

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to treat a resident with dignity and respect when staff stated they did not have time to provide range of motion for muscle spasms to 1 of 3 residents sampled for dignity. (Resident #124).</p> <p>The findings included:</p> <p>Resident #124 was admitted to the facility on 09/03/15 with diagnoses which included paralysis of arms and legs and muscle spasms. A review of the admission Minimum Data Set (MDS) dated 09/10/15 indicated Resident #124 was cognitively intact for daily decision making and was totally dependent on staff for activities of daily living.</p> <p>A review of a facility document titled Employee Handbook with a revised date of December 2006 revealed in part: Section 4: Employment Practices Category I Work Rules 1. Employees must maintain acceptable standards of respect for residents, visitors, co-workers and supervisors.</p> <p>A review of admission physician's orders dated 09/03/15 indicated in part: Tizanidine 8 milligrams (mg) by mouth every 6 hours for muscle spasms</p>	F 241	<ol style="list-style-type: none"> The nursing assistant was removed from resident #124's assignment on 9/17/15 at the time the concern was voiced. Current residents have potential to be affected by the alleged deficient practice. RN Supervisor interviewed other alert and oriented residents on that assignment at the time the concern was voiced. No other concerns were voiced by other residents. Resident Ambassadors (department heads) will interview all residents with BIMS greater than 12 to ensure residents are being treated with respect and dignity. DON/ADON will in-service all nursing staff regarding resident's right to be treated with respect and dignity which will be completed by 10/23/15. Resident Ambassadors will then interview 5 residents a week for 4 weeks and then 10 residents monthly for 2 months to ensure residents are continuing to be treated with respect and dignity. Any concerns discussed during the interviews by residents will be brought to the administrator then discussed in morning stand up to ensure the concern has been addressed with satisfaction. 	10/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/23/2015

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.

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F 241	<p>Continued From page 1</p> <p>Baclofen 30 mg by mouth twice daily for muscle spasms Baclofen 40 mg by mouth every day at bedtime for muscle spasms Flexaril 5 mg by mouth three times a day for muscle relaxation</p> <p>A review of a facility document titled Concern Form dated 09/07/15 revealed Resident #124 reported a concern about a Nurse Aide (NA) response when he asked her to stretch out his right knee. He stated the NA told him she did not have time for that because she had others to take care of.</p> <p>During a telephone interview on 10/01/15 at 11:49 AM with NA # 1 she explained about a month ago she was assigned to care for Resident #124 and he required a lot of assistance and frequently called on his call light. She stated she went in his room when he called and he wanted her to stretch his legs out because he was having muscle spasms but she had 4 call lights going off at the time so she told him she didn't have time to stretch his legs out. She further stated it was a busy night and she didn't have time to stretch his legs out because she had other residents to take care of. She explained she felt what he requested her to do was above the general range of motion she was allowed to do. She further explained she told him she had to check on other residents and would come back later and left the room.</p> <p>During an interview on 10/01/15 at 11:55 AM Nurse #2 stated she was routinely assigned to care for Resident #124. She explained he had paralysis and had muscle spasms in his arms and legs. She further explained Nurse Aides</p>	F 241	<p>4. Data obtained during interviews will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement meeting (QAPI) by Administrator for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 2 (NAs) had to provide all of his care and do everything he needed because he could not do any of his own care. She stated the NAs had to do range of motion when they provided his care because when one of his extremities was moved another extremity contracted and the range of motion help relieve the muscle spasms. During an interview on 10/01/15 at 3:00 PM with Resident #124 he explained he had a problem with NA #1 on the night shift a few days after he was admitted to the facility and it upset him. He stated he felt NA #1 was not respectful to him when he asked her to straighten out his right leg because it was cramping and in spasm. He explained she said she didn't have time to provide range of motion when he requested it because she had other residents to take care of and then she walked out of his room. He stated he felt she did not treat him with dignity and respect because her response to his request for range of motion was disrespectful. During an interview on 10/01/15 at 3:41 PM the Director of Nursing stated it was her expectation for staff to treat residents with dignity and respect. She further stated range of motion was an expected task for NAs to perform and she expected NAs to do range of motion for residents as requested.	F 241			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		10/30/15	

