PRINTED: 07/08/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345080	B. WING _		_	C <b>06/04/2015</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE	NW	
DIVIAN OL	MILK HEALIN & KENA	B THERORT VIEWWORT		HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)	
F 242 SS=D	MAKE CHOICES  The resident has the	ERMINATION - RIGHT TO right to choose activities,	F 2	42		7/2/15
	her interests, assessi interact with member inside and outside the	n care consistent with his or ments, and plans of care; s of the community both e facility; and make choices or her life in the facility that resident.				
	by: Based on observatio resident and staff inte honor food preference	ns, record review, and erviews the facility failed to es for 2 of 4 sampled r choices (Resident # 81		F242 SS=D Alleged deficient properties of the second secon	٦-	
	diagnoses including of and diabetes mellitus Review of the annual dated 03/13/15 revea moderately impaired make his needs know	admitted on 03/24/14 with chronic respiratory failure  Minimum Data Set (MDS) led Resident #81 had cognition and was able to		conducted an inter with Resident #129 preferences. Resident #129 preferences. Resident #129 preferences. Resident #129 preferences. Resident #120 policy #120 poli	view Pregarding food dent #129 stated sh carrots in some thing ould like to be serve Chicken Pot Pies the preferences were ant cooked carrots. ger created food outer so that Resider	e s. d nat
ARORATORY !	History/Food Preference revealed Resident #8 carrots and lima bear An interview with Resident 11:08 AM revealed he was served them in the	nce List" dated 03/17/15 1 listed food dislikes as	RF.	like soups stews a On 06/04/2015 The Interview with Res food preferences. disliked Lima bear	and chicken pot pie. E DM conducted an sident # 81 regarding Resident #81 stated as, and carrots ger ensured residen	he

(X6) DATE

06/26/2015 **Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345080	B. WING		C 06/04/2015
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2010
				220 13TH AVENUE PLACE NW	
BRIAN CE	NTER HEALTH & REH	AB HICKORY VIEWMONT		HICKORY, NC 28601	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PRÉFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
F 242	Continued From pag	ge 1	F 24	2	
	Observations in the	dining room on 06/02/15 at		2.All residents have the potential to	
	12:22 PM revealed	Resident #81 eating lunch		be affected by the same alleged	
	which included a se	rving of mixed vegetables that		deficient practice; therefore,	
	contained carrots ar	nd peas. When asked if he		The Dietary Manager audited on 6	/8/2015
	was enjoying his lur	nch Resident #81 stated the		the current resident population to id	entify
	lasagna was good b	out he did not like carrots or		that food preferences are documen	ted
	peas.			and updated to reflect accuracy in	the
				food	
		nducted with the Dietary		service computer system.	
		6/04/15 at 10:35 AM. The DM			
		erences and dislikes were		3.Measures put into place to ensure	
		nputer. The DM accessed		the alleged deficient practice does	
		of food dislikes in the		reoccur include: The Social Service	es
		nd noted the list included:		Director and Dietary Manager	
		a beans, carrots, and		conducted in-service/ re-education	
		riew further revealed the		for Dietary and Nursing Staff regard	
		ulled the disliked food item		the residents' right to make choices	
		vould not pull other foods that ed food item. The DM further		consistent with their interests,	od.
		getables would have to be		specifically, honoring choices related to food preferences on 6/24/2015.	
		nputer as a food dislike for		Administrator	THE
		nen he would not be served		will review concerns during morning	,
	mixed vegetables.	ien ne wedia net be eerved		stand up meeting to identify	'
	mixed vegetablee.			opportunities related to providing for	or
	2. Resident #129 w	as admitted to the facility on		resident choices and ensure timely	
		oses including cerebral		follow-up. The Dietary Manager	
	_	emiplegia, and dysphagia.		or Registered Dietician will obtain f	ood
		ed a mechanical soft diet with		likes/dislikes/ preferences during the	
	no corn or rice on he	er meal tray.		admission assessment and docume	ent the
				information in the medical record a	nd
	Per dietary notes da	ated 01/31/15, Resident #129		dietary tray card system.	
	disliked spinach, gre	eens, cooked cabbage,		The Admissions Coordinator	
	carrots and oatmeal	l.		completes a Comprehensive	
				Preference Worksheet Upon	
	The admission Minii	mum Data Set (MDS) dated		admission that includes	
		sident #129 as having intact		plan of care, well being, and food	
		iors, eating independently with		preferences. The facility's Ambass	adors
		outh or denture problems and		(team members who visit with the	
	needing a mechanic	cally altered diet.		resident routinely to identify	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345080	B. WING _			1	04/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00/	04/2010
					H AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			RY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 242	having intact cognition requiring supervision a mechanically altered. A nutritional care plan 02/10/15 was update acute illness, poor into the interventions inclused and determine individed on 06/02/15 at 12:30 served her meal in he wheelchair. Her mean vegetables which inclused she left the mixed vestray.  On 06/02/15 at 3:29 sinterviewed. She start different staff that she vegetables, especially cabbage, preferring her aw.  On 06/04/15 at 9:42 served (DM) and surveyor, to note dated 01/30/15 or a disliked. DM stated mechanical soft diet arraw vegetables. Whe mixed vegetables who carrots, a documente was a result of the coout the tray cards in the coordinate of t	ated 04/24/15 coded her as in, having no behaviors, during meals and receiving diet.  In, originally developed don 04/17/15 to address an ake and weight loss. One of uded to offer preferred foods final likes and dislikes.  PM, Resident #129 was er room while sitting in a lincluded a bowl of mixed uded squares of carrots. getables untouched on her  PM, Resident #129 was ted that she has told a does not like cooked y cooked carrots or her vegetables to be eaten  AM, the Dietary Manager of pether, reviewed the dietary which indicated carrots was a Resident #129 was on a land therefore could not get en asked why she received	F2	corrand ress rand ress to inclusivill Courrela a ti com  4.Th will pref Am and cor mor The effe will on i	ncerns/ needs). Will interview 6 dom sidents weekly for 4 weeks and the dom sidents every other week for 2 mont ude questions regarding preference h as food choices. The Administrative review the minutes from Resident uncil monthly to identify concerns sted to food preferences and providingly response to ensure continued appliance.  The Administrator and Dietary Manager review data obtained during food ference audits, concerns, and abassador Rounds; analyze the data dreport patterns/ trends to the QAF mmittee every month for three on this.  The QAPI committee will evaluate the extiveness of the above plan, and add additional interventions based dentified trends/ outcomes to ensuratinued compliance.	hs es or e I ger	
		the computer system for					

Facility ID: 923004

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY LETED
		345080	B. WING			C 04/2015
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW  HICKORY, NC 28601	1 00/	04/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	automatically print ou carrots was the main However, if carrots w such as mixed vegeta computer would not k served. The printed t list of dislikes for staff for dislikes mixed in v computer just printed to be provided on the Resident #129 was a foods.	t the alternative vegetable if vegetable of the day. ere included in a recipe, ables, pot pie, etc, the mow that a dislike was being tray cards did not contain a fit to be able to easily check with other foods. The on the tray card what items meal tray. DM stated ble to as for alternative	F 24	12		
F 253 SS=E	she had to change the to clarify what items of 06/04/15 at 12:10 PM spoken to Resident # eat cooked carrots in and stews. DM state create food groups in Resident #129 would soup but not mixed ve 483.15(h)(2) HOUSE MAINTENANCE SER The facility must prove maintenance services sanitary, orderly, and This REQUIREMENT by:	I, DM stated that she had 129 who stated she could some things such as soups d she had been able to the computer so that get things like vegetable egetables with carrot pieces. KEEPING & EVICES ide housekeeping and s necessary to maintain a	F 25	53 F253 SS=E		7/2/15
		ns and staff interviews, the personal care equipment		F253 SS=E Alleged deficient practice		

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		345080	B. WING				04/2015	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	04/2015	
TO UNIC OF TH	TO VIDER OR OUT FEILING				20 13TH AVENUE PLACE NW			
BRIAN CE	NTER HEALTH & REI	HAB HICKORY VIEWMONT			ICKORY, NC 28601			
	OLIMANA DV	OTATEMENT OF REFIGIENCIES			·		9.45	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 253	Continued From pa	age 4	F2	253				
	stored to prevent c	ontamination, maintain walls in			in Housekeeping &			
	good condition, kee	ep bathrooms in good and			Maintenance Services			
	clean condition and	d maintain furnishings in good						
	condition on 4 of 4	halls.			1 .A. On 06/04/2015 Room 205			
					The wash basins were disposed			
	The findings includ	ed:			of and replaced with new basins			
	4.5				labeled, bagged, and stored off			
		quipment was not labeled and			of the floor.			
	stored to prevent c	ontamination as follows:			B. On 06/03/2015 Room 401			
	a Poom 205 shar	ed by 2 residents was			Graduated cylinder and			
		ay wash basins stacked			toothbrush was disposed of.			
