

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345323</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CTR HLTH &amp; REHABILITATIO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>647 S RAILROAD STREET BOX 966</b> <b>WALLACE, NC 28466</b>		
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F 159 SS=D	<p>483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>(f)(10)(i) ...If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.</p> <p>(f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$100 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund.</p> <p>(f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and</p>	F 159		2/22/17	

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

TITLE

(X6) DATE

Electronically Signed

02/20/2017

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 159	<p>Continued From page 1</p> <p>separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>(C)The individual financial record must be available to the resident through quarterly statements and upon request.</p> <p>(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-</p> <p>(A) When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and</p> <p>(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to have (1)of (1) sampled resident access her personal funds on ongoing basis and arrange for access to larger funds.(Resident # 1)</p> <p>The resident was admitted to the facility on 3/31/2014 with the diagnoses of Dementia without behavioral, Perefheral Vascular Disease(PVD), Gout, Dementia in other Disease, Muscle wasting and atrophy, Lack of coordination, Pneumonia, Urinary Tract</p>	F 159	<p>Resident # 1- Facility administrator spoke with patient's daughter, Janice Hall, on 2/15/17 and scheduled a meeting with her for 2/22/17 at facility to issue reimbursement check.</p> <p>Facility administrator or designee will complete audit of current residents identified with resident trust funds last sixty days. The audit will ensure resident has access to their personal funds and arranged for access to larger funds by</p>		

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F 159	<p>Continued From page 2</p> <p>Infection(UTI), Hypertension and Cataract. Review of the Minimum Data Set (MDS) dated 12/1/2016 indicated the resident's cognitively was severely impaired.</p> <p>Review of the "Resident's Statement Landscape" report revealed the facility received the resident's liability money for the amount of \$ 368 per month for December 2016 and January 2017. The statement also revealed the facility deducted \$180 from the resident's personal funds account to pay for the resident's care cost at the facility.</p> <p>Interview with the Business Manager on 2/7/2017 at 11:00 AM, revealed the resident liability money paid to the facility when the resident was first admitted on 3/31/2014 was \$408 per month and then it was reduced to \$368 per month on September 2015. She further reported resident's personal funds was used to pay the care cost at the facility. The Business manager also admitted she should not have used the resident's personal funds to pay the resident's care cost. She added she was going to reimburse the resident's estate the money that the facility had used to pay the care cost.</p> <p>Interview with the Administrator on 2/7/2017 at 10:52 AM, revealed he was not aware that Resident # 1 did not have access to her personal funds in December 2017 and January 2017. He stated his expectation was for the residents at the facility to have access to their personal funds and the money was not to be used for paying the resident's care cost at the facility. The Administrator also added the facility was going to reimburse the resident the money that was used to pay the care cost.</p>	F 159	<p>2/15/17 and completed on 2/15/17</p> <p>Facility administrator will provide re-education with Business office manager on 2/8/17 regarding accessing ongoing trust to resident trust funds and arranged for access to large funds.</p> <p>The facility administrator will review two residents identified with resident trust funds, weekly times four and monthly times two.</p> <p>The facility administrator will report finding of the audits to QAPI committee weekly times four, monthly times two. The committee will review the results of the audits for negative patterns and trends to determine if additional interventions are necessary to maintain substantial compliance.</p>		

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F 356 F 356 SS=C	Continued From page 3 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION  483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis:  (i) Facility name.  (ii) The current date.  (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:  (A) Registered nurses.  (B) Licensed practical nurses or licensed vocational nurses (as defined under State law)  (C) Certified nurse aides.  (iv) Resident census.  (2) Posting requirements.  (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.  (ii) Data must be posted as follows:  (A) Clear and readable format.  (B) In a prominent place readily accessible to residents and visitors.	F 356 F 356		2/11/17	

