

3/6/15

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview staff interviews and record review the facility filed to provide the correct size bed frame for a bariatric mattress for 1 of 1 sampled resident (Resident #117).</p> <p>The findings included:</p> <p>Resident #117 was admitted to the facility on 10/25/14 with a diagnosis that included deep vein thrombosis to left lower extremity, anemia, mycloneuropathy, urinary retention, acute renal failure, and myelitis. The Minimum Data Set (MDS) assessment dated 12/14/14 revealed Resident #117 required extensive assistance for bed mobility with the use of 2 staff persons and was totally dependent on staff for transfers. The MDS further coded Resident #117 as being cognitively intact.</p> <p>Resident #117's care plan updated 12/19/14 revealed a "problem" of Pressure ulcers. The approaches included; apply pressure reduction mattress to bed (air mattress), turn and reposition while in bed frequently for comfort and pressure reduction, and wedge for positioning.</p>	F 246	<p>This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>F248 Accommodation of Needs</p> <ol style="list-style-type: none"> Residents number 117 received the appropriate size bed frame and mattress on 1/28/15 by the Director of Nursing. The treatment nurse evaluated all resident utilizing air mattresses and validated appropriate size bed frames on 2/19/15. Maintenance staff was re-educated by the Administrator on 2/19/15 on ensuring appropriate size bed frame utilized for air mattresses. Air mattress audits will be conducted on five random residents by the Director of Nursing, Unit Manager or treatment nurse, 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 2 months to ensure ongoing compliance. These measures are to ensure corrections are achieved and sustained. The Director of Nursing will report the results of these audits and observation during the Quality Assessment and Process Improvement meeting quarterly. The QAPI team will evaluate and make further recommendations as indicated. 	2/27/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Glenda Sullivan* TITLE RN-NHA (X6) DATE 3/5/15

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 246	<p>Continued From page 1</p> <p>Review of Resident #117 physician order dated 12/23/14 indicated Clarification order; air mattress to setting of 6.5 check every shift for setting and proper functioning.</p> <p>Observation of Resident #117 on 1/27/15 at 10:12 am revealed Resident #117 was lying on a bariatric air mattress. The mattress was observed wider than the standard bed frame it laid on. The bed's side rails were observed in the up position and the mattress was wedged in-between. Resident #117's air mattress control unit was observed to be set at 5.</p> <p>During an interview on 1/27/15 at 10:14 am Resident #117 stated his mattress was way too big for his bed. Resident #117 stated that about a month ago his previous air mattress went flat. Maintenance retrieved him a bariatric mattress from an empty room. Resident #117 stated that he was told by maintenance that he would locate a mattress that would fit his standard bed frame. Resident #117 stated that due to the width of the mattress it was difficult for him to access his bedside table. He had to perform more tasks with his right hand due to the location of the bedside table being on the right side of his bed.</p> <p>Observation on 1/28/15 at 10:00 am revealed Resident #117 was lying in bed. The air mattress control unit was observed to be set at 5. The air mattress was observed to extend out further than the frame of the bed. The air mattress was further observed to be wedged in-between the bed's raised side rails.</p> <p>During an interview and observation with the Maintenance Director on 1/28/15 at 11:07 am he</p>	F 246			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 246	<p>Continued From page 2</p> <p>indicated rented specialty beds were provided to the facility by an outside agency. He was contacted by nursing in the event there was an issue with a resident's air mattress. When asked about Resident #117's current mattress the Maintenance Director stated, "I probably did put the mattress on." The Maintenance Director indicated that there should have been a smaller mattress on Resident 117's bed. The Maintenance Director identified that Resident #117's bed frame did not have the ability to be extended. Resident #117's mattress was on a standard bed and his bariatric mattress needed to be on a bed frame that was equal in size. The standard bed frame was measured at 35 inches in width, and the bariatric mattress was measured at 42 inches in width. The Maintenance Director stated he "just grabbed" a mattress because Resident #117's went flat. The Maintenance Director stated he was unaware of how long Resident #117 had been using the 42 inch mattress.</p> <p>Interview with the Director of Nursing (DON) on 1/28/15 at 10:59 am revealed the facility utilized an outside agency that delivers and sets up the specialized beds for residents. She would contact central supply to communicate what type of bed the resident was in need of and central supply then contacts the outside agency that would deliver and setup the bed. The DON further stated the facility owned a different type of mattress and these mattresses are assigned by the resident's needs and maintenance would put them on the bed.</p> <p>Interview on 1/28/15 at 2:46 pm with a representative from the outside agency that provided specialized beds to the facility revealed</p>	F 246			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 246	Continued From page 3 they had no case number in regards to Resident #117 and any specialized mattress. The agency representative indicated that if it was one of the outside agency 's mattresses they did not set up or deliver it for the resident in question. The outside agency representative further indicated that it was not the manufacturer's recommendations to place a bariatric mattress that was 42 inches wide on a standard bed that was 35 inches wide. The representative stated if the mattress is 42 inches wide the bed should be 42 inches wide. Interview with the Nurse Consultant on 1/30/15 at 2:30pm revealed it was her expectation that resident equipment be set up by the contracted outside agency. The Nurse Consultant further indicated that it was the responsibility of the DON to order mattresses and to ensure specialty beds were ordered.	F 246		
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview the facility failed to clean and repair heating/air conditioning systems for the following rooms (100, 101, 102, 103, 104, 105, 106, 108, 110, 112, 113, 115, 116, 117, 119, 120, 121, 122, 123, 124, 126, 127, 128, 129, 200, 201, 202, 203, 204, 206, 208, 209, 211, 214, 216, 217, 219, 220, 221, 223, 225, 227, 301, 304, 321, 322, 323, 325,	F 253	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F253 Housekeeping and Maintenance Services	2/27/15

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 253	<p>Continued From page 4</p> <p>326, 328, and 333) 51 out of 81 rooms; 5 out of 81 rooms with holes in walls for the following rooms (110, 112, 118, 225, and 123); 2 out of 81 rooms without blinds for the following rooms (210, and 321); 6 rooms with broken dresser drawers (108, 111, 112, 126, 127, and 128); 6 rooms with missing baseboards (110, 112, 117, 123, 226, and 323), and 6 rooms with missing knobs for dresser drawers for the following rooms (102, 103, 109, 118, 123, and 127).</p> <p>The findings included:</p> <p>1. Observations on 1/25/15 though 1/27/15 revealed 51 out of 81 resident rooms 100, 101, 102, 103, 104, 105, 106, 108, 110, 112, 113, 115, 116, 117, 119, 120, 121, 122, 123, 124, 126, 127, 128, 129, 200, 201, 202, 203, 204, 206, 208, 209, 211, 214, 216, 217, 219, 220, 223, 225, 227, 301, 304, 321, 322, 323, 325, 326, 328, and room 333 to have one inch or more of dust built up on the heating/air-conditioning unit filters. Observation on 1/25/15 at 6:38 pm revealed resident room #108 to have heavy lint on hating/air-conditioning system. Observation on 1/26/15 revealed heavy lint on heating/air-conditioning system for room #112 at 9:03am, #120 at 9:13am, #126 at 9:32am #201 at 10:52 am, #204 at 10:17am, #206 at 2:29am, #214 at 2:02pm, #225 at 2:07 pm, #226 at 8:38am, #321 at 1:27 pm, #322 at 9:21am, #323 at 9:53 am, and Room 333 at 10:06am. Observation on 1/27/15 revealed heavy lint on heating/air-conditioning system for room #128 at 10:47 am, #325 at 9:05am, and #328 at 9:55am and rooms #100, #101, #102, #103, #104, #105, #106, #108, #110, #113, #115, #116, #117, #119, #121, #122, #123, #124, #127, #129, #200, #202, #203, #208, #209, #211, #216, #217, #219, #220,</p>	F 253	<p>1. Corrective action for the alleged deficiency included the following:</p> <ol style="list-style-type: none"> 1) Heating/air conditioning systems in rooms 100, 101, 102, 103, 104, 105, 106, 108, 110, 112, 113, 115, 116, 117, 119, 120, 121, 122, 123, 124, 126, 127, 128, 129, 200, 201, 202, 203, 204, 206, 208, 209, 211, 214, 216, 217, 219, 220, 221, 223, 225, 227, 301, 304, 321, 322, 323, 325, 326, 328, and 333 will be cleaned and repaired by the maintenance team by 2-27-15. 2) Holes in walls in rooms 110, 112, 118, 225, and 123 will be repaired by the maintenance team by 2-27-15. 3) Replaced blinds in rooms 210 and 321 by the maintenance team on 1-28-15. 1. Broken dresser drawers in rooms 108, 111, 112, 126, 127 and 128 will be repaired or replaced by the maintenance team by 2-27-15. 2. Missing baseboards replaced/repared in rooms 110, 112, 117, 123, 226, and 323 by the maintenance team by 2-27-15. 3. Knobs replaced on dressers in rooms 102, 103, 109, 118, 123, and 127 by the maintenance team on 2-27-15. 		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 253	<p>Continued From page 5</p> <p>#221, #223, #227, #301, #304, and #326 at 11:07am</p> <p>2. Observation on 1/26/15 at 11:07 am revealed baseboards missing from rooms #123, #112, #117, #110, #323, and #226 had loose baseboards.</p> <p>3. Observation on 1/26/15 at 11:07 am pm revealed room #118, and 225 to have holes in walls. Observation on 1/26/15 at 10:40 pm revealed rooms 3112, and #118 to have holes in walls.</p> <p>4. Observation on 1/26/15 at 1:27am revealed room 321 to have a no blinds. A sheet was observed to be hung over the window. Observation on 1/27/15 at 11:07am revealed room #210 to have no blinds. A sheet was observed to be hung over the window.</p> <p>Review of the facility work orders revealed an order for room #321. The work order stated "blind in window". There was not date provided on the work order. There was no action provided by maintenance.</p> <p>5. During an observation on 1/27/15 at 3:00 pm revealed 6 rooms without knobs to dressers (resident rooms #118, #127, #109, #103, #102, and #123). Room #102 knobs were observed to be loose as evidenced by knobs hanging from dresser by visible screws. Room #103 had broken knobs on the closets. Room #118 had missing knobs for dresser drawers, Room #123 and #127 dresser drawers were missing knobs.</p> <p>6. Observation of room #123 on 1/26/15 at 11:00</p>	F 253	<p>2. All residents have the potential to be affected by the alleged deficient practice. Therefore a 100% audit of all resident rooms and common areas was conducted on 1/27/15 by facility and district team for required repairs and a prioritized repair schedule was developed by the Division Maintenance Director by 1/28/15.</p> <p>3. Measures put into place to ensure that the alleged deficient practices do not recur are as follows:</p> <p>The Division Maintenance Director will re-educate the facility maintenance staff on timely completion of maintenance concerns by 2-27-15. All Staff will be re-educated by the Area Educator by 2-27-15 on recognizing and reporting a Maintenance request for needed repairs. The Administrator review maintenance logs 3 times a week for timely completion and will monitor 10 rooms weekly for 12 weeks to identify needed repairs and maintenance</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Administrator will report the results of these audits and observations during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendation as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 253	<p>Continued From page 6</p> <p>am revealed missing base boards behind the resident's door. Missing baseboard behind bed A bed revealed a 2 inch gap from the wall to the floor. A telephone cord was observed to run from the ceiling to the floor. The cord was draped on the floor running along 2 inch gap between baseboard and wall. The cord was observed to run behind bed A and into a phone jack. Out of the exposed wires entering the phone jack there are two wires that were broken off and not inserted into the phone jack. The wires and phone jack were observed to be covered in dust. A glass lense, orange food crumbs and a bead in the corner of the resident's room that was covered in dust.</p> <p>Review of maintenance work ordered dated 1/9/15 indicated a repair need for room 123 of; baseboard under bed has while where snail comes in. The action identified by maintenance on 1/12/15 revealed "checked."</p> <p>7. Observation of room #117 on 1/26/15 at 3:00 pm revealed a dried substance under bed A. The air-conditioning/heating unit cover was observed not attached to the unit. A whole was observed in the wall by the bathroom door. Base board was observed as missing from the wall.</p> <p>Review of maintenance work order for room #117 dated 1/9/15 revealed "holes by bathroom door." There were no documented actions taken by maintenance.