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F 253	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record review the facility failed to change a privacy curtain stained with blood for 1 of 1 stained curtain (Resident #128).</p> <p>The findings included:</p> <p>On 09/30/15 at 11:20 AM Resident #128 was observed in his room sitting in a geri chair next to the privacy curtain that was pulled in a way that covered the resident. Resident #128's right forearm was bleeding from a skin tear. Resident #128 was gripping the privacy curtain with his left hand and blotted the bleeding skin tear with the privacy curtain. The privacy curtain was noted to a 1 inch x 3 inch oval shaped blood stain.</p> <p>On 09/30/15 at 11:30 AM nurse #1 was observed in the room with Resident #128.</p> <p>On 10/01/15 at 10:50 AM Resident #128's privacy curtain was observed to have the dried blood stain. The stain was noted to have turned slightly brown and had dark reddish-brown border surrounding the stain.</p> <p>On 10/01/15 at 11:00 AM the housekeeping director was interviewed and explained that rooms were checked daily by housekeeping staff and concerns with dirty or stained privacy curtains were to be addressed immediately. He added that he kept an ample supply of clean privacy curtains to replace ones that were dirty. During the interview the housekeeping director observed Resident #128's privacy curtain and stated it should have been changed the day the stain occurred. He added that the stain resembled dried blood.</p> <p>On 10/02/15 at 11:30 AM nurse #1 was interviewed and explained that on 09/30/15 she was treating Resident #128's skin tear and observed the blood stain on the privacy curtain</p>	F 253	<ol style="list-style-type: none"> 1. The curtain was replaced by the Housekeeping Supervisor on 10/1/15. 2. Current residents have the potential to be affected by the alleged deficient practice. An audit of all privacy curtains was completed by the Housekeeping Supervisor on 10/8/15 to ensure all curtains were clean and in good repair. 3. The Housekeeping Supervisor completed in-servicing for housekeeping staff on 10/20/15 regarding checking privacy curtains for cleanliness. DON/ADON completed in-servicing for all nursing staff on 10/15/15 regarding checking privacy curtains for cleanliness. The Housekeeping Supervisor and/or Administrator will audit 10 curtains weekly for 4 weeks and then 10 curtains monthly for 2 months, to ensure cleanliness of resident privacy curtains. 4. Data obtained during audits will be analyzed for patterns and trends and reported to QAPI committee by Housekeeping Supervisor for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and will determine if further auditing is needed. 		

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F 253	Continued From page 4 and notified housekeeper #1 that the curtain needed to be changed on 09/30/15. Nurse #1 was not aware of why the curtain had not been changed. Housekeeper #1 was not interviewed. On 10/02/15 at 11:35 AM the Administrator was interviewed and explained that she would have expected housekeeper #1 to change the stained curtain immediately when the nurse asked him.	F 253			
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to include Hospice services in the admission orders when a resident was re-admitted to the facility with orders from the hospital to receive hospice services in the facility for 1 of 1 sampled resident on Hospice (Resident #128). The findings included: Resident #128 was re-admitted to the facility on 06/11/15. The hospital discharge summary dated 06/11/15 read in part, "resident will be re-admitted to facility under hospice services." Review of Resident #128's Admission orders dated 06/11/15 and signed by the physician on 06/12/15 did not indicate hospice services. On 10/02/15 at 11:20 AM the Director of Nursing (DON) was interviewed and explained the process for transcribing admission orders. She stated that the admitting nurse would review the	F 271	1. A clarification order was obtained for Hospice Services rendered on 10/2/15 effective the day of readmission, June 11, 2015. 2. All residents receiving hospice services have the potential to be affected by the alleged deficient practice. An audit of all residents receiving hospice services was completed on 10/2/15 by an Administrative RN to ensure hospice orders were in place. 3. DON/ADON will re-educate licensed nursing staff by 10/23/15 on obtaining physician orders for hospice services at the time of admission. All admission orders will be verified to ensure hospice orders are in place as needed, within 24 hours of admission by an Administrative RN. Charts for residents receiving	10/30/15	

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F 271	Continued From page 5 discharge summary and medications to obtain all physician ordered medications and services. She stated that she was not certain if the facility needed a physician's order for the hospice services since the services were started in the hospital. The DON reviewed Resident #128's medical record and stated that the record did not indicate orders for hospice services from the admission on 06/11/15. She stated that it must have been overlooked.	F 271	hospice services will be audited weekly for 4 weeks and then monthly for 2 months by Admin RN to ensure hospice orders are in place. 4. Data obtained during audits will be analyzed for patterns and trends and reported to QAPI committee by DON for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and will determine if further auditing is needed.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		10/30/15	

