STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A follow up and compliant investigation was conducted on 4/9-11/2017. F241 was recited. The facility remains out of compliance.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review, the facility failed to maintain a resident's dignity when a pancake style call light (a flat call light pad used for those with limited upper extremity/hand function) was not placed within a resident's reach to allow the resident to request staff assistance if needed. Resident #10 was reviewed for dignity and respect for 1 of 10 sampled residents. The findings included: Resident #10 was admitted to the facility on 03/22/17 from an acute hospital. The resident's diagnoses included neurogenic bladder (flaccid or spastic bladder dysfunction), quadriplegia, need for assistance with personal care, generalized muscle weakness and Type II Diabetes Mellitus. A review of Resident #10's Admission Minimum Data Set (MDS) dated 03/29/17 revealed the resident was cognitively intact. He required extensive assistance from two or more staff	F 241	Brian Center Health and Rehabilitation/Salisbury acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on April 9-11, 2017. Brian Center Health and Rehabilitation/Salisbury's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, the Brian Center Health and Rehabilitation/Salisbury reserves the right	5/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 members for bed mobility, transferring, dressing, toileting, personal hygiene and showers. He required extensive assistance from one staff member for eating. Resident had impairment to both sides of his upper and lower extremities due to diagnosis of quadriplegia. A review of Resident #10's care plan, initiated 03/30/17, revealed resident was dependent on staff for all activities of daily living (ADL). Included in the care plan was resident's risk related to falls and staff were to "be sure the resident's call light was within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." During an observation and interview with Resident #10 on 04/10/17 at 10:25 AM, resident was noted to answer questions and able to communicate well. During the interview, it was observed resident's call light had not been placed within his reach. The call light was attached to resident's sheet (covering his mattress) on the right side of his bed. Resident #10 had total paralysis of his right arm and hand and had very little use of his left arm and hand. Resident #10 stated he was paralyzed on his right and left sides, but could activate his call light with his left hand, if the call light was placed on his chest. Resident demonstrated how he could activate the call light if placed on his chest. During an interview with nurse #2 on 04/11/17 at 08:20 AM, she stated she would at times leave resident's room door open so he could be more closely monitored. Nurse #2 stated she and the nursing assistants (NAs) on her shift (3rd shift) would "have his call bell on his chest and if he can't reach his call bell, he will yell out".	F 241	to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F241 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #10 call bell placed within reach on the appropriate side of the bed. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: 100% audit of call bell placement, including those residents with special needs. Staff were educated by DON or designee in regards to observing residents for call bell placement and ensuring the call bell is within reach, taking into account resident's special needs. Measures put in place or systemic changes made to ensure that the deficient practice will not occur: Weekly audits will be conducted for eight weeks, by DON or designee, of four residents per unit to ensure appropriate access to call bell. If any adverse outcomes are identified via the weekly audit, immediate action will be taken, to include reporting incident via 24 hour	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 An observation was made of Resident #10 on 04/11/17 at 8:39 AM. Resident #10 was lying on his back in bed with the head of his bed elevated approximately 40 degrees. His pancake style call bell was attached to the sheet (covering the mattress) on the right side of his bed at elbow level. Resident stated he was unable to reach his call light. After observing the location of the resident's call light, surveyor left the room at 8:42 AM to locate and inform Resident #10's NA. Resident's NA on the 200 Hall could not be located at the time of the observation. The NA for the other end of resident's Hall (NA #10) was located at that time and shown the placement of resident's call light. Nurse #2 entered the resident's room shortly thereafter and was also made aware of the location of the