DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 04/01/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				520 VALLEY STREET	
BRIAN CE	NIER HEALIH & REHA	BILITATION/STATESVILLE		STATESVILLE, NC 28677	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 253 SS=E	MAINTENANCE SEF	RVICES ide housekeeping and s necessary to maintain a	F 253	3	4/29/16
	by: Based on observatio facility failed to repair and splintered lamina failed to repair smoke and splintered lamina and paint the door of facility also failed to corresident's wheelchair cover a plunger in a shalls. The findings included 1. a. Observations of 1:11 PM revealed the had a dime-sized are laminate on the edge bottom door hinge. The bathroom door had but laminate. b. Observations of Roor PM revealed the door broken and splintered the door above and but bottom edge of the bat and splintered laminate.	Room 224 on 03/29/16 at door of the residents' room a with broken and splintered s of the door just above the he bottom edge of the roken and splintered boom 227 on 03/29/16 at 1:11 r of the residents' room had d laminate on the edges of elow the door jam. The athroom door had broken		Criteria 1 The Maintenance Director repaired, painted or stained doors for Rooms 224,227,304,307,302, 138, 301, 303, 1 and 403 by 4-25-16. The Maintenance Director removed the toilet plunger from Resident # 1's bathroom by 4-25-16. Resident #1's arm trough was cleaned. Criteria 2 All Resident's with Rooms having damaged door are at risk of being affected by this alleged deficient practic Criteria 3 Every Resident door and every bathrood door and every smoke containment door was repaired, painted or stained as needed. These repairs, painting and staining were completed by 4-25-16. T Maintenance Director completed an au of Resident Bathrooms to remove othe toilet plungers. This audit and removal was completed by 4-25-16. The administrator will audit the building wee for dirty equipment and see that it is cleaned x 4 weeks. Nursing Staff and Housekeeping Staff were re-educated by the Administrator regarding the process for completion of maintenance request forms when repair needs are identified and storage of toil	n ce. om or dit r skly

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.

04/25/2016

CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3	C
	345128	B. WING		04/01/2016
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ITER HEALTH & REHAB	BILITATION/STATESVILLE		520 VALLEY STREET STATESVILLE, NC 28677	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	ILD BE COMPLETIC
Continued From page	e 1	F 25	53	
the door above the kid the bathroom door ha strip of laminate missi door with rough edges d. Observations of Ro PM revealed the door broken and splintered the door above and b e. Observations of Ro PM revealed the door broken and splintered the door above and b f. Observations of Ro PM revealed the door broken and splintered the door above and b g. Observation of Ro AM revealed the door broken and splintered the door above and b bottom edge of the ba and splintered lamina h. Observations of Ro AM revealed revealed room had broken and edges of the door just hinge. The bottom ha an approximately 1/4	ck plate. The bottom half of d an approximately 1/4 inch ng from the edge of the s noted. oom 307 on 03/29/16 at 4:10 of the residents' room had laminate on the edges of elow the door jam. oom 302 on 03/29/16 at 4:20 of the residents' room had laminate on the edges of elow the door jam. om 138 on 03/29/16 at 5:42 of the residents' room had laminate on the edges of elow the door jam. om 301 on 03/30/16 at 9:01 of the residents' room had laminate on the edges of elow the door jam. om 301 on 03/30/16 at 9:01 of the residents' room had laminate on the edges of elow the door jam. The throom door had broken te.		Maintenance Director will randomly inspect 10 Resident Room doors a Bathroom doors weekly for 12 wee The Maintenance Director will repa and/or stain doors as needed and identified during these audits. The Maintenance Director and Houseke Supervisor will randomly inspect 10 Resident Bathrooms per week for weeks to monitor for appropriate s of toilet plungers. Opportunities wi corrected as identified by the Main Director and Housekeeping Superv Licensed nurses, Resident Care Specialists, Housekeepers, and department heads were educated I Administrator regarding correcting resident equipment. Criteria 4 The Maintenance Director will press results of these audits monthly for months, to the Quality Assurance a Performance Improvement (QAPI) committee The committee will mak changes or recommendations as indicated. The Administrator will pre-	y nd ks. iir, paint eeping b 12 torage II be tenance visor. by the dirty ent the 3 ind e esent t at
	ITER HEALTH & REHAU SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page broken and splintered the door above the kin the bathroom door ha strip of laminate missi door with rough edges d. Observations of Ro PM revealed the door broken and splintered the door above and be e. Observations of Ro PM revealed the door broken and splintered the door above and be f. Observations of Ro PM revealed the door broken and splintered the door above and be g. Observation of Roo AM revealed the door broken and splintered the door above and be and splintered lamina h. Observations of Ro AM revealed the door broken and splintered the door above and be bottom edge of the ba and splintered lamina h. Observations of Ro AM revealed revealed the door just hinge. The bottom ha an approximately 1/4 missing from the edge edges noted.	DVIDER OR SUPPLIER ITER HEALTH & REHABILITATION/STATESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 broken and splintered laminate on the edges of the door above the kick plate. The bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough edges noted. d. Observations of Room 307 on 03/29/16 at 4:10 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. e. Observations of Room 302 on 03/29/16 at 4:20 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. f. Observations of Room 138 on 03/29/16 at 5:42 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. f. Observations of Room 301 on 03/30/16 at 9:01 AM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. g. Observation of Room 301 on 03/30/16 at 9:01 AM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. h. Observations of Room 303 on 03/30/16 at 9:48 AM revealed revealed the door of the residents' room had broken and splintered laminate on the edges of the bathroom door had broken and splintered laminate. h. Observations of Room 303 on 03/30/16 at 9:48 AM revealed revealed the door of the residents' room had broken and splintered laminate on the edges of the bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough	DVIDER OR SUPPLIER ITER HEALTH & REHABILITATION/STATESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 25 Continued From page 1 F 25 broken and splintered laminate on the edges of the door above the kick plate. The bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough edges noted. F 25 d. Observations of Room 307 on 03/29/16 at 4:10 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. F e. Observations of Room 302 on 03/29/16 at 4:20 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. F f. Observations of Room 301 on 03/29/16 at 5:42 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. The bottom edge of the bathroom door had broken and splintered laminate. h. Observations of Room 303 on 03/30/16 at 9:48 AM revealed the door of the residents' room had broken and splintered laminate. h. Observations of Room 303 on 03/30/16 at 9:48 AM revealed revealed the door of the residents' room had broken and splintered laminate on the edges of the door just above the bottom door hinge. The bottom half of the bathroom door had an approximately 1	Divider OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET HEALTH & REHABILITATION/STATESVILLE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 1 F 253 Droken and splintered laminate on the edges of the door above the kick plate. The bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough edges noted. F 253 A. Observations of Room 307 on 03/29/16 at 4:10 F 265 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. F 265 f. Observations of Room 302 on 03/29/16 at 5:42 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. F 265 g. Observation of Room 301 on 03/30/16 at 9:01 AM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. The Vaintenance Director will pres- secution and Housekeepers, and department heads were educated 1 Administrator regarding correcting resident equipment. g. Observation of Room 303 on 03/30/16 at 9:48 AM revealed the door of the residents' room had broken and splintered laminate on the edges of the door just above the bottom door hinge. The bottom half of the bathroom door had an approximately 1/4 inch this of alminate missing fr