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F 356	Continued From page 4  (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post accurate nurse staffing information for 1 of 3 days reviewed (02/05/17).  The Findings Included:  Accompanied by the facility's Director of Nursing (DON), an observation made on 02/05/17 at 4:05 p.m. revealed a daily nursing staff posting dated 01/30/17 posted in the administrative hallway.  During an interview with the DON on 02/05/17 at 4:05 p.m., the DON stated the posting was not accurate because the nurse who was assigned to complete the task had gone on vacation and no one had updated it during her absence.  During an interview with the Administrator on 02/07/17 at 5:15 p.m., the Administrator stated the daily nursing staff information had been being checked daily as part of their ongoing Plan of Correction which had been put into place after their November 2016 recertification and complaint investigation survey. The Administrator stated he could not provide documentation of this daily check. The Administrator stated due to	F 356	The facility Daily Nursing Staff Posting sheet was revised and posted by Director of Nursing on 2/5/17. The Director of Nursing or designee will print the next day Daily Staffing sheets (Monday <input type="checkbox"/> Friday) prior to leaving the facility and place behind current staffing sheets. The Director of Nursing or designee will print Daily Staffing sheets for Saturday and Sunday prior to leaving the facility and place in file folder in DON door. The facility licensed nursing staff will be re- educated on the process of changing out the daily staffing sheets and making any adjustments on 2/8/17 and completed by 2/16/17. The departments managers will be re- educated regarding the validation of the daily staffing sheet are posted on Saturday and Sunday on 2/8/17 and completed by 2/11/17. The facility Director of Nursing will validate Monday <input type="checkbox"/> Friday that Daily Staffing sheet is posted and adequately reflects the staffing hours for thirty days.		

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F 356	Continued From page 5 limited access to the part of their computer system that contained the nursing staffing information, the posting had not been updated since the designee had gone on vacation. The Administrator stated it was his expectation the nursing staffing information be posted daily.	F 356	The results of the validation of Daily Staffing sheets will be reviewed weekly times four weeks, bi- monthly times one and monthly times three. The committee will monitor for negative patterns and trends to determine if additional interventions are necessary to maintain substantial compliance.		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);  (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of	F 441		2/24/17	

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F 441	<p>Continued From page 6</p> <p>communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff</p>	F 441	The facility nursing assistant caring for		

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F 441	<p>Continued From page 7</p> <p>interviews, the facility staff failed to handle linens and an adult brief soiled with urine in a sanitary manner by placing the items on the floor of a semi-private resident room and failed to do hand hygiene after providing incontinence care to 1 of 7 residents observed to receive care (Resident #5).</p> <p>The findings included:</p> <p>A review of the facility's Hand Hygiene policy, taken from the Infection Prevention Manual for Long Term Care 2012, indicated hand washing and hand hygiene was considered the most important single procedure for preventing healthcare associated infections. The policy, in part, indicated staff should wash their hands before performing a procedure and after providing care to a resident.</p> <p>A review of the facility's Soiled Linen Collection &amp; Transfer policy, taken from the Department Operations manual released/revise March 2009, indicated soiled linen was to be placed in containers labeled "Soiled Linen" and staff are to wash their hands immediately after handling soiled laundry and removing gloves.</p> <p>During an observation on 02/05/17 at 6:10 p.m., Nursing Assistant (NA) #1 was observed to provide incontinent care to Resident #5. NA #1 placed a urine soiled adult brief and a urine soiled pad on the floor near the foot of the resident's bed. NA #1 then slid these two urine soiled items away from the bed to the middle of the room near the divider curtain. NA #1 removed a urine soiled fitted bed sheet from the resident's bed and placed it on the floor in front of the resident's nightstand. NA #1 then wiped Resident #5's perineal area with a wet wipe and placed the</p>	F 441	<p>Resident # 5 on 2/5/17 was provided re-education regarding handling of linen, hand hygiene and soiled adult briefs by ADON.</p> <p>The facility nursing assistant providing care for Resident # 5 was observed providing care for 3 sampled residents on 2/9/17 by ADON and demonstrated proper steps of handling of linen, hand hygiene and soiled items.</p> <p>The facility Director of Nursing and/or Assisted Director of Nursing will provide re- education to facility staff regarding infection control to include handling of linen, hand hygiene and soiled items on 2/9/17 and completed 2/17/17. Newly hired staff will be provided education on infection control during orientation.</p> <p>The facility Director of Nursing and/or Assisted Director of Nursing will complete 2 care observations of staff handling linen, hand washing and disposing of soiled items weekly times four, bi- monthly times two and monthly times two.</p> <p>The results of the care observations will be reviewed weekly times four weeks, bi-monthly times one and monthly times three. The committee will monitor for negative patterns and trends to determine if additional interventions are necessary to maintain substantial compliance.</p>		

