the Administrator that day, then given to Department head to investigate for a reasonable plan of action and action placed on form within 72 hours. The department head will have a discussion with the resident or responsible party within 72 hours. Once it has been completed then it will be given back to the Administrator. Administrator will contact the resident or responsible party on the expectation of the resolution within 7 days.<br>The facility staff was provided re-education on procedures regarding resident and family grievances on 11/6/13 by director of Nursing and completed on 12/5/13. The in-service included: what a concern is, that it is written on a concern form within 24 hours, given to the Administrator by hand or under | 1215 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 166 | Continued From page 13<br><br>On 6/28/13, Resident #183 filed a grievance about a second concern he had with his restorative aide. Administrative Staff #2 wrote that she finished her investigation on 7/1/13 but relayed the outcome to Resident #183 on 7/8/13 and that he was not satisfied with the result.<br><br>On 6/29/13, Resident #183 filed a grievance regarding confidentiality. The record indicated that Administrative Staff finished her investigation on 6/29/13 but relayed the outcome of the grievance to Resident #183 on 7/9/13.<br><br>On 7/1/13, Resident #183 filed a grievance regarding resident rights. The record indicated that Administrative Staff #2 followed up with the resident on 7/9/13.<br><br>On 7/15/13, Resident #183 filed a concern regarding treating residents with dignity and respect. The record indicated that on 7/22/13, Administrative Staff #2 met with Resident #183, to discuss his concerns. He was unsatisfied with the outcome.<br><br>On 11/6/13 at 5:20 pm, Administrative Staff #1 was interviewed regarding Resident #183's grievances. When asked why Resident #183's grievances weren't followed up until 7/8/13, she commented that Administrator Staff #2 was on vacation around the 4th of July holiday. Regarding the grievance that he filed on 7/1/13, she stated that she had never seen the written concern. She reviewed it, and then commented that the nurse handling the matter didn't investigate his concern.<br><br>On 11/7/13 at 2:30 pm, a phone call was place to | F 166 | door of Administrator office to be dealt with within 24 hours or first business day following receipt.<br><br>The facility department managers will complete 1-2 random interviews weekly times four , bi-weekly times four , bi- monthly times one, to ensure that residents grievances and or concerns are being captured and resolved. The above interviews will be kept and reviewed by the Administrator as an audit tool to ensure compliance.<br><br>The facility Administrator will report findings to QAPI weekly times four and bi- monthly times one. Changes will be made to the plan of correction if any discrepancies found | 12/5 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 166 | Continued From page 14<br>Administrative Staff #2 who was no longer employed at the facility. She was not available for comment.<br><br>On 11/7/13 at 2:50 pm, Resident #183 was interviewed by phone. He had discharged from the facility on 8/12/13. He stated that when he resided at the facility and had concerns, he would attempt to phone Administrative Staff #1 but she did not return his calls or address him directly in the halls. He shared that Administrative Staff #2 would listen to his concerns, "but nothing was ever done."<br><br>He commented that "I used to put written grievances in the mailbox of Administrative Staff #2 but suspected that she wasn't getting them, so I started putting them under her door, but she never acknowledged them."<br><br>On 11/14/13 at 1:32 pm, Administrative Staff #2 returned the call and discussed Resident #183's grievances. She commented that he made multiple grievances in a short period of time that she tried to address. She shared that she was on vacation 6/27/13 to 7/9/13, but during her absence; Administrative Staff #1 should have immediately handled all grievances.<br><br>2. Resident #10 was admitted on 4/26/2006 with diagnosis including paraplegia, depression, severe cervical stenosis and Diabetes Mellitus.<br><br>The Quarterly Minimum Data Set (MDS) Assessment dated 10/10/13 revealed Resident #10 was cognitively intact. | F 166 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 166 | Continued From page 15<br>Review of the facility Grievances/Concern Log since June 1/2013 revealed no grievances listed for Resident #10.<br><br>Interview with Resident #10 on 11/4/13 at 4:26 PM reveled that he had complained to Nurse #2 regarding Nurse #3 as well as the previous Administrator. He stated that he felt they had a personality conflict and he didn ' t want Nurse #3 working with him but Nurse #2 said they didn ' t have enough Nursing Staff to reassign Nurse #3. Resident #10 added that he didn ' t like they way Nurse #3 spoke to him and that he felt she was accusatory when he was incontinent and when his catheter came out.<br><br>Interview with Nurse #2 on 11/6/13 at 4:22 PM revealed that approximately two months prior (September, 2013) Resident #10 had complained to her about Nurse #3 but indicated that Nurse #3 was from New York and sometimes her way of speaking loudly was misinterpreted by residents and that it was something Nurse #3 had been working on her tone, as Administrative Staff #1 had already talked to her about it prior to September 2013. Nurse #2 said that she spoke with Nurse #3 and Resident #10 together and Nurse #3 denied saying that Resident #10 had pulled out his own catheter but Resident #10 thought that is what she said and was upset about it. Nurse #2 added that " at some point they (Resident #10 and Nurse #3) talked among themselves and seemed to resolve things. " Nurse #2 indicated that she did not know the contents of the conversation between Resident #10 and Nurse #3 which she felt resolved the situation and said that this resolution took more than 1 shift. She also acknowledged that she did not write the incident up as a concern because | F 166 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 166 | Continued From page 16 | F 166 | | |