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345128	B. WING	Image: Street Address, City, State, Zip Code Street Address, City, State, Zip Code 520 VALLEY STREET STATESVILLE, NC 28677 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION COMPLETION			
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 253	had broken and splint at the bottom half of t hole with splintered e down the inside of the J. Observations of Roy PM and 03/31/16 at 1 of the residents' room laminate on the edges door near the hinges. An interview with the 04/01/16 at 3:43 PM n assistant painted doo each week but he did documentation of the Supervisor further sta bathroom doors were into by wheelchairs an which made it difficult and repairs. An interview with the 3:55 PM revealed she some bathroom doors had not compiled of a repairs. During an environmen beginning at 4:04 PM Supervisor and Admin for rooms 134, 138, 2 307, and 403 with bro laminate. An interview was con Supervisor and the Ad 4:33 PM. The Admin	tered laminate on the edges he door. A quarter-sized dges was noted half way e bathroom door. om 403 on 03/30/16 at 6:33 2:35 PM revealed the door had broken and splintered s of the bottom half of the Maintenance Supervisor on revealed he and his rs and door frames one day not maintain any painting. The Maintenance ted the room doors and constantly being bumped nd resident care equipment to keep up with painting Administrator on 04/01/16 at e was aware there were s that needed attention but list of which doors needed htal tour on 04/01/16 the Maintenance nistrator observed the doors 24, 227, 301, 302, 303, 304,	F	253			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/29/2016 // APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345128	B. WING					C 01/2016
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATI	E, ZIP CODE	_	
BRIAN CE	NTER HEALTH & REHAI	BILITATION/STATESVILLE			320 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 253	and the facility had a could consult with reg 2. Observations of th on 200 hall near Roor PM revealed the door laminate on the edges door. During an environmer 04/01/16 at 4:09 PM t and Administrator obs doors on 200 hall near Maintenance Supervis and painted the edge ago and was not awa were rough again. Th Maintenance Supervis prevention doors would 3. Observations of the nourishment room on 03/29/16 at 12:29 PM black scuff marks and surface of the door. During an environmer 04/01/16 at 4:01 PM t and Administrator obs nourishment room on Maintenance Supervis assistant painted doo each week but he did documentation of the Supervisor further sta and agreed the door n	ould need to be repaired Divisional Manager they parding repairs. e smoke prevention doors m 227 on 03/29/16 at 1:11 is had broken and splintered is of the bottom half of the the bottom half of the ntal tour and interview on the Maintenance Supervisor served the smoke prevention in Room 227. The sor stated he had caulked is of the door a few months re the edges of the door ne Administrator and the sor both stated the smoke ld be repaired. e metal door to the the courtyard hall on revealed the door had is scratches over the entire thal tour and interview on the Maintenance Supervisor served the metal door to the the courtyard hall. The sor stated he and his rs and door frames one day not maintain any painting. The Maintenance ted he had missed this door	F	253				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/29/2016 MAPPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C 01/2016
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			20 VALLEY STREET TATESVILLE, NC 28677		
		ATEMENT OF DEFICIENCIES	ID	3	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	COMPLETION DATE
F 253	Continued From page	e 4	F:	253			
		ne was self propelling in the					
	-	chair with her right arm					
		igh. Five areas of dried e of a pencil eraser were					
		her right hand on the arm					
		sible surface of the arm					
	trough was covered v	vith a dried white film.					
	Subsequent observat	tions of Resident #1 on					
		1, 03/31/16 at 5:53 PM, and					
		revealed she was self vay in her wheelchair with					
		in an arm trough. Five areas					
		the size of a pencil eraser					
	-	nt of her right hand on the re visible surface of the arm					
	•	with a dried white film.					
		ducted with the Director of					
		/01/16 at 11:05 AM. The ekeeping department had a					
		residents' wheelchairs but					
	she expected the star	ff to clean the surfaces of					
		s anytime they were soiled. Resident #1's arm trough on					
		I which still had the dried					
		ed white film and stated it					
	would be cleaned im	mediately.					
	5. Observations of th	e shared bathroom for					
		on 03/29/16 at 3:40 PM					
		n the floor beside to the toilet					
	which was making his	sang sound.					
		hared bathroom for rooms					
		0/16 at 10:38 AM revealed a					
		eside the toilet which was nd. NA #7 was in room 302					
		ervation and was asked if					

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/29/2016 M APPROVED O. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345128	B. WING			C / 01/2016
NAME OF PR	OVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CEI	NTER HEALTH & REHAE	BILITATION/STATESVILLE		20 VALLEY STREET STATESVILLE, NC 28677		
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 272 SS=D	in the bathroom and p toilet and then place the beside the toilet. Subsequent observation for rooms 302 and 30- and 04/01/16 at 7:15 / remained on the floor During an interview or Environmental Service the housekeepers sho a bag if it needed to b bathroom. 483.20(b)(1) COMPRI ASSESSMENTS The facility must cond a comprehensive, accorreproducible assessment functional capacity. A facility must make a assessment of a resider resident assessment if by the State. The asses least the following: Identification and dem Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior pa Psychosocial well-beit	ing properly. NA #7 came proceeded to plunge the he plunger on the floor ons of the shared bathroom 4 on 03/31/16 at 8:35 AM AM revealed the plunger beside the toilet. In 04/01/16 at 3:45 PM the es Accounts Manager stated ould have put the plunger in e stored in the residents' EHENSIVE uct initially and periodically curate, standardized pent of each resident's comprehensive lent's needs, using the nstrument (RAI) specified ressment must include at hographic information;	F 253			4/29/16

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/29/2016 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345128	B. WING _			(04/	C 01/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
				520 VALLEY STREET			
BRIAN CE	NIER HEALTH & REHAL	BILITATION/STATESVILLE		STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	CTION SHOULD BE COMPL D THE APPROPRIATE DAT		
F 272	Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and Documentation of par	status; nd procedures; nmary information regarding ment performed on the care e completion of the Minimum ticipation in assessment.	F 2	272			
	by: Based on observation resident and staff inter complete a Care Area addressed the underly factors, and risk factor (Residents #13, #72 a psychotropic medicate The findings included 1. Resident #13 had of schizophrenia and an Minimum Data Set (M indicated the resident impaired. The MDS a had received antipsyce	ying causes, contributing rs for 3 of 5 residents and #145) reviewed for ion. : diagnoses which included, xiety disorder. The annual IDS) dated 12/19/15, was moderately cognitively lso indicated Resident #13 chotic and antianxiety days, and had reported		Criteria 1 The Resident Care Manager (RCMD) updated and submit Area Assessments for Reside and #145 to reflect the Resid psychosocial well-being, diag medications, underlying caus contributing factors, and risk is related to the Psychotropic prescribed to these Resident Criteria 2 All Residents requiring a CAA for being affected by this alle practice. The RCMD will rev comprehensive assessments during the 30 days prior to 4 complete Care Area Assessm MDSs will be opened if need	tted the Ca ents #13, # dent's gnosis, ses, factors as c Medicatio ts by 4-29- A are at ris eged deficie view all s completed 4/4/16 for ments. New	re ¢72 it ns 16. k ent d	