	_	or behind the toilet on 06/02/15			Replaced with new			
	•	7 PM, on 06/03/15 at 11:30			toothbrush, labeled and in			
	AM, and on 06/04/				toothbrush holder. Replaced			
					cylinder, labeled, bagged and			
	b. Room 401 share	ed by 3 residents was observed			stored off of floor.			
		ncovered graduated cylinder						
		toilet and a unlabeled			C. On 06/03/2015 Room 503			
		pack of the toilet on 06/01/15 at			Disposed of wash basin.			
	3:21 PM and on 06	7/02/15 at 9:00 AM.			Replaced with new wash basin,			
	a Doom E02 abore	d by 2 residents was absented			labeled, bagged, and stored off of the floor.			
		d by 2 residents was observed uncovered gray wash basin			of the noor.			
		he floor on 06/01/15 at 10:17			D. On 06/03/2015 Room 506			
		8:50 AM and at 9:22 AM.			Wash basins, metal shelf supports,			
	7 1111, 011 007 027 10 0	. 0.00 / IIII dila di 0.22 / IIII.			screws, and urine hat were disposed			
	d. Room 506 share	ed by 2 residents was observed			of. New wash basins were placed			
		overed, unlabeled gray wash			in room. Labeled, bagged, and stored			
		helf supports and screws			off of the floor.			
		and an unlabeled, uncovered						
		or on 06/01/15 at 10:32 AM, on			E. On 06/03/2015 Room 510 Wash			
		M, on 06/03/15 at 9:18 AM and			basins,			
	at 4:00 PM.				Hair brush, and toothbrush were disposed.	sed		
	e. Room 510 share	ed by 2 residents was observed			New wash basins placed. Labeled,			
		ed uncovered wash basins on			bagged,			
		e commode, one uncovered			And stored off of the floor. New			
	unlabeled wash ba	sin was on the back of the			toothbrush			

Facility ID: 923004

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		345080	B. WING			06/	04/2015
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RDIAN CE	NTED HEALTH & DEHA	B HICKORY VIEWMONT		2:	20 13TH AVENUE PLACE NW		
DINIAN CL	NIEK IIEAEIII & KEIIA	B HICKORT VIEWWONT		Н	IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page	a 5	F	253			
	commode on the floo			_00	Was provided, with label and toothbrus	h	
		rush was on the sink at			holder.	''	
	06/01/15 at 11:02 AM	1 and on 06/02/15 at 8:59			New hair brush provided and labeled.		
	AM.				·		
					F. On 06/03/2015 Room 305 Wash		
		by 2 residents was observed			Basins		
		abeled wash basins on the n 06/02/15 at 3:52 PM and			Were disposed of. New wash basins provided.		
	on 06/03/15 at 11:32				Labeled, bagged, and stored off of the		
	o oo. oo o at o =				floor.		
	On 06/03/15 at 1:30 I	PM housekeeper #2 stated					
	during interview that when she cleans rooms, if  Walls to be repaired						
		are equipment on the floor			A Desar 2014 as heathers are considered		
	and not covered, she	will throw it away.			A .Room 304¿s bathroom was stripped Re-plastered, sanded, and painted.	,	
	On 06/03/15 at 1:36 I	PM med aide #1 stated			Repairs completedOn 06/25/15.		
		nent items should bed			(Cont.)		
	labeled and keep in r	esident closets or dressers.			F253 SS=E		
	On 06/03/15 at 1:38 l	PM NA #4 was interviewed			1.(Cont.)		
		nal care equipment should					
		nd stored in drawers or			B. Room 310 area painted. Repair		
		e floor. Toothbrushes should ner and stored in resident			Completed 06/04/15.		
		or closets. Hair brushes			C. Room 505 scheduled to be		
	should be in resident				Stripped, re-plastered, sanded, and		
					painted. Repair completion date 6/26/1	15.	
	On 06/03/15 at 3:56 I	PM NA #2 stated during					
		al care equipment should be			Commodes Repair/ Cleaning		
		and stored in resident closet			A D 404 00/04/45		
	areas.				A. Room 401 on 06/04/15 was cleaned By the housekeeping director. The		
	On 06/04/15 at 9:28	AM Nurse Aide (NA) #3			maintenance		
		ns should be labeled and			Director applied caulking to the base of	f	
		and placed in the closet,			the toilet		
	not on the floor.				On 06/04/2015.		
	On 06/04/15 at 11:17	AM the Director of Nursing			B. Room 310 on 06/04/15 was cleaned	bv	
	(DON) stated person				Housekeeping, Repairs were then	- ,	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245090	B. WING				0
	201/1252 02 01/221/52	345080	D. WING_			06/	04/2015
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			20 13TH AVENUE PLACE NW		
				Н	ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 253	stored in a bag and not a. Walls in need of rea. Room 304's bather was observed with the plaster and unpainted section between the emirror and wall. This at 3:55 PM, on 06/03 06/04/15 at 10:43 AMOn 06/04/15 at 10:43 AMOn 06/04/15 at 10:43 director who stated a in the wall needed to subsequently patched gotten back to finish a painting.  b. Room 310 shared with a patched unpainting. b. Room 310 shared with a patched unpainting. c. Room 505 shared with the painted wall across the wall in at 13:16 PM, on 06/03/15 06/04/15 at 10:50 AMOn 00 AMON 0	to be clean, tabled and tot on the floor.  epair included:  oom shared by 2 residents e wall covered with rough dover a 2 feet by 1 foot commode and mirror and was observed on 06/22/15 /15 at 11:33 AM, and on 1.  6 AM with the maintenance bout 4 weeks ago the pipes be replaced and down the dry wall work and  by 2 residents was observed and the wall on 06/02/15 at 3:49 at 11:34 AM.  by 2 residents was observed paper peeling at each seam east 6 places on 06/02/15 at 5 at 8:50 AM, and on 1.  O AM, interview with the restated some rooms on this inted wall paper removed and	F	253	completed By the maintenance director, including new caulking applied to the base of the commode.  C. Room 406 on 06/04/15 The maintenance director completed repairs to the base of the commode. Including, new caulking applied.  Furnishings  A. Room 510 on 06/04/15 The maintenance Director disposed of the over bed table New Over bed table was placed at the bedsit  B. Room 505 on 06/04/15 The Maintenance Director disposed of the over bed table New over bed table was placed at the bedside.  2. All residents have the potential to be affected by the same alleged deficient practice; therefore, The Director of Nursing, Assistant Director of Nursing, Maintenance Director, and Housekeeping Director have completed an audit of all patient rooms to be completed by 7/2/2015. (any areas noted or of concern will be corrected	de. e. A	
	a. Room 401's toilet,	shared by 3 residents, had			Immediately). Audit included personal care equipment stored to prevent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345080	B. WING _				C <b>04/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	0-1/2010
				22	0 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	
F 253	Continued From page	e 7	F 2	253			
	discolored brown resi 06/02/15 at 3:43 PM, on 06/04/15 at 10:05 On 06/04/15 at 10:05	AM an interview with the			contamination. Checking walls to ensure proper condition. Inspect furnishings, resident rooms an bathrooms to ensure in good repair an proper sanitation.		