she felt it had been addressed at some point but she was aware of the policy requiring concerns to be written up if they were not immediately resolved. She also stated that she did not report the incident to Administrative Staff #1 or any other Administrative Staff.

Interview with Administrative Staff #1 on 11/6/13 at 4:40 PM revealed that it was her expectation that she would be informed if a Resident had a particular concern about a nurse and that concerns which could not be resolved within one shift be written up as formal grievances for appropriate follow up and resolution.

Interivew with Resident #10 on 11/6/13 at 4:43 PM revealed that he told the Social Worker and the Administrator about his concerns regarding Nurse #3 earlier today (11/6/13).

Interview with the Administrator on 11/6/13 at 4:50 PM revealed he had talked with Resident #10 that day but he indicated Resident #10 did not have any concerns.

Interview with the Social Worker on 11/6/13 at 4:53 PM revealed that she had asked Resident #10 today (11/6/13), as well as other residents, if they had any concerns as directed by the Administrator. She stated that Resident #10 indicated Nurse #3 had accused him of doing things he did not do and he did not want to work with her anymore. The Social Worker added that she wrote up the concerns on a piece of paper instead of a Grievance/Concern form because she was going from room to room. She added that she gave a copy of the written concerns to the Administrator and discussed Resident #10 ' s concerns with him.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 166 | Continued From page 17<br><br>Interview with Nurse #3 on 11/6/13 at 5 PM revealed that she was aware Resident #10 did not like her and that he didn ' t like the sound of her voice. She added that he would turn her comments, like encouraging him to drink more fluids when he had an infection, into something negative. Nurse #3 denied accusing Resident #10 of pulling out his own catheter but indicated that she did ask him " if " he pulled out his own catheter. She added that she tried to take care of him and do the same good job she does with all her residents but acknowledged that his room is the facility was his home and if his home were in the community he would not likely invite her into it. | F 166 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review, the facility failed to wash dishes at the required temperature when using a hot water dish washer and failed to ensure staff changed gloves or sanitized hands before touching dirty and then clean dishes: The | F 371 | F 371<br><br>On 11/8/13 the dish wash machine was immediately shut down. Eco Lab was called to evaluate the temperatures of Dish machine and was determined to be in acceptable temperature ranges after adjustments were made (160-165 degrees wash temperature and ≥ 180 degrees for rinse temperature). Paper products were used for lunch and dinner on 11/8/13 until dish machine adjustment completed.<br><br>Facility Dietary aid #1 was immediately re- educated on 11/8/13 regarding appropriate hand washing and gloving when going from dirty area and/or items to clean area and/or items by Dietary Manager. | 1/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 18<br>findings included:<br><br>Review of the ECOLAB WH-44 high temperature Dishmachine manufacture ' s information titled " Dishmachine Lease Program " dated 2009, revealed that the operating capacity of the machine was 215 racks per hour. It also indicated that the minimum temperature for the wash cycle was 160 degrees Fahrenheit and the minimum temperature for the rinse cycle was 180 degrees Fahrenheit, with recommended incoming temperatures of 180 degrees for both the wash and rinse cycles.<br><br>1. On 11/8/13 at 9:20 AM dishes were observed being washed in the dishwasher (ECOLAB WH-44 high temperature Dishmachine). During the wash cycle the temperature of the water for the wash cycle was 120 degrees Fahrenheit. Dietary Aide #1 was observed looking at the temperature gauge at this time. The temperature of the rinse cycle was 180 degrees Fahrenheit.<br><br>On 11/8/13 Dietary Aide #1 was observed handling dirty dishware and then clean dishware that had come out of the dishmachine. Administrative Staff #2 then asked Dietary Aide # 1 to rewash the clean dishware that Dietary Aide #1 had just picked up.<br><br>Interview with Dietary Aide #1 on 11/8/13 at 9:28 AM revealed that he thought Administrative Staff #2 had asked him to rewash the dishware because the wash cycle temperature wasn ' t high enough. Dietary Aide #1 continued to run dishware through the dishmachine. The wash cycle temperature was observed to be 130 degrees Fahrenheit (F) at this time. | F 371 | All facility dishes from breakfast meals on 11/8/13 were re- washed (the trays, the adaptive equipment, and pots and pans were washed in three compartment sink for lunch/dinner. Paper products were used for lunch and dinner on 11/8/13 until dish machine adjustment completed. and when the dish machine was operating at proper temps after adjustment on 11/8/13 the dishes were run through the dish machine, by dietary aides.<br><br>Facility Dietary staff received re- education on 11/8/13 for proper procedure for checking dish machine to ensure that appropriate temperature were present during dish washing cycles by Dietary Manager and completed on 11/11/13. Newly hired dietary staff will receive the education during orientation.