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F 272	<p>Continued From page 6</p> <p>Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff and resident interviews the facility failed to accurately reflect a resident's dental status who required a comprehensive dental assessment which identified how their condition affected the resident's function and quality of life for 1 of 4 sampled residents. (Resident #52).</p> <p>The findings included:</p> <p>Resident #52 was admitted to the facility on 05/05/09 with diagnoses which included spinal cord injury with paralysis, abnormal involuntary movements and diabetes.</p> <p>The Annual Minimum Data Set (MDS) dated 09/29/15 coded Resident #52 as cognitively intact for daily decision making skills, requiring supervision and limited assistance with Activities of Daily Living (ADL) which included dressing, bathing and personal hygiene. The MDS coded Resident #52 with no natural teeth or tooth fragments and there was no indication of broken</p>	F 272	<ol style="list-style-type: none"> 1. A dental appointment for resident #52 was made for 11/5/15. 2. Current residents have the potential to be affected by the alleged deficient practice. An audit of all residents was completed on 10/23/15 by Administrative RNs to assess for the need of dental services. Appointments will be made accordingly. 3. DON re-educated MDS Coordinators on coding accuracy related to dental needs on 10/20/15. MDS coordinators will complete the audit tool with all quarterly, annual and admission assessments for 3 months. If dental issues are identified, MDS Coordinators will notify the Social Worker or Administrator who will ensure dental appointment is offered. 4. Data obtained during audits will be analyzed for patterns and trends and report to QAPI committee by MDS Coordinator for 3 months, at which time the QAPI committee will evaluate the 		

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F 272	<p>Continued From page 7 dentures.</p> <p>Review of the care plan dated 09/29/15 indicated Resident #52 required limited assist or less with all ADL other than bathing to promote highest level of functioning. Review of the care plan for nutrition dated 09/11/15 indicated nutritional risk potential related to the resident's food preferences with many dislikes or intolerance's. The care pan further indicated the resident had no mouth problems. Interventions for nutrition were offer preferred foods, meal assistance when needed, and determine the individuals likes and dislikes.</p> <p>Review of nursing notes and weekly monthly summaries for the past 6 months revealed the assessment was not completed for the condition of the resident #52's mouth, his dentures or had no teeth.</p> <p>Review of the physician progress notes and consultation reports indicated no referrals or consultations were made for a dental exam.</p> <p>Review of the Social services assessment and history updated annually revealed no notes related to Resident#52's dentition, missing teeth or broken dentures or services of dental referrals made by the facility.</p> <p>During an interview on 09/29/15 at 9:05 AM Resident #52 stated he had not seen a dentist in a long time and needed his dentures fixed. He explained he had asked the facility about a year ago to see the dentist but had not heard anything more about it except they said they were working on a dental contract. Resident #52 stated he was not sure if a dentist came to the facility anymore.</p>	F 272	effectiveness of the interventions and determine if further auditing is needed.		

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F 272	Continued From page 8 During a follow up interview on 09/30/15 at 12:22 PM Resident #52 explained he had asked the social worker about 6-8 months ago to see a dentist but there was no follow-up. He further explained he had asked a few times since then and nothing had happened. Resident #52 stated he lost 2 teeth a few months ago on the bottom that held his dentures in place but now he could no longer wear his dentures and had trouble chewing without them. Resident #52 stated his dentures were on the table in a cup but cracked and he could not wear them. During an observation of the breakfast meal on 10/01/15 at 9:11 AM Resident #52 pulled his dentures out of the cup and showed this surveyor the bottom set had 2 wire spacers to fit on 2 bottom teeth to hold the denture into place. The observation revealed one of the wires was not connected showing a sharp edge, and the pink gum part of the denture was cracked through and was held together by the false teeth and the wire. He put the denture in his mouth and demonstrated that the denture did not stay in place and flopped in his mouth. He stated "see it won't stay in right so I can't chew with it." He further stated he didn't have pain in his mouth when he chewed food with his gums, but when he tried to use the dentures the wire would jag and poke his tongue." Observation of Resident #52's breakfast tray revealed everything was eaten except the toast. Resident #52 explained he did not eat his toast because bread was difficult to gum it small enough to swallow. He further explained he had a regular diet of food but there were some foods he could not chew. Resident #52 stated food was usually pretty soft except for meats but he could chew sausage with his gums	F 272			