	housekeeping superv cleaned with an abra	risor stated it needed to be sive.			3.Measures put into place to ensure that the alleged deficient practice		
	with the base of the discolored caulking a	round the base. on on 06/03/15 at 11:34 AM,			does not reoccur include: The Director of Nursing, Maintenance Director, and Housekeeping Director conducted an in-service/ re-education for All Staff on 6/25/2015 Regarding Storage	ı	
	supervisor stated the	AM the housekeeping base of the commode nd he could try a stronger			and labeling of personal care equipme to prevent contamination. Observation of furnishings, walls, cleanliness of rooms and bathrooms, and	nt	
	sprays and wipes she	AM interview with aled she did not think the had would get the base of as it was probably build up	appropriate process for repo needed repairs. The facility's Ambassadors (team member visit with residents routinely to identify concerns/ needs) will		appropriate process for reporting	and	
	with cracked discolor commode base on 06	by 3 residents was observed ed caulking around the 6/02/15 at 3:46 PM, on I, and on 06/04/15 at 10:06			residents room weekly for 4 weeks and then 10 random rooms every other week for 2 months to include observation of walls, personal care equipment stored to prevent contamination, cleanliness		
	housekeeping superv	I report if the caulking could leaners.			of bathrooms/ rooms, and observation of condition of furnishings.  4.The Administrator, Maintenance Director, Director of Nursing, and Housekeeping Director will review		
		-r -			data obtained during facility audits		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 06/04/2015
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC 28601	1 00/04/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 272 SS=E	table with peeling lamexposing the wood or 06/03/15 at 8:47 AM above table with peeling lamexposing the wood or 06/03/15 at 8:50 AM, AM.  On 06/03/15 at 8:50 AM, AM.  On 06/03/15 at 4:02 Few would not know who did it needed repair.  On 06/04/15 at 10:50 director stated that the overbed tables which resident use to use for back in resident room replaced 10 last week 483.20(b)(1) COMPR ASSESSMENTS  The facility must concar comprehensive, accomprehensive, accompre	served with an over bed sinate all around the edges, a 06/02/15 at 3:37 PM, on and on 06/03/15 at 4:02 PM.  served with an over bed sinate all around the edges, a 06/02/15 at 3:16 PM, on and on 06/04/15 at 10:50  PM, NA #2 stated that she so report the overbed table to a compart the overbed table to a compart their work and they end up as. He further stated he had as.  EHENSIVE  State of the comparison of	F 25	and rounds; analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	7/2/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		345080	B. WING_			C 6/ <b>04/2015</b>
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP COI 220 13TH AVENUE PLACE NW HICKORY, NC 28601	•	00/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 272	Continence; Disease diagnosis a Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by th Data Set (MDS); and	patterns; eing; and structural problems; and health conditions; al status; and procedures; and procedures; and procedures on the care be completion of the Minimum	F 2	72		
	by: Based on record reviated facility failed to compute that addressed the uncontributing factors, sampled residents recomprehensive Miniu #17, #30, #46, #52, #111, #129).  The findings included 1. Resident #9 was	and risk factors for 12 of 19 eviewed for the most recent mum Data Set (Residents #9, #68, #80, #81, #90, #95,		F272 SS=E Alleged deficient practice in Comprehensive Assessments  1.Corrective action has been accomplished for the alleged deficient practice with regard to Residents #9, #17, #30, # #68, #80, #81, #90, #95, #111, and #129 by reassess the Care Area Assessments	l l 46, sing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	0-10000			FREET ADDRESS, CITY, STATE, ZIP CODE	06/	04/2015
NAME OF FI	NOVIDER OR SUFFLIER						
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			0 13TH AVENUE PLACE NW		
				HI	ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	Continued From pag	e 10	F 2	272			
F 272	failure, and osteoarth recent comprehensive dated 01/28/15 reveault severely impaired context extensive assistance dated 01/28/15 stated limited assistance with with the revealed Resident #5 previous assessment.  Review of Resident #5 previous assessment.  Review of Resident #6 previous assessment.  The value of the review of the problem, causes and related risk factors in findings for the Falls.  During an interview of the MDS Nurse confirmed Resident #9's CAA S comprehensive MDS The MDS Nurse state MDS 3.0 a few years in-depth session on MDS nurse further state into much detail whe	aritis. Review of the most re Minimum Data Set (MDS) aled Resident #9 had gnition and required with transfer. The MDS d Resident #9 required th walking in her room. MDS dated 01/28/15 had two falls since the t.  #9's Care Area Assessment Falls dated 02/19/15 due to physical performance coalance, gait, strength, and Supporting documentation wer entries, the January ation Record, pain interview, es, and diagnosis record but the pertinence of this vas no description of the la contributing factors, or cluded in the analysis of	F 2	272	(CAAs) and making addendum documentation to support the findings. Action could not be taken for Resident #52 due to resident discharged.  2.Residents who have comprehensive assessments completed have the potential to be affected by the same alleged deficient practice; therefore, the Resident Care Management Director and MDS Coordinator have reviewed the last 30 days of comprehensive assessments and CAAs to ensure that triggered areas have information present that describes the residents strengths, weaknesses, and functionali 3.Measures put into place to ensure the alleged deficient practice does not reor include: The District Director of Care Management has conducted in-service re-education for the Resident Care Management Director, MDS Coordinate and Social Services Director regarding CAA completion expectations as described in the RAI manual on 6/24/2015. The Resident Care Management Director will audit at 5 comprehensive assessments and CAAs per month for 6 months to	at ccur / or,	
	further revealed the or reviewed CAA Summ	Corporate MDS Nurse naries last month and had lurse to analyze more and			ensure that information addresses the analysis of the resident's strengths, weaknesses, and how these areas affethe resident's	ect	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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TO WILL OF T	NOVIDER OR COLL FIER				20 13TH AVENUE PLACE NW		
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F 272	10/15/14 with diagnor disease. Review of the comprehensive Minin 01/29/15 revealed Resimpaired cognition and assistance with transion 01/29/15 noted she hassisted by one personassessment period. In dated 01/29/15 reveals since the previous as Review of Resident # (CAA) Summary for Frevealed supporting or referenced the Januar Record, nursing note record but gave no dethis information. The problem, causes and related risk factors in findings for the Falls of During an interview of MDS Nurse confirmer Resident #68's CAA's comprehensive MDS The MDS Nurse state MDS 3.0 a few years in-depth session on wind MDS nurse further stainto much detail where findings for CAA Summartured the MDS Nurse confirmer revealed the Coreviewed CAA Summartured the MDS North MDS Nurse further revealed the Coreviewed CAA Summartured the MDS North MDS	admitted to the facility on ses including Parkinson's he most recent num Data Set (MDS) dated esident #68 had severely ad required extensive fers. The MDS dated ad walked in her room on once or twice during the Further review of the MDS alled Resident #68 had 3 falls sessment.  668's Care Area Assessment falls dated 02/25/15 documentation which ary Medication Administration is, hospice, and diagnosis etails as to the pertinence of the was no description of the contributing factors, or cluded in the analysis of CAA Summary.  In 06/04/15 at 3:30 PM the dishe had completed Summary for Falls for the completed on 01/29/15. The desident of the completed on 01/29/15. The dishe received training in ago but didn't recall an writing CAA Summaries. The ated she did not usually go in completing the analysis of imaries. The interview Corporate MDS Nurse aries last month and had lurse to analyze more and	F 2	272	functionality to ensure continued compliance.  4. The Resident Care Management Director will review data obtained during comprehensive assessment audits, analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on identified trends/ outcomes to ensure continued compliance.		
	MDS nurse further stainto much detail wher findings for CAA Sum further revealed the Creviewed CAA Summ	ated she did not usually go not completing the analysis of smaries. The interview Corporate MDS Nurse saries last month and had lurse to analyze more and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 272	03/24/14 with diagnorespiratory failure, diadisorder. Review of tomprehensive Minim 03/13/15 revealed Reimpaired cognition and assistance with bedint toilet use, and person 03/13/15 also noted Rependent on staff for Review of Resident # (CAA) Summary for A Living) Functional dais supporting document tracker entries, the M Administration Record and diagnosis record.	admitted to the facility on ses including chronic abetes mellitus and seizure he most recent num Data Set (MDS) dated esident #81 had moderately and required extensive mobility, transfers, dressing, all hygiene. The MDS dated Resident #81 was totally rebathing.  181's Care Area Assessment ADL (Activities of Daily ted 03/24/15 revealed ation which referenced care arch Medication d, progress/ nursing notes, but gave no details as to the ormation. There was no blem, causes and	F	272	FICIENCY)		
	During an interview of MDS Nurse confirme Resident #81's CAA comprehensive MDS Nurse stated she received few years ago but did session on writing CA nurse further stated smuch detail when confindings for CAA Sumfurther revealed the Coreviewed CAA Summer	Summary for Falls for the dated 03/13/15. The MDS eived training in MDS 3.0 a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP COD 220 13TH AVENUE PLACE NW HICKORY, NC 28601		00/04/2015	
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F 272	diagnoses including dysphagia, acute reshemiplegia.  Review of the admisdated 02/06/15 code requiring set up only or denture problems receiving a mechanical Review of the Care nutritional status date resident had a receivith left hemiparesis listed her height and flow record and spewas no description of contributing factors, included in the analy Nutritional Status Company of the MDS Nurse confirmed CAA summary for more than the MDS Nurse states and the MDS and the session on MDS nurse further session on	re depth. as admitted on 01/30/15 with cerebral vascular accident, spiratory failure, and assion Minimum Data Set ed her with intact cognition, with eating, having no mouth as weighing 223 pounds and ically altered diet.  Area Assessment (CAA) for ted 02/10/15 revealed the ent cerebral vascular accident as was able to feed herself, weight. Then referred to the each therapy notes. There of the problem, causes and or related risk factors as of findings for the AA summary.  on 06/04/15 at 3:33 PM, the ed she had completed the autrition for Resident #129. The sago but didn't recall an awriting CAA Summaries. The stated she did not usually go an completing the analysis of mmaries. The interview Corporate MDS Nurse maries last month and had Nurse to analyze more and	F 2	72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW				
BRIAN CE	NIEK HEALIH & KEHA	B HICKORT VIEWWONT		HICKORY, NC 28601				
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F 272	Continued From page	e 14	F 2	272				
	weakness, urinary tra stress disorder, and o	ct infection, post traumatic lysphagia.						