<br><br>The Facility Dietary Staff received re- education regarding proper procedure when going from dirty to clean areas, to include hand washing and gloving on 11/8/13 and completed 11/11/13 by Dietary<br><br>manager. Newly hired dietary staff will receive the education during orientation. | 12/5 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 19<br>On 11/8/13 at 9:45 AM the wash cycle temperature was observed as dishes were being cleaned with Administrative Staff #2. The temperature for the wash cycle got up to 140 degrees F. Administrative Staff #2 stated that the required temperature for the hot water with this high temperature dishmachine was 160 degrees F, for the wash cycle and 180 degrees F for the rinse. She added that the machine just needed to be turned off for 5 minutes to let the water temperature increase and indicated that it was normal for this it to need to be turned off during use at times, to reset the temperature of the water. Administrative Staff #2 also indicated that she expected staff to monitor the wash and rinse cycle temperatures during use but that the temperature was only recorded at the beginning of the dish washing process. Administrative Staff # 2 stated that the dishmachine had been serviced recently and the water temperature of the water entering the system had also been reset.<br><br>On 11/8/13 at 9:50 AM, with the dishmachine turned off, the wash cycle temperature gauge registered 168 degrees F and the rinse cycle temperature gauge registered 150 degrees F. Administrative Staff #2 turned the automatic dishmachine on at this time, the wash cycle temperature decreased to 140 degrees F before the wash cycle was over and the rinse cycle temperature had increased to 170 before the machine was again turned off.<br><br>On 11/8/13 at 9:55 AM Administrative Staff #2 stated that the facility would use paper plates until the hot water automatic dishwasher could be fixed and that cookware food preparation items would be washed in the 3 compartment sink. | F 371 | The facility dietary manager or cook will complete 2-3 random sampled documented observations of dish washing while in operation to ensure that acceptable temperatures are being achieved and maintained weekly times four weeks including random weekends, bi- monthly times one.<br><br>The facility Dietary Manager or cook will complete 2-3 random documented observations of kitchen staff going from dirty to clean areas to ensure that hand washing and gloving occurs appropriately weekly times four including random weekends and bi-monthly times one.<br><br>The facility Dietary Manager will record findings of the observations on an audit tool which will be presented to QAPI weekly times four and bi- monthly times one. Changes will be made to the plan of correction if any discrepancies found. | 12/5 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 20<br><br>2. On 11/8/13 at 9:25 AM Dietary Aide #1 was observed wearing gloves and handling dirty dishes. Dietary Aide #1 arranged the dirty dishes on pallet to go through the high temperature dishmachine. He then picked a pallet of clean meal trays and a palate of plate covers that had just been cleaned in the dishwasher, without changing his wet gloves. Administrative Staff #1 then asked Dietary Aide # 1 to rewash the meal trays and plate covers.<br><br>Interview with Dietary Aide #1 on 11/8/13 at 9:28 AM revealed that he thought he had been aware he needed to change his gloves after touching the dirty dishware and before touching clean dishware but he had forgotten.<br><br>Interview with Administrative Staff #2 indicated she expected staff to change gloves or sanitize their hands after touching dirty dishware and before touching clean dishware. She added that at times they are able to have 3 people on the dish washing line which helps prevent cross contamination. | F 371 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate | F 425 | F425<br>Clonodine 0.1 mg was removed from cart on 11/7/13 by Unit manager.<br>Clonodine 0.1 mg was removed from cart on 11/7/13 by Unit manager.<br>Escitalopram Oxalate 5 mg was removed from cart on 11/7/13 by Unit manager.<br>Vitamin D 400IU was removed from medication storage room on 11/7/13 by charge nurse. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 636 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 425 | Continued From page 21<br>acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to remove expired medications from two of seven medication carts and one of three medication storage rooms. The findings include:<br><br>1. An observation of the 100 Hall Nurses' medication cart was made on 11/7/2013 at 2:30 PM. Twenty tablets of Clonodine 0.1 mg (a medication used to lower blood pressure) with an expiration date of 10/31/2013 were observed in the medication cart. Twenty-seven tablets of Clonodine 0.1 mg with an expiration date of 9/30/2013 were observed in the medication cart.<br><br>2. An observation of the Med Aide medication cart for rooms 100 - 116 was made on 11/7/2013 at 2:46 PM. 23 tablets of Escitalopram Oxalate 5 mg (a medication used to treat anxiety and depression) with an expiration date of 10/31/2013 were observed in the medication cart.<br><br>An interview was conducted with Nurse #2 on 11/7/2013 at 2:50 PM. Nurse #2 stated the Med Aides and Nurses were expected to check the expiration date of each medication before it was | F 425 | The facility medication carts and storage rooms were checked for any expired medication on 11/7/13 by<br><br>Director of Nursing with no expired medications found.<br><br>All Facility Licensed nurses and All Certified Medication Aids were provided re-education on removing medication from medication carts and medication room that have expired, completed on 12/5/13 by Director of Nursing, both by phone and in person. Newly hired licensed nurses and medication aids will be provided the education during orientation.<br><br>The facility unit manager or supervisor will observe the medication rooms and medication carts weekly times four and bi- monthly times one to ensure that expired medication are being removed including random weekends on audit tools.<br><br>The facility Director of Nursing will record findings on an audit tool to QAPI weekly times four and bi-monthly times one.<br>Changes will be made to the plan of correction if any discrepancies found. | 12/5 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING _____ B. WING _____ | C 11/08/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD SALISBURY, NC 28144 |