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/29/2016 DRM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/01/2016	
		345128	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			0 VALLEY STREET ATESVILLE, NC 28677		
(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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	(CAA) for Psychotrop revealed the diagnos received, but there w summary/analysis of factors related to the indicate if there was a adverse drug reaction reductions. The CAA was necessary or if n had seen the residen Resident #13's Care on 3/30/16) indicated potential to be verbal and was at risk for fai of Resident 13's verb was first addressed in On 4/1/16 at 12:03 P she thought she had Drug Use CAA summ said, "I must not have that I wrote."	e13's Care Area Assessment bic Drug Use dated 12/19/15, es and medications as no documentation in the contributing factors, or risk care area. The CAA did not any behavior monitoring, n or attempted dose did not indicate if a referral mental health rehab services t. Plan (most recently updated	F	272	by 4-29-16. Criteria 3 The Resident Care Management Dire (RCMD) re-educated the MDS Coordinators and Social Services Dir regarding completion of Care Area Assessment related to Psychotropic Medication to include the Resident's psychosocial well-being, diagnosis, medications, underlying causes, contributing factors, and risk factors . education included instructions on documenting descriptive Care Area Assessments in all areas according f RAI Manual. The RCMD will random audit 10 completed Comprehensive Assessments weekly for 12 weeks to validate descriptive CAAs. Opportuni will be corrected as identified by the RCMD as a result of these audits. Criteria 4 The results of these audits will be presented by the RCMD to the QAPI monthly for 3 months. The committee make changes or recommendations a needed.	ector This to the hly ties	
	 assessments to be co 2. Resident #72 was 2/20/15 and had diag anxiety, major depression psychosis. The annual dated 2/10/16, indical cognitively intact but behavioral symptoms 	ated she expected the omplete for each resident. admitted to the facility on noses which included, ssion, and unspecified al Minimum Data Set (MDS) ted the resident was had exhibited some verbal directed toward others. The Resident #72 had received					

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		345128	B. WING _			OULD BE COMPLETION	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			20 VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 272	antipsychotic, antidep medication for 7 of 7 period. Review of Resident # (CAA) for Psychotrop revealed only the diag received. There was a summary/analysis of factors related to the indicate if there was a adverse drug reaction reductions. The CAA was necessary or if m had seen the resident On 3/29/16 at 12:15 F observed eating lunch was sitting at a table interacted positively w During an interview o Coordinator #2 indica risk factors and behav considered for inclusi Use CAA summary. During an interview o Director of Nursing st assessments to be co 3. Resident #145 was 08/10/15 with diagnos disorder, major depre unspecified psychosis Record review of nurs revealed the Residen	bressant and antianxiety days during the assessment ic Drug Use dated 2/10/16, gnoses and medications no documentation in the contributing factors, or risk care area. The CAA did not any behavior monitoring, n or attempted dose did not indicate if a referral nental health rehab services t. PM, Resident #72 was n in the dining room. She with other residents and also vith staff. n 4/1/16 at 12:01 PM, MDS ted she was unaware the vior monitoring should be on in the Psychotropic Drug n 4/1/16 at 12:46 PM, the ated she expected the omplete for each resident. a admitted to the facility on ses of generalized anxiety assive disorder, and	F 2	272			

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SUMMARY ST	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128 BILITATION/STATESVILLE	A. BUILDING B. WING		CON	TE SURVEY MPLETED C
NTER HEALTH & REHAI SUMMARY STJ (EACH DEFICIENC		STI			C
NTER HEALTH & REHAI SUMMARY STJ (EACH DEFICIENC	BILITATION/STATESVILLE				4/01/2016
SUMMARY ST	BILITATION/STATESVILLE		REET ADDRESS, CITY, STATE, ZIP CO	DE	
(EACH DEFICIENC			0 VALLEY STREET TATESVILLE, NC 28677		
REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
Continued From page	9	F 272			
energy, and increase					
Area Assessment (CA 02/24/16 revealed Re scheduled antidepress medications. Orders of place the Resident or Resident #145 being needed antidepressa medications. No docu describing the impact psychotropic medicat resident. Additionally, provided for the care that were put in place the Resident's conditi complications, streng During an interview o Coordinator #2 indica risk factors and behavior	AA) Summary dated esident #145 received sant and antianxiety were signed on 02/18/16 to a Hospice Care with prescribed additional as ant and antianxiety umentation was noted of the prescribed ions being used by the there were no rationales plan decisions/interventions . The CAAs failed to identify on, weaknesses, ths, and overall progress. n 4/1/16 at 12:01 PM, MDS ted she was unaware the vior monitoring should be				
Director of Nursing st assessments to be co 483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus resident's status. A registered nurse mu	ated she expected the omplete for each resident. SSMENT NNATION/CERTIFIED t accurately reflect the ust conduct or coordinate	F 278			4/29/16
VOSTRETTOFTETTO CONCLEAZY - T. Ve	Area Assessment (CA 02/24/16 revealed Re scheduled antidepress medications. Orders we oblace the Resident or Resident #145 being meeded antidepressau medications. No docu- describing the impact obsychotropic medicat resident. Additionally, provided for the care that were put in place the Resident's conditi complications, streng During an interview o Coordinator #2 indica risk factors and behav considered for inclusi Jse CAA summary. During an interview o Director of Nursing st assessments to be co 483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus resident's status.	During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	Area Assessment (CAA) Summary dated02/24/16 revealed Resident #145 receivedscheduled antidepressant and antianxietymedications. Orders were signed on 02/18/16 toblace the Resident on Hospice Care withResident #145 being prescribed additional asneeded antidepressant and antianxietymedications. No documentation was noteddescribing the impact of the prescribedbycychotropic medications being used by theresident. Additionally, there were no rationalesporvided for the care plan decisions/interventionshat were put in place. The CAAs failed to identifyhe Resident's condition, weaknesses,complications, strengths, and overall progress.During an interview on 4/1/16 at 12:01 PM, MDSCoordinator #2 indicated she was unaware theisk factors and behavior monitoring should beconsidered for inclusion in the Psychotropic DrugJse CAA summary.During an interview on 4/1/16 at 12:46 PM, theDirector of Nursing stated she expected theassessments to be complete for each resident.483.20(g) - (j) ASSESSMENTACCURACY/COORDINATION/CERTIFIEDThe assessment must accurately reflect theresident's status.A registered nurse must conduct or coordinateeach assessment with the appropriate	Area Assessment (CAA) Summary dated 2/2/4/16 revealed Resident #145 received scheduled antidepressant and antianxiety medications. Orders were signed on 02/18/16 to blace the Resident on Hospice Care with Resident #145 being prescribed additional as heeded antidepressant and antianxiety medications. No documentation was noted describing the impact of the prescribed basychotropic medications being used by the resident. Additionally, there were no rationales brovided for the care plan decisions/interventions hat were put in place. The CAAs failed to identify he Resident's condition, weaknesses, complications, strengths, and overall progress. During an interview on 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she was unaware the isk factors and behavior monitoring should be considered for inclusion in the Psychotropic Drug Jse CAA summary. During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident. 483.20(g) - (i) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	Area Assessment (CAA) Summary dated 2/24/16 revealed Resident #145 received Scheduled antidepressant and antianxiety nedications. Orders were signed on 02/18/16 to place the Resident on Hospice Care with Resident #145 being prescribed additional as reeded antidepressant and antianxiety nedications. No documentation was noted fescribing the impact of the prescribed by psychotropic medications being used by the esident. Additionally, there were no rationales provided for the care plan decisions/interventions hat were put in place. The CAAs failed to identify he Resident *2 condition, weaknesses, complications, strengths, and overall progress. During an interview on 4/1/16 at 12:01 PM, MDS coordinator #2 indicated she was unaware the isk factors and behavior monitoring should be coordinator #2 indicated she was unaware the isk factors and behavior monitoring should be possible for each resident. vassessments to be complete for each resident. ta32.0(g) - (j) ASSESSMENT Accouracy/coordDINATION/CERTIFIED F 278 The assessment must accurately reflect the esident's status. A registered nurse must conduct or coordinate hat were put the appropriate