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F 441	<p>Continued From page 8</p> <p>soiled wipe on top of the sheet on the floor. NA #1 took the trash bag out of the trash can near the sink and gathered the soiled linen and soiled wipe from the floor. Without removing her soiled gloves, NA #1 replaced the lid on the tub of barrier cream and placed the tub of cream in a drawer. NA #1 placed the palm of her gloved hand on top of the resident's over bed table and pushed the table closer to the resident. NA #1 opened the door to the resident's room, stopped in the threshold and removed her gloves and placed the gloves in the trash bag she was holding. NA #1 walked out of the resident's room and entered the beauty shop located near the nurses' station and disposed of the trash bag in one of three 3-bin soiled linen/trash containers being stored in the beauty shop. NA #1 exited the beauty shop, held up her hands and stated "now I have to wash my hands" and opened a door to another room by the nurses' station.</p> <p>During an interview with NA #1 on 02/05/17 at 6:50 p.m. NA #1 stated she knew she should wash her hands in between resident care and before and after wearing gloves. When asked why she did not wash her hands after providing incontinent care, NA #1 stated she had been in a rush. When asked why she threw the soiled items on the floor, NA #1 asked if she was in trouble.</p> <p>During an interview with the Director of Nursing (DON) on 02/07/17 at 2:03 p.m., the DON stated it was her expectation the nursing staff follow the hand hygiene policy. The DON stated it was her expectation the nursing staff appropriately bag soiled linen and carry it out of a room in a manner to prevent the transmission of infection.</p>	F 441			

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F 520 SS=D	<p>During an interview with the Administrator on 02/05/17 at 4:15 p.m., the Administrator stated it was his expectation facility staff wash their hands and handle soiled linen according to policy.</p> <p>483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as</p>	F 520		2/17/17	

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F 520	<p>Continued From page 10</p> <p>such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in November 2016. This was for 3 deficiencies which were originally cited in November 2016 on a recertification and complaint investigation survey and were cited again on the current complaint investigation survey. The deficiencies were in the areas of infection control, posted nursing staffing information and QAA. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program.</p> <p>The findings included:</p> <p>This tag is cross referenced to:</p> <ol style="list-style-type: none"> <li>1) F 356 Based on observation and staff interviews, the facility failed to post accurate nurse staffing information for 1 of 1 days reviewed (02/05/17).</li> <li>2) F 441 Based on observation, record review and staff interviews, the facility staff failed to handle linens and an adult brief soiled with urine in a sanitary manner by placing the items on the floor of a semi-private resident room and failed to</li> </ol>	F 520	<p>The QAPI committee met on 2/7/17 to discuss potential complaint survey results to include discussion of repeat citation related to F441 and F356. The committee met on 2/13/17 and discussed final results of the complaint on 2/7/17.</p> <p>The District Director of Clinical Service provided re- education to the facility Administrator and Director of Nursing regarding maintaining consistent Quality Assurance and Performance Improvement process , to include following plan of correction for past survey citation of F441 and F356 on 2/7/17.</p> <p>The District Director of Clinical Services and/or District Director of Operations will attend and/or by phone, the facilities QAPI committee meeting weekly times four, bi-monthly times one, monthly times two.</p> <p>The facility administrator will report finding of the audits of F441 and F356 to QAPI committee weekly times four, monthly times two. The committee will review the results of the audits for negative patterns and trends to determine if additional interventions are necessary to maintain substantial compliance.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345323</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CTR HLTH &amp; REHABILITATIO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>647 S RAILROAD STREET BOX 966</b> <b>WALLACE, NC 28466</b>		
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F 520	<p>Continued From page 11</p> <p>do hand hygiene after providing incontinence care to 1 of 7 residents observed to receive care (Resident #5).</p> <p>During an interview with the Administrator on 02/07/17 at 5:15 p.m., the Administrator stated the facility QAA committee consisted of the department heads, the medical director and the consultant pharmacist. The Administrator stated the QAA committee met monthly and had met after the November 2016 recertification and complaint investigation survey and a Plan of Correction (POC) had been put into place for the nursing staffing posting; the area of infection control had been in another area. The Administrator stated limited access to the part of their computer system which contained the nursing staffing information was causing them to re-evaluate their process.</p>	F 520			