	05/23/14, coded him down, feeling tired, m might notice, having to 3 days in the asse extensive assistance living skills (ADLS), reantianxiety and antips the last 7 days.  The Care Area Assess no description of the contributing factors, of included in the analyst triggered areas as fol *Cognitive Loss/Dem resident had a diagnor disorder, depression, make needs known a *ADL CAA stated he in a hip fracture, was incontinence, pressure extensive assistance and toileting. It also recrebral vascular account and was nonambulate *Psychosocial Wellber extensive assistance and was nonambulate *Psychosocial Wellber extensive assistance and Wellber extensive assistance and was nonambulate *Psychosocial Wellber extensive assistance and Wellber extensive assistance and was nonambulate *Psychosocial Wellber extensive assistance and Wellber extensive assistance	or related risk factors sis of findings for the lows: entia CAA stated the sis of post traumatic stress anxiety, and he was able and understand others. had a fall at home, resulting at risk for further falls, re ulcers due to needing with bed mobility, transfers, noted he had a history of a ident with left hemiplegia						
	diagnoses of anxiety, traumatic stress disor							
		the August MAR.  n 06/04/15 at 3:33 PM, the d she had completed the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		220	REET ADDRESS, CITY, STATE, ZIP CODE  13TH AVENUE PLACE NW  CKORY, NC 28601		0-112010
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F 272	The MDS Nurse state MDS 3.0 a few years in-depth session on w MDS nurse further state into much detail wher findings for CAA Sumfurther revealed the Creviewed CAA Summinstructed the MDS Nexplain things in more 6. Resident #17 was 02/18/15 with diagnostatus, congestive he infarct, gastrointestinabilateral below the kn The admission Minim coded her with intact extensive assistance of daily living skills (Aincontinent and havin The Care Area Asses 03/09/15 had no des causes and contributifactors included in the triggered areas as fol *ADL CAA stated she for acute frontal lobe gastrointestinal bleed being a bilateral amprequiring extensive as participating in therap with family. *Incontinence CAA staincontinent of bladded in the following in the cap with family.	trition for Resident #129. The desident #129. The d	F	272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW  HICKORY, NC 28601		•	
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F 272	Continued From pactors.  *Pressure ulcer CAD breakdown was was extensive assistance and having diagnoss disease, diabetes, at the continuation of the MDS Nurse confirm CAA summary for normal that the modern of the MDS nurse start MDS 3.0 a few year in-depth session on MDS nurse further significant into much detail who findings for CAA Summary for C	ge 16  A stated she had no skin at risk due to needing e with ADLS, incontinence es of peripheral vascular and bilateral amputation.  on 06/04/15 at 3:33 PM, the ed she had completed the utrition for Resident #129. Ited she received training in a sago but didn't recall an writing CAA Summaries. The stated she did not usually go en completing the analysis of mmaries. The interview Corporate MDS Nurse maries last month and had Nurse to analyze more and one depth.  Is admitted to the facility on oses including dementia,	F 2	DEFICIENCY)			
	requiring extensive	view for mental status), assistance for bed mobility, nd being unsteady but able to					
	Daily Living Skills (Ashe required limited ADLs, ambulated us incontinent episode family until she need	essment related to Activities of ADLs) dated 02/16/15 stated to extensive assistance with sing a rollator walker, had and previously lived with ded more assit with ADLs. ription of the problem, causes					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI IDENTIFICATION NUMBER: A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC 28601	1 00/04/2013
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F 272	included in the analysic Nutritional Status CA  During an interview of MDS Nurse confirme CAA summary for nutrithe MDS Nurse state MDS 3.0 a few years in-depth session on wide MDS nurse further strinto much detail where findings for CAA Sumfurther revealed the Coreviewed CAA Summinstructed the MDS Niexplain things in more 8. Resident #30 was 07/10/12. Diagnoses behavioral disturbance Resident #30's annual dated 04/10/15 indicated the MDS Niexplain things in more severely impaired conduction making. The Resident #30'receive antidepressant medical look back period. Call triggered from the an Psychotropic Drug Use Review of the CAA Signed Drug Use dated 04/10 triggered due to the canti-depressant medical description of the profactors, related risk factors.	ors, or related risk factors sis of findings for the A summary.  In 06/04/15 at 3:33 PM, the d she had completed the trition for Resident #129. The desident #129 of the desident	F 27		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 272	Continued From paç	ge 18	F 2	72			
	MDS Nurse confirm. Resident #30's CAADrug Use for the and 04/10/15. The MDS training in MDS 3.0 recall an in-depth set Summaries. The ME did not usually go in completing the analysummaries. The interest Corporate MDS Nur last month and had analyze more and e 9. Resident #52 was 08/17/12. Diagnose disease, anxiety, de dementia with psychography Minimum E 04/12/15 indicated F and long-term memorimpaired cognitives The quarterly Minimum Summaried cognitives The quarterly MDS received antianxiety antidepressant med look back period. Catriggered from the an Psychotropic Drug Use dated 04/triggered due to the anti-psychotic and a There was no descreontributing factors,	ysis of findings for CAA terview further revealed the se reviewed CAA Summaries instructed the MDS Nurse to explain things in more depth.  Is admitted to the facility on the included Parkinson's pressive disorder and thosis. Resident #52's Data Set (MDS) dated Resident #52 had both short tory problems and moderately kills for daily decision making. The vealed Resident #52 The antipsychotic and fications daily during the 7 day fare Area Assessments (CAA) finual MDS included: The service of the ser					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	06/04/2015	
				220 13TH AVENUE PLACE NW			
BRIAN CE	NTER HEALTH & RE	EHAB HICKORY VIEWMONT		HICKORY, NC 28601			
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F 272	Continued From բ	page 19	F 2	.72			
	MDS Nurse confir Resident #52's Carbriag Use for the 604/12/15. The MI training in MDS 3 recall an in-depth Summaries. The 1 did not usually go completing the an Summaries. The Corporate MDS N last month and ha analyze more and 10. Resident #90 06/22/12 with diag cerebral vascular Data Set (MDS) desident #90 had assessment and ranti-depression a during the 7 day in Assessments (CAMDS included fall Review of the CA 05/21/15 stated Redue to a history of falls due to interm further stated Resrolling walker, wo incontinent episod alarm on her bed psychotropic drug triggered due to pantianxiety and ar summary further stated as summary further stated as summary further stated and summary furth	aw on 06/04/15 at 3:30 PM the remed she had completed AA Summary for Psychotropic quarterly MDS completed on DS Nurse stated she received to a few years ago but didn't session on writing CAA MDS nurse further stated she into much detail when alysis of findings for CAA interview further revealed the lurse reviewed CAA Summaries and instructed the MDS Nurse to a explain things in more depth. It was admitted to the facility on gnoses of heart failure and accident. The annual Minimum lated 004/24/15 revealed 2 falls since the last received antipsychotic, and antianxiety medications book back period. Care Area AA) triggered from the annual sand psychotropic drug use.  A summary for falls dated resident #90 triggered for falls and a continued risk for a fall a falls and a continued risk for a falls and a continued risk					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT	22	REET ADDRESS, CITY, STATE, ZIP CODE 20 13TH AVENUE PLACE NW ICKORY, NC 28601	1 33.0-9.2010		
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F 272		roblem, causes and , or related risk factors ysis of findings for any of	F 272				
	MDS Nurse confirm Resident #90's CAA psychotropic drug ushe received trainin but didn't recall an i CAA Summaries. S Corporate MDS Nusummaries recently	on 06/04/15 at 3:30 PM the ned she had completed A summary for falls and use. The MDS Nurse stated use in MDS 3.0 a few years ago in-depth session on writing the further stated the use reviewed her CAA and informed her they in-depth and comprehensive.					
	05/05/14 with diagn non-Alzheimer's de Data Set (MDS) dat Resident #111 had assessment and ha choking during mea Area Assessments	vas admitted to the facility on loses of difficulty walking and mentia. The annual Minimum ted 04/16/15 revealed 1 fall since the last of problems with coughing and las when swallowing. Care (CAA) triggered from the led falls and nutritional status.					
	05/20/15 stated Redue to being at risk cognition, incontine assistance with acti summary for nutritic #111 triggered due diet with honey thic was able to feed se	summary for falls dated sident #111 triggered for falls for falls due to impaired nce and needing extensive vities of daily living. The CAA onal status stated Resident to being on a mechanical soft kened liquids. Resident #111 lf. There was no description ses and contributing factors,					

AND PLAN OF CORRECTION IDENTIFICATION NU		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP COI 220 13TH AVENUE PLACE NW HICKORY, NC 28601	•	104/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 272		e 21 included in the analysis of ese CAA Summaries.	F 2	772			
	MDS Nurse confirme Resident #111's CAA nutritional status. The received training in M didn't recall an in-dep summaries. She furth MDS Nurse reviewed	on 06/04/15 at 3:30 PM the old she had completed a summary for falls and the MDS Nurse stated she MDS 3.0 a few years ago but the session on writing CAA the stated the Corporate of the CAA summaries of the they needed to be comprehensive.					