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F 272	<p>Continued From page 9</p> <p>but he could not eat bacon or something like fried chicken. He explained he could pull off the crusty part of fried chicken and cut it up pretty good, but anything that was crunchy he could not chew it or gum it enough to swallow.</p> <p>During an interview on 10/01/15 at 4:14 PM the Social worker (SW) stated she was responsible for scheduling referrals and making appointments for residents' with dental issues either to be seen by in house contract services or sent out to appointments. She further stated nursing or the administration of the facility would notify her of residents who needed to be seen by dentistry and they provided her with the resident medical record face sheet and what the dental concern was. The SW explained the facility did not currently have a dental contract service to provide residents with in facility dental care. The SW further explained when a resident's dental concern was reported to her she arranged appointments with the dentist of their choice or with another dental facility who accepted Medicaid payments. The SW indicated she had prior information from the previous SW who no longer worked at the facility of 2 residents for dental appointments but Resident #52 was not one of them.</p> <p>During an interview with the MDS Coordinator on 10/02/15 at 8:00 AM revealed she currently completed the MDS assessments and records for residents in the building. The MDS coordinator stated when completing the record she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She explained she then arranged for the resident to be seen by the dentist based on the complication of the condition. The MDS coordinator stated she completed the annual</p>	F 272			

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F 272	<p>Continued From page 10</p> <p>MDS for Resident #52 on 09/29/15 and when she completed the quarterly MDS assessments she also looked at the dental part. The MDS coordinator explained the section L for dental was coded for Resident #52 as he had no natural teeth or fragments, and no dentures. She further explained she answered that section for no teeth because he had not used his denture appliance in the past 7 days. The MDS coordinator indicated there were no specific care plans for dental issues when a dental issue was identified in the MDS, but it was referred to the social worker to make a referral or dental appointment and if there was pain involved that was reported to the nurse on staff that day, and the issue was reviewed in the administrative staff meeting in the mornings.</p> <p>During an interview on 10/02/15 at 10:00 AM the Director of Nursing (DON) stated dental assessments were completed on admission assessments and completed by the MDS coordinator as a part of her assessment annually and quarterly. She explained if at any time a dental concern for a resident was reported an assessment should be completed and nursing would work with the SW for the resident to have a dental referral and or appointment scheduled. The DON further stated the SW worked with the resident or the family member for their preference of dentists because the facility did not have a current contracted dental service to come to the facility but this was an ongoing process to set up. The DON further explained to her knowledge Resident #52 did not have very many teeth, or if he wore his dentures. The DON indicated it was her expectation for identifying residents with dental needs to be assessed at admission and yearly on the MDS and as needed or when a resident reported a concern.</p>	F 272			

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F 272	Continued From page 11 During an interview on 10/02/15 at 10:00 AM the Administrator (AD) stated dental assessments should be completed on admission assessments and completed by the MDS coordinator as a part of her assessment annually and quarterly. She further stated if at any time a dental concern for a resident was reported an assessment should be completed and nursing would work with the SW for the resident to have a dental referral and or appointment scheduled. The AD further stated the SW would work with the resident or the family member for their preference of dentists because the facility did not have a current contracted dental service to come to the facility. The AD further explained to her knowledge Resident #52 did not have very many teeth, or if he wore his dentures. The AD indicated it was her expectation for identifying residents with dental needs to be assessed at admission and yearly on the MDS and as needed or when a resident reported a concern.	F 272			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 274		10/30/15	

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F 274	Continued From page 12 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to conduct a significant change assessment for 1 of 1 sampled resident (Resident #128) who experienced a change in condition, when the resident returned from the hospital with Hospice services for end of life care. The findings included: Resident #128 was re-admitted to the facility on 06/11/15 with Hospice services. Review of the medical record revealed that a re-entry Minimum Data Set (MDS) was completed for Resident #128. Further review revealed that no additional MDS assessments were completed until 08/05/15 for Resident #128's quarterly assessment. On 09/30/15 at 10:25 AM MDS Coordinator #2 was interviewed and explained she had been in her role approximately 1 month. She added that the facility had 2 weeks to complete a significant change assessment when a resident started or stopped Hospice services. MDS Coordinator #2 stated she was not in her role when Resident #128 returned from the hospital under Hospice care and the MDS Coordinator at the time was no longer employed at the facility. The MDS Coordinator #2 explained that starting or stopping hospice was considered a "stand alone" event that constituted a significant change assessment. And she added that she would have completed an assessment after the re-admission to reflect the change.	F 274	1. A significant change assessment for Resident #128 was completed by MDS Coordinator on 10/2/15 to reflect the resident was receiving hospice services. 2. All residents receiving hospice services have the potential to be affected by the alleged deficient practice. MDS coordinator completed an audit of all hospice residents on 10/1/15 to ensure significant change was completed. 3. MDS Coordinators were re-educated by DON 10/20/15 regarding the requirements for completing a significant change when a resident receives orders for hospice services or is taken off of hospice services monthly for 3 months to ensure significant change was completed. 4. Data obtained during audits will be analyzed for patterns and trends and reported to QAPI committee by MDS Coordinator for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and will determine if further auditing is needed.		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		10/30/15	