</p> <p>During an interview with the family for the Resident in room #117 on 1/26/15 at 3:30 pm revealed they had informed the facility that there was dried nutritional supplement on the floor under the resident's bed more than 2 weeks ago.</p>	F 253			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 253	<p>Continued From page 7</p> <p>8. During observation on 1/26/15 at 3:20 pm revealed 6 resident rooms had broken dresser drawers (room#108, 111, 112, 126, 127, and 128). Room #108 was observed to have 2 broken dresser drawers with exposed clothing. Room #128 had 2 dresser drawers missing. Underneath the missing drawers were exposed clothing in remaining dresser drawers.</p> <p>Interview with Housekeeping Manager on 1/26/15 at 4:15 pm revealed it was the responsibility of maintenance to clean heater/air-condition filters. The Housekeeping Manager further indicated that resident rooms were cleaned daily as evidenced by sweeping, moping, cleaning resident restrooms, and dusting. Housekeeping indicated that they perform spot cleaning in rooms when notified by nursing about spills or other housekeeping needs throughout the day.</p> <p>During an interview and observation with the Maintenance Director on 1/26/15 at 4:15 pm revealed that staff were to document maintenance issues or concerns on the facility work order form. The facility work order requests were located in a notebook at each nursing station. Maintenance indicated that he would sign off on work orders once completed as evidence as complete. Maintenance identified if the work order was not signed by him he had not completed the task.</p> <p>Review of facilities work orders obtained at each nursing station revealed the following facility work orders as not addressed:</p>	F 253			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 253	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Facility work order (no date provided) stated, "Molding around floor loose in room #334". -Facility work order (no date provided) stated, "Ceiling coming through " in room #301 -Facility work order (no date provided) stated, "Blind in window " for room #321. -Facility work order (no date provided) stated, "Small holes near bathroom in room wall" for room #329. -Facility work order dated 12/20/14 stated "window cracked" -Facility work order dated 12/20/14 stated "bathroom door has a hole in it for room" 332/334. -Facility work order dated 1/9/15 stated, "holes in wall by window" for room #108. -Facility work order dated 1/9/15 stated, "holes at baseboard on wall bed is up against" for room #109. -Facility work order dated 1/9/15 stated, "holes by door" for room #110. -Facility work order dated 1/9/15 stated, "walls need patched with paint" for room #332. -Facility work order dated 1/13/15 stated, "wallpaper peeling off wall" for room #333. -Facility work order dated 1/14/15 stated, "wall at head of bed needs to be repaired" for room #105. -Facility work order dated 1/19/15 stated, " drawer broken " for room #123. <p>During an interview and observation with the Administrator on 1/26/15 at 4:15 pm revealed it was her expectation that maintenance needs be taken care of timely. The Administrator further indicated she was unaware of the maintenance concerns being observed. The Administrator stated that in the instance maintenance had a large amount of maintenance concerns that he</p>	F 253			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 253	Continued From page 9	F 253			
F 278 SS=B	inform her so that she could locate him assistance to ensure the maintenance needs were addressed timely. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 278	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F278 Accuracy of Assessment 1. Residents' number 30, 68 and 146 MDS was corrected on 2/2/15 and 2/5/15 by the Resident Care Management Director to accurately reflect the level II PASRR. 2. All residents with the coding of the MDS with level II PASRR have the potential of being affected by the alleged deficient practice. The Resident Care Management Director will complete an audit of all residents with level II PASRR to validate the MDS assessment has been coded accurately to reflect status of the resident. The audit was completed on 2/8/15.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 278	<p>Continued From page 10</p> <p>facility failed to accurately code the Minimum Data Set to reflect the Level II Preadmission Screening and Resident Review determination for 3 of 7 residents (Resident #30, #68, and #146) identified as Level II PASRR residents.</p> <p>The findings included:</p> <p>1) Resident #68 was admitted to the facility on 10/08/2014 and had diagnoses including anxiety, depression, bipolar disorder, psychotic disorder, and schizophrenia.</p> <p>A review of Resident #68's Admission Minimum Data Set (MDS) dated 10/15/2014 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.</p> <p>A review of the facility's list of Level II PASRR residents revealed that Resident #68 was included among the residents named on the list.</p> <p>The Business Office Manager was interviewed on 01/29/2015 at 11:21 AM, regarding PASRR status and how it was communicated to the MDS Coordinator. She indicated that PASRR renewals were not being done when she started working there and said, "It is such a simple thing but no one had been assigned to do it so I started this tracking book." The Business Office Manager said, "I know that MDS needs to know so I let people know in morning meetings."</p>	F 278	<p>3. The Regional Care Management Director re-educated all MDS staff on the accurate completion of section A on 2/4/15. The Resident Care Management Director will randomly review 5 completed MDS weekly for 1 month then biweekly for 2 months to verify accurate completion. The results of this monitoring will be documented on the MDS Accuracy Audit. Opportunities will be corrected by the Resident Care Director or MDS Coordinator as identified during audits.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Resident Care Management Director will report the results of these audits during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY	STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 278	<p>Continued From page 11</p> <p>The Resident Care Management Director, was interviewed on 01/29/2015 at 2:18 PM regarding Resident #68's assessment. She stated she was not aware the resident's MDS did not reflect the PASRR status accurately. She could not explain why it was coded incorrectly but the MDS should have reflected the resident had a PASRR Level II status.</p> <p>On 01/29/2015 at 4:40 PM the Interim Director of Nursing (DON) was interviewed. The Interim DON indicated it was her expectation that the Level II PASRR determination would be coded accurately on each resident's MDS.</p> <p>2) Resident #30 had diagnoses including depressive disorder, anxiety and schizophrenia.</p> <p>A review of Resident #30's Annual Minimum Data Set (MDS) dated 09/10/2014 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The MDS did indicate Resident #30's diagnoses included anxiety, depression and schizophrenia.</p> <p>A review of the facility's list of Level II PASRR residents revealed that Resident #30 was included among the residents named on the list.</p> <p>The Business Office Manager was interviewed on 01/29/2015 at 11:21 AM, regarding PASRR status and how it was communicated to the MDS Coordinator. She indicated that PASRR renewals were not being done when she started working there and said, "It is such a simple thing but no</p>	F 278		
-------	---	-------	--	--

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 278	<p>Continued From page 12</p> <p>one had been assigned to do it so I started this tracking book." The Business Office Manager said, "I know that MDS (staff) needs to know so I let people know in morning meetings."</p> <p>The Resident Care Management Director, was interviewed on 01/29/2015 at 2:18 PM regarding Resident #30's assessment. She, stated she was not aware the resident's MDS did not reflect the PASRR status accurately. She could not explain why it was coded incorrectly but the MDS should have reflected the resident had a PASRR Level II status.</p> <p>On 01/29/2015 at 4:40 PM the Interim Director of Nursing (DON) was interviewed. The Interim DON indicated it was her expectation that the Level II PASRR determination would be coded accurately on each resident's MDS.</p> <p>3) Resident #146 was admitted to the facility on 10/08/2014 and had diagnoses including bipolar disorder.</p> <p>A review of Resident #146's Admission Minimum Data Set (MDS) dated 10/15/2014 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The MDS did indicate Resident #146 's diagnoses included bipolar disorder.</p> <p>A review of the facility's list of Level II PASRR residents revealed that Resident #146 was included among the residents named on the list.</p> <p>The Business Office Manager was interviewed on</p>	F 278			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 278	Continued From page 13 01/29/2015 at 11:21 AM, regarding PASRR status and how it was communicated to the MDS Coordinator. She indicated that PASRR renewals were not being done when she started working there and said, "It is such a simple thing but no one had been assigned to do it so I started this tracking book." The Business Office Manager said, "I know that MDS (staff) needs to know so I let people know in morning meetings." The Resident Care Management Director, was interviewed on 01/29/2015 at 2:18 PM regarding Resident #146's assessment. She, stated she was not aware the resident's MDS did not reflect the PASRR status accurately. She could not explain why it was coded incorrectly but the MDS should have reflected the resident had a PASRR Level II status. On 01/29/2015 at 4:40 PM the Interim Director of Nursing (DON) was interviewed. The Interim DON indicated it was her expectation that the Level II PASRR determination would be coded accurately on each resident's MDS.	F 278			
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F279 Develop Comprehensive Care Plans I. On 2-4-15 Resident #79's pressure ulcer care plan was updated to reflect current interventions by the Resident Care Management Director on.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 279	<p>Continued From page 14</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to complete a care plan with interventions to prevent a pressure ulcer from reoccurring for one of two sampled residents with pressure ulcers. Resident #79</p> <p>The findings included:</p> <p>Resident #79 was initially admitted to the facility on 9/27/11 with diagnoses including anoxic brain injury, diabetes, seizure disorder and hypertension.</p> <p>The annual Minimum Data Set (MDS) dated 7/25/14 indicated memory and cognition were not assessed due to persistant vegetative state. The MDS indicated Resident #79 required extensive assistance of two staff for bed mobility, extensive assistance of one person was required for toileting and personal hygiene and total assistance of one person was required for bathing. The bowel and bladder assessment indicated Resident #79 was always Incontinent of both. Pressure ulcers were indicated as being present as a stage 3 on this MDS. Total nutrition and hydration for this resident was provided by a</p>	F 279	<p>2. The Resident Care Management Director will audit the pressure ulcer care plan of all residents with current pressure ulcers by 2-27-14.</p> <p>3 .On 2-18-15 the Regional Care Management Director will re-educate all Interdisciplinary Team, which includes the Director of Nursing, Unit Managers, Resident Care Management Director, Activities Director and Social Services regarding the development of comprehensive care plans, including interventions to prevent pressure ulcers. The Resident Care Management Director will randomly observe 5 residents' pressure ulcer care plans weekly for 4 weeks then biweekly for 2 months to validate all current interventions are appropriate for the resident and are in place. The results of this review will be documented on the Care Plan Audit Tool. Opportunities will be corrected as needed by the Resident Care Director or MDS Coordinator.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Resident Care Management Director will report the results of these audits during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 279	<p>Continued From page 15</p> <p>feeding tube. Resident #79 was assessed as having a tracheostomy in place.</p> <p>Review of the Care Area Assessments (CAAS) dated 7/30/14 indicated "Pressure Ulcer" was triggered due to the resident had a new stage 3 on the coccyx and developed a stage 3 pressure ulcer on her neck due to the tracheostomy strap. The stated goal included there would be no further signs of break down. The decision was made to proceed to care plan and monitor for and prevent pressure ulcers.</p> <p>Review of the care plan with an update of 7/23/14 included the pressure ulcers on the coccyx and the neck. Approaches included pressure reduction mattress to the bed, pressure reduction cushion to the chair or wheelchair, complete a full body check weekly and document, wound care physician and a wedge to be used at all times. Updates to the care plan indicated the coccyx wound would heal and re open.</p> <p>Review of the medical record for Resident #79 revealed the pressure ulcer on the posterior neck first occurred on 7/20/14 and healed on 9/3/14. A pressure ulcer reoccurred on 9/23/14 on the back of her neck and healed again on 10/8/14.</p> <p>Review of the Treatment Administration Records for December and January revealed the order to place an ABD pad (thick padded dressing) to the posterior neck every day. These records did not include the use of soft Velcro ties for the tracheostomy ties.