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/29/201 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED C
		345128	B. WING		04/01/2016
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER HEALTH & REHAI	BILITATION/STATESVILLE	-	20 VALLEY STREET STATESVILLE, NC 28677	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 278	Continued From page	e 10	F 278		
		ust sign and certify that the			
		completes a portion of the n and certify the accuracy of sessment.			
	willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material and	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money han \$5,000 for each			
	Clinical disagreement material and false sta	does not constitute a tement.			
	by: Based on record revi facility failed to accura Data Set for 7 of 17 s (Residents #1, #13, # #157). The findings included	24 #72, #73, #86, and :		Criteria1 The MDS for Resident #1 was correct by the RCMD to reflect an active diagnosis of Hemiplegia. The MDS for Resident #13 was correct by the RCMD to accurately reflect the Level II PASRR and the assessment	ected
	schizophrenia and an The resident's annual dated 12/19/15 indica considered by the sta	Minimum Data Set (MDS) ted the resident was not te Level II Preadmission		the Oral/Dental section. The MDSs for Residents #24, #72, # #86 and #157 were corrected by the RCMD to accurately reflect the assessments of the Residents for the Oral/Dental section	
	Screening and Reside process to have a ser	ent Review (PASRR) ious mental illness and/or		Criteria 2 All Residents have the potential of b	eing

Facility ID: 922999

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
						С
		345128	B. WING		0	4/01/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		520 VALLEY STREET STATESVILLE, NC 28677		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 278	Continued From page	a 11	F 278	3		
	intellectual disability. screening and review determination of need appropriate care setti recommendations for individual's plan of ca assessment section of none of the above pre about broken or ill-fitt teeth or tooth fragme cavities or broken nai bleeding gums, mout difficulty chewing. Be section indicated no of Area Assessment (C/ assessment. A review of the facility residents, provided of Resident #13 was into named on the list. During an observation 4:39 PM, Resident #1 upper denture but no On 4/1/16 at 12:01 P MDS Coordinator #2 Coordinator #1 indica position and was uns status was communic accurate on the MDS	The results of this are used for formulating a d, determination of an ing and a set of services to help develop an are. The Oral/Dental of the MDS was coded as esent, which had questions ing dentures, no natural ints, abnormal mouth tissue, tural teeth, inflamed or h or face pain, discomfort or ecause the Oral/Dental concerns, the Dental Care AA) did not trigger for further y's list of Level II PASRR in 3/29/2016, revealed cluded among the residents in and interview on 3/29/16 at 13 indicated she had an natural teeth. M, MDS Coordinator #1 and were interviewed. MDS ated she was new to the ure how the Level II PASRR cated, but that it should be . MDS Coordinator #2 t if the person had dentures		affected by this alleged deficient Criteria 3 The RCMD audited all the MDS Comprehensive Assessments of during the 30 days before 4/4/1 accurate coding and corrected The audit was completed by 4/2 any MDSs that needed to be m redone were opened by that da The RCMD re-educated the MD on accurate coding of all Assess including the diagnosis of Hemi Oral/Dental section and Level II The re-education was completed 4-29-16. The RCMD will randomly review Quarterly or Annual MDS assess weekly for 12 weeks to verify ad coding of the Resident's status. Opportunities will be corrected identified by the RCMD. Criteria 4 The RCMD will report the result audit to the QAPI Committee at meetings. The committee will m changes or recommendations a indicated.	completed 6 for as needed. 29/16 and nodified or te. 25 Team sments plegia, 1 PASRR. d by v 10 ssments ccurate as	
	During an interview o Director of Nursing st	n 4/1/16 at 12:46 PM, the ated she expected the				

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	-					FORM	M APPROVED
				וחו			0.0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE COMP	PLETED
						(с
		345128	B. WING				01/2016
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
		BILITATION/STATESVILLE			520 VALLEY STREET		
		BILITATION/STATESVILLE			STATESVILLE, NC 28677		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
		,			DEFICIENCY)		
F 278	Continued From page	e 12	F	278	8		
	2. Resident #72 was admitted to the facility on						
2/20/15. The annual Minimum Data Set (MDS) dated 2/10/16, was reviewed. The Oral/Dental							
		of the MDS was coded as					
		esent, which had questions					
		ing dentures, no natural					
		nts, abnormal mouth tissue,					
		tural teeth, inflamed or					
		h or face pain, discomfort or ecause the Oral/Dental					
		concerns, the Dental Care					
		AA) did not trigger for further					
	assessment.						
	-	n and interview on 3/30/16 at 72 stated she no longer had					
	any of her own teeth.						
	On 4/1/16 at 12:01 PI	M, MDS Coordinator #2					
		t if the person had dentures					
	then was not conside	red edentulous.					
	During on interview o	n 4/4/16 at 12:46 DM tha					
		n 4/1/16 at 12:46 PM, the acted she expected the					
	•	ccurate for each resident.					
	3. Resident #73 had of mellitus.	diagnoses including diabetes					
	menitus.						
	Record review of a D	ental Care Progress note					
	dated 9/30/13 revealed	ed, "Patient is now					
	edentulous."						
	Resident #73's annus	al Minimum Data Set (MDS)					
		viewed. The Oral/Dental					
		of the MDS was coded as					
		esent, which had questions					
	about broken or ill-fitti	ing dentures, no natural					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY LETED
		345128	B. WING			04/01/2016	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	teeth or tooth fragmen cavities or broken nat bleeding gums, mouth difficulty chewing. Be section indicated no of Area Assessment (CA assessment. On 3/29/16 at 3:45 PH room. The resident di lower natural teeth an On 4/1/16 at 12:01 PH indicated she thought then was not conside During an interview o Director of Nursing st assessments to be ad 4. Resident #86 was a 7/6/12. The annual M dated 3/10/16, was re assessment section of none of the above pre about broken or ill-fitti teeth or tooth fragmen cavities or broken nat bleeding gums, mouth difficulty chewing. Be section indicated no of Area Assessment. On 3/31/16 and 12:06 observed eating lunch resident did not have	hts, abnormal mouth tissue, aural teeth, inflamed or h or face pain, discomfort or ecause the Oral/Dental concerns, the Dental Care AA) did not trigger for further M, Resident #73 was in her d not have any upper or id was not wearing dentures. M, MDS Coordinator #2 if the person had dentures red edentulous. In 4/1/16 at 12:46 PM, the ated she expected the ccurate for each resident. admitted to the facility on inimum Data Set (MDS) eviewed. The Oral/Dental of the MDS was coded as esent, which had questions ing dentures, no natural hts, abnormal mouth tissue, cural teeth, inflamed or n or face pain, discomfort or ecause the Oral/Dental concerns, the Dental Care AA) did not trigger for further AB PM, Resident #86 was n in the dining room. The any upper or lower natural	F	278			
	observed eating lunch	n in the dining room. The any upper or lower natural					

Facility ID: 922999

If continuation sheet Page 14 of 33

	-	ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 04/29/2016 FORM APPROVED B NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345128	B. WING			C 04/01/2016
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STA 520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page	e 14	F 27	78		
		M, MDS Coordinator #2 t if the person had dentures red edentulous.				
	Director of Nursing st	n 4/1/16 at 12:46 PM, the ated she expected the ccurate for each resident.				
		admitted to the facility on the medical record revealed l as diagnosis.				
		Minimum Data Set (MDS) led hemiplegia was not diagnosis.				
	Resident #1 had an a self-performance defi limited range of motio mobility, and impaired	n dated 02/29/16 revealed activities of daily living cit related to a stroke, on, hemiplegia, limited d balance. Interventions og arm trough when up in				
	AM revealed she was hallway in her wheeld resting in an arm trou	hair with her right arm gh. A self gripping strap er lower right arm which was				
	03/31/16 at 12:49 PM 04/01/16 at 7:15 AM propelling in the hallw	ions of Resident #1 on I, 03/31/16 at 5:53 PM, and revealed she was self vay in her wheelchair with in an arm trough. A self				