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F 278	<p>Continued From page 13</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to accurately reflect that a resident was receiving Hospice services on a quarterly Minimum Data Set (MDS) for 1 of 1 sampled residents (Resident #128). The findings included: Resident #128 was admitted to the facility on 05/07/15 with diagnoses that included Alzheimer's</p>	F 278	<p>1. Resident #128's quarterly assessment was modified by MDS Coordinator on 9/30/15 to reflect hospice services rendered.</p> <p>2. All residents with hospice services have the potential to be affected by this alleged deficient practice. The MDS Coordinator audited all residents receiving hospice</p>		

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F 278	Continued From page 14 disease, atrial fibrillation, hypertension, pain and others. Resident #128 had a discharge assessment dated 06/07/15 with a return anticipated. A hospital progress note dated 06/10/15 specified, "Anticipate discharge to the facility under hospice services when bed is available." Resident #128 was re-admitted to the facility on 06/11/15 with Hospice services. A document in the medical record dated 06/12/15 read in part "Attention Staff this patient is under the Hospice Care." Further review of the medical record revealed that Resident #128 weekly Hospice visits were documented in the medical record. A quarterly MDS dated 08/05/15 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident was not receiving Hospice services. On 09/30/15 at 10:25 AM MDS Coordinator #1 was interviewed and reviewed Resident #128's quarterly MDS dated 08/05/15; she verified the resident was receiving Hospice services and the MDS should have reflected the service. She added that it must have been an oversight that Hospice was not coded on the MDS.	F 278	services on 10/1/15 to ensure coding accuracy. 3. MDS Coordinators were re-educated by DON on 10/20/15 on MDS accuracy coding related to coding hospice services. MDS Coordinator will audit all assessments of residents receiving hospice services monthly for 3 months to ensure coding accuracy. 4. Data obtained during audits will be analyzed for patterns and trends and reported to QAPI committee by MDS Coordinator for 3 months, at which time, the QAPI committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		10/30/15	

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F 314	<p>Continued From page 15</p> <p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, nurse practitioner and staff interviews the facility failed to prevent a skin abrasion from becoming a pressure sore and failed to promote healing for 1 of 2 residents sampled for pressure sores. (Resident #84).</p> <p>The findings included:</p> <p>Resident #84 was admitted to the facility on 01/09/13 with diagnoses which included diabetes, heart disease, high blood pressure and a stroke. A review of the annual Minimum Data Set (MDS) dated 08/22/15 indicated Resident #84 had short and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #84 required extensive assistance from staff for activities of daily living and was at risk for pressure sores.</p> <p>A review of a change of condition form titled Situation, Background, Assessment and Request (SBAR) dated 09/15/15 indicated Resident #84 had a small abrasion and wound on her left buttock that started on 09/15/15. The form revealed the condition had occurred before. The form further revealed the nurse assessment indicated a friction abrasion on Resident #84's left buttock, treatment was provided and referred to the treatment nurse and the responsible party and Nurse Practitioner were notified.</p>	F 314	<ol style="list-style-type: none"> 1. A clarification order was obtained from the Nurse Practitioner on 10/2/15 and 10/22/15 for wound assessment and proper treatment. 2. Current residents with pressure wounds have the potential to be affected by the alleged deficient practice. Administrative RNS completed assessments of all residents with wounds on 10/23/15 to verify accurate treatment order and documentation. 3. Licensed nursing staff were re-educated by DON/ADON by 10/15/15 on ulcer prevention and proper documentation and assessment. Administrative RNs to assess all pressure ulcers 5 times weekly for 2 weeks for accurate treatment, accurate documentation, as well as assess for signs and symptoms of wounds worsening. Then Administrative RNs will continue to assess all wounds, treatments, and documentation weekly for 3 months. 4. Data obtained during audits will be analyzed for patterns and trends and reported to QAPI committee by Administrative RN for 3 months, at which time the QAPI committee will evaluate the effectiveness of the interventions and will determine if further auditing is needed. 		