resident's call light. Nurse #2 relocated resident's call light so it was within resident's reach. An interview was conducted with Resident #10 on 04/11/17 at 09:03 AM. Resident #10 stated it made him feel unsafe and scared when he was unable to reach his call light to request assistance. He stated, if he saw someone he knew coming down the hall, he would holler for them and they may come in his room and tell him they would go get someone or they may see his call light and just walk by his room. He stated he may have had a bowel movement and had to sit in it a long time or he could be having a heart attack, or could be choking or something. An interview was conducted with NA #11 (Resident #10's NA) on 04/11/17 at 10:25 AM. NA #11 stated she worked as needed (PRN) and was not aware Resident #10 was paralyzed and no one had told her.	F 241	report. Residents with special requirements for Call Bells, ie: type of call bell or specific side for placement will be added to Care Plan and C.N.A. Care Cards to ensure appropriate placement. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 An interview was conducted on 04/11/17 at 3:42 PM with the facility's Director of Nursing (DON) in regards to Resident #10's call light not being placed within resident's reach. The DON indicated her expectations were for staff to place resident call bells within resident's reach and stated call bells were to be answered within a reasonable amount of time. The DON stated any staff member going down the hall was to check on a resident to see what they needed.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review, the facility failed to place a pancake style call light (a flat call light pad used for those with limited upper extremity/hand function) within reach of a resident to allow a resident to request staff assistance if needed. This was evident in 1 (Resident #10) of 10 residents reviewed for accommodation of needs. The findings included: Resident #10 was admitted to the facility on 03/22/17 from an acute hospital. The resident's	F 246	F246 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #10 call bell placed within reach on the appropriate side of the bed. Corrective action accomplished for those residents having the potential to be affected by the deficient practice:	5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 4 diagnoses included neurogenic bladder (flaccid or spastic bladder dysfunction), quadriplegia and generalized muscle weakness. A review of Resident #10's Admission Minimum Data Set (MDS) dated 03/29/17 revealed the resident was cognitively intact. He required extensive assistance from two or more staff members for bed mobility, transferring, dressing, toileting, personal hygiene and showers. He required extensive assistance from one staff member for eating. Resident had impairment to both sides of his upper and lower extremities due to diagnosis of quadriplegia. A review of Resident #10's care plan, initiated 03/30/17, revealed resident was dependent on staff for all activities of daily living (ADL). Included in the care plan was resident's risk related to falls and staff were to "be sure the resident's call light was within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." During an observation and interview with Resident #10 on 04/10/17 at 10:25 AM, resident was noted to answer questions and able to communicate well. During the interview, it was observed resident's call light had not been placed within his reach. The call light was attached to resident's sheet (covering his mattress) on the right side of his bed. Resident #10 had total paralysis of his right arm and hand and had very little use of his left arm and hand. Resident #10 stated he was paralyzed on his right and left sides, but could activate his call light with his left hand, if the call light was placed on his chest. Resident demonstrated how he could activate the call light if placed on his chest.	F 246	100% audit of call bell placement, including residents with special needs. Staff were educated by DON or designee in regards to observing residents for call bell placement and ensuring call bell is within reach, taking into account resident's special needs. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Weekly audits will be conducted for eight weeks, by the DON or designee, of four residents per unit to ensure appropriate access to call bells. If any adverse outcomes are identified via the weekly audit, immediate action will be taken, to include reporting incident via 24 hour report. Residents with special requirements for call bells, ie: type of call bell or specific side for placement will be added to care plan and CNA care cards to ensure appropriate placement. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 5	F 246		