| (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 425 | Continued From page 22<br>administered to the resident. The nurse on duty should have been notified by a Med Aide if an expired medication was found on one of the medication carts.<br><br>An interview was conducted with Administrative staff #1 on 11/7/2013 at 3:42 PM. She stated the Nurses and Med Aides were expected to check the expiration dates of medications prior to being administered to residents. Administrative staff #1 said the facility did not have a policy for medication storage or monitoring for expired medications. The Unit Managers were responsible for checking the medication storage rooms for expired medications monthly. Administrative staff #1 also stated "it is expected that no one should get an expired med."<br><br>3. Observation of the medication storage room on the 200 hall on 11/7/13 at 9:45 AM revealed 1 bottle of Vitamin D 400 IU (international units) with an expiration date of 10/2013.<br><br>During an interview on 11/7/13 at 9:52 AM, Nurse #1 indicated the expired Vitamin D should have been sent back to the pharmacy by the end of October.<br><br>During an interview on 11/8/13 at 1:34 PM, Administrative Staff #1 stated she expected nursing staff to return expired medications to the pharmacy. | F 425 | | 145 |
| F 520 SS=B | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and | F 520 | Tag 520<br><br>A refund check was issued to the estate of Resident #109 on 11/15/13 by the Business Office Manager. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345115 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 11/21/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD<br>SALISBURY, NC 28144 |