</p> <p>Interview with the MDS nurse on 01/29/2015 at 3:03 PM revealed she was not sure why Resident #79 was not care planned for interventions to</p>	F 279			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 279	Continued From page 16 prevent reoccurrence of the pressure ulcer on the posterior neck. The ABD pad was ordered and must have been overlooked. The type of ties for the tracheostomy to prevent pressure ulcers from reoccurring was missed and not added to the care plan.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to update care plans for 4 of 52 sampled residents with care plans reviewed. (Residents #131, 147, 159 and 116)	F 280	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F280 RIGHT TO PARTICIPATE PLANNING CARE REVISE CP 1. Resident # 131 care plan was revised on 1-29-15 to reflect correct size of tracheostomy Shiley trach by the Resident Care Management Director. Residents' # 147 care plan revised on 2-18-14 and #159 care plan was revised on 2-11-15 for current fall interventions by the Resident Care Management Director. Resident # 116 was discharged on 1-4-15. 2. All residents care plans were audited to reflect correct tracheostomy care and size, current fall interventions, and infections related to contact isolation by 2-27-15 by the Resident Care Management Director and MDS Coordinator.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 280	<p>Continued From page 17 Findings included:</p> <p>1. Resident #131 was initially admitted to the facility on 5/13/14. The most recent re admission was on 1/12/15 with diagnoses including respiratory infection, neurogenic bladder and anoxic brain damage.</p> <p>The respiratory therapist note dated 11/10/14 indicated tracheostomy care was provided and a #6 Shiley was used to replace the inner cannula.</p> <p>The Minimum Data Set (MDS) dated 11/13/14 indicated Resident #131 had a tracheostomy and was total care for activities of daily living.</p> <p>The care plan updated on 11/13/14 included problems related to a tracheostomy. Approaches for care of the tracheostomy indicated the size of the tracheal inner cannula (Shiley) was 14.</p> <p>Review of a physician 's consult dated 12/17/14 revealed the trach was changed using a #6 cuffless Shiley.</p> <p>Review of a telephone order dated 1/12/15 revealed a #6 Shiley was to be used for tracheostomy care.</p> <p>Observations on 1/27/15 at 7:55 AM revealed #6 Shiley was in the room for tracheostomy care.</p> <p>Interview on 01/29/2015 at 10:16 AM with the MDS nurse revealed the care plan was in error. The size of the Shiley should have been #6.</p> <p>2. Resident #147 was admitted to the facility on 11/14/14 with diagnoses including diabetes and stroke.</p>	F 280	<p>3.The Regional Care Management Director will re-educate all Interdisciplinary Team, which includes the Director of Nursing, Unit Managers, Resident Care Management Director, Activities Director and Social Services on updating care plans to include interventions for tracheostomy and size of Shiley trach, current fall interventions and infections related to e diff and contact isolation on 2-18-14. The Resident Care Management Director will randomly observe 5 residents' care plans for 4 weeks then biweekly for 2 months to validate care plans are in place for tracheostomy, fall interventions, and infections related to isolation. The results for this monitoring will be documented on the Care Plan Update Audit Tool. Opportunities will be corrected as needed by the Resident Care Director or MDS Coordinator as identified during audits.</p> <p>4.These measures are to ensure corrections are achieved and sustained: The Resident Care Management Director will report the results of these audits during the Quality Assessment and Process Improvement Meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY	STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 280	<p>Continued From page 18</p> <p>The Minimum Data Set (MDS) dated 11/21/14 indicated Resident #147 had moderate impairment with short and long term memory, required extensive assistance with bed mobility, transfers, personal hygiene and toileting and was non ambulatory. The MDS indicated Resident #147 had experienced a fall.</p> <p>The care plan dated 11/16/14 included a problem of falls with intervention of a personal alarm to be applied to the bed at all times. An updated intervention for 12/8/14 included when the resident was out of her room, for staff to attempt to keep the resident in a supervised area.</p> <p>Review of the January orders revealed an order for a personal alarm to be used when in bed and the chair.</p> <p>Observation on 01/29/2015 at 9:14 AM revealed Resident was in her wheelchair (Broda type) and the personal alarm was on the back of the chair with the clip not attached to the resident.</p> <p>On 1/29/2015 at 10:02 AM an interview was conducted with the MDS nurse. Interview revealed the care plan should have been updated for fall prevention with use of a personal alarm when out of bed in a chair.</p> <p>3. Resident #159 admitted to the facility on 9/9/14 with diagnosis of Alzheimer and anxiety.</p> <p>Review of the Minimum Data Set (MDS) dated 12/16/14 indicated Resident #159 had problems with long and short term memory and had no behaviors. Resident #159 required extensive assistance of one staff for bed mobility, transfers,</p>	F 280		
-------	---	-------	--	--

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 280	<p>Continued From page 19</p> <p>dressing, and personal hygiene. She was able to walk with limited assistance of one staff. This MDS indicated she had a history of two falls without injury since admission and/or prior assessment.</p> <p>Review of the care plan dated 1/23/14 indicated a problem of falls with interventions including use of a personal alarm while in bed and in the wheel chair. The care plan included the use of a mattress pad alarm.</p> <p>Review of the January monthly orders indicated the resident was to have a mattress pad alarm when in bed and to check the alarm every shift.</p> <p>Observation on 01/28/2015 at 1:49PM revealed a sensor pad was located under Resident #159 and the cord was hanging down from the pad. The sensor pad was not attached to any type of alarm box.</p> <p>Interview on 01/29/2015 at 9:58 AM with the MDS nurse revealed the personal alarm was the fall intervention to be used when in bed. Further interview revealed she was not aware of a sensor pad on the bed. The MDS nurse explained the personal alarm was to be used when the resident was in a chair and in the bed.</p> <p>Interview on 01/29/2015 at 3:06:06 PM with the MDS nurse revealed the sensor pad alarm was not a current intervention and the care plan should have been revised.</p> <p>4. Resident #116 was re-admitted to the facility</p>	F 280			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 280	Continued From page 20 on 12/18/14 with diagnosis including urinary tract infection, clostridium difficile colitis (c-diff) and vascular dementia. Resident #116 was discharge to the hospital on 1/4/15 for an evaluation due to symptoms of confusion and hypotension. A record review revealed a nurse ' s note dated 12/18/14 that Resident #116 was placed in contact isolation for c-diff. A physician telephone order dated 1/1/15 indicated to discontinue contact precautions. The care plan initiated on 11/13/14 for actual infection was not updated to reflect changes on re-admission 12/18/14 for c-diff colitis and contact precautions. An interview with Unit Coordinator #2 on 1/28/15 at 10:15 AM revealed that care plans are expected to be updated within 24 hours of admission. It is the practice of the facility to review and update the care plan for any changes each morning in morning meeting.	F 280			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to have medications available and and ensure medications were administered as ordered by the physician for 1 of 6 residents (Residents #29)	F 281	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 281 SERVICES PROVIDED TO MEET PROFESSIONAL STANDARDS	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 281	<p>Continued From page 21 reviewed for medications.</p> <p>The findings included:</p> <p>1. Resident #29 was originally admitted to the facility on 5/30/2013 with diagnoses including constipation and hypertension. The most recent Minimum Data Set (dated 11/17/2014) indicated Resident #29 was cognitively intact.</p> <p>Review of the record revealed Resident #29's medication list included physician orders for Colace 100 milligrams (mg) dated 06/24/2014, "Take 2 caps (capsules) by mouth twice daily for constipation" and Altace 5mg, dated 09/05/2014, "Take 1 cap by mouth every day." Altace is a medication used to treat hypertension and congestive heart failure.</p> <p>Review of Resident #29's Medication Administration Record (MAR) for October 2014, revealed the initials for the administration of Colace were circled on October 26, 27, 28 and 29, 2014. There was no explanation provided on the back of the MAR or in the clinical record to say why the initials were circled on those dates.</p> <p>Review of Resident #29's Medication Administration Record (MAR) for January 2015, revealed the initials for a the administration of Altace was circled on January 5, 2015. On the back of the January MAR there was a notation for 01/05/2015 for the 8 AM administration which indicated the Altace was not available.</p> <p>During an interview on 01/28/2015 at 2:21 PM, Resident #29 stated there were times when the facility had not ordered her medication and she had gone days without one of the pills ordered by</p>	F 281	<p>1. Resident number 29 medications have been received for medication availability. A Medication variance report was completed for all medications indicating discrepancies.</p> <p>2. All resident's current medication records were audited related accurate documentation of administration by the Director of Nursing and Unit Managers by 2/23/15.</p> <p>3. The Area Staff Development and or Director of Nursing will re-educate all nurses and certified medication aides related to medication availability and accurate documentation on the medication administration record by 2/23/15. Medication Administration Audit are conducted by the Director of Nursing and or Unit Managers to ensure medications are given as prescribed, three times a week for 4 weeks, weekly for 4 weeks, and then monthly for 3 months, to ensure ongoing compliance. Audits will be documented utilizing the MAR Audit tool.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of these audits and observations during the Quality Assessment and Process Improvement Meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 281	<p>Continued From page 22</p> <p>the physician. Resident #29 said, "They ran out of my Colace for four days in October (2014)." The resident also said, "On January 5 and January 6, (2015), I didn't get my blood pressure medicine. I've had a stroke you know, and without my blood pressure medicine, I was afraid I might have another stroke."</p> <p>During an interview on 01/30/2015 at 9:25 AM, Unit Coordinator (UC) #1 reviewed Resident #29's Medication Administration record for October 2014. She stated initials were circled on the MAR when a medication was not administered as ordered. UC#1 had no explanation for why the Colace was not administered October 26-29. She indicated the expectation was that the Medication Aides would have made a note on the back of the MAR about why the medication had not been given. After review of the initials, the Unit Coordinator indicated the circled initials included Medication Aide (MA) #1, #3, #4 and #5. UC #1 further stated her expectation was that the Medication Aides notify the nurse on duty if the medication had run out so the pharmacy could be called. The UC stated, "(Scheduler/Central Supply Specialist) routinely orders medications, but we can notify the pharmacy to have them send us a house stock medication. It usually will come in within less than 24 hours." The UC indicated the nurses supervising the Medication Aides on the days in question were Nurse #1, #2, and #3. UC #1 indicated the Medication Aide in January when the Altace was circled, was MA #2.</p> <p>The Scheduler/Central Supply Specialist was interviewed on 01/30/2015 at 10:11 AM. She indicated when she entered a medication order into the computer it then had to wait for approval</p>	F 281			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY	STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 281	<p>Continued From page 23</p> <p>from the Administrator, and once approved the medication would arrive at the facility on the next business day. The Central Supply Specialist (CSS) indicated the former Administrator would often not sign the approval in a timely manner and had to be reminded so the medications would be shipped. The CSS provided the October 2014 Order Invoice which indicated the CSS had entered the request for Colace into the computer on 10/23/2014, and the former Administrator 's approval was dated 10/25/2014. The CSS added that the approval date of 10/25/14 was a Saturday. She provided the Package Tracking for October 2014 which indicated the medications arrived on Monday, 10/27/2014. The CSS did not know why the Colace was not available to the Medication Aides October 27-29, but added, "The Med Techs know to notify the pharmacy if they run out of something. It would have been here that same night. (The Order Invoice and Package Tracking) shows that I ordered it on 10/23 and we received it on 10/27."</p> <p>Medication Aide #2 was interviewed on 01/30/20 at 10:15 AM about the Altace that was unavailable on 01/05/2015. MA#2 said, "It wasn't in (the medication cart). On the back I wrote that she refused two medications and that the Altace was not available. I went to the nurse (Nurse#2) to tell her the med was out. She said she would let the pharmacy know. I also let the person taking over the cart that day (that the Altace had not been given)."</p> <p>Medication Aide #1 was interviewed on 01/30/2015 at 10:53 AM about the Colace that was not given on 10/27/2014 at 8AM. MA#1 said she must have forgotten to write the reason for circling her initials on that day but add, " I believe</p>	F 281		