During an interview with nurse #2 on 04/11/17 at 08:20 AM, she stated she would at times leave resident's room door open so he could be more closely monitored. Nurse #2 stated she and the nursing assistants (NAs) on her shift (3rd shift) would "have his call bell on his chest and if he can't reach his call bell, he will yell out".

An observation was made of Resident #10 on 04/11/17 at 8:39 AM. Resident #10 was lying on his back in bed with the head of his bed elevated approximately 40 degrees. His pancake style call bell was attached to the sheet (covering the mattress) on the right side of his bed at elbow level. Resident stated he was unable to reach his call light. After observing the location of the resident's call bell, surveyor left the room at 8:42 AM to locate and inform Resident #10's NA. Resident's NA on the 200 Hall could not be located at the time of the observation. The NA for the other end of resident's Hall (NA #10) was located at that time and shown the placement of resident's call light. Nurse #2 entered the resident's room shortly thereafter and was also made aware of the location of the resident's call light. Nurse #2 relocated resident's call bell so it was within resident's reach.

An interview was conducted with NA #11 (Resident #10's NA) on 04/11/17 at 10:25 AM. NA #11 stated she worked as needed (PRN) and was not aware Resident #10 was paralyzed.

An interview was conducted on 04/11/17 at 3:42 PM with the facility's Director of Nursing (DON) in regards to Resident #10's call bell not being placed within resident's reach. The DON indicated her expectations were for staff to place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 6 resident call bells within resident's reach and stated call bells were to be answered within a reasonable amount of time. The DON stated any staff member going down the hall was to check on a resident to see what they needed.	F 246		
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 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 observations and staff interviews, the facility failed to disinfect a shared glucometer (device used to measure a resident's blood sugar level) in accordance with the manufacturer's directions after the glucometer was used for 1 of	F 441	F441 Corrective action accomplished for those residents found to have been affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8 1 resident (Resident #15) receiving blood glucose (blood sugar) monitoring. The findings included: The Centers for Disease Control and Prevention (CDC) Summary statement on Infection Prevention during Blood Glucose Monitoring and Insulin Administration reports, in part: "The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose monitoring and insulin administration ...Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer ' s instructions." A review of the facility's policy and audit tool entitled, "Cleaning and Disinfecting Glucometers" was completed. The facility ' s policy (a statement dated 4/10/17) read as follows: "Glucometers must be cleaned in between resident use with [Brand Name] germicidal wipes. Once wiped leave meter wrapped in wipe for three minutes." Steps #7 and #8 of the procedures outlined in the audit tool included: #7) "Remove [Brand Name] Germicidal Wipes. If wipe is noticeable saturated, squeeze excess liquid out over wastebasket." #8) "Wipe by thoroughly wetting the exterior of the equipment surface Use additional wipe if necessary to ensure glucose meter visibly wet. Contact time for Hepatitis is 3 minutes for [Brand Name] wipes." An observation was conducted on 4/10/17 at 9:50	F 441	Nurse #1 was re-educated on 4/11/17 by SDC on the proper glucometer cleaning methods. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Licensed staff were educated by the DON or designee on the proper glucometer cleaning process. Licensed staff were educated by 4/17/17. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Glucometer skill checks will be conducted weekly by the SDC, DON and Unit Managers, on all shifts with licensed staff to ensure the proper glucometer cleaning methods. The weekly audits will continue for eight weeks by the DON or designee. Thereafter, the Unit Managers will be responsible for routine observations of facility nurses to ensure practice is kept in place. Monitoring Process: The results of the weekly audits will be reviewed in Quality Assurance and Performance Improvement Committee monthly, with QAPI committee responsible for on-going compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9	F 441		

PM as Nurse #1 used a glucometer to obtain a blood glucose reading for Resident #15. After the reading was taken, the nurse was observed as she placed the glucometer in a small plastic basket (which also contained lancets and individual packets of alcohol wipes) in the top drawer of the medication cart. The glucometer was not disinfected. At that time, Nurse #1 reported she would do the next blood glucose check for another resident around 11:00 AM.

An observation was conducted of Nurse #1 on 4/10/17 at 11:07 AM as she prepared to do the next blood glucose check for another resident. Upon inquiry, the nurse confirmed she had not done any blood glucose checks on a resident since Resident #15 ' s blood glucose check had been observed earlier that morning. Nurse #1 reported she had two blood glucose checks to do at this time. At 11:08 AM, Nurse #1 was observed as she removed the glucometer previously used for Resident #15 from the top medication cart drawer, set it on the medication cart, and gathered the remaining supplies required for the blood glucose check. Nurse #1 picked up the glucometer and supplies, approached a resident ' s room, and knocked on the door for permission to enter the room. At that time, a request was made for the nurse to stop. Nurse #1 was asked when the shared glucometer was disinfected. The nurse did not specify when the glucometer was last disinfected, but reported it was disinfected several times a day with an alcohol wipe. When asked if there were any other disinfectant wipes available on the medication cart for use, Nurse #1 reported she didn ' t think so. Accompanied by Nurse #1, an observation of her medication cart revealed there were no germicidal wipes stored on the cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10	F 441		

Upon inquiry, the nurse reported she would go to her Unit Manager for guidance if she had any questions regarding the facility ' s policy on disinfecting a glucometer.

On 4/10/17 at 11:12 AM, Nurse #1 was observed as she asked the 100 Hall Unit Manager for clarification on the procedures required to disinfect a shared glucometer. The Unit Manager stated the shared glucometer needed to be disinfected for at least three minutes using a germicidal disinfectant wipe after each use. The Unit Manager also told the nurse there was a second glucometer kept on the medication cart that should be utilized while doing blood glucose checks. She instructed Nurse #1 to alternate the use of the glucometers; disinfecting one glucometer after being used while the second glucometer was utilized for the next blood glucose check.