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING				C /01/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	INTER HEALTH & REHA	BILITATION/STATESVILLE			320 VALLEY STREET STATESVILLE, NC 28677		
(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 278	gripping strap was ob arm which was attach trough. An interview was con on 04/01/16 at 2:54 P MDS Coordinator #1 annual MDS dated 11 assessment had been worked 2 days a wee assessments. MDS 0 Resident #1's annual coded to include hem diagnosis. The interv Coordinator #1 was re MDS assessments co assisted 2 days a wee she had reviewed Re 6. Resident #24 was diagnoses including of Review of an annual dated 06/27/15 revea in the dental status se dental problems durin period. Possible optio status section include fragment(s) (edentulo Observations of Resid AM revealed the tray she received a puree liquids. No natural te of the observation. N Resident #24 at the ti	ducted MDS Coordinator #1 PM. During the interview reviewed Resident #1's 1/15/15 and stated this in completed by a nurse who k assisting with MDS Coordinator #1 confirmed MDS should have been hiplegia as an active view further revealed MDS esponsible for reviewing the pompleted by the nurse who ek but she could not recall if sident #1's annual MDS. admitted on 07/19/14 with dementia and dysphagia. Minimum Data Set (MDS) iled Resident #24 was coded ection as not having and ng the 7-day look back ons for coding in the dental ed no natural teeth or tooth	F	278			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED C	
		345128	B. WING			04/01/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHAI	BILITATION/STATESVILLE			20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	An interview was com Coordinator #1 on 04, the interview MDS Co Resident #24's annual stated this assessment nurse who worked 2 of MDS assessments. Me explained she was not when Resident #24's completed. MDS Coor Resident #24 was edu MDS should have beet the dental status sect 7. Resident #157 was 02/16/16. Resident #7 Data Set (MDS) dated was cognitively intact assistance of one star hygiene. The MDS di #157 did not have any fragments and was edu Review of admission 02/16/16 revealed that set of upper and lowe not checked on this a Interview with Reside AM revealed that he f weeks ago and he co edentulous. Resident had no trouble chewin Observation of Reside AM revealed Resident had no dentures in his	ducted with MDS /01/16 at 9:19 AM. During pordinator #1 reviewed al MDS dated 06/27/15 and in thad been completed by a days a week assisting with MDS Coordinator #1 of employed by the facility annual MDS was pordinator #1 confirmed entulous and the annual en coded as edentulous in ion. s readmitted to the facility on 157's most recent Minimum d 02/23/16 indicated that he and required total ff member for personal id not indicate that Resident y natural teeth or tooth dentulous. nursing assessment dated at Resident #157 had a full er dentures. Edentulous was ssessment. nt #157 on 03/30/16 at 9:06 had lost his dentures about 3 nfirmed that he was #157 further stated that he ing or swallowing.	F	278			

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TEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED			
		345128	B. WING		C 04/01/2016			
AME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
			52	20 VALLEY STREET				
RIAN CE	NIER HEALIH & REHA	ABILITATION/STATESVILLE	S	TATESVILLE, NC 28677				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO			
F 278	Continued From pag	ie 17	F 278					
-		esident #157 was edentulous						
		dent #157 on 04/01/16 at esident #157 was edentulous s in his mouth.						
	12:42 PM revealed t that helped her comp MDS Coordinator #1 checked their work a assessment. MDS C when they complete and talk to the reside needed to complete Coordinator #1 confi	Coordinator #1 on 04/01/16 at hat she had 2 other nurses plete Minimum Data Sets. stated that she spot and then signs off on the coordinator #1 further stated d Minimum Data Sets they go ent to gather the information the assessment. MDS rmed the MDS for Resident een coded as edentulous and correction.						
F 312 SS=D	expected the assess accurate for each res	ARE PROVIDED FOR	F 312		4/29/16			
	daily living receives	able to carry out activities of the necessary services to on, grooming, and personal						
	by: Based on observation	T is not met as evidenced ons, record reviews, and erviews the facility failed to		F312 Criteria 1 Oral Care and Nail care was provided				

Facility ID: 922999

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/29/2016 RM APPROVEE O. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			04	C 1/01/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			20 VALLEY STREET TATESVILLE, NC 28677		
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From page	e 18	É E	312			
	dependent residents daily living (Residents	reviewed for activities of s #82, #16, and #68).			Residents #82, 16 and 68 by the Dire of Nursing and Unit Managers on 4/1/ Criteria 2		
	The findings included				Resident requiring assistance with Activities of Daily Living (ADLs) have		
	1. Resident #82 was diagnoses including o weakness.	admitted on 05/28/15 with dementia and muscle			potential to be affected by this alleged deficient practice. An audit of Resider requiring assistance with ADLs was completed by the DON, SDC and Unit	nts	
	dated 01/05/16 revea moderately impaired extensive assistance	rly Minimum Data Set (MDS) iled Resident #82 had cognition and required with personal hygiene. The			Managers by 4-29-16 to validate Oral Care and Nail Care was provided as needed. Opportunities were corrected the DON and Unit Managers as identi	d by	
	quarterly MDS also n impaired range of mo extremities and one I				Criteria 3 Nursing Staff were re-educated by Director of Nursing (DON) and Staff Development Coordinator (SDC) on		
	Resident #82 had an self-performance def	n dated 01/11/16 revealed activities of daily living icit related to dementia,			providing assistance with ADLs to incl Oral Care and Nail Care. The DON, andUnit Managers will audit at least 1	SDC, 0	
	knee amputation. Intextensive assistance	bbility, confusion, and a right below the butation. Interventions included: assistance with transfers, gather and eeded supplies, and provide cueing with needed.			residents weekly for 12 weeks to valic completion of Oral Care and Nail Care Opportunities will be corrected as identified by the DON, SDC and Unit Managers.		
	Resident #82 stated anyone had assisted Observations during	n 03/30/16 at 9:35 AM it had been a while since her with brushing her teeth. the interview revealed			Criteria 4 The DON will report the results of the audits to the QAPI committee monthly 3 months. The committee will make changes or recommendations as		
		have any top teeth and her vered with white matter.			indicated.		
	had returned to her reactivity. Resident #8 her with brushing her	was conducted with 31/16 at 10:49 AM after she com after a group exercise 2 stated no one had assisted t teeth last night or this ns during the interview					

Facility ID: 922999

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/29/2016 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345128	B. WING		_	04/0	; 01/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
BRIAN CE	NTER HEALTH & REHAR	BILITATION/STATESVILLE		520 VALLEY STREET STATESVILLE, NC 2867	77		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	 and her bottom teeth matter. An interview was cond #5 on 03/31/16 at 2:3 was assigned to Resid her up and assisted h NA #5 stated she had teeth this morning bed Observations of Resid at 3:05 PM revealed steeth and her bottom white matter noted. N during this observatio brushed Resident #82 was cod During an interview of Director of Nursing stabrush residents' teeth and evening care. 2. Resident #16 was a 12/10/2014 with diagr of hypertension, anox osteoarthritis. Review of the Quarted (MDS) dated 02/23/16 had moderately impail extensive assistance including personal hypertension of hypertensio	2 did not have any top teeth were covered with white ducted with Nurse Aide (NA) 0 PM. NA #5 confirmed she dent #82 and had washed er out of bed this morning. not brushed Resident #82's cause she was in a rush. dent #82's teeth on 04/01/16 she did not have any top teeth were clean with no IA #6 was interviewed n and stated she had 2's teeth that morning and operative. n 04/01/16 at 3:15 PM the ated she expected NAs to while providing morning admitted to the facility on nosis which included history ic brain damage and cly Minimum Data Set 5 specified Resident #16 red cognition and required with activities of daily (ADL)	F 312				
		vas observed and noted to					