-------	--	-------	--	--

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 281	<p>Continued From page 24</p> <p>it was out of stock. We didn't have any in the building." MA#1 said, "If we can't find any we tell the nurse." But she was unable to remember so far back if she had actually informed the nurse that there was no supply of Colace.</p> <p>Medication Aide #3 and #4 were not available for interview.</p> <p>Medication Aide #5 was interviewed on 01/30/2015 at 10:58 AM about the Colace that was not given on 10/28/2014. MA#5 said if the Colace was out of stock then, "we go to every unit to see if they have it and if not then we let (the nurse) know."</p> <p>Nurse #1 was interviewed on 01/30/2015 at 11:10 AM about the Altace that was not available in 01/05/2015. Nurse #1 could not recall if she had called the pharmacy for the Altace. She indicated the medication was to be given every day and said, "It doesn't necessarily have to be given in the morning." When asked if she had told the on-coming shift that the medication had not been given Nurse #1 said, "I'm sorry, I don't recall if I did. It was given the next morning so apparently it came in."</p> <p>During an interview on 01/30/2015 at 11:16 AM, Nurse #2 indicated when she worked on October 25 she normally would have called the pharmacy for an out-of-stock medication. Nurse #2 could not recall if she had actually done so and added, "I don't know what happened."</p> <p>Nurse #3 was interviewed on 01/30/2015 at 11:26 AM to see if a Medication Aide had reported to her that there was no supply of Colace when she worked on Monday, October 27, 2015. Nurse #3</p>	F 281			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 281	Continued From page 25 said, "They probably did but honestly I don't remember." Nurse #3 could not recall if a shipment of medications had been delivered to the facility on that day, or if she had looked for a supply of Colace.	F 281			
F 314 SS=G	ON 01/30/2015 at 11:30 AM, the Regional Director of Clinical Services indicated it was her expectation that residents receive medications as ordered by the physician. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to prevent a pressure ulcer and failed to implement physician ordered interventions for pressure ulcers for one of two sampled residents with pressure ulcers. Resident #79. The findings included: Resident #79 was initially admitted to the facility on 9/27/11 with diagnoses including anoxic brain injury, diabetes, seizure disorder and	F 314	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 314 TREATMENT TO PREVENT/HEAL PRESSURE SORES 1. An order for Resident # 79 was received on 2-11-15 for soft ties to be used daily and changed as needed during tracheostomy care. A pressure reduction cushion was placed in chair on 2-20-15 to be used when the resident is out of bed. 2. Residents with pressure ulcers have the potential to be affected by this alleged deficient practice. The Director of Nursing and Unit Managers will complete an audit of all residents with pressure sores to ensure physician ordered interventions are in place by 2-27-15.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 314	<p>Continued From page 26 hypertension.</p> <p>The annual Minimum Data Set (MDS) dated 7/25/14 indicated memory and cognition were not assessed due to persistant vegetative state. The MDS indicated Resident #79 required extensive assistance of two staff for bed mobility, extensive assistance of one person was required for toileting and personal hygiene and total assistance of one person was required for bathing. The bowel and bladder assessment indicated Resident #79 was always incontinent of both. Pressure ulcers were indicated as being present as a stage 3 on this MDS. Total nutrition and hydration for this resident was provided by a feeding tube.</p> <p>Review of the Care Area Assessments (CAAS) dated 7/30/14 indicated "Pressure Ulcer" was triggered due to the resident had a new stage 3 on the coccyx and developed a stage 3 pressure ulcer on her neck due to the tracheostomy strap. The stated goal included there would be no further signs of break down. The decision was made to proceed to care plan and monitor for and prevent pressure ulcers.</p> <p>Review of the care plan with an update of 7/23/14 included the pressure ulcers on the coccyx and the neck. Approaches included pressure reduction mattress to the bed, pressure reduction cushion to the chair or wheelchair, complete a full body check weekly and document, wound care physician and a wedge to be used at all times.</p> <p>a. Review of a nurse's note dated 7/20/14 at 2:10 PM provided documentation of an area to the back of neck that measured 16 centimeters (cm) length (L) by 0.5 cm width (W) and .2 cm</p>	F 314	<p>3. The Area Staff Development and Director of Nursing will re-educate all licensed nurse staff regarding implementing physician ordered interventions to prevent pressure ulcers, to include completing treatments, pressure reduction cushions and completing skin checks by 2-27-15. Treatment Administration Records will be audited by Director of Nursing and or Unit Managers for completion. Five residents randomly selected, will be audited for completion of pressure ulcer treatments, placement of pressure reduction cushions and completion of weekly skin checks. This audit will be conducted three times a week for 2 weeks, weekly for 4 weeks and then monthly for 3 months to ensure ongoing compliance. These audits will be documented on the pressured reduction cushion and weekly skin checks audit tool. Treatment records will also be reviewed three times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months to ensure ongoing compliance. Treatment audits will be documented on the TAR audit form.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of these audits and observations during the Quality Assessment and Process Improvement meeting monthly for 3 months and then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY	STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 314	<p>Continued From page 27</p> <p>depth (D). The nurse ' s note indicated the treatment nurse did an assessment of the wound and initiated a treatment of Santyl (a debridement agent) covered with an ABD dressing (thick padded dressing).</p> <p>Review of the Treatment Administration Record for 7/20/14 indicated the neck wound would be cleaned with normal saline solution. Santyl would be applied to the wound. An ABD pad would be placed to the area under the tracheostomy collar at the back of neck.</p> <p>Review of the Respiratory Therapist note dated 7/23/14 indicated she made a visit to provide respiratory/tracheostomy care. A wound was noted at the back of the neck when the neck collar was changed. "...appears green elastic strap on trach mask (tracheostomy collar) is what caused open area. ABD pad wrapped around strap & (and) taped together to protect skin. DON (Director of Nursing) aware."</p> <p>Review of a wound note dated 7/23/14 by the wound physician indicated the neck wound was caused by pressure from the tracheostomy collar strap. The physician indicated he would look into options to replace collar strap. The wound physician assessed the wound as a stage 3, (a full thickness tissue loss) that measured 17.5 cm L by .2 cm D by .7 cm W. The wound had light serous exudate (drainage).</p> <p>Review of the physician orders revealed the treatment to the neck wound was changed on 7/23/14. The new order was to clean the neck wound with normal saline and apply hydrogel with an ABD pad every day. The documentation on the July 2014 TAR indicated the treatments were</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 314	<p>Continued From page 28 provided as evidenced by the presence of the nurses' initials.</p> <p>Review of the Respiratory Therapist note dated 8/18/14 revealed "Trach (tracheostomy) care done & ties changed. Dressing change done on back of the neck, area is still open. Remove elastic strap from trach collar & replaced it c (with) a Velcro trach strap ... "</p> <p>Review of the wound physician's note dated 9/3/14 revealed the pressure ulcer on the back of the neck was resolved.</p> <p>Review of the Respiratory Therapist note dated 9/23/14 revealed "When removing trach ties noted they were wet & had an odor. Neck checked there is an open area from trach mask strap again. Nsg (nursing) notified & dressing was put on area. Removed elastic from trach mask & used Velcro trach tie ... "</p> <p>Review of the wound physician's progress note dated 9/24/14 indicated a stage 2 (partial thickness tissue loss) that measured .2 cm L by 3.0 cm W and .1cm D. The drainage was light serous. Additional Information: "wound has reopened. This area will be vulnerable to breakdown due to trach collar. Dressing: Dry Protective Dressing - once Daily, Hydrogel - Once Daily."</p> <p>Review of January monthly signed physician orders indicated an ABD pad was to be placed under the trach ties at the back of the neck. This was to be checked every shift. Documentation by the nurses on the TAR indicated the ABD pad was being used as evidenced by nurses' initials each day for "6-2" shift.</p>	F 314			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 314	<p>Continued From page 29</p> <p>Observations on 01/28/2015 at 10:56 AM revealed the ABD pad was not in place at the back of Resident #79's neck.</p> <p>Interview with nurse #2 on 1/28/15 at 11:13 AM revealed supplies were available for trach care. Supplies included use of soft ties to secure the trach and humidification. Nurse #2 checked Resident #79 ' s skin behind the neck which revealed the skin was intact with no breakdown. Further interview with nurse #2 revealed the respiratory therapist had changed the type of ties used to secure the humidification collar. The skin breakdown had occurred at the fold in the back of neck. Nurse # 2 was not sure if Resident #79 was to have padded dressing to the back of the neck. At the time of this interview an ABD pad was not located at the back of the resident's neck. Nurse #2 explained she thought the dressing order (padded dressing) was used when the wound had been present.</p> <p>Interview on 01/29/2015 at 10:59 AM with nurse #2 revealed Resident #79 should have an ABD pad as protection at the back of the neck.</p> <p>Observations on 01/29/2015 at 11:06 AM revealed Resident #79 did not have an ABD pad under the tracheostomy ties at the back of her neck. The soft Velcro ties were observed around her neck.</p> <p>An interview with nurse #7, who worked on the evening shift, was conducted on 01/29/2015 at 2:53 PM. Nurse # 7 was asked what treatments she had provided Resident #79 on her shift. She explained she did not do any dressing changes on her shift. When asked if an ABD pad was</p>	F 314			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 314	<p>Continued From page 30 supposed to be kept at the back of Resident #79's neck, she stated she could not remember.</p> <p>On 01/29/2015 at 1:18 PM an interview was conducted with the Respiratory Therapist who made monthly visits and provided tracheostomy care for Resident #79. The Respiratory Therapist explained she could not remember exactly when the ties (to the tracheostomy and collar) were switched from the green elastic to the soft velcro. She could not remember if it was replaced after the first occurrence or after the last occurrence of the pressure ulcer on the neck. Further interview revealed she did not bring in supplies when respiratory care was provided. She explained she " used what the facility had in the room. "</p> <p>Interview with the supply clerk on 1/29/15 at 11:35 PM revealed she could not say when the Velcro ties were ordered. She thought there had been a large order in the building and the staff had used from that supply. When asked if she could locate a date of the order, she stated she couldn't. The supplies had been in the building for residents with tracheostomies.</p> <p>Interview with the Corporate Regional Nurse on 1/29/15 at 2:30 PM revealed the weekly skin checks for September 2014 were not available for review.</p> <p>The Director of Nursing and Administrator who had been aware of the resident ' s wounds was not available for interview. The Interim Administrator and interim DON had no knowledge about this resident ' s care.</p> <p>b. Review of the wound care physician's progress note dated 1/21/15 included an</p>	F 314			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 314	<p>Continued From page 31</p> <p>assessment of a coccyx pressure ulcer for Resident #79. The pressure ulcer was present upon admission to the facility. The physician assessed the wound as a stage 3 (full thickness of tissue) and measured 2.5 cm by .1cm by .1 cm. The wound had light serous exudate. Healing was assessed as 80% of the wound. Interventions included use of a gel cushion in the wheelchair, multivitamins and protein supplement.