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F 314	<p>Continued From page 16</p> <p>A review of physician's orders dated 09/15/15 indicated to cleanse area on left buttock with normal saline, apply hydrocolloid (wafer dressing to promote wound healing) and change every week on Tuesday and as needed.</p> <p>A review of nurse practitioner progress notes dated 09/17/15 indicated Resident #84 was seen today for report of a new superficial buttock wound to left buttock. The notes revealed the area on left buttock was red with a small abrasion, no drainage, no tenderness, hydrocolloid dressing and continue to monitor. The notes further revealed to keep area clean and dry and follow up next week.</p> <p>A review of nurse practitioner progress notes dated 09/22/15 indicated Resident #84 was seen for buttock wound last week that appeared to be a skin tear from friction. The notes indicated a hydrocolloid dressing was applied and resident was ordered to off load. The notes revealed today the wound appeared as a stage 1 or 2 pressure sore, add Bactroban (ointment to treat skin infections), continue to off load, avoid friction and change dressing daily and recheck in 1 week.</p> <p>A review of physician's orders dated 09/22/15 at 6:05 PM indicated to clean left buttock with normal saline, apply optifoam dressing (absorbent and water proof to keep bacteria out) and change daily.</p> <p>A review of a facility document titled Head to Toe Skin Checks dated 09/22/15 indicated positive results for stage 3 pressure sore to left gluteal fold that was 3 centimeters (cm) length x 3 cm length x 0 cm depth. The notes further indicated</p>	F 314			

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F 314	<p>Continued From page 17</p> <p>to apply Bactroban with optifoam after wound was cleaned with normal saline.</p> <p>A review of a facility document titled Head to Toe Skin Checks dated 09/23/15 indicated wound diagnosis clarification as unstageable friction wound to left buttock and gluteal fold.</p> <p>A review of a care plan titled Non-pressure Ulcer Skin Impairment with a revised date of 09/23/15 indicated a left buttock/gluteal fold friction wound with potential and actual skin impairment related to thin, fragile skin. The goals revealed Resident #84 would be free of further skin impairment related to risk factors through next review in 90 days. The approaches indicated in part to observe skin weekly and document findings as indicated, document observation of any non-pressure related skin impairments on facility non-pressure ulcer wound documentation form, wound care as ordered and frequent repositioning.</p> <p>A review of a facility document titled Resident Care Specialist (RCS) Care Grids that was not dated indicated in part Resident #84 was incontinent of bowel and bladder, lay down after lunch and air mattress on bed.</p> <p>During an observation and interview on 09/29/15 at 4:33 PM Nurse #2 who was the wound treatment nurse was standing in the hallway outside of Resident #84's room and was holding a large dressing in her hand. She stated she was going to put a dressing on the wound on Resident #84's left buttock and entered the resident's room. Nurse #2 further stated the dressing on the wound on Resident #84's buttocks was supposed to be changed every 3 days and she</p>	F 314			