	04/23/14 with diagno dysphagia. The annu dated 04/10/15 revea mechanically altered hemodialysis three ti	mes a week. Care Area triggered from the annual					
	dated 04/27/15 state nutritional status due soft diet with nectar thistory of dysphagia being recommended she and family were and family were educ swallowing problems the problem, causes related risk factors in	ummary for nutritional status d Resident #80 triggered for to being on a mechanical hickened liquids, having a (trouble swallowing), and to be on a pureed diet but noncompliant. The resident cated concerning her . There was no description of and contributing factors, or cluded in the analysis of ese CAA Summaries.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW  HICKORY, NC 28601	1 00/04/2010
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F 272	Continued From page During an interview MDS Nurse confirm Resident #80's CAA status. The MDS Nu training in MDS 3.0 recall an in-depth se summaries. She fur MDS Nurse reviewe recently and informe more in-depth and of 483.20(g) - (j) ASSE ACCURACY/COOR The assessment mu resident's status.  A registered nurse re each assessment w participation of healt A registered nurse re assessment is comp	on 06/04/15 at 3:30 PM the ed she had completed summary for nutritional arse stated she received a few years ago but didn't ession on writing CAA ther stated the Corporate dher CAA summaries ed her they needed to be comprehensive.  ESSMENT DINATION/CERTIFIED ast accurately reflect the must conduct or coordinate ith the appropriate the professionals.  In the sign and certify that the pleted.  Completes a portion of the gen and certify the accuracy of	F 2	72	7/2/15
	Under Medicare and willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessmen	I Medicaid, an individual who ply certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ply causes another individual and false statement in a t is subject to a civil money than \$5,000 for each			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345080 B. WING		3		C 06/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/04/2013	
				220 13TH AVENUE PLACE NW			
BRIAN CE	NIER HEALIH & REHA	B HICKORY VIEWMONT		HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 278	Continued From pag	e 23	F 2	78			
	Clinical disagreemer material and false sta	t does not constitute a atement.					
	This REQUIREMEN by:	Γ is not met as evidenced					
	Based on observation interviews, the facility complete the Minimulassessments) for 2 complete the management of the second control o	m Data Set (comprehensive		F278 SS=D Alleged deficient practice in Assessment Accuracy/ Coordination/ Certified.			
	The findings included  1. Resident #95 was  08/16/14 with diagno	admitted to the facility on ses including muscle		1.Corrective action has been accomplished for the alleged depractice with regard to resident #95, and #129. The assessmen will be modified/ corrected by 0	t nts		
	weakness, a fracture stress disorder (PTS	d hip, and post traumatic D).		All residents have the potent to be affected by the same alle			
	05/23/14 coded Resi cognition, feeling down speaking so slowly it verbal and other behassessment period, i	vn and tired, moving or could be noticed, having aviors 1 to 3 times in the equiring extensive		deficient practice; therefore, the Resident Care Management Di and MDS Coordinator have revall assessments completed in t 30days to ensure coding accuracy as a proper coding for all	irector viewed the last		
	and receiving antipsy antianxiety medication	n and antidepressant		proper coding for all diagnosis to include Level II P/			
	MDS, staff marked "I the resident was eva Preadmission Screet (PASRR) and determ mental illness, mental condition.	dentification section of the NO" in the section asking if luated by Level II ning and Resident Review nined to have a serious al retardation or related		3. Measures put into place to e the alleged deficient practice does include: The District Director of Management has conducted in re-education for the Resident C Management Director, MDS Co and Social Services Director or regarding	not reoccur f Care I-service/ Care pordinator,		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345080	B. WING _			1	C <b>04/2015</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	04/2010
				2	20 13TH AVENUE PLACE NW		
BRIAN CE	NIER HEALIH & REHA	B HICKORY VIEWMONT		Н	IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	level of care a person The FL 2 contained a "F" which indicated h	e FL 2 (form identifying the n requires) dated 08/14/14. a PASRR number ending in le was assessed a Level 2	F2	278	MDS Accuracy and proper coding for a Diagnosis to include what constitutes III PASSAR as described in the RAI manual.	evel	
	PASRR and required nursing care but was only approved on a time limited basis.  Administration provided a web site print out form the NC Uniform Screening Tool dated 06/03/15 showing resident history information. This form				The Resident Care Management Director will audit 10 assessments per month for 3 months to ensure accurate coding of ADL¿s and to include proper coding of all diagnosis.		
	noted that Resident # 08/13/14 as a PASRI approved for 60 days  On 06/04/15 at 4:24  Administrator were in Resident #95 was ac PASRR number endinursing home stay w			4.The Resident Care Management Director will review data obtained during assessment audits, analyze th data and report patterns/ trends to the QAPI committee every month x months. The QAPI committee will evaluate the effectiveness of the above			
	days). MDS nurse stated that she knew he did not have a diagnosis of mental retardation which would indicate PASRR Level II, but was not sure of a mental illness. She did not consider PTSD a mental illness and therefore did not mark the correct section on the MDS.  plan, and will add interventions on identified trends/ outcomes to ensure continued compliance.		· -				
	06/04/15 at 4:32 PM, impression that an er on Resident #95 to ir Level I or II and that	tated during interview on that she was under the valuation was not completed indicate if he was a PASRR determination would be limitation was ready to be					
	01/30/15 with diagno	s admitted to the facility on ses including cerebral emiplegia, acute respiratory a.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	l` ´com		OMPLETED
		345080	B. WING _			C <b>06/04/2015</b>
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC 28601	<b>,</b>	00/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	02/11/15 coded Res cognition, no behavi assistance of 2 pers and hygiene. She re persons for transfers required human assi MDS coded her at b dressing with set up.  The quarterly MDS of Resident #129 as re of 2 persons for dressident #129 was a 10:55 AM sitting in a left foot pedal under	num Data Set (MDS) dated ident #129 as having intact ors, requiring extensive ons for bed mobility, toileting, equired total assistance of 2 s, was nonambulatory and istance to balance. This eing independent with dated 04/24/15 coded quiring extensive assistance ssing.  Observed on 06/01/15 at a high back wheelchair, with a her left foot which had a eff arm rested on a pillow and	F2	78		
F 311 SS=D	had miscoded the dr survey the activity of documented Reside assistance of 2 pers assessment period e stated that the facilit check a sampling of accuracy, but not ev accuracy. 483.25(a)(2) TREAT IMPROVE/MAINTAI A resident is given the services to maintain	PM, MDS nurse stated she ressing and showed the fadily living sheets which int #129 needed extensive ons for dressing during the ending 02/11/15. She further y has a system in place to MDS's to ensure MDS ery MDS was checked for MENT/SERVICES TO NADLS  The appropriate treatment and or improve his or her abilities on (a)(1) of this section.	F3	311		7/2/15

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245000	B. WING			1	
		345080	B. WING			06/	04/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			20 13TH AVENUE PLACE NW		
				Н	ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 311	Continued From page	e 26	F	311			
	This REQUIREMENT	is not met as evidenced					
	by:						
	-	ons, record review and staff			F311 SS=D		
		failed to provide restorative			Alleged deficient		
	_	o improve or maintain the			practice in Treatment/		
		status for 3 of 3 resident's			Services To Improve		
	reviewed for restorati	ve services (Resident #90,			/ Maintain ADL's		
	#111 and #58).						
	,				1.Resident #90 showed no sign of		
	The findings included	l:			functional decline on 6/4/2015.		