</p> <p>Monthly orders for January 2015 included a treatment to be done every shift to the coccyx pressure ulcer. The treatment consisted of cleaning the wound with normal saline and applying Therahoney and a cover dressing.</p> <p>Observations on 01/28/2015 at 1:13 PM revealed Resident #79 was sitting in a reclined Geri -chair. A pressure reduction cushion was not observed under the resident's buttocks in chair.</p> <p>Interview on 1/28/15 at 3:35 PM with the aide #4 revealed Resident #79 did not have a cushion in Geri-chair when she transferred her back to bed.</p> <p>Interview with nurse #6 on 01/29/2015 at 8:08 AM revealed she had changed the dressing on the coccyx on her shift (night shift).</p> <p>Observations on 01/29/2015 at 11:06 AM of wound care provided by nurse #2 revealed the dressing on Resident's #79 ' s coccyx was dated 1/28/15 with initials "MW." Interview with nurse #2 revealed the initials were the treatment nurse's that had worked on 1/28/15. Nurse #2 explained the wound was a healing stage III pressure ulcer with a red/pink wound bed.</p>	F 314			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 314	Continued From page 32 Interview with nurse #7 on 01/29/2015 at 2:53 PM revealed she had worked on 3-11 on 1/28/15 and provided care for Resident #79. Nurse #7 explained she did not do any dressing changes on her shift. Further interview revealed she had thought the treatment nurse had done the treatment to the coccyx. She had seen the treatment nurse in the facility that day.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide physician ordered irrigations of a supra pubic catheter (Resident #131) to secure the catheter tubing (Resident #143) for two of three sampled residents with indwelling catheters.	F 315	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER 1. Resident number 131 suprapubic catheter was irrigated as ordered 2/1/15. Resident number 143 was provided a leg strap on 1/28/15 to secure the catheter tubing by the Unit Manager. 2. All residents indwelling catheters will be audited to ensure compliance with securing of the catheter tubing and flushing of suprapubic as ordered by the Director of Nursing and Unit Managers by 2/23/15.	2/27/15

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 315	<p>Continued From page 33</p> <p>The findings included:</p> <p>1. Resident #131 was initially admitted to the facility on 5/13/14. The most recent re admission was on 1/12/15 with diagnoses including respiratory infection, neurogenic bladder and anoxic brain damage.</p> <p>The Minimum Data Set (MDS) dated 11/13/14 indicated Resident #131 was not able to participate in an interview, had short and long term memory impairment. The MDS assessed the resident as requiring extensive to total assistance from one or two staff for all activities of daily living. A supra pubic catheter was used for bladder function.</p> <p>A care plan dated 5/26/14 for suprapubic catheter use included approaches to anchor the catheter to prevent excessive tension, secure the catheter to facilitate flow of urine, maintain urinary drainage bag below the level of the bladder, monitor temperature and vital signs, monitor labs, notify physician as needed, and observe urine odor, color, clarity and amount.</p> <p>Review of the monthly orders for January 2015 included irrigation of the catheter with 10 milliliters (ml) of acetic acid 0.25% irrigation solution every day.</p> <p>Review of the Treatment Administration Record for January revealed the nurses' initials were not present for this treatment after re-admission from the hospital on 1/12/15.</p> <p>Interview with nurse #2 on 1/28/15 at 3:38 PM indicated the suprapubic catheter was not irrigated. Nurse #2 explained she thought it was</p>	F 315	<p>3. The Area Staff Development Coordinator will re-educate all nursing staff on the care of maintenance of indwelling catheters to include irrigation and securing by 2/23/15. The Director of Nursing or Unit Manager will randomly audit 5 residents with indwelling catheters 3 times a week for 4 weeks, weekly for 4 weeks then monthly to validate irrigation as ordered and appropriately secured. Audits will be documented utilizing the Catheter audit tool.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of these audits and observations during the Quality Assessment and Process Improvement Meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 315	<p>Continued From page 34</p> <p>PRN (as needed). Further interview revealed she didn't know when it had been irrigated last.</p> <p>Interview with nurse #7 on 01/28/2015 at 3:52 PM indicated the suprapubic irrigations were to be done every day. This nurse explained she had returned form the hospital on 1/13/15. The TAR was reviewed and the treatment was listed as a current treatment. Nurse #7 stated she would check with the unit manager for clarification. She explained she did not usually work on that hall. She had worked with Resident #131, when she was on " her hall prior to discharge to the hospital. " Further interview revealed the catheter had to be irrigated or it would " leak " or become " stopped up. "</p> <p>2. Resident #143 had diagnoses that included urinary retention and chronic kidney disease. A review of the Admission Minimum Data Set (MDS) dated 10/22/2014 revealed Resident #143 was severely cognitively impaired but did not have any behaviors or resist care.</p> <p>Record review revealed the resident was sent out to the hospital on 01/07/2015 for urinary retention and returned from the hospital with an indwelling catheter.</p> <p>An observation and interview was conducted with Resident #143 on 01/28/2014 at 8:10 AM. When asked if his catheter was secured to his leg, the resident said, "No. See?" and the resident pulled back the sheet covering his legs. The catheter tubing was not secured. Resident #143 indicated he had never had any kind of strap or band that would secure the catheter tubing to his leg but added that he wanted a strap to secure the</p>	F 315			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 315	Continued From page 35 tubing. During an interview on 01/28/2015 at 4:46 PM, Unit Coordinator #1 indicated it was facility policy to have the catheter tubing secured for stability. At 4:29 PM Unit Coordinator #1 observed the resident did not have anything securing the tubing, and at 4:32 PM, Unit Coordinator #1 obtained and applied a leg strap to secure Resident #143's indwelling catheter. NA #3 was interviewed on 01/29/2015 at 3:47 PM about securing catheter tubing for Resident #143. She indicated she frequently cared for this resident but was not aware he was to have the tubing secured. NA#3 said, "The strap? - Not to him, no." and added, "I was not aware he (Resident #143) had one."	F 315			
F 323 SS=D	On 1/29/15 at 4:50 PM the Interim Director of Nursing (DON) stated it was her expectation and facility policy indicated catheters were to be secured with a strap to prevent trauma. She indicated Resident #143 should have a strap or something that would secure the catheter tubing. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F323 Accidents 1. The Director of Nursing applied the personal alarm to Resident number 147 on 1/29/15.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 323	<p>Continued From page 36</p> <p>by: Based on observations, record review and staff interviews the facility failed to implement fall prevention interventions for one of five sampled residents with falls. (Resident #147)</p> <p>The findings included:</p> <p>Resident #147 was admitted to the facility on 11/14/14 with diagnoses including diabetes and stroke.</p> <p>The Minimum Data Set (MDS) dated 11/21/14 indicated Resident #147 had moderate impairment with short and long term memory, required extensive assistance with bed mobility, transfers, personal hygiene and toileting and was non ambulatory.</p> <p>The care plan dated 11/16/14 included a problem of falls with intervention of a personal alarm to be applied to the bed at all times. An updated intervention for 12/8/14 included when the resident was out of her room, for staff to attempt to keep the resident in a supervised area.</p> <p>Record review of the falls investigation report revealed Resident #147 had experienced three falls since admission to the facility. The first fall occurred on 11/16/14 at 7:00 AM when she fell out of bed. Resident #147 sustained a skin tear to her arm. Treatment was provided by the facility for the skin tear. The second fall occurred on 12/7/14 at 8:00 PM when she fell out of her wheelchair while in the dining room. The third fall occurred on 12/29/14 at 8:15 AM when she fell out of bed onto the mat beside the bed. She sustained a skin tear that was treated by the facility.</p>	F 323	<p>2. The nursing team (DON, unit managers, MDS) will complete review of residents with falls in past 30 days to ensure interventions are in place by 2/27/15.</p> <p>3. The Area Staff Development will re-educate all nursing staff on fall prevention and application of fall interventions to prevent falls by 2/27/15. Director of Nursing or Unit Managers will randomly observe 5 residents three times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Audits will be documented on the Fall Intervention Audit Sheets.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of these audits and observations during the Quality Assessment and Process Improvement Meeting Monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 323	<p>Continued From page 37</p> <p>Review of the January orders revealed an order for a personal alarm to be used when in bed and when in the chair.</p> <p>Observations on 1/25/15 at 7:00 PM revealed Resident #147 was in bed lying on her right side. The alarm was on the left side of the bed and the resident was turned towards the right side of the bed. The alarm had a string attached from the alarm box with a metal clip on the other end. The clip was not attached to the resident.</p> <p>Observations on 01/29/2015 at 9:14 AM revealed Resident was in her wheelchair (Broda type) in her room next to the window. Her room was the last room down the hall from the nurse 's desk. The personal alarm was on the back of the chair with the clip not attached to the resident.</p> <p>Interview on 1/29/14 at 9:45 AM with the aide (aide #47) who provided care for Resident #147 revealed she knew what care Resident #147 required by using her assignment list. The assignment list was reviewed with aide # 47 which indicated no information regarding use of personal alarms. Further interview revealed aide #47 was not aware the alarm on the chair was supposed to be clipped to the resident as a fall intervention.</p> <p>01/29/2015 10:02:34 AM interview with the MDS nurse revealed the personal alarm was for fall prevention when the resident was up in a chair. The unit manager was responsible for updating the assignment sheets. The unit had been without a unit manager and the assignment sheet had not been updated.</p>	F 323			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 328 F 328 SS=D	Continued From page 38 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide podiatry services for 1 of 1 diabetic resident (Resident #143) with a long, jagged mycotic toenail. Findings included: Resident #143 was admitted to the facility on 10/15/2014 with diagnoses including diabetes mellitus, anemia, and incomplete tetraplegia (tetraplegia is defined as paralysis of all four extremities). A review of the Admission Minimum Data Set (MDS) dated 10/22/2014 revealed Resident #143 was severely cognitively impaired but did not have any behaviors or resist care. The MDS assessment also revealed that Resident #143 had functional limitation in range of motion in an upper and lower extremity and required extensive assistance for grooming and hygiene.	F 328 F 328	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F328 Treatment/Care for Special Needs 1. Resident # 143 was seen by podiatrist on 2-13-15 and received toenail care. 2. The Director of Nursing and Unit Managers will assess all diabetic residents' toenails for care and podiatry need by 2/27/15. All diabetic residents needing toenail care were addressed by referring to podiatry as required. Podiatrist was in facility on 2/20/15. 3. Area Staff Development will re-educate all nursing staff on providing appropriate toenail care and podiatry referral for diabetic residents as required. The Director of Nursing or Unit Manager will conduct random audit on 5 diabetic residents to assess toenail care 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 2 months to ensure ongoing compliance of diabetic toenail care and podiatry care. Audits will be documented utilizing the Toenail Care/Podiatry Consult Audit Tool.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 328	<p>Continued From page 39</p> <p>On 01/26/2015 at 8:06 AM, Resident #143 was observed eating breakfast in bed. Resident #143 had a long, uneven toenail on his right great toe that extended approximately 0.5 centimeters beyond the tip of the resident's toe. The toenail was thickened and discolored and appeared to have a fungal infection.</p> <p>An observation made on 01/28/2014 at 8:10 AM revealed that Resident #143 had a long, uneven, mycotic (fungal infection) toenail on his right great toe that extended approximately 0.5 centimeters beyond the tip of the resident's toe. The resident was in bed and had finished his breakfast but had not yet had assistance getting dressed. During an interview at that time, the resident stated he was unable to clip that toenail because he was paralyzed on his right side. On 01/28/2015 at 8:35 AM, Nursing Assistant #53 entered the room to provide care.