Amended 7-22-11

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

PRINTED: 07/07/2011 FORM APPROVED OMB NO 0938-0301

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128 NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER:	A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY	
			1	COMPLETED		
		8. WNG				
BRIAN CE	ENTER HEALTH & REHA	BILITATION/STATESVILLE	52	EET ADDRESS, CITY, STATE, ZIP CODE 0 VALLEY STREET FATESVILLE, NC 28677	_ 06/	22/201
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	MDec	COM
SS=D	or maintain the highes mental, and psychoso	NG ceive and the facility must care and services to attain t practicable physical	F 309	F 309 I. Corrective action has be accomplished for the all deficient practice in reg Resident # 3 by providing oxygen tank at the time discovery by the survey June 22, 2011. Resident provided with oxygen act to the physician's order day.	leged ards to ng a new of or on #3 was	7/
i c	by: Based on observation and staff interviews the provide oxygen to a res continuous oxygen whi	sident who required le waiting for an eye exam facility lobby in one (1) of		 Residents who require the oxygen therapy have the to be affected by the sam deficient practice; therefor Director of Nursing and/Managers made a list of with orders for continuou oxygen and began on 6/2 	potential . e alleged ore, the or Unit residents s	
ļ	he findings are:			observe these residents da Monday through Friday for compliance with the phys	or ician's	
obstru walkin Set (M had no proble A revis June 2	pstructive pulmonary of alking. A review of the et (MDS) dated 04/30/ ad no short term or lon oblems, and no impair	s including severe chronic lisease and difficulty with a quarterly Minimum Data 11 revealed the resident g term memory ment in cognition.		order whether they are in room or using a portable to Measures put into place of changes to ensure that the deficient practice does not include: The Staff Develop Coordinator, Director of Nor Unit Manager(s) began 6/22/11 to conduct inserveducation for Nurses, Resident	their ank. system alleged recur oment ursing, on	
A res oxy sho	review of Resident #3's spiratory risk included a ygen delivery related to orthess of breath and reconstructions or providers our providers ou	s plan of care for an intervention for o difficulty breathing, espiratory infection.	agre alle defi and	eparation and/or execution of this plan of ection does not constitute admission or sement by the provider of the truth of the ged or conclusions set forth in the stateme ciencies. The plan of correction is prepare or executed solely because it is required bisions of federal and state law."	facts :	

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 program participation.