					Resident ambulates with rollator walke	r	
	1. Resident #90 was admitted to the fac				ad lib. Resident #111 showed no sign of	of	
	06/22/12 with diagnos	ses of heart failure, cerebral			functional decline on 6/4/2015.		
	vascular accident, pe	ripheral vascular disease,			Resident #58 showed no sign of		
	chronic obstructive pu	ulmonary disease and			functional decline on 6/4/2015.		
	non-Alzheimer's dem	entia. The annual Minimum					
	Data Set (MDS) date				<ol><li>All residents in the Restorative</li></ol>		
		gnitively intact and required			Nursing Program have the		
		th bed mobility, dressing and			potential to be affected by the		
	personal hygiene.				same deficient practice; therefore,		
					The Director of Nursing		
		al Therapy (PT) assessment			in-serviced/ re-educated all nursing sta	ff	
	•	4/15 revealed Resident #90			on		
		services due to a recent			the process for using PRN staff for call		
		ated Resident #90 did not			outs and		
		ces but was referred to the			med aides to assist in performing		
		ogram for lower extremity			modalities and documentation for		
		maintain her current level of			restorative nursing on 6/11/2015.		
	function.				The Director of Nursing and		
	Davious of the Debah	to Postorative Transition			Assistant Director of Nursing		
		to Restorative Transition			Will complete a 100% Audit		
		sident #90 was referred by			of all residents receiving Restorative		
	PT to the restorative	for Resident #90 were for her			Nursing for the past 30days. Audit to		
	_	emity exercises seated and			ensure Restorative Nursing provided per plan	of	
		-			• • • • • • • • • • • • • • • • • • • •	Ji	
		es at a time and ambulate es per week for 16 weeks.			care. If audit reveals Restorative was not		
	330 to 300 leet o tillit	es per week for 10 weeks.			provided		
	Pavious of the Bohah	ilitation/Postorative Service			•		
	review of the Renab	ilitation/Restorative Service			per plan of care will refer resident to		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345080	B. WING				C
NAME OF D	20//050 00 01/00/150	343000	B. WING	-	TREET ARRESTS OFFI OFFI	06/	04/2015
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REH	AB HICKORY VIEWMONT			20 13TH AVENUE PLACE NW		
				Н	IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 311	Continued From page	ge 27	F	311			
	Delivery Records re	vealed Resident #90 received			therapy		
	_	3 times during the week of			to screen for any possibly decline or to		
		ne week of 04/05/15, 3 times			change any		
		5, 4 times the week of			part of their restorative nursing progra	m.	
		e week of 05/04/15, 4 times			Audit		
		5, 3 times the week of sthe week of 05/25/15.			will be completed by 7/2/2015.		
					3.Measures put into place to ensure the	at	
	An interview was co	enducted with the Restorative			the		
	Nurse on 06/03/15 a	at 2:39 PM. She stated			alleged deficient practice does not reod	cur	
	restorative were not	being provided as ordered			include: The Director of Nursing hired		
	due to restorative st	aff being pulled to work as			additional PRN Staff to utilize for direct		
	medication aides or	nurse aides on the floors.			care coverage. All Nursing Staff will be	e	
	She further stated a	dministration was in the			trained in modules of Restorative care	,	
	process of hiring sta	aff on an as needed basis to			including		
	help with the restora	ative nursing program.			documentation by 07/02/15. The DON, ADON, and Unit Manager will audit to		
	Interview conducted	I with Restorative Aides #1			ensure		
	and #2 on 06/03/15	at 3:09 PM revealed there			proper documentation , and		
	were 4 restorative a	ides scheduled to cover			residents receive restorative nursing pe	er	
		7 days a week 12 hours a			plan of care. Will audit 6		
		hey were pulled to the floor to			residents receiving restorative nursing		
		r medication aide assignment,			weekly for		
		the restorative services for			4 weeks and then 6 residents every oth	ner	
		ng on their assigned hall but			week for		
		complete the restorative			2 months.		
	•	ed they had made the					
		Assistant Director of Nursing			4.The Administrator and		
		Nursing (DON) aware that			Director of Nursing will		
		were not always being			review data obtained from audits,		
	provided as schedu				analyze the data and report patterns/ trends to the QAPI		
		conducted with the Corporate			committee every month		
		Training and the Administrator			for three months.		
		PM they revealed problems			The QAPI committee will		
		Program were identified and			evaluate the effectiveness		
		plan was developed which			of the above plan, and		
		of new staff and cross training			will add additional		
	existing Medication	Aides to complete restorative			interventions based		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(XX	3) DATE SURVEY COMPLETED
		345080	B. WING _			C 06/04/2015
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STAT 220 13TH AVENUE PLACE NV HICKORY, NC 28601		30/34/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 311	Corporate Director of 06/04/15 at 1:53 PM aides were trained to be completed pricipass.  An interview conduct with the Restorative restorative services aides, that service we restorative services.  An interview with Me at 4:26 PM revealed restorative services, nurse, restorative aid what tasks needed to the floor to providing restorative not follow the restorative with Me at 4:27 PM revealed pulled to the floor to providing restorative not follow the restorative with Me at 4:31 PM revealed services to residents pulled to the floor to follow the restorative but would help them and walk them to the 2. Resident #111 was	was conducted with the of Clinical Services on and Services on a provide restorative services on to or following medication of the documentation of the documentation of the documentation of the documentation.  Addication Aide #1 on 06/04/15 when has completed the has asked the restorative of the performed.  Addication Aide #3 on 06/04/15 of the restorative aides were work she was responsible for the services. She stated she did ative plan of care for the end range of motion (ROM), the bathroom.  Addication Aide #4 on 06/04/15 of the restorative aide was work. She stated she did not the plan of care for the resident dress, do ROM exercises	F3	on identified trends/ of to ensure continued		
	_	dementia. The annual				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	COMPLETED
		345080	B. WING		C 06/04/2015
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW  HICKORY, NC 28601	1 00/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 311	revealed Resident # cognitive skills and refor bed mobility, transpersonal hygiene.  Review of the Physic summary, dated 02/2 was discharged from nursing program. Per Resident #111 was the exercises, ambulation transfers with standing maintain his current order to prevent decorder to prevent decorder to the restorative goals of the intervent range of motion of being minutes consistently days, tolerate transfer consistently for 6 to and ambulate for a goal days a week for 90 complete Resident #111 only	MDS) dated 04/16/15 111 had severely impaired equired extensive assistance sfers, dressing, toileting and cal Therapy (PT) discharge 24/15 revealed Resident #111 a PT to the restorative r the PT discharge summary or receive lower extremity in using a rolling walker and ing balance activities to level of performance and in line.  In the total total total total total total total to the sident #111 was referred by program on 02/24/15. The tions were to tolerate active both lower extremities for 15 for 6 to 7 days a week for 90 days loal of 100 to 130 feet 6 to 7	F 3	11	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345080	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	343000		STR	REET ADDRESS, CITY, STATE, ZIP CODE	06/	04/2015
IVANIE OF T	TOVIDER OR OUT FEEL				13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	AB HICKORY VIEWMONT			CKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	Continued From pag	e 30	F:	311			
	due to restorative star medication aides or She further stated as process of hiring star help with the restoral Interview conducted and #2 on 06/03/15 were 4 restorative air restorative services day. They stated if the work a nurse aide or they tried to provide the resident 's resident have to consider the storative Nurse, A and the Director of N	being provided as ordered aff being pulled to work as nurse aides on the floors. It is a market and the food of the floor					
	Director of Clinical T on 06/04/15 at 1:30 with the Restorative a quality assurance included the hiring of existing Medication Aprograms.  A follow up interview Corporate Director of 06/04/15 at 1:53 PM aides were trained to be completed prior pass.	conducted with the Corporate raining and the Administrator PM they revealed problems Program were identified and plan was developed which if new staff and cross training Aides to complete restorative was conducted with the if Clinical Services on She stated medication provide restorative services in to or following medication					
	An interview conduc	ted on 06/04/15 at 3:34 PM					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	` '	ATE SURVEY OMPLETED
		345080	B. WING _			C <b>06/04/2015</b>
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC 28601	- '	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 311	restorative services aides, that service or restorative services. An interview with M at 4:26 PM revealer restorative services nurse, restorative a what tasks needed. An interview with M at 4:27 PM revealer pulled to the floor to providing restorative not follow the restorative and walked them to An interview with M at 4:31 PM revealer services to resident pulled to the floor to follow the restorative but would help them and walk them to the services to resident so the floor to follow the restorative but would help them and walk them to the services included.	e Nurse revealed when were provided by medication was not captured in the documentation.  edication Aide #1 on 06/04/15 d when has completed, he has asked the restorative ide, DON or therapy manager to be performed.  edication Aide #3 on 06/04/15 d if the restorative aides were owork she was responsible for e services. She stated she did rative plan of care for the led range of motion (ROM), the bathroom.  edication Aide #4 on 06/04/15 d she provided restorative s if the restorative aide was owork. She stated she did not e plan of care for the resident in dress, do ROM exercises	F3			
	coded Resident #58	m Data Set dated 02/21/15 3 with severely impaired uiring extensive assistance of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	I' '		O DATE SURVEY COMPLETED	
		345080	B. WING			C 06/04/2015	
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP COD 220 13TH AVENUE PLACE NW HICKORY, NC 28601		10/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 311	non-ambulatory, ha transfers requiring himself and receivir therapies.  Review of the Physisummary, dated 03 was discharged fror his maximum poten summary, Resident restorative nursing performance and to discharge summary and instruction for a transfers was developed.  Review of the Reha Record revealed RePT to the restorative goals of the interventis lower extremities be performed with to the reperformed with the therapeutic exercises motion to the lower of motion to the right resistance; and	lity and transfers, being ving unsteadiness during numan assistance to stabilize and occupational and physical dical Therapy (PT) discharge /21/15, revealed Resident #58 m PT on 03/20/15 having met tial. Per the discharge #58 was discharged to the program to facilitate the goal his current level of a prevent decline. The restated that the development active range of motion and oped and completed.  The resident #58 was referred by the program on 03/20/15. The motion were for strengthening and transfers. Activities to the resident included: the set of assisted active range of left extremity and active range at lower extremity with	F3	11			
	possible or at least These were to be possible or at least These were to be possible or at least These were to be possible or at least Review of the Rehat Delivery Records re	side rail, sit to stand if partial stand. erformed 6 times per week for sibilitation/Restorative Service evealed Resident #58 received ces after 04/20/15 until					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		345080	B. WING _			C <b>06/04/2015</b>
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP COD 220 13TH AVENUE PLACE NW HICKORY, NC 28601		00/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 311	06/03/15 at 1:47 PM restorative referral. at 2:39 PM revealed an error when servi subsequently caughthe restorative progression of the May Rehabilitation/Restorative revealed Record revealed Restorative restoration.	with the Restorative Nurse on A revealed therapy sets up a Further interview on 06/03/15 d the restorative nurse made ces ended 04/20/15. She at her error and re-established ram for Resident #58 on	F	311		
	observed being trar to bed via 2 staff ar required 2 staff as I remained in a squa transfer.	PM Resident #58 was insferred from the wheelchair ind a sit to stand lift. He incomplained of leg pain ted position during the				
	2:39 PM revealed the as scheduled 6 time staff being pulled to further stated admin	estorative nurse on 06/03/15 at nat services were not provided es per week due to restorative work on the floors. She nistration was in the process an as needed basis to help vices.				