</p> <p>A review of Resident #143's clinical record revealed no referral for podiatry services, and no podiatry consult record.</p> <p>In a second interview with Resident #143 on 01/28/2014 at 4:22 PM, he stated he could not remember the last time he had his toenails trimmed on the right foot, but that he was able to reach and clip the toenails of his left foot.</p> <p>During an observation and interview on 01/28/2015 at 4:32 PM, the Nurse Unit Coordinator (UC) removed Resident #143's shoe and sock. The UC indicated the right great toenail extended approximately 1 inch from the base of the nailbed. The UC said because the nails were mycotic, the resident would have to see a</p>	F 328	<p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of these audits and observations during the Quality Assessment and Process Improvement meeting quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 328	Continued From page 40 podiatrist to have the nails cut. NA #21 was interviewed on 01/29/2015 at 3:45 PM about Resident #143's nail care. The NA said, "The nursing assistant who has him should report it to the nurse. I don't have him much so I have not reported it." The NA indicated the nurses were responsible for cutting nails for residents with diabetes and that NAs were responsible for reporting a nail care need to the nurses. NA #16 was interviewed on 01/29/2015 at 3:47 PM about nail care. The NA indicated she usually provided care for Resident #143. The NA said, "Yes I usually take care of him. I wasn't aware he had long nails." She also indicated she had not reported to any nurse that Resident #143 had a long toenail. During an interview on 01/29/2015 at 4:17 PM the Unit Coordinator said she had put Resident #143 on the Podiatry list and he would be seen in February. Nurse #2 provided a measurement of the toenail she had taken on 01/29/2015. The nurse said Resident #143's toenail was 2 centimeters (cm) long but that the nail had been filed down approximately 2cm by someone on the evening of 01/28/2015. She stated it still extended approximately 0.3 cm beyond the tip of the toe. On 1/29/15 at 4:50 PM the Interim Director of Nursing (DON) stated it was her expectation that the NAs look at nails during daily baths or showers. The Interim DON added that nurses were to cut the nails of diabetic residents, but the podiatrist was responsible for cutting mycotic toenails because they split and cracked easily.	F 328			
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 329 SS=D	<p>Continued From page 41 UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to administer medications as ordered by a physician for 2 of 5 sampled residents. Resident #138 received doses of pain medication two times the amount ordered and Resident #56 received an antidepressant after it was discontinued. The facility failed to administer eye drops according to manufacturer's recommendation for one of one sampled</p>	F 329	<p>This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>F329 Unnecessary Medications</p> <ol style="list-style-type: none"> 1. Resident # 27 Latanoprost was discontinued on 2-11-15. Resident # 56 Lexapro was removed from medication administration record on 1-26-15. Resident #138 was discharged on 1-1-15. 2. All residents have the potential to be affected by alleged deficient practice. All physician orders for medications received during the last 30 days were reviewed for accuracy and appropriate transcription. The pharmacist has completed and reviewed all residents and medication regimen on 2-12-15. 3. The Area Staff Development will re-educate the licensed nursing staff regarding medication management techniques including transcribing orders, administration of medication and documentation of medication administration by 2-27-15. All MD orders will be reviewed three times a week in morning meeting to ensure accurate and complete and validate by reviewing the medication or treatment record. Pharmacy will review monthly all residents and medication regimen and recommendations to MD and nursing as needed. The Director of Pharmacist will re-educate the pharmacist on Latanoprost eye drops by 2-27-15. 		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 329	<p>Continued From page 42 residents. (Resident #27.)</p> <p>The Findings included:</p> <p>1. Resident #138 was admitted to the facility on 7/23/14 with a diagnosis that included osteomyelitis, convulsions, pressure ulcer of the lower back, arterial fibrillation, encephalopathy, and acute kidney failure. The Minimum Data Set (MDS) Assessment dated 7/30/14 indicated Resident #138 required extensive assistance from staff to complete activities of daily living (ADL ' s). The MDS further revealed Resident #138 was cognitively intact.</p> <p>Review of Resident #138 physician order dated 8/11/14 indicated, " Start Morphine Immediate Release (IR) .5 milligrams (mg) by mouth every 6 hours routine if not sedated/asleep. "</p> <p>Review of Medication Variance report dated 8/13/14 revealed Resident #138 revealed on 8/12/14 Resident #138 received the wrong dosage for Morphine. The report indicated the error was a transcription error. The report indicated Resident #138 was intended to receive Morphine IR 5 mg every 6 hours (unless sedated) for wound pain. The medication actually administered to Resident #138 was Morphine IR 15 mg by mouth at a frequency of every 6 hours.</p> <p>Review of Medication Variance report dated 8/12/13 revealed Resident #138 received the wrong dose on 8/11/14 at 1800 hours. The error type included wrong dose and wrong strength. The report further indicated the error was a transcription error. The report stated Resident #138 was intended to receive Morphine IR 5mg every 6 hours routinely by mouth for wound pain.</p>	F 329	<p>4) These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of observations and pharmacy reviews during the Quality Assessment and Process Improvement meeting for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 329	<p>Continued From page 43</p> <p>The medication actually administered to Resident #138 was Morphine IR 15 mg.</p> <p>Interview with Nurse #4 on 1/29/15 at 3:45 pm revealed she had identified a medication error for Resident #138 on 8/12/14 in which the resident had received 2 doses of morphine at the incorrect dose. Nurse #138 stated that the medication administration record (MAR) indicated Resident #138 had received 2 doses of Morphine 15 mg. Nurse #4 stated that the order written 8/11/14 indicated Resident #138 was to receive Morphine 5mg. As a result of the error Nurse #4 stated that she had contacted the physician to notify him of the error and notified the unit manager.</p> <p>Interview with Nurse #5 on 1/30/15 at 12:45 pm revealed she had administered Resident #138 morphine 15mg on 8/12/14. Nurse #5 stated that she became aware of the error when her unit manager notified her that a medication error had occurred because Resident #138 was intended Morphine 5 mg. Nurse #5 indicated that she had observed that Morphine 15 mg had been administered during the previous shift as evidenced by the medication being punched out. She stated that she did not pay attention that the order was supposed to be for .5 mg and not for the 15 mg. Nurse #5 stated that she did not match the medication with the order to ensure it was administered as ordered</p> <p>Interview with Nurse #3 on 1/30/15 at 10:39 am revealed she recalled administering Resident #138 Morphine 15mg on 8/12/14. Nurse #3 stated that the medication error was brought to her attention by the Unit Manager. Nurse #3 stated that she did not look at the order to match with the medication.</p>	F 329			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 329	<p>Continued From page 44</p> <p>Interview with the Corporate Director of Nursing (DON) on 10/30/15 at 12:10 pm revealed that the facility pharmacy had sent the wrong dose and drug form. The DON further revealed it was her expectation that facility nurses incorporate the 5 rights when administering medications to residents. The corporate DON indicated that the five rights included; the right dose, the right route, the right resident, right time, and right medication. The Corporate DON further indicated when the error was identified the facility documented the error on the appropriate medication error form.</p> <p>2. Resident #27 was admitted to the facility on 12/4/14 from the hospital with pertinent diagnosis of glaucoma.</p> <p>As per the Minimum Data Set conducted on 12/4/14, Resident #27 was noted as having severely impaired cognitive skills and moderately impaired vision.</p> <p>Hospital discharge instructions recommended Travoprost (Travatan Z) 0.004% Instill 1 drop both eyes twice daily. However, at the facility on 12/20/14, the medication was substituted to Latanoprost (Xalatan) 0.005% Instill 1 drop in both eyes twice daily.</p> <p>The prescribing information was researched on the Xalatan website on 1/29/15. It clearly stated "The dosage of Xalatan should not exceed once daily...It has been shown that administration of these prostaglandin drug products more than once daily may decrease the intra-ocular</p>	F 329			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 329	<p>Continued From page 45 pressure (IOP) lowering effect or cause paradoxical elevations in IOP."</p> <p>Nurse #1 was interviewed at 12:53 PM on 1/28/15 about the frequency of the Xalatan administration. She stated that she administered 1 drop in both eyes twice daily as ordered, and was not aware that Xalatan was supposed to be given only once daily.</p> <p>The facility physician was interviewed by phone on 1/28/15 at 12:55 PM. He stated that "Perhaps the ophthalmologist wanted it that way but I am not at the facility right now and so I cannot say In general practice this medication is not given twice daily. I do monthly reviews of the medical charts so I would have made a referral for an ophthalmology consult when I got around to it, but glaucoma has been pretty low on (Resident #27's) priority list."</p> <p>The physician's assistant later arrived at the facility and was interviewed at 1:51 PM on 1/28/15. She stated that "If they (residents) came in on medications that may have originated from a specialty physician then we generally don't change those medications; we assume that they are on it for a reason. I will address it now"</p> <p>The Regional Director of Clinical Services was interviewed on 1/28/15 at 2:30 PM. When addressing the medication frequency issue for Resident #276, she stated that "I would expect the medical team to assess all medications that a resident is admitted with, regardless of whether the medications were prescribed by a specialist."</p> <p>Unit Coordinator #2 provided updated information on 1/30/15 at 3:00 PM that the ophthalmologist</p>	F 329			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 329	<p>Continued From page 46</p> <p>had been consulted and provided orders to change to Xalatan 0.005% Instill 1 drop both eyes daily.</p> <p>3. Resident #56 was admitted to the facility on 11/14/12 with diagnosis of depression.</p> <p>The December monthly orders included administration of Lexapro (anti depressant) 5 milligrams to be given once a day.</p> <p>Review of a telephone order dated 12/17/14 revealed Lexapro was to be discontinued.</p> <p>The December Medication Administration Record (MAR) included the order to discontinue the Lexapro on 12/17/14. The medication was not administered after 12/17/14.</p> <p>Review of the January monthly orders included the hand written order for Lexapro 5 milligrams orally every day for anxiety. The Lexapro had not been included on the pharmacy print out of the orders.</p> <p>Review of the MAR for January revealed Lexapro was added to page 6 of the medication sheet. The medication had been administered every day.</p> <p>Interview with nurse #1 on 01/28/2015 at 1:25 PM revealed she was not sure how it (Lexapro) was missed. She explained end of the month medication/order checks had been completed. The checks would be done by the unit manager and/or the Director of Nursing.</p> <p>The current unit manager and Director of Nursing were not working when the December to January</p>	F 329		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 329 F 371 SS=E	Continued From page 47 medication orders had been checked. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 observation and staff interview, the facility failed to be sure food preparation equipment was free of debris for 14 of 14 large baking sheet pans. Findings included: During review of the kitchen on 01/26/2015 at 4:42 PM, 3 large sheet pans were observed by the sanitizing sink area. The Dietary Manager indicated the sheet pans had been cleaned and were drying before being stored on racks. A soft brown, sticky substance was observed under the rim of each pan. The debris was approximately 0.2 to 0.4 centimeters deep all the way around the underside of the rim of the baking sheet pans. On 01/28/2015 at 4:35 PM the Kitchen was reviewed with the District Dietary Manager. The large baking sheet pans were stacked upside down on a rack and ready for use. Examination revealed the 14 food trays all had the brown/black	F 329 F 371	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY 1) On 1-29-15 the district dietary manager removed all identified baking sheet pans from the kitchen and deep cleaned. 2) All residents have the potential of being affected by this alleged deficient practice related to cleaning of food preparation equipment. 3) The Dietary Manager will re-educate all dietary staff on proper pot and pan washing procedures by 2-27-15. All baking sheet pans will be placed on a weekly cleaning schedule. The Dietary Manager will monitor cleaning by observation of pans three times a week for 2 weeks, weekly for 4 weeks and then monthly for 3 months. The results of the observations will be recorded on the sanitation rounds and audit tool. 4) These measures are to ensure corrections are achieved and sustained: The Dietary Manager will report the results of these audits during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 48 substance under the tray 's rim. The substance was hard in some areas and soft in other areas and extended all the way around the underside of the rim of the baking sheet pans. The District Dietary Manager indicated he expected the trays to be clean to prevent contamination during food preparation when handling the trays.	F 371	<p>This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>F 425 PHARMACEUTICAL ACCURATE PROCEDURES, RPH</p> <ol style="list-style-type: none"> 1. Resident's #138 was discharged from the facility on 1-1-15. 2. All residents' medication administration records with morphine have been audited to ensure correct dose present. 3. The Area Staff Development will re-educate all licensed nurses and Certified Medication Aides on medication administration and the five rights of medication administration by 2-27-15. The Director of Nursing and or Unit Managers will complete audit of 3 random residents who receive morphine to ensure correct dose present 3 times a week for two weeks, weekly for four weeks then monthly for two months. The pharmacy will randomly select 3 residents to monitor new orders twice weekly for four weeks and then 2 residents once a week for two weeks to ensure correct medication transcribed and dispensed. Pharmacy will send audit results via email for facility to review. 	2/27/15	