FORM CMS-2567(02-99) Provious Versions Obsolete Evention BOXON

Facility ID: 922999

JUL Proffinuation sheet Page 1 of 7

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BY: MH

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

Amended 7-22-11 PRINTED: 07/07/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA				OMB	NO. 0938-039
		IDENTIFICATION NUMBER:	·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
1			1A. 80	ILU		1	
		345128	8. W	NG.			С
NAME OF:	PROVIDER OR SUPPLIER			Τ.		0	6/22/2011
DOIAN C	CENTED HEALTH & BOW			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAINO	ENJER HEALTH & REHA	BILITATION/STATESVILLE		1	520 VALLEY STREET		
(X4) ID	CIMILADVOT	ATCHICUT OF OFTINITION		L	STATESVILLE, NC 28677		
PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID ID		PROVIDER'S PLAN OF CORR	ECTION	(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREF		(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE PROPRIATE	COMPLETION DATE
F 309	! Continued From page	. 1			Care Specialists, Depar	tment	
· · · · · · · · · · · · · · · · · · ·			F	30	91 Heads, Therapists, Hou	sekeeners	
	During on character	2010211	i		Maintenance workers,	Dietary	,
	During an observation	on 06/22/11 at 11:22 a.m.			workers regarding obse		•
	wheelchair An example	ig in the activity room in her	:		portable oxygen tanks t		1
	hack of her whoolsho	on tank was attached to the	!		determine if they are er		
	Dack of tiet Wilesicial	ir but there was no tubing or ted from the tank to the	1		observing portable tank		•
	resident. The regulate	or on the oxygen tank	1		concentrators to determ		!
	indicated the tank was	om the oxygen tank	,		cannula is in place. Nu		i
	increased the talk was	s empty.	1		charged with providing	the tenk	!
	During an observation	on 06/22/11 at 12:13 p.m.	i		before the resident leav		
	Resident #3 was sitting	G in the John in her	:		room if the order is for	es uie	ı
	wheelchair with the ox	ygen tank attached to the	!		continuous oxygen. Oth	on ata ff in	
	back of her wheelchair	r and there was no oxygen	1				
	tubing or nasal cannul	a attached from the tank to	1		charged with asking the		<u> </u>
	the resident.	The state of the s	<u>;</u>		assistance if they observe		i
					empty tank or a cannula		1
	During an observation	on 06/22/11 at 12:37 p.m.	j		place. The inservices co until July 9 to insure the	munuea	. :
i	Resident #3 was sitting	in her wheelchair next to	1				1
	her bed and the oxyge	n tubing and nasal cannula	į.		facility staff received th		;
•	were lying on top of he	r bed.	!		Interported to dispute COI		!
					are achieved and sustain QA&A	iea:	:
	During an observation	on 06/22/11 at 12:42 p.m.				.d	
•	LN #1 entered Residen	it #3's room, put the nasal	:		Unit Managers will con		1
	cannula on the residen	t and turned the oxygen	i 1		rounds to observe oxyge		: i
	concentrator on at two	(2) liters per minute.	!		administration at least :		
1	During as inter-		ţ		for 4 weeks and then at		! !
	ot 10:14 m an interview with	Resident #3 on 06/22/11		į	week thereafter for the		}
İ	at 12:14 p.m. she stated	d she has not had her		i	to ensure continued con		
į	Lidon't know what they's	nd "they took it off me and		i	The Director of Nursing		
	I don't know what they'v	oothing olders to she		į	Manager will review da	iai	1
1	stated site is Di	eathing alright for now."		1	obtained during and rou		i i
į	During an interview with	Resident #3 on 06/22/11		1	analyze the data and rep	ort	ĺ
i.	at 12:38 p.m. she etator	I "I've not had my oxygen		!	"Preparation and/or execution of this plan	of	ĺ
	for awhile and I'm feeling	a short of brooth "		i	correction does not constitute admission (of .	1
i		g short or breath."		i	agreement by the provider of the truth of	he facts	
· · · · · · · · · · · · · · · · · · ·	During an interview with	I N #1 on 06/22/44 at			alleged or conclusions set forth in the stat	ement of	ĺ
1.	12:41 p.m. she stated Re	esident #3 weare her		i	deficiencies. The plan of correction is pre and/or executed solely because it is require	pared	l l
	,				provisions of federal and state law."	eu by the	

DEPARTMENT OF HEALTH AI CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES	ND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Mend			FC	TED: 07/07/2011 DRM APPROVED NO. 0938-0391
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILO		CONSTRUCTION	(X3) DATE COMP	
	345128	B. WNG	·			C
NAME OF PROVIDER OR SUPPLIER			CTOECT	ADDRESS STATE OF THE		5/22/2011
BRIAN CENTER HEALTH & REHAI			620 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY STREET ESVILLE, NC 28677		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 309 Continued From page	2	!	!			!
		! F 30)91	patterns/trends to the QA&A		-
to take a shower or be	ind takes it off long enough th. She stated she was	:		committee monthly for the nex		•
unaware Resident #3	did not have her oxygen on	:		12 months. The QA&A	X.	
until she went into her	room and put it on her.	ł	1	committee will evaluate the		
	and part of fiel.	į		effectiveness of the above plan		•
During an interview wit	th Resident #3 on 06/22/11	į		and will amend the plan as	,	
at 3:00 p.m. she stated	I she is unable to transport	İ	1	needed correct problems and to	ı	
herself in her wheelcha	air and staff usually		1	ensure continued compliance.		' 1
connected her oxygen	tubing to the oxygen tank	İ	1	T		
on the back of her whe	elchair when they		ļ			
Sometimes the everen	ner room. She explained		i			
wheelchair runs out an	in her oxygen tank on her d she calls the staff to	1				
change it. She stated	she can tell when she's	<u>}</u>	;			i
she is supposed to wea	from the oxygen tank and	!	:			
time.	ir the oxygen all of the	:	1			
		i 				į
During an interview with	LN #1 on 06/22/11 at	i _	1			
3:15 p.m. she verified R	Resident #3's physician	-				i
orders were for continue	ous exygen one to two	1				
liters per minute by nas	al cannula. She explained		:			:
Resident #3 had an app	ointment to see the eye		1			}
doctor in the activity roo	m this morning but she		1			;
appointment and she sh	oorted Resident #3 to her		į		!	
appointment and she sh Resident #3's oxygen ta	e dig not know when		ļ			!
l l l l l l l l l l l l l l l l l l l	int tras last changed.				ļ	
During an interview with	the Director of Nurses	į	i		}	
(DON) on 06/22/11 at 3:	53 p.m. she stated the	į	ļ		1	1
activity room does not ha	ave oxygen concentrators		İ		1	ı
and residents who need	continuous oxvoen		1		i	1
should be connected to a	an oxygen tank on their					1
wheelchair. She stated to	Resident #3 had an	<u> </u>				1
appointment to see an or	otometrist in the activity				•	1
room this morning and si staff transported the resid	te the anti-	İ			į	
for her appointment. She	a stated it was her	į			į	1
PP TOTAL OIL	י שישישים ווקו	· ·			ı	ı