	06/03/15 at 3:09 PM restorative aides so services 7 days per	orative Aides #1 and #2 on  If revealed there were 4 heduled to cover restorative week. They stated that if they oor to work a nurse aide				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	ONSTRUCTION (X3)	
		345080	B. WING _			C <b>06/04/2015</b>
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE 220 13TH AVENUE PLACE NW HICKORY, NC 28601		33.0 20 . 0
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATI ICIENCY)	(X5) COMPLETION DATE
F 311	services for the residence assigned hall but may restorative workload made the restorative Nurses and the Direct that restorative servit provided as schedule.  Interview with DON or revealed problems we was identified and a developed including servicing existing starestorative programs.  During an interview of Director of Clinical Ton 06/04/15 at 1:30 with the Restorative a quality assurance pincluded the hiring or existing Medication Aprograms.  A follow up interview Corporate Director of 06/04/15 at 1:53 PM aides were trained to be completed prior pass.  An interview conduct with the Restorative restorative services of the programs of the complete prior pass.	de to provide the restorative dent's residing on their by not be able to complete the anurse, Assistant Director of ctor of Nurses (DON) aware ces were not always being ed.  On 06/04/15 at 1:30 PM with the restorative program quality assurance plan was the hiring of new staff and in aff to also complete fraining and the Administrator PM they revealed problems Program were identified and plan was developed which if new staff and cross training and the restorative was conducted with the folinical Services on a She stated medication of provide restorative services in to or following medication as not captured in the	F	311		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED
		345080	B. WING _			C 5/04/2015
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT	•	STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW  HICKORY, NC 28601	1	, v
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 311	Continued From page	e 35	F 3	11		
	at 4:26 PM revealed verstorative services, I nurse, restorative aid what tasks needed to An interview with Medat 4:27 PM revealed in	ne has asked the restorative e, DON or therapy manager be performed.  dication Aide #3 on 06/04/15 f the restorative aides were				
	providing restorative not follow the restoration	vork she was responsible for services. She stated she did tive plan of care for the drange of motion (ROM), ne bathroom.				
F 312 SS=D	at 4:31 PM revealed a services to residents pulled to the floor to vertical follow the restorative but would help them and walk them to the	RE PROVIDED FOR	F 3	12		7/2/15
	daily living receives the	able to carry out activities of the necessary services to on, grooming, and personal				
	by: Based on observatio resident and staff inte provide nail care for a	ns, record review, and erviews the facility failed to a dependent resident for 1 of for activities of daily living		F312 SS=D Alleged deficient practice in ADL Care Provided for Dependent		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		0.45000	345080 B. WING				
		345080	B. WING _		•	/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
BRIAN CE	NTER HEALTH & RE	HAB HICKORY VIEWMONT		220 13TH AVENUE PLACE NW			
				HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 312	Continued From p	age 36	F 3	12			
	(Resident #81).			Residents			
	The findings included Resident #81 was	ded: admitted to the facility on		1.Resident #81 on 06/04/15 RN assessed residents nails for cleanliness. Left hand nai			
	03/24/14 with diag	gnoses including chronic		were neat and trimmed with i	no		
	respiratory failure,	diabetes mellitus and seizure		debris. Right hand 3rd digit			
	disorder.			nail length long with some de	ebris		
				under nail. Nail Care provide			
		ual Minimum Data Set (MDS)		including trimming 3rd digit n			
		vealed Resident #81 had		with residents permission. Re			
		red cognition and required		Stated he was growing his na			
		nce with personal hygiene and		however, agreed to have nail	i cleaned		
	was totally depend	dent on staff for bathing.		and trimmed.			
		olan for activities of daily living 4/15 stated Resident #81		2.All residents have the potential affected by the same alleged			
		e assistance of 1 to 2 staff		practice; therefore, The Dire			
		completion of ADL needs. The		Nursing,			
		dent #81 to have all his ADL		Assistant Director of Nursing	, and		
	needs identified a	nd met with staff assistance		Unit Manager will complete a	100% Audit		
	_	the highest level of independent		of all current residents to incl			
		e: brushing hair, washing face		cleanliness and length of nail	ls. Audit to be		
	and hands, and bi	rushing teeth daily.		completed by 6/25/2015.			
		esident #81's right hand on		3.Measures put into place to			
		AM revealed black debris under		the alleged deficient practice			
	all four fingernails			reoccur include: The Directo	•		
				and Assistant Director of Nur	sing		
	_	w on 06/01/15 at 11:08 AM		completed	an all Man d		
		erved his right hand and stated		an In-service/ re-education fo	or all inursing		
	he would need to ask the nurse aide (NA) to clean under his fingernails.			staff	sident Care		
	clean under his fir	igerrialis.		on 06/11/2015. Including Res			
	Subsequent obse	rvations of Resident #81		of shower and PRN. Educate			
	revealed the follow			initiated	ca on and		
		0:00 AM black debris was		bath worksheet to be comple	ted on		
	noted under all for			shower days			
		3:17 AM black debris was noted		and signed off by the nurse.	Including		

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345080	<b>345080</b> B. WING		_		C
NAME OF DE	DOVIDED OD SLIDDLIED	04000	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	04/2015
NAME OF PROVIDER OR SUPPLIER					20 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	AB HICKORY VIEWMONT					
					IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	ge 37	F3	312			
	under all four fingerr	nails.			nail care provided at time.		
		53 AM black debris was			The DON/ ADON/ UM will randomly au	udit	
	noted under all four				6		
		-			residents weekly for 4 weeks and then	6	
	An interview with NA	A #5 on 06/03/15 at 2:59 PM			random		
		ncluding cleaning under			resident every other week for 2 months	s to	
	-	s, was provided during			ensure nails are trimmed and clean.		
	showers and as nee	ded.					
	A fallace con intervious	with Decident #04 en			4.The Administrator and		
	A follow up interview with Resident #81 on 06/04/15 at 10:53 AM revealed he had been				Director of Nursing will review data obtained from audits,		
		ver earlier in the morning but			analyze the data and report		
		ned under the fingernails on			patterns/ trends to the QAPI		
		dent #81 could not recall if he			committee every month for three mon	ths.	
		an under his fingernails during			The QAPI committee will		
	his shower and state	ed he did like to be a bother.			evaluate the effectiveness of the above plan, and		
	An interview was co	nducted with the Director of			will add additional		
	Nursing (DON) on 0	6/04/15 at 10:57 AM. The			interventions based		
DON stated she expected resi		ected resident's fingernails to			on identified trends/ outcomes		
	be cleaned with showers and as needed when				to ensure continued compliance.		
		care. The DON was					
		sident #81's room on 06/04/15					
		rve his right hand and					
		should have been cleaned					
	out from under the fi	ngernails on his right hand.					
	During a follow up in	sterview on 06/04/15 at 3:05					
		e was assigned to Resident					
		#6 from the night shift had					
	_	er. NA #5 could not recall if					
		rnails needed cleaning this					
	week.						