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review staff and pharmacy interview the pharmacy failed to provide the correct dose for medication sent for administration for 1 of 6 residents (Resident</p>	F 425			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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	<p>Continued From page 49 #138) according to physician order.</p> <p>The Findings included:</p> <p>Resident #138 was admitted to the facility on 7/23/14 with a diagnosis that included osteomyelitis, convulsions, pressure ulcer of the lower back, arterial fibrillation, encephalopathy, and acute kidney failure. The Minimum Data Set (MDS) Assessment dated 7/30/14 indicated Resident #138 required extensive assistance from staff to complete activities of daily living (ADL 's). The MDS further revealed Resident #138 was cognitively intact.</p> <p>Review of Resident #138 physician order dated 8/11/14 indicated, " Start Morphine Immediate Release (IR) .5 milligrams (mg) by mouth every 6 hours routine if not sedated/asleep. "</p> <p>Review of Medication Variance report dated 8/13/14 revealed Resident #138 revealed on 8/12/14 Resident #138 received the wrong dosage for Morphine. The report indicated the error was a transcription error. The report indicated Resident #138 was intended to receive Morphine IR 5 mg every 6 hours (unless sedated) for wound pain. The medication actually administered to Resident #138 was Morphine IR 15 mg by mouth at a frequency of every 6 hours.</p> <p>Interview with the Corporate Director of Nursing (DON) on 10/30/15 at 12:10pm revealed that the facility pharmacy had sent the wrong dose of Morphine.</p> <p>Interview with the facilities pharmacy on 1/30/15 at 12:20pm revealed orders were received by the facility via fax. The pharmacy representative</p>	F 425	<p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of morphine audits during the Quality Assessment and Process Improvement meeting for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 50 indicated that the pharmacy had received an order that indicated resident #138 was to receive 5 mg of Morphine by mouth every 6 hours routine and monitor for sedation. The representative stated that the pharmacy sent the wrong dose to the facility of morphine 15mg. Pharmacy indicated that probably an import error had occurred while putting the order in the system	F 425			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to identify and resolve a drug irregularity for 1 of 5 sampled residents reviewed for unnecessary medications resulting in the continued administration of an eye medication (Resident #27). Findings included: Resident #27 was admitted to the facility on 12/4/14 from the hospital with pertinent diagnosis of glaucoma. As per the Minimum Data Set conducted on 12/4/14, Resident #27 was noted as having	F 428	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F428 Drug Regimen Review, Report Irregular 1. Corrective action has been accomplished for the alleged deficient practice involving Resident #27. Latanoprost eye drops were discontinued on 2-11-15. 2. All residents who receive Latanoprost eye drops have the potential to be affected by alleged deficient practice. The Director of Nursing and Unit Managers will audit all residents who receive Latanoprost eye drops by 2-27-15 to ensure receiving proper dosage.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 428	<p>Continued From page 51</p> <p>severely impaired cognitive skills and moderately impaired vision.</p> <p>Hospital discharge instructions recommended Travoprost (Travatan Z) 0.004% Instill 1 drop both eyes twice daily. However, at the facility on 12/20/14, the medication was substituted to Latanoprost (Xalatan) 0.005% Instill 1 drop in both eyes twice daily.</p> <p>The prescribing information was researched on the Latanoprost website on 1/29/15. It clearly stated "The dosage of Xalatan should not exceed once daily...It has been shown that administration of these prostaglandin drug products more than once daily may decrease the intra-ocular pressure (IOP) lowering effect or cause paradoxical elevations in IOP."</p> <p>The pharmacist conducted a drug regimen review for Resident #27 on 1/2/15, with "No concerns" documented on the pharmacy consult sheet.</p> <p>The pharmacist was interviewed by phone on 1/29/15 at 9:04 AM. He indicated that he was driving and was not sure if he conducted the chart review for Resident # 27 or if the prior pharmacist had done the chart review. He stated that "I believe you use Xalatan 2-3 times per day depending on the resident's medical variances. If I see an issue I leave a note for the physician. I do not recall any medication issues with (Resident #27's) medications."</p> <p>The Regional Director of Clinical Services was interviewed on 1/28/15 at 2:30 PM. Regarding the frequency administration error for Resident #27, she stated "I would expect the pharmacist to catch these types of administration issues</p>	F 428	<p>3.The Area Staff Development will re-educate all licensed nurses and certified medication aides on Latanoprost eye drops recommended dosage by 2-27-15. All MD orders will be reviewed three times a week in morning meeting to ensure accurate and follow-up complete. Pharmacy will review monthly all residents and medication regimen and recommendations to MD and nursing as needed. Director of Nursing will ensure recommendations follow-up completed. The Director of Pharmacy will re-educate the pharmacist on Latanoprost eye drops by 2-27-15.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of order reviews and pharmacy reviews during the Quality Assessment and Process Improvement meeting for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 428	Continued From page 52 when they do their monthly chart reviews and look up dosages and frequencies that they are not sure of." Unit Coordinator #2 provided updated information on 1/30/15 at 3:00 PM that the ophthalmologist had been consulted and provided orders to change to Xalatan 0.005% Instill 1 drop both eyes daily.	F 428			
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 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	F 441	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 441 Cleaning of Glucometers 1. No adverse outcome was noted on Residents # 109, #6, #68, and #136. 2. Nurses # 1 and # 5 was in-serviced related to cleaning of glucometers for resident safety. 3. Area Staff Development will re-educate all licensed nurses on the cleaning and disinfection of glucometers by 2/27/15. Cleaning and disinfection glucometer checklist were conducted by the Director of Nursing, unit managers and Area Staff Development on all licensed nurses by 2/27/15. The cleaning and disinfection glucometer checklist will be conducted 2 times a week for 4 weeks, weekly for 4 weeks and monthly for 2 to ensure ongoing compliance. Audits will be documented on the Cleaning and Disinfection Glucometer Checklist sheet.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 441	<p>Continued From page 53</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to properly sanitize glucometers between uses on 4 of 4 residents observed for glucometer checks (Residents # 109, 6, 68, and 136). Findings included:</p> <p>Nurse #5 was observed for medication administration on 1/25/15 at 4:15 PM. The medication cart used by Nurse #1 contained 2 glucometers, which will be referred to as glucometer A and glucometer B.</p> <p>The facility's policy for cleaning glucometers between resident uses indicated that a germicidal agent be used between uses and then left in full contact of the glucometer for several minutes.</p> <p>1. Nurse #5 was observed utilizing glucometer A at 4:20 PM on 1/25/15 to check the blood sugar for Resident #109. After utilizing glucometer A, Nurse #5 wiped glucometer A with an Epi-Clenz hand sanitizing wipe. She then used another Epi-Clenz wipe to wrap glucometer A before laying it on the medication cart.</p> <p>The Epi-Clenz wipes were found to contain 65%</p>	F 441	<p>4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results of the medication administration observations and pharmacy reviews during the Quality Assessment and Process Improvement meeting for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 441	<p>Continued From page 54</p> <p>ethyl alcohol only; the wipes did not contain any germicidal agent. The uses labeled on the container stated "Instant hand sanitizer and antiseptic - for hand washing to decrease bacteria on the skin between patients, before and after eating, or using the rest room."</p> <p>Nurse #5 was interviewed at 5:15 PM on 1/25/15 about the use of the wipes. She stated "I have bleach wipes in my cart as well, but I thought the bleach wipes were for cleaning the carts."</p> <p>Nurse #1 was also interviewed at 5:20 PM on 1/25/15 about the use of the wipes. She stated "I believe we are supposed to use either the bleach wipes or the Epi-Clenz hand sanitizing wipes. We just got the bleach wipes about 6 months ago, before that we had been using the hand sanitizer wipes to clean the glucometers."</p> <p>The Regional Director of Clinical Services was interviewed on 1/29/15 at 3:20 PM. She stated "Our policy states to use germicidal wipes. The expectation is that the germicidal wipes be used to clean any resident care equipment before, after, and in between uses."</p> <p>2. Nurse #5 was observed utilizing glucometer B at 4:25 PM on 1/25/15 to check the blood sugar for Resident #6. After utilizing glucometer B, Nurse #5 wiped glucometer B with an Epi-Clenz hand sanitizing wipe. She then used another Epi-Clenz wipe to wrap glucometer B before laying it on the medication cart.</p> <p>The Epi-Clenz wipes were found to contain 65% ethyl alcohol only; the wipes did not contain any germicidal agent. The uses labeled on the container stated "Instant hand sanitizer and</p>	F 441			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 441	<p>Continued From page 55</p> <p>antiseptic - for hand washing to decrease bacteria on the skin between patients, before and after eating, or using the rest room."</p> <p>Nurse #5 was interviewed at 5:15 PM on 1/25/15 about the use of the wipes. She stated "I have bleach wipes in my cart as well, but I thought the bleach wipes were for cleaning the carts."</p> <p>Nurse #1 was also interviewed at 5:20 PM on 1/25/15 about the use of the wipes. She stated "I believe we are supposed to use either the bleach wipes or the Epi-Clenz hand sanitizing wipes. We just got the bleach wipes about 6 months ago, before that we had been using the hand sanitizer wipes to clean the glucometers."</p> <p>The Regional Director of Clinical Services was interviewed on 1/29/15 at 3:20 PM. She stated "Our policy states to use germicidal wipes. The expectation is that the germicidal wipes be used to clean any resident care equipment before, after, and in between uses."</p> <p>3. Nurse #5 was observed utilizing glucometer A at 4:30 PM on 1/25/15 to check the blood sugar for Resident #68. After utilizing glucometer A, Nurse #5 wiped glucometer A with an Epi-Clenz hand sanitizing wipe. She then used another Epi-Clenz wipe to wrap glucometer A before laying it on the medication cart.</p> <p>The Epi-Clenz wipes were found to contain 65% ethyl alcohol only; the wipes did not contain any germicidal agent. The uses labeled on the container stated "Instant hand sanitizer and antiseptic - for hand washing to decrease bacteria on the skin between patients, before and after eating, or using the rest room."</p>	F 441			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 441	<p>Continued From page 56</p> <p>Nurse #5 was interviewed at 5:15 PM on 1/25/15 about the use of the wipes. She stated "I have bleach wipes in my cart as well, but I thought the bleach wipes were for cleaning the carts."