Amended 7-22-11 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/07/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C B. WNG 345128 06/22/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE **520 VALLEY STREET** STATESVILLE, NC 28677 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 3 F 3091 expectation the optometry staff should have put the oxygen on Resident #3 before they transported her or they should have gotten a nurse to put the oxygen on the resident. During an interview on 06/22/11 at 3:58 p.m. the DON verified the oxygen tank on the back of Resident #3's wheelchair was empty and it should have been changed. She stated she confirmed with LN #1 that Resident #3's oxygen saturation percentage was 96% on room air after Resident #3 was returned to her room. F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS=D | SPREAD, LINENS F 441 The facility must establish and maintain an 1. Corrective action has been Infection Control Program designed to provide a accomplished for the alleged safe, sanitary and comfortable environment and deficient practice in regards to to help prevent the development and transmission Resident #1 by removing and of disease and infection. discarding the soiled washcloth (a) Infection Control Program during the surveyors observation on 6/22/1 land cleaning the The facility must establish an Infection Control overbed table on the same day. s. Program under which it -Investigates, controls, and prevents infections The identified staff member in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and "Preparation and/or execution of this plan of (3) Maintains a record of incidents and corrective correction does not constitute admission or actions related to infections. agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared (b) Preventing Spread of Infection and/or executed solely because it is required by the (1) When the Infection Control Program provisions of federal and state law." determines that a resident needs isolation to prevent the spread of infection, the facility must

isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions

		ND HUMAN SERVICES MEDICAID SERVICES	Meno	led 7-22-11	F	ITED: 07/07/201 ORM APPROVE INO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION LOING	(X3) DATE	SURVEY PLETED
		345128	8. WN	G	o d	C 6/22/2011
	ROVIDER OR SUPPLIER ENTER HEALTH & REHAI	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	direct contact will tran (3) The facility must re hands after each direct hand washing is indice professional practice. (c) Linens Personnel must handle transport linens so as infection. This REQUIREMENT by: Based on observation and staff interview the properly dispose of a s incontinence care for of (Resident #1) The findings are: Resident #1 was re-ad 11/04/09 with diagnose sided paralysis and urin review of the quarterly dated 04/02/11 reveale short term or long term no impairment in cognit A review of the Plan of activities of daily living it total care and required	h residents or their food, if smit the disease. Equire staff to wash their stresident contact for which ated by accepted e, store, process and to prevent the spread of is not met as evidenced is not met as evidenced is record review, resident facility staff failed to oiled washcloth during ne (1) of two (2) residents. mitted to the facility on as of hypertension, left (L) hary tract infection. A Minimum Data Set (MDS) d the resident had no memory problems, and ion. Care dated 04/05/11 for ndicated Resident #1 was	F	received one-on-one eregarding infection prepractices for clean and handling on 6/22/11 2. Residents who require with incontinence care potential to be affected same alleged deficient therefore, the Director made a list of residents require incontinent care assistance with bathing 6/22/11. Residents will or subtracted from the lindicated on caretracker and Action Team review and Resident Care Special inservice educing 6/22/11, 6/23/11, 6/29/17/9/11 on handling Clean Dirty linen. New Resides Specialists will received on clean and dirty linen during orientation and a department staff will recannual inservice on the total department contains the deficient practice recur include: The DON a Staff Development Coordand the Unit Managers has	evention I dirty linen assistance have the I by the practice; of Nursing who e and g on I be added list as r review ws. Nurses cialists ation on I I, and an and ent Care I training handling III nursing ceive topic. or to ensure e will not and the edinator	