If continuation sheet Page 20 of 33

		MEDICAID SERVICES	(X2) MI II TIP	PLE CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	3	· · ·	MPLETED
						С
		345128	B. WING		0	4/01/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		520 VALLEY STREET		
				STATESVILLE, NC 28677		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE
F 312	Continued From page	e 20	F 31	2		
		ation of white debris covering				
		between all visible teeth.				
		AM Resident #16 was				
		s wheelchair in the lobby and ar appearance of heavy				
		e debris covering the surface				
	of and in between all	visible teeth.				
	On 03/30/16 at 10:10	AM a family interview was				
		e interview Resident #16's				
	family member stated	that Resident #16 was not				
		his teeth and the staff did not				
	frequently.	ney should be brushed				
		AM NA#1 stated she had				
		t #16 and was familiar with 1 stated Resident #16				
		ssistance with bathing,				
		/giene and supervision with				
		erview, NA#1 stated she had				
		e on Resident #16 and she				
		ovide oral care. She stated care was part of daily care of				
	-	nowledge she should have				
	provided oral care.					
	An interview was con	ducted on 04/01/16 at 9:42				
		stated oral care should be				
		g before breakfast and in the				
		stated, she did not provide was her understanding oral				
		/ third shift staff before				
	breakfast and she did					
	Resident #16 oral car	re.				
	Interview conducted	on 04/01/16 at 11:30 AM with				
		ng (DON). She stated her				
		all residents receive oral				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345128	B. WING				。 01/2016
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER HEALTH & REHAI	BILITATION/STATESVILLE			520 VALLEY STREET STATESVILLE, NC 28677		
(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 312	the Administrator and was for staff to provid needed. 3. Resident #68 was in 03/02/16 with diagnoss partial amputation of fir recent minimum data indicated that he was required extensive as member for personal care was identified. Observation of Reside AM revealed all 10 fm ¼ inch long and had b them. Observation of Reside AM revealed all 10 fm ¼ inch long and had b them. Observation of Reside AM revealed all 10 fm ¼ inch long and had b them. Observation of Reside 10:43 AM revealed al approximately ¼ inch substance under them Interview with Reside AM revealed that he of but since he had beer to do so. Resident #6 never asked the staff	puently as needed. on 04/01/16 at 11:38 AM with she stated her expectation e oral care daily and as readmitted to the facility on ses diabetes mellitus and foot. Resident #68 most set (MDS) dated 02/06/16 cognitively intact and sistance of one staff hygiene. No rejection of ent #68 on 03/30/16 at 8:56 agernails were approximately prown substance under ent #68 on 03/31/16 at 8:36 agernails were approximately prown substance under ent #68 on 04/01/16 at 1 10 fingernails were long and had brown	F	312			
	than what he liked.						

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TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DAT	10. 0938-039 TE SURVEY MPLETED	
		345128	B. WING		04	C 4/01/2016	
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE	520	REET ADDRESS, CITY, STATE, ZIP CODE 0 VALLEY STREET TATESVILLE, NC 28677	•		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312 F 356 SS=C	Interview with Nursing 04/01/16 at 3:15 PM talking care of Reside aware his nails neede she had been "runnin had not had time to d that she had not repon nails needed to be tri Interview with Directo 04/01/16 at 3:34 PM should be done anytin dirty but should routin resident shower or ba that if the resident wa should let the nurse k them. The DON state to perform nail care d anytime they need it a then they should be of 483.30(e) POSTED N INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number and by the following catego unlicensed nursing st resident care per shiff - Registered nurs - Licensed practic	g Assistant (NA) #4 on revealed that she was ent #68 and that she was ed to be trimmed but stated ig around like a chicken" and o it. NA #4 further stated rted to the nurse that his mmed. or of Nursing (DON) on revealed that nail care me that the nails are long or hely be done during the ath. The DON further stated is a diabetic then the NA show and they would trim ad that she expected all NA's furing shower or bath or and if the nails were dirty cleaned and filed. NURSE STAFFING the following information on aff directly responsible for t: es. cal nurses or licensed a defined under State law).	F 312			4/29/16	

Facility ID: 922999

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/29/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 04/01/2016
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		20 VALLEY STREET	
			S	STATESVILLE, NC 28677	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 356	Continued From page	22	F 250		
F 350			F 356		
		daily basis at the beginning just be posted as follows:			
	o Clear and readable	•			
		e readily accessible to			
	residents and visitors	•			
	The feeility much use				
		n oral or written request, lata available to the public			
		ot to exceed the community			
	standard.				
	staffing data for a mir	ntain the posted daily nurse nimum of 18 months, or as r, whichever is greater.			
	This REQUIREMENT	is not met as evidenced			
	-	ns, record reviews and staff		F356	
		failed to accurately post the		Criteria 1	
	daily staffing sheet fo	5		The Staffing Posting was corrected by	' the
		conducted on 03/29/16,		Director of Nursing on 4-2-16.	
	03/30/16, 03/31/16, a	ind 04/01/16.		Criteria 2	
	The findings included	:		All residents have the potential to be effected by this alleged deficient pract Criteria 3	ice.
	Observation made or	n initial tour of facility on		On 4/20/2016 The DON, re-educated	the
		revealed the daily staffing		Scheduler on the requirements for	
		the entrance of facility and		Regulation F356 regarding the daily	
		ne census of the facility, and		staffing posting requirements and the	
		ed for all 3 shifts. The daily		maintenance and filing of these record	ls.
		shift indicated that they had		The Scheduler will be responsible for	
		RN), 4 license practical		ensuring the staffing positing daily. Th	
		sing assistants (NA), and 2		DON, SDC or Unit Managers will mo	
		A). For second shift the daily		the posting daily for 7 days, then 3 tin a week for 3 weeks, then weekly for 8	
	-	ed that they had 2 RN's, 5 2 MA's. The daily staffing		weeks to ensure the posting is timely	
		dicated that they had 0 RN,		accurate. Opportunities will be correct	
	4 LPN's, 13 NA's, and	-		as identified by the DON.	

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		MEDICAID SERVICES				IO. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, í		· · ·	(X3) DATE SURVEY COMPLETED	
		B. WING			4/01/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE	
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE				520 VALLEY STREET STATESVILLE, NC 28677		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 356	Continued From page	e 24	F 35	6		
1 000	Continued From page	5 27	1 33	Criteria 4		
	Review of the daily a	ssignment sheet dated		The results of these audits	will be	
	-	at for first shift they had 1		reported by the DON to the		
	RN, 4 LPN's, 9 NA's,	-		committee monthly for 3 m		
	-	second shift indicated that		committee will recommend	further action	
	The daily assignment	PN's, 9 NA's, and 2 MA's.		as needed.		
		ad 0 RN, 4 LPN's, 5 NA's,				
	and 0 MA.	,,				
	Observation made of	the daily staffing sheet on				
		which was posted at the				
		y and contained the date and				
		for all 3 shift. No census was				
	•	For first shift the daily				
		ed that they had 4 RN's, 5 2 MA's. The daily staffing				
		t indicated that they had 0				
		's, and 1 MA. The daily				
		d shift indicated that they had				
	0 RN, 3 LPN's, 10 NA	A's, and 0 MA.				
	Review of the daily a	ssignment sheet dated				
		at for first shift they had 1				
		s, and 2 MA's. The daily				
		second shift indicated that				
	· · ·	N's, 10 NA's, and 1 MA. The et for third shift indicated				
		3 LPN's, 9 NA's, and 0 MA.				
	Observation made of	the daily staffing sheet on				
		which was posted at the				
		y contained the date and				
	actual hours worked	for all 3 shifts. Census was				
	130. For first shift the					
	-	ad 4 RN's, 4 LPN's, 11 NA's,				
	-	y staffing sheet for second ey had 0 RN, 4 LPN's, 10				
		daily staffing sheet for third				