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F 314	<p>Continued From page 18</p> <p>used a hydrocolloid dressing. Resident #84 was turned on to her right side which revealed an open area of skin that was circular on her left hip with redness around the perimeter of the wound and the center of the wound was white. Nurse #2 stated the wound was 3 cm x 2.5 cm and had no depth. She explained the wound was not a pressure sore but was caused by friction and shearing. She further explained when the nurse practitioner first saw the area on Resident #84 ' s left buttock she said she thought it came from friction caused by her wheelchair.</p> <p>During a follow up interview on 10/01/15 at 10:23 AM with Nurse #2 who was the wound treatment nurse she stated Resident #84's skin was fragile and her skin was easy to break down. She explained she and the Nurse Practitioner saw Resident #84's wound on her left buttock on 09/17/15 and the Nurse Practitioner said she thought it was caused by friction from something in her wheel chair. She stated they were using the hydrocolloid dressings but the wound had not improved and she did not stage wounds but the Nurse Practitioner staged them. She confirmed on 09/22/15 she documented Resident #84 had a stage 3 pressure sore on the Head to Toe Skin Checks because that was what the Nurse Practitioner told her.</p> <p>During an interview on 10/01/15 at 12:21 PM with the Nurse Practitioner she explained the first time she saw the wound on Resident #84's left buttock on 09/17/15 it looked like a small red area. She further explained the next time she looked at it on 09/22/15 it had developed into an ulcer that she thought was a stage 1 or stage 2 pressure sore and the skin was completely peeled off the top of it. She stated it was her expectation for nursing</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>staff to call her or the physician on call for changes in wounds and she expected for wound dressings to be changed according to physician's orders.</p> <p>During a follow up interview on 10/01/15 at 2:47 PM. with the Nurse Practitioner she stated she did not know if the initial area on Resident #84's left buttock could have been prevented because she did not know what had caused it. She further stated when she first saw the area on 09/17/15 it looked like a scraped area and did not look like the skin was broken but when she saw it again on 09/22/15 she was very surprised to see the condition and size of it. She confirmed she had not seen the wound on Resident #84's left buttock since 09/22/15 and when she wrote off load in her progress notes it meant to stay off the area when she was in bed and in the wheelchair.</p> <p>During an interview on 10/02/15 at 8:54 AM with NA #3 she confirmed she was assigned to Resident #84's care. She explained it usually took 2 staff to turn Resident #84 because she was on an air mattress and that made it more difficult to turn her. She stated she was not aware of any special instructions for positioning Resident #84 while she was seated in her wheelchair.</p> <p>During an interview on 10/02/15 at 10:02 AM the Director of Nursing (DON) stated she had been told Resident #84 had a shear wound on her left buttocks and was not aware that it was now a pressure sore and did not know what stage it currently was. She stated it was her expectation for the Nurse Practitioner to see the resident weekly and she expected for nursing staff to do wound measurements weekly and discuss</p>	F 314			

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F 314	Continued From page 20 staging of pressure sores with the physician or Nurse Practitioner. She explained the physician's and Nurse Practitioner's progress notes were supposed to be placed in the resident's chart and she expected for nursing staff to read them and if there were orders to make sure the orders were written. She confirmed there had been confusion and missing communication about the wound on Resident #84's left buttock.	F 314			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and family interviews the facility failed to order requested dental services and schedule follow-up for 1 of 4 residents reviewed for dental status and services (Resident #71). The findings included:	F 411	1. Resident #71 was assessed by DON on 10/19/15 for signs and symptoms of dental pain or discomfort. Administrator contacted Resident #71 Responsible Party on 10/19/15. RP declined for resident to be sent out for dental services. RP was informed of new dental contract being secured and is agreeable to	10/30/15	

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F 411	<p>Continued From page 21</p> <p>Resident #71 was admitted to the facility on 02/18/14 with diagnoses which included depression, chronic deconditioning and Alzheimer's dementia.</p> <p>The Annual Minimum Data Set (MDS) dated 06/21/15 coded Resident #71 as significantly cognitively impaired for daily decision making skills, required total dependence for assistance from staff with Activities of Daily Living (ADL) which included dressing, bathing and personal hygiene. The Annual and quarterly MDS coded Resident #71 with no dental concerns.</p> <p>Review of the care plans last updated 09/04/15 indicated Resident #71 required extensive assistance with all ADL including personal hygiene and bathing to promote highest level of functioning.</p> <p>Review of nursing notes and weekly monthly summaries for the past 6 months revealed a nurse's note dated 06/16/15 indicated resident was assessed for a missing tooth. The notes further indicated Resident #71's missing tooth had been loose for some time but no pain was reported from the missing tooth when noted missing that morning. The nurse's notes reported communication with Resident #71's family member of the missing tooth and his preference to not have interventions for the missing tooth at that time.</p> <p>Review of the physician progress notes and consultation reports indicated no referrals or consultations were made for a dental exam.</p> <p>During the family interview on 09/29/15 at 03:08 PM the family representative (FR) reported</p>	F 411	<p>receiving dental services with contracted dental services group.</p> <p>2. Current residents have the potential to be affected by the alleged deficient practice. Dental services contract secured 10/22/15. All residents will be assessed by Administrative RNs for need of dental services by 10/23/15. If dental issues are identified, Administrative RN staff will notify the Social Worker or Administrator who will ensure dentist appointment is obtained.</p> <p>3. MDS Coordinator will complete dental audit tool for all quarterly, annual, and admission assessments to assess for dental needs. Licensed nursing staff will be re-educated by DON/ADON by 10/23/15 regarding identifying dental concerns and reporting to Social Worker or Administrator to ensure dental appointment is obtained.</p> <p>4. Data obtained during audits will be analyzed for patterns and trends and reported to QAPI committee for 3 months by MDS Coordinator, at which time the QAPI committee will evaluate the effectiveness of the interventions and will determine if further auditing is needed.</p>		