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II (222) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.<br><br>CFR#: 42 CFR 483.70 (a) | K 000 | | |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 11/21/2013 the following Life Safety item was observed as noncompliant, specific findings include: The required exit near room 107 was dragging on the bottom of the door and the door frame. | K 038 | K038<br>Correction for the alleged deficient practice noted as "The required exit near room 107 was dragging on the bottom of the door and the door frame", was immediate adjustment of the door and sweep to maintain proper operation without obstruction. The Maintenance Director surveyed the remainder of the building exit doors for proper open, swing, and latch without binding or dragging and repaired or adjusted upon discovery. The Maintenance Director will continue exit door operation checks at a minimum of weekly, with all results presented to and discussed during the next three monthly Safety Committee meetings. Safety Committee reviews of weekly checks will then continue quarterly until next annual survey. Completion date of 1/1/14 | 1/1/14 |
| K 076 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. | K 076 | | |

DEC 16 2013

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Luther Smith | Administrator | 12/13/13 |

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.

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 |
|---|---|---|---|
| | 345115 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 11/21/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD<br>SALISBURY, NC 28144 |

| (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 |
|---|---|---|---|---|
| K 076 | Continued From page 1<br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interviews on 11/21/2013 the following Life Safety item was observed as noncompliant, specific findings include: The oxygen cylinders at the oxygen storage locations were a mixture of full and empty cylinders. | K 076 | K076<br>Correction for the alleged deficient practice noted as "the oxygen cylinders at the oxygen storage location were a mixture of full and empty cylinders", was to immediately segregate cylinders with all full cylinders together and all empty cylinders together, including proper signage above each group designating status. The facility will provide an inservice for all staff relating to proper oxygen storage procedures at earliest possible date. The Maintenance Director or Administrator designee will conduct spot checks during daily rounds to insure continued compliance, with all data and findings from inservice and spot checks presented to and discussed during the next monthly Safety Committee meeting. Spot checks will continue for the next three months with results submitted at each Safety Committee meeting and then<br><br>continue with quarterly reviews until next annual survey.<br>Completion date of 1/1/14 | 1/1/14 |

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 |
|---|---|---|---|
| | 345115 | A. BUILDING 02 - BUILDING 0202<br>B. WING _____ | 11/21/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CTR HEALTH & REHAB/SALISBURY | 635 STATESVILLE BLVD<br>SALISBURY, NC 28144 |

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II (222) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.<br><br>CFR#: 42 CFR 483.70 (a)<br><br>NOTE: There were no Life Safety Code Deficiencies noted in this building during the survey. | K 000 | Preparation and/or execution of this plan of correction does not constitute admission by the provider of the truth of the facts alleged or conclusions set forth is the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law | 1/1/14 |

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

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.