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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 NAME OF PROVIDER OR SUPPLIER 345128 B. WING 04/01/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677 520 VALLEY STREET STATESVILLE, NC 28677 520 VALLEY STREET STATESVILLE, NC 28677		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
345128 B. WING	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE STREET ADDRESS, CITY, STATE, ZIP CODE (Z0) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (2000) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORREC	345128			B. WING			-		
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE STATESVILLE, NC 28677 (K4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 25 shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA. F 356 F 356 Review of the daily assignment sheet dated 03/31/16 indicated that for first shift they had 1 RN, 3 LPN's, 11 NA's, and 2 MA's. The daily assignment sheet for third shift indicated that they had 0 RN, 4 LPN's, 11 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA. Observation made of the daily staff sheet on 04/01/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 10 NA's, and 3 MA's. The daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily	NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
PREEX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREEX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETM DATE F 356 Continued From page 25 shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA. F 356 F 356 Review of the daily assignment sheet dated 03/31/16 indicated that for first shift they had 1 RN, 3 LPN's, 11 NA's, and 2 MA's. The daily assignment sheet for second shift indicated that they had 0 RN, 4 LPN's, 11 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA. Observation made of the daily staff sheet on 04/01/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 3 MA's. The daily staffing sheet for second shift indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 2	BRIAN CE	ENTER HEALTH & REHA	BILITATION/STATESVILLE						
 shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA. Review of the daily assignment sheet dated 03/31/16 indicated that for first shift they had 1 RN, 3 LPN's, 11 NA's, and 2 MA's. The daily assignment sheet for second shift indicated that they had 0 RN, 4 LPN's, 11 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA. Observation made of the daily staff sheet on 04/01/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR				3E	COMPLETION		
Review of the daily assignment sheet dated 04/01/16 indicated that for first shift they had 1 RN, 4 LPN's, 10 NA's, and 1 MA. The daily assignment sheet for second shift indicated that they had 1 RN, 3 LPN's, 9 NA's, and 1 MA. The daily assignment sheet indicated that they had 0 RN, 3 LPN's, 5 NA's, and 0 MA. Interview with MA #1 on 04/01/16 at 12:14 PM revealed that she had worked at the facility for 11 years and was responsible for completing the daily staffing sheets up until last Thursday when she was relieved of her duties by the Director of Nursing (DON). MA #1 indicated that she would complete the daily staffing sheets daily by 11:00 AM and would go by the daily assignment sheet	F 356	shift indicated that the NA's, and 0 MA. Review of the daily as 03/31/16 indicated the RN, 3 LPN's, 11 NA's assignment sheet for they had 0 RN, 4 LPN daily assignment sheet that they had 0 RN, 3 Observation made of 04/01/16 at 8:00 AM entrance of the facility actual hours worked for was present on the sl staffing sheet indicated LPN's, 10 NA's, and 3 sheet for second shiff RN's, 5 LPN's, 10 NA's taffing sheet for the daily assignment sheet for they had 1 RN, 3 LPN's, 10 NA's assignment sheet for they had 1 RN, 3 LPN's, 5 NA's, Interview with MA #1 revealed that she had years and was respond daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON). MA # complete the daily staffing sheets u she was relieved of h Nursing (DON).	ey had 0 RN, 3 LPN's, 6 ssignment sheet dated at for first shift they had 1 s, and 2 MA's. The daily second shift indicated that N's, 11 NA's, and 1 MA. The et for third shift indicated B LPN's, 6 NA's, and 0 MA. The daily staff sheet on which was posted at the y contained the date and for all 3 shifts. No census heet. For first shift the daily ed that they had 4 RN's, 5 3 MA's. The daily staffing t indicated that they had 2 N's, and 1 MA. The daily d shift indicated that they had s, and 0 MA. ssignment sheet dated at for first shift they had 1 s, and 1 MA. The daily second shift indicated that N's, 9 NA's, and 1 MA. The et indicated that they had 0 and 0 MA. on 04/01/16 at 12:14 PM d worked at the facility for 11 nsible for completing the up until last Thursday when er duties by the Director of et indicated that she would affing sheets daily by 11:00	F 3	356				

Facility ID: 922999

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY
				С		
		345128	B. WING			4/01/2016
AME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DE	
RIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		VALLEY STREET ATESVILLE, NC 28677		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 356 F 431 SS=D	MA #1 also indicated and NA's that were di the Minimum Data Se included in the number sheets. MA #1 further instructed to update to census or staffing cha she would fill them out for the weekend staff Interview with the DC confirmed that she had duties of the complete and was in the proces was not sure who wo staffing sheets going that she had complete the survey and was a incorrect because she staff was included on The DON further state that the daily staffing reflection of the direct in the facility through 483.60(b), (d), (e) DF LABEL/STORE DRU	s on the daily staffing sheet. that she only put the nurses irect care staff, the DON or et (MDS) nurse were not ers on the daily staffing r stated that she was never he daily staffing sheet as anged and on the weekend ut on Friday and leave them to hang up. N on 04/01/16 at 4:31 PM ad relieved MA #1 of her ing the daily staffing sheets ss of realigning staff and uld be completing the daily forward. The DON stated ed them this week during ware that the numbers were e was misinformed of which the daily staffing sheets. ed that the expectation was sheets would be accurate t care staff that was present but the 24 hour period. RUG RECORDS,	F 356			4/29/16
	of records of receipt a controlled drugs in su accurate reconciliatio records are in order a	t who establishes a system and disposition of all ifficient detail to enable an n; and determines that drug and that an account of all aintained and periodically				

Facility ID: 922999

If continuation sheet Page 27 of 33

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/29/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345128			B. WING		C 04/01/2016
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.00
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		520 VALLEY STREET	
				STATESVILLE, NC 28677	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 431	Continued From page	e 27	F 43	1	
	labeled in accordanc	e with currently accepted			
	professional principle				
	appropriate accessor	y and cautionary expiration date when			
	applicable.				
		tate and Federal laws, the drugs and biologicals in			
		s under proper temperature			
		only authorized personnel to			
	have access to the k	eys.			
	The facility must prov	vide separately locked,			
	permanently affixed of	compartments for storage of			
		d in Schedule II of the			
		Abuse Prevention and and other drugs subject to			
		the facility uses single unit			
	package drug distribu	ution systems in which the			
		nimal and a missing dose can			
	be readily detected.				
	This REQUIREMENT	Γ is not met as evidenced			
		ons and staff interviews the		Criteria 1	
	facility failed to remove	ve expired medications from		The Director of Nursing discarded a	all
		ts and failed to remove		identified expired drugs on 4-2-16.	
	expired medication fr	om 1 of 1 central supply		Criteria 2 All residents have the potential to b	e
				affected by this alleged deficient pra	
	The findings included	l:		An audit of all medication storage ro	ooms,
	A review of the facility	y's policy "Storage and		refrigerators and medication carts w conducted and completed by 4-29-	
		tions, Biologicals, Syringes,		the DON, SDC and Unit Managers.	
		12/01/07 read in part that the		expired and unlabeled items were	
		y or return all discontinued,		discarded immediately.	
	outdated/expired, or	deteriorated medications or		Criteria 3	