An observation was made on 4/10/17 at 11:17 AM as Nurse #1 obtained [Brand Name] germicidal wipes from another medication cart. At 11:18 AM, the nurse was observed as she pulled a second glucometer from the medication cart and wiped each glucometer with a germicidal wipe for 30 seconds. She then set the glucometers on top of a paper towel on the med cart to dry. Nurse #1 reported she could use one of the glucometers when it was dry. Upon request, the nurse reviewed the manufacturer ' s instructions for use printed on the container of the germicidal wipes. The manufacturer ' s instructions indicated the germicidal wipes required a 3-minute contact time for disinfection. Nurse #1 stated she would need to clarify the instructions for disinfection with the Unit Manager before she used the glucometer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 On 4/10/17 at 11:33 AM, the 100 Hall Unit Manager and Staff Development Coordinator (SDC) were observed as they approached Nurse #1 standing at the medication cart. Nurse #1 was in-serviced on the cleaning and disinfection of glucometers at that time. The Unit Manager was observed as she explained the shared glucometer needed to be wrapped in a wet germicidal wipe and timed to ensure it had at least three minutes of wet contact time with the meter. An interview was conducted on 4/11/17 at 2:27 PM with the facility ' s Director of Nursing (DON) regarding the cleaning and disinfection of shared glucometers. The DON indicated her expectation was for nursing staff to use the approved germicidal wipes (not alcohol wipes) in accordance with the manufacturer ' s instructions. She stated the glucometer needed to have a wet contact time with the germicidal wipes for three minutes in order to properly disinfect the meter after each use.	F 441		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's	F 520		5/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 12 staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (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 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the facility ' s Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 3/11/2017 complaint investigation survey. This was for a recited deficiency in the area of dignity (F241). This deficiency was cited again on the current complaint investigation survey of 4/11/2017. The	F 520	F520 Corrective action accomplished for those residents found to have been affected by the deficient practice: Quality Assurance and Performance Improvement Committee to meet monthly, with purpose of identifying areas out of compliance and establishing a plan to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 13 continued failure of the facility during two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This tag is cross referenced to: F241-Dignity During the compliant investigation survey of 3/11/2017, the facility was cited F241 for failing to attend to the needs of one of three residents reviewed for dignity, when the resident was left on a bedpan for two hours and resulted in the resident being embarrassed and upset. The current complaint investigation of 4/11/2017 the facility failed to maintain a resident ' s dignity when a pancake style call light was not placed within a resident ' s reach to allow the resident to request staff assistance if needed. An interview was conducted with the Administrator on 4/11/2017 at 4:45 PM. He reported the QAPI meeting took place monthly with him, the Director of Nurses, Assistant Director of Nurses, the medical director and other department leaders attending. The Administrator reported the QAPI team will outline the deficiency, discuss a plan of correction, plan audits and follow up. The Administrator further reported he did not feel that dignity was a widespread issue in the facility and was an isolated incident.	F 520	correct deficient practice and follow up on areas addressed in Performance Improvement plans to ensure practices are being maintained. (Dignity concerns to be a priority in upcoming meetings.) Corrective action accomplished for those residents having the potential to be affected by the deficient practice: An audit of all occupied resident rooms was conducted on 4/12/17 to ensure call bells were available for use. Education was provided by DON or designee to staff about proper call bell placement for residents. This education included to be aware of residents physical inabilities when placing the call bell. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Administrator and Director of Nursing educated by District Director of Clinical Services on Quality Assurance and Performance Improvement process with focus on establishing and maintaining corrective actions to ensure consistent delivery of care and services. Administrator completed a re-education with facility QAPI committee on 4/14/17, related to the facility process and intent of the Quality Assurance Performance Improvement (QAPI), which included the responsibilities of the QAPI Committee to ensure sustainability with identified areas of opportunity, with members of the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 14	F 520	committee, which included, MDS Nurses, Director of Nursing, ADON, Administrative Nurses, Social Services and Activities. Facility met with the facility Medical Director, on 4/14/17, to review the current survey outcome and reviewed preliminary plan of correction for this survey. Facility will utilize internal audits and input from facility staff to determine potential areas for improvement on an ongoing basis. ADHOC QAPI meetings will be held should areas be identified prior to scheduled monthly meetings. Monitoring Process: QAPI meetings to be held monthly, with minimal attendance of Administrator, DON, Social Services and a Nurses' Aid (if possible), with Medical Director input into identified concerns and Performance Improvement Plans. District Director of Clinical Services to randomly review Quality Assurance and Performance Improvement minutes and to attend meetings when possible.	