</p> <p>Nurse #1 was also interviewed at 5:20 PM on 1/25/15 about the use of the wipes. She stated "I believe we are supposed to use either the bleach wipes or the Epi-Clenz hand sanitizing wipes. We just got the bleach wipes about 6 months ago, before that we had been using the hand sanitizer wipes to clean the glucometers."</p> <p>The Regional Director of Clinical Services was interviewed on 1/29/15 at 3:20 PM. She stated "Our policy states to use germicidal wipes. The expectation is that the germicidal wipes be used to clean any resident care equipment before, after, and in between uses."</p> <p>4. Nurse #5 was observed utilizing glucometer B at 4:40 PM on 1/25/15 to check the blood sugar for Resident #136. After utilizing glucometer B, Nurse #5 wiped glucometer B with an Epi-Clenz hand sanitizing wipe. She then used another Epi-Clenz wipe to wrap glucometer B before laying it on the medication cart.</p> <p>The Epi-Clenz wipes were found to contain 65% ethyl alcohol only; the wipes did not contain any germicidal agent. The uses labeled on the container stated "Instant hand sanitizer and antiseptic - for hand washing to decrease bacteria on the skin between patients, before and after eating, or using the rest room."</p> <p>Nurse #5 was interviewed at 5:15 PM on 1/25/15 about the use of the wipes. She stated "I have</p>	F 441			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 441	Continued From page 57 bleach wipes in my cart as well, but I thought the bleach wipes were for cleaning the carts." Nurse #1 was also interviewed at 5:20 PM on 1/25/15 about the use of the wipes. She stated "I believe we are supposed to use either the bleach wipes or the Epi-Clenz hand sanitizing wipes. We just got the bleach wipes about 6 months ago, before that we had been using the hand sanitizer wipes to clean the glucometers." The Regional Director of Clinical Services was interviewed on 1/29/15 at 3:20 PM. She stated "Our policy states to use germicidal wipes. The expectation is that the germicidal wipes be used to clean any resident care equipment before, after, and in between uses."	F 441			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and resident interviews the facility failed to maintain a properly working call bell system for 22 of 28 room bathrooms on the 300 hall, also known as the locked dementia unit (Resident rooms #302, 304, 306, 307, 308, 309, 310, 311, 312, 314, 315, 322, 323, 325, 326, 327, 328, 329, 330, 331, 332, and 334). Findings included: During the initial tour on 1/25/15 at 3:00 PM, call	F 463	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 463 RESIDENT CALL SYSTEM-ROOMS/TOILET/BATH 1.No adverse outcome was noted in resident rooms 302, 304, 306, 307, 308, 309, 310, 311, 314, 315, 322, 323, 325, 326, 327, 328, 329, 330, 331, 332, and 334. 2. All residents' rooms, bathrooms, shower rooms were audited to ensure appropriate functioning of all call-bell systems on 1-26-15.	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 463	<p>Continued From page 58</p> <p>bells in the 300 hall room bathrooms were found to either not light up outside of the rooms and/or were found to ring very lightly at the nurses station. Room #302, 304, 306, 307, 308, 309, 310, 311, 312, 314, 315, 322, 323, 325, 326, 327, 328, 329, 330, 331, 332, and 334 door lights did not work consistently, and rooms 306, 310, 322, and 328 did not sound at the nurses station consistently when the bathroom call bell was activated. The sound made at the nurses' station from call bell activation in rooms #302, 304, 307, 308, 309, 311, 312, 314, 315, 323, 325, 326, 327, 329, 330, 331, 332, and 334 began as a loud and strong one but faded to a very faint sound within a few seconds.</p> <p>Medication Aide #1 was interviewed at 4:00 PM on 1/26/15. She indicated that she had been working at the facility for the past two months. Regarding the call bells she stated that "That is just how the bells are, so we don't really rely on the bathroom bells; we just make rounds constantly and go to those who need help. Since this is the locked unit we assist all of those residents to the bathroom if they are able to use the bathroom; the majority of our residents do not use the bathroom." She was not able to state for how long the call bells had not been working properly.</p> <p>The resident residing in room 334 stated "We normally stick our heads out (of the room door) and holler for help." He did not indicate for how long he had needed to yell for assistance.</p> <p>The Maintenance Supervisor was interviewed at 4:17 PM on 1/26/15. He described his process for checking call bells. He stated "I choose 5 rooms on each hall to check. For these rooms I</p>	F 463	<p>3. The Area Staff Development will re-educate all staff on the facilities resident call system/ failure and preventive maintenance program policy by 2-27-15. Call light audits were conducted by the Maintenance Director and Administrator to ensure ongoing compliance with the resident call systems. All residents room identified to not be functioning appropriately have been replaced and or repaired. Five random rooms will be audited by the Maintenance Director or Administrator three times a week for 2 weeks, weekly for 4, then monthly for 2 months to ensure ongoing compliance. Audits will be documented utilizing the call light audit form.</p> <p>4. These measures are to ensure corrections are achieved and sustained: The Maintenance Director will report the results of the Call light audit form during the Quality Assessment and Process Improvement meeting for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.</p>		

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 463	<p>Continued From page 59</p> <p>check both the bedside and bathroom call bells. I check 5 rooms from the beginning of the hall during the beginning of the month, then 5 rooms in the middle of the hallway during the middle of the month, and then 5 rooms at the end of the hallway during the end of the month. That way I have covered just about every room on each hallway each month. I don't write down which rooms I have checked because I didn't know that I had to do that. The way I check is that I push the button, step out to listen for the ring and check for the door light. I have not known of any widespread problem with the call bell system nor has anyone reported any call bell issues to me."</p> <p>Documentation of this process was provided and indicated that the last time call bells on the 300 hall were checked was 1/22/15 with a side note indicating that call bells were "All working good." Prior to this date, the 300 hall call bells were checked on 1/15/15 with a note indicating "All was good."</p> <p>The call bell issue was demonstrated to the Maintenance Supervisor, the Administrator, and the Regional Director of Clinical Services on 1/26/15 at 4:45 PM. They all agreed that the call bell system sounded like a "dying battery". The Maintenance Supervisor stated "The light and noise pattern of the bathroom call bells should not fade in and out like it is doing right now." The Maintenance Supervisor, the Administrator, and the Regional Director of Clinical Services checked each bathroom call bells on the 300 hall and agreed that the bells were not lighting up and sounding consistently.</p> <p>The Administrator was interviewed at 4:53 PM on 1/26/14. She stated "I didn't know that bathroom</p>	F 463			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 463	Continued From page 60 lights did that. We will call the company that services the call bells to come out tonight because we expect all call bells to be in good working order." Nursing Assistant #43 was interviewed at 5:00 PM on 1/26/15. He stated that "I have worked here for two years. There should be a constant flashing and ringing if the call comes from the bathroom; it is not supposed to be weak and dying like it is. I worked over the weekend but did not notice this being an issue. I am aware of how to complete a maintenance order." The Regional Director of Clinical Services was interviewed at 8:45 AM on 1/27/15. She indicated that the company representative who was called in to check the call bell system on the night of 1/26/15 also agreed that the lights and rings were working inconsistently. She added that the company replaced all light bulbs, increased the sound of the alarms at the nurses' station, and checked the wires. She also reported that the company had planned to visit the facility a few more times that week to ensure proper working condition of the call bell system.	F 463			
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure handrails on 5 of 5 halls were securely affixed to the wall.	F 468	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 468 Corridors have firmly secured handrails	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 636 STATESVILLE BOULEVARD 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 468	Continued From page 61 The findings included; Observation on 1/25/15 at 4:37 pm revealed hallway 100 though 107 had 5 loose handrails out of 14 handrails. Hallway 108 though 129 revealed 8 out of 28 handrails to be loose. Handrail directly outside of the nutrition room was observed to completely come off the brackets. Hallway 201 though 214 revealed 4 loose handrails out of 17 handrails. Hallway 215 though 228 revealed 2 loose handrails out of 16 handrails. The locked unit was observed to have 4 loose handrails out of 31 handrails. Review of the facilities maintenance log for the month of January 2015 revealed no maintenance request in regards to loose handrails. During an interview and observation with maintenance on 1/26/15 at 4:15 pm The Maintenance director revealed the side rails were checked for maintenance concerns monthly. The Maintenance director further revealed staff that observe maintenance concern were to document the maintenance issue on a maintenance request form. The maintenance request notebook was located at each nursing station. Maintenance could not recall any maintenance concerns regarding handrails being submitted. During an interview and observation of the facilities handrails with the administrator on 1/26/15 at 4:15 pm revealed it was her expectation that handrails be firmly secured to the wall.	F 468	1. All hand rails throughout building on 100, 200 and 300 halls were tightened securely to wall on 1/26/15. 2. All handrails throughout the building will be audited by the maintenance director to ensure all handrails are secured to wall. 3. The Area Staff Development will re-educate all staff related to secured handrails and maintenance work order request by 2/27/15. Handrail audit were conducted by the Maintenance Director or Administrator to ensure ongoing compliance with the handrails. All handrails identified to be loose have been tightened and or repaired. Random Handrail audits will be conducted by the Maintenance Director and or Administrator three times a week for 2 weeks, weekly for 4, then monthly for 2 months to ensure ongoing compliance. Audits will be documented utilizing the Handrail audit form. 4. These measures are to ensure corrections are achieved and sustained: The Maintenance Director will report the results of the Handrail audit form during the Quality Assessment and Process Improvement meeting for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497			

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 497	<p>Continued From page 62</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that performance reviews were completed once every 12 months for 47 of 53 Nurse Aide 's (NA) (NA#1,3,4,5,6,7,9,10,11,12,14,15,16,17,18,19,20,21,22,23,24,26,27,28,29,30,32,33,34,35,36,37,38,39,40,41,42,44,45,46,47,48,49,50,51,52,53)</p> <p>Review of the performance reviews titled " My Check Up " on 1/30/15 at 10:50 AM revealed that 6 NA 's had performance reviews completed on 3/6/14.</p> <p>On 1/30/15 at 10:50 AM there were 47 NA 's identified with no performance reviews available.</p> <p>The person that was responsible for completing NA performance reviews was not available for interview.</p>	F 497	<p>This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>F497 Nurse Aide Perform Review – 12 hr/yr in-service</p> <p>1. The Director of Nursing, Unit Managers and Charge Nurses have completed the performance evaluation/My Checkup for Resident Care Specialist/Nurse Aides #1, 3, 4, 5, 6, 7, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, and 53.</p> <p>2. All Resident Care Specialists/Nurse Aides that have been employed a year will have performance evaluations/My Check Up completed by 2/27/15 by the Unit Manager, Charge Nurse or Director of Nursing.</p> <p>3. All Resident Care Specialists/Nurse Aides will have at least yearly evaluations using the My Check Up tool. The My Check Up tool will be monitored by the Director of Nursing to ensure performance evaluations are completed at least yearly. All Resident Care Specialists/Nurse Aides were completed in February. The Area Human Resources will monitor performance evaluation/My Checkup tool monthly to ensure complete.</p>	2/27/15	

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

PRINTED: 02/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD 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 497	Continued From page 63 An interview with the Regional Director of Clinical Services on 1/30/15 at 11:30 AM revealed that performance reviews could not be provided. She indicated that her expectations were that NA performance reviews were to be completed every 12 months.	F 497	4. These measures are to ensure corrections are achieved and sustained: The Director of Nursing will report the results during the Quality Assessment and Process Improvement meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.		