Event ID: SMY711

Facility ID: 922999

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128		. ,	LE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		A. BUILDING		C			
		B. WING	04/01	/2016			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE				520 VALLEY STREET STATESVILLE, NC 28677			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 431	Continued From page	e 28	F 43	1			
	biologicals in accorda return/destruction gui	ance with Pharmacy		The DON re-educated the Cen Clerk and Licensed Nurses reg storage and labeling of medica	arding		
		ne 200 hall Medication cart 1 PM revealed a bottle of		education was completed by 4 On-going the 3rd shift Nurses	-29-16.		
	Levemir insulin that of when it had been ope	contained no date indicating ened.		responsible for the nightly audi medication carts for expired me	eds, Unit		
		e 100 hall Medication cart 1 PM revealed a bottle of		Managers will audit the carts w the pharmacy consultant will a monthly. The DON, SDC, or a	udit them		
		ned an expiration date of		Manager will audit all medication rooms and refrigerators weekl	on storage y to verify		
		Courtyard Medication cart 1 AM revealed a bottle of		medication storage per policy of on-going basis. Opportunities v	vill be		
	Humalog insulin that			corrected as identified. The Ce Supply Clerk has completed ar sheet that includes expiration of	n inventory		
	d. Observation of the	central supply closet on		over-the-counter meds in her s room. She will check this inven	itory		
		revealed 2 bottles of iron In expiration date of 03/16		monthly to discard expired med	ds timely.		
		f magnesia that contained		Criteria 4 Results of audits and inventorio			
	the 200 hall Medication	#1 that was responsible for on cart 1 on 03/30/16 at 2:00		presented to the QAPI commit for 3 months by the DON. The will make changes or recomme	committee		
	the Levemir was ope knowing if the medica	she was not aware of when ned and she had no way of ation was expired or not. would discard the insulin and		as indicated.			
	reorder from the pha						
	Courtyard Medication AM confirmed that He	#2 that was responsible for cart 1 on 04/01/16 at 11:30 umalog was good for 28					
		ned and that it had indeed and should have been					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/29/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED		
		345128	B. WING				C / 01/2016
NAME OF P	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE					
				S	TATESVILLE, NC 28677		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431 F 520 SS=E	at 2:52 PM revealed to a week and when she medications she rotate back of the shelf and used first to the front supply clerk stated the on the milk of magnet sure how she missed Interview with the Dir 04/01/16 at 3:39 PM nurses were response medication carts nighted medications. She also medication for expirate administering the met that the pharmacy state on 03/29/16 and had medications and rem- nurses were expected carts for expired med the pharmacy per the 483.75(o)(1) QAA COMMITTEE-MEMB QUARTERLY/PLANSE A facility must maintate assurance committee nursing services; a pl facility; and at least 3 facility's staff. The quality assessmet committee meets at least 3	htral supply clerk on 04/01/16 that she received stock twice a put up the new stock of ted the new stock to the pulled what needed to be of the shelf. The central at she had checked the date sia yesterday and was not it. ector of Nursing (DON) on revealed that the third shift ible for checking the tly looking for expired o stated that each nurse or d be expected to check each tion date prior to dication. The DON reported aff had been to the building found some expired oved them. The DON stated d to inspect the medication ication and return them to e facility policy. ERS/MEET an a quality assessment and e consisting of the director of hysician designated by the other members of the		431			4/29/16

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/29/2016 MAPPROVED D. 0938-0391	
-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345128	B. WING				01/2016	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
BRIAN CE	ENTER HEALTH & REHAI	BILITATION/STATESVILLE			20 VALLEY STREET TATESVILLE, NC 28677			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 520	develops and implem action to correct ident A State or the Secret disclosure of the reco except insofar as suc compliance of such correquirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on observatio interviews the facility' Assurance Committee implemented procedu interventions the com 2015. This was for tw were originally cited in recertification survey. were in the area of re continued failure of the surveys of record sho inability to sustain an Program. The findings included The tags were cross of F 272: Comprehensive observations, record	 ies are necessary; and ents appropriate plans of tified quality deficiencies. ary may not require ords of such committee h disclosure is related to the committee with the section. by the committee to identify ficiencies will not be used as is not met as evidenced ns, record reviews, and staff s Quality Assessment and e failed to maintain ures and monitor the mittee put into place in July vo recited deficiencies that n June 2015 and April 2016 on the current The repeated deficiencies sident assessment. The he facility during two federal ow a pattern of the facility's effective Quality Assurance 	F	520	Criteria 1 Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 4-25-16 to discuss the outcomes of the annual survey and rep citations of F272 related to Resident C Area Assessments and F278 related to accurate coding of the MDS. The Interdisciplinary Department Head Tea reviewed the previous plans of correct related to accurate CAA and coding for the MDS. Criteria 2 Residents requiring a Comprehensive MDS Assessment are at risk for being affected by this alleged deficient practi Criteria 3 The RCMD will review all comprehensive assessments completed during the 30 days prior to 4/4/16 for complete Care	oeat are o m ion r ce.		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/29/2016 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	CONSTRUCTION	(X3) DATE SURVE COMPLETED			
	345128		B. WING _			04	C 4/01/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			0 VALLEY STREET TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Care Area Assessme underlying causes, co factors for 3 of 5 resid and #145) reviewed for The facility was recite complete CAAs that a causes, contributing for residents reviewed for F 272 was originally of recertification survey Area Assessments the causes, contributing for when completing con- assessments 2 reside ADL Functional/Reha Psychosocial Well-Be Falls, Nutritional State F 278: Accuracy of Ar- review and staff inter- accurately code the M- sampled residents (R #73, #86, and #157). The facility was recite accurately code the M- sampled residents (R #73, #86, and #157). The facility was recite accurately code the M- preadmission Screer (PASRR), Oral/Denta Diagnoses. F 278 wa June 2015 recertifica the Minimum Data Se Hospice care and Be During an interview of Administrator stated a been monitored or dia- monthly Quality Assu came to work at the f November 2016. The	nt (CAA) that addressed the portributing factors, and risk dents (Residents #13, #72 for psychotropic medication. ed for F 272 for failing to addressed the underlying factors, and risk factors for 3 or psychotropic medications. cited during the June 2015 for failing to complete Care at addressed the underlying factors, and risk factors nprehensive MDS ents in the following areas: abilitation Potential, eing, Behavioral Symptoms, us, and Pressure Ulcer. ssessment. Based on record views, the facility failed to Alinimum Data Set for 7 of 17 tesidents #1, #13, #24 #72, ed for F 278 for failing to Alinimum Data Set for ning and Resident Review al Status, and Active as originally cited during the tion survey for failing to code et accurately to reflect haviors. on 04/01/16 at 6:42 PM the accuracy of MDS had not scussed in the facility's rance meeting since she	F	520	Area Assessments. Opportunities for correction were identified and correcti was begun by the RCMD by 4-29-16. The Interdisciplinary Department Hea Team were re-educated by the Directo Nursing and the Administrator regardi the regulatory requirement for F272 Resident Care Area Assessment and F278 accurate MDS coding. This education was completed by 4-29-16. The Administrator will hold a weekly A Hoc QAPI committee meeting for the 4 weeks to review F272 Resident Car Area Assessment and F278 accurate MDS coding to ensure compliance wit these regulations. Opportunities will b corrected as identified. Criteria 4 Measures to ensure that corrections achieved & sustained include: The res of these weekly meetings will be submitted to the QAPI Committee by Administrator for review by IDT memb at the next 6 meetings. The QAPI committee will evaluate the effectiven and amend as needed.	on ad or of ng ad next re th e are sults the bers	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
345128			B. WING			C 04/01/2016		
NAME OF PI	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			0 VALLEY STREET TATESVILLE, NC 28677			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 520	Continued From page weekly conference ca Coordinators the last review of MDS asses	Ils with the MDS month which included a	F	520				

Event ID: SMY711

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