F 328 SS=D	483.25(k) TREATME NEEDS	ENT/CARE FOR SPECIAL	F3	328			7/2/15
	The facility must ens	sure that residents receive					
		d care for the following					
propor troutment and oute for the following							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345080		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345080	B. WING		C 06/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010	
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT			:	220 13TH AVENUE PLACE NW		
BRIAN CE	NIER HEALIH & REHA	AB HICKORY VIEWMON	1	HICKORY, NC 28601		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 328	Continued From pag	e 38	F 328			
	special services:					
	Injections;					
	Parenteral and enter					
		tomy, or ileostomy care;				
	Tracheostomy care;					
	Tracheal suctioning; Respiratory care;					
	Foot care; and					
	Prostheses.					
	T Tooling Gos.					
	This REQUIREMEN by:	T is not met as evidenced				
		ons, record review and		F328 SS=D		
		erviews the facility failed to		Alleged deficient		
	secure a compresse	d oxygen cylinder in a		practice in Treatment/ Care		
	resident's room and	failed to change the		For Special Needs		
	, , ,	n tubing for a resident for 2 of				
		d with oxygen therapy		1.Resident #90 Portable oxygen cylind	er	
	(Residents #90 and	#139).		holder was secured to the residents		
	Th - 6:	4.		walker by the Maintenance Director		
	The findings included	J:		06/01/2015. Resident # 139 Nasal		
	1 Review of the fac	ility policy Transport of a		Cannula was replaced on 06/01/15.		
		n with an origin date of		2.All residents have the potential to		
		ed date of 12/2009 read in		be affected by the same alleged		
	part:			deficient practice; therefore,		
	•	containers must be secured		The Director of Nursing, and		
	as follows:			Assistant Director of Nursing,		
	· Oxygen related	equipment must be securely		Will complete a 100% Audit on		
	mounted or fastened	to the wheelchair, vehicle		all Residents requiring Oxygen		
	seat or floor during tr			to include proper cylinder storage,		
		s oxygen cylinders should be		tubing clean, with in date, and		
	secured to prevent m			stored appropriately by 7/2/2015.		
		ontainers should be secured				
	in an upright position	to prevent leakage.		3.Measures put into place to ensure th	at	
	Decide	locition to the feedlife.		the alleged deficient practice does not		
		Imitted to the facility on		reoccur include: The Director of Nursing	ig,	
	UU/ZZ/ IZ WILII UIAGNO	ses of chronic obstructive		and Assistant Director of Nursing		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED  C 06/04/2015	
345080	B. WING				
NAME OF PROVIDER OR SUPPLIER			<u></u> DE	00/04/2010	
PRIAN CENTER HEALTH & REHAR HICKORY VIEWMONT					
B HICKORY VIEWWON'I		HICKORY, NC 28601			
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIA		
e 39	F3	28			
Summary statement of Deficiencies (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 39 pulmonary disease. The annual Minimum Data Set (MDS) dated 04/24/14 revealed Resident #90 was cognitively intact.  An observation made on 06/01/15 at 12:05 PM revealed an unsecured portable oxygen cylinder with the gauge reading ½ full in a black unzipped cloth bag lying on the seat of Resident #90's rolling walker.  During an interview conducted on 06/01/15 at 12:05 PM with Resident #90 she stated her portable oxygen cylinder was always stored on her rolling walker so she could wear her oxygen when she ambulated.  An interview was conducted on 06/01/15 at 12:07 PM with nurse aide (NA) #1. She stated Resident #90's portable oxygen cylinder was always kept on the seat of her rolling walker.  An observation of the unsecured portable oxygen cylinder lying in Resident #90's seat of her rolling walker and interview was conducted with the Administrator on 06/01/15 at 12:08 PM. The Administrator confirmed the portable oxygen cylinder was not secured in the seat of the rolling walker and should not have been lying in the seat but secured to the walker.  2. Resident #139 was admitted to the facility on 05/22/15 with diagnoses including delirium tremors, altered mental status and chronic airway obstruction.  Physician orders originating on 05/22/15 included oxygen to be administered at 2 liters per minute via nasal cannula to maintain saturation levels greater than 88%.		completed an in-service/ re-education to staff on Oxygen safety and storage, including infection corpractices on 6/1/2015. The far Ambassadors (team member visit with residents routinely to identify concerns/ needs) will observe 5 residents who use weekly for 4 weeks and then 5 residents Week for 2 months to include of portable oxygen cylinder, stored securely, and tubing on with in date, and stored approximation.  4. The Administrator, and Director of Nursing, will revie data obtained during facility a and rounds; analyze the data report patterns/ trends to the committee every month x 3 rounds and will add additional intervents and will add additional intervents assed on identified trends/ o	ontrol acility's rs who to	er	
	AB HICKORY VIEWMONT  TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  e 39 The annual Minimum Data 24/14 revealed Resident #90 tt.  e on 06/01/15 at 12:05 PM ed portable oxygen cylinder ing ½ full in a black unzipped e seat of Resident #90's  conducted on 06/01/15 at lent #90 she stated her inder was always stored on she could wear her oxygen l.  inducted on 06/01/15 at 12:07 NA) #1. She stated Resident en cylinder was always kept ling walker.  e unsecured portable oxygen dent #90's seat of her rolling was conducted with the 01/15 at 12:08 PM. The ined the portable oxygen ured in the seat of the rolling ot have been lying in the seat alker. as admitted to the facility on ises including delirium ital status and chronic airway  ginating on 05/22/15 included stered at 2 liters per minute	A. BUILDIN  345080  B. WING _  AB HICKORY VIEWMONT  TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  E 39  The annual Minimum Data (24/14 revealed Resident #90) t.  E on 06/01/15 at 12:05 PM ed portable oxygen cylinder ng ½ full in a black unzipped e seat of Resident #90's  Conducted on 06/01/15 at lent #90 she stated her nder was always stored on she could wear her oxygen I.  Inducted on 06/01/15 at 12:07 NA) #1. She stated Resident en cylinder was always kept lling walker.  E unsecured portable oxygen dent #90's seat of her rolling was conducted with the 01/15 at 12:08 PM. The ned the portable oxygen ured in the seat of the rolling oth have been lying in the seat alker. Es admitted to the facility on sess including delirium stal status and chronic airway  ginating on 05/22/15 included stered at 2 liters per minute	A BUILDING  345080  B. WING  STREET ADDRESS, CITY, STATE, ZIP COE  220 13TH AVENUE PLACE NW HICKORY, NC 28601  ID PROPRIETS PLAN OF CC.  220 13TH AVENUE PLACE NW HICKORY, NC 28601  ID PROPRIETS PLAN OF CC.  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  e 39  The annual Minimum Data 24/14 revealed Resident #90 t. e on 06/01/15 at 12:05 PM ed portable oxygen cylinder ng ½ full in a black unzipped e seat of Resident #90's  conducted on 06/01/15 at lent #90 she stated her nder was always stored on she could wear her oxygen l. enducted on 06/01/15 at 12:07 NA) #1. She stated Resident en cylinder was always kept liing walker.  en unsecured portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling was conducted with the out/15 at 12:08 PM. The ned the portable oxygen dent #90's seat of her rolling out have been lying in the seat alker. sa admitted to the facility on ses including delirium that status and chronic a	A BUILDING  345080  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW HICKORY, NC 28601  PREPIX TAG  PROVIDER'S PLAN OF CORRECTION (ECAN CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  F 328  The annual Minimum Data 24/14 revealed Resident #90 t. e on 06/01/15 at 12:05 PM ed portable oxygen cylinder ng ½ full in a black unzipped e seat of Resident #90's  conducted on 06/01/15 at lent #90 she stated her nder was always stored on she could wear her oxygen ling walker.  noulding walker.  noulding infection control practices on 6/1/2015. The facility's Ambassadors (team members who visit with residents routinely to identify concerns/ needs) will observe 5 residents who use oxygen weekly for  4 weeks and then 5 residents every oth Week for 2 months to include observatio of portable oxygen (stored securely, and tubing clean, with in date, and stored appropriately to prevent contamination.  4. The Administrator, and Director of Nursing, will review data obtained during facility audits and rounds; analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified trends/ outcomes to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		<b>345080</b> B. WING				C <b>06/04/2015</b>	
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT				STREET ADDRESS, CITY, STATE, ZIP CODE  220 13TH AVENUE PLACE NW  HICKORY, NC 28601		00/04/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 328	observed sitting on the oxygen concentrator cannula was on the first and the was a locate his oxygen. To activate his call ligentered the room an repositioned. At 12:5 picked his nasal can reapplied it to his not cleaning. When Med she was interviewed that Resident #139 coxygen and this was replaced it. She furth replace the tubing which should have replaced on the floor, before reface.  Interview with Nurse revealed oxygen tub weekly and as needed soiled or on the floor resident dropped the staff should replace in tubing.  During interview on Contractor of Nursing should be changed were reconsidered to the staff should replace in the sta	PM, Resident #139 was ne edge of his bed, the was running but the nasal floor by the bed. Resident uncomfortable and could not he surveyor encouraged him ht. Medication Aide #2 d assisted him get	F3	28			