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F 411	<p>Continued From page 22</p> <p>Resident #71 had dental problems and needed to have dental services for cleaning and a checkup. The FR explained that Resident #71 was declining in health, had anxiety and depression and he wanted her to be seen by a dental services in the facility and not take her out to reduce her anxiety. The FR further explained he had requested this from the administration a number of times in the past 6-8 months and was told they were working on dental contract services because there was not any dental services currently being provided unless a resident was sent out to an appointment. The FR further indicated he was aware of Resident #71's missing tooth for some time because it had been loose for a long while but that he still wanted to have her teeth cleaned to prevent further dental decline.</p> <p>During multiple observations on 09/30/15 at 10:30 AM in her room and at Social activities on 09/30/15 at 11:34 AM & 10/01/15 at 10:25 AM Resident #71 was sitting in her wheelchair and had missing teeth in her mouth when she talked or drank coffee.</p> <p>During an interview on 10/01/15 at 4:14 PM the Social worker (SW) stated she was responsible for scheduling referrals and making appointments for residents' with dental issues either to be seen by in house contract services or sent out to appointments. She further stated nursing or the administration of the facility would notify her of residents who needed to be seen by dentistry and they provided her with the resident medical record face sheet and what the dental concern was. The SW explained the facility did not currently have a dental contract service to provide residents with in facility dental care. The SW further explained</p>	F 411			

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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
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F 411	<p>Continued From page 23</p> <p>when a resident's dental concern was reported to her she arranged appointments with the dentist of their choice or with another dental facility who accepted Medicaid payments. The SW indicated she had prior information from the previous SW who no longer worked at the facility of 2 residents for dental appointments but Resident #71 was not one of them.</p> <p>During an interview with the MDS Coordinator on 10/02/15 at 8:00 AM revealed she currently completed the MDS assessments and records for residents in the facility. The MDS coordinator stated when completing the record she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. She explained she then arranged for the resident to be seen by the dentist based on the complication of the condition. The MDS coordinator further stated she completed the quarterly MDS for Resident #71 on 09/04/15 and when she completed the quarterly MDS assessments she also looked at the dental part. The MDS coordinator explained the section L for dental was not coded for Resident #71 because she had no dental concerns in the past 7 day look back period or any reports from nursing. The MDS coordinator indicated there were no specific care plans for dental issues when a dental issue was identified in the MDS, but it was referred to the social worker to make a referral or dental appointment and if there was pain involved that was reported to the nurse on staff that day, and the issue was reviewed in the administrative staff meeting in the mornings.</p> <p>During an interview on 10/02/15 at 10:00 AM the Director of Nursing (DON) stated it was her expectation that dental assessments were</p>	F 411			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 411	<p>Continued From page 24</p> <p>completed on admission assessments and completed by the MDS coordinator as a part of her assessment annually and quarterly. She explained if at any time a dental concern for a resident was reported an assessment should be completed and nursing would work with the SW for the resident to have a dental referral and or appointment scheduled. The DON further stated the SW worked with the resident or the family member for their preference of dentists because the facility did not have a current contracted dental service to come to the facility but this was an ongoing process to set up. The DON indicated it was her expectation for identifying residents with dental needs to be assessed at admission and yearly on the MDS and as needed or when a resident reported a concern.</p> <p>During an interview on 10/02/15 at 10:00 AM the Administrator (AD) stated dental assessments should be completed on admission assessments and completed by the MDS coordinator as a part of her assessment annually and quarterly. She further stated if at any time a dental concern for a resident was reported an assessment should be completed and nursing would work with the SW for the resident to have a dental referral and or appointment scheduled. The AD further stated the SW would work with the resident or the family member for their preference of dentists because the facility did not have a current contracted dental service to come to the facility. The AD further explained to her knowledge Resident #52 did not have very many teeth, or if he wore his dentures. The AD indicated it was her expectation for identifying residents with dental needs to be assessed at admission and yearly on the MDS and as needed or when a resident reported a concern.</p>	F 411			

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