FORM CMS-2567(02-99) Previous Versions Obsolete

incontinence indicated Resident #1 required

Event ID: BCXO11

Facility ID: 922999

If continuation sheet Page 5 of 7

"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."

DEPARTMENT OF HEALTH AND HUMAN SERVICES 1-22-11 CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED

STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1,,,,,,	_		OME	NO. 0938-039
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345128	a. ww	IG_			С
NAME OF	PROVIDER OR SUPPLIER			г		0	6/22/2011
BRIAN	CENTED HEALTH A			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIVIAN	CENTER HEALTH & REHA	BILITATION/STATESVILLE			620 VALLEY STREET		
(X4) IC	CINAMAN CT	Trust -			STATESVILLE, NC 28677		
PREFIX	(LACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORREC	TION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX		(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	II A DE	(X5) COMPLETION DATE
F 44	1 Continued From page	5	1				1
			, F 4	141	initiated skills validations	for	!
	slaff.	y and as needed by nursing	!		certified nursing assistants	related	1
	Jan,				to infection control related	l to	
	During an chaosastics	of Death Line			clean and soiled linen hand	dlina	:
	During an observation	Of Resident #1's	,		The Staff Development	umg	1
	#2 gathered clean tow	06/22/11 at 11:43 a.m. NA	!		Coordinator (SDC), Direct		•
	Diaced them on one of	els and washcloths and	•		Nursing (DON), or Unit	OF OF	i
	Resident #1's room A	de of the overbed table in IA #2 washed her hands,	•		Manager(s) will conduct fi	(6)	:
	Dut on cloves and unfa	istened Resident #1's brief	!		skills validations per week	ve (3)	· •
	saturated with urine.	She wat the washeleth	!		regarding clean and dirty li		:
	applied soap and clear	ned Resident #1 front to	1		handling until current staff	nen hav-	•
	back by turning the war	shcloth from one side to	1		been observed. Newly hired	nave	1
	the other. NA #2 then	placed the soiled	!		nursing staff will have these	J 1-211	!
	washcloth on the top st	Urface of Resident #1's	!		validations during their	SKIIIS	:
	overbed table next to the	ne clean towels and			orientation period and all nu		1
	washcloths. Resident	#1 was turned to his side	1		staff will be observed quarte	ırsıng	
	and NA #1 completed to	he incontinence care	1	i	for the next year.	riy	
	i placed her soiled wash	cloth inside a pad	!		4. Measures to ensure correction		
	underneath the residen	t and assisted NA #1 with	!	- !	are achieved and	ons	}
	dressing Resident #1. N	IA #2 removed her gloves,		1	sustained:QA&A		
	washed her hands, put	on clean gloves and took	1	1	The Director of Nursing or S		:
	the solled washcloth fro	m Resident #1's overbed	•		Development Coordinator w	an Harr	1 1
	to a soiled lines have	ed linens out of the room		i	review data obtained during	(III olektio	! !
	to a soiled linen hamper	. NA #2 went back into		- !	validations, and analyze the	into	
	Resident #1's room, was	sned her hands and		1	and report patterns/trends to	iala ho	
	immediately went back of with passing meal trays	to residents		;	QA&A committee monthly.	liie The	
	passing modi (rays	to residents.		1	QA&A committee will evalu	r i i c	
i	During an interview with	NA #2 on 08/22/44		-	the effectiveness of the above	. I	1
	12:11 p.m. she stated sh	R Should not have put		Ĺ	plan, and will add additional	1	í
!	the soiled washcloth on I	Resident #1's overhed		i	interventions based on negative	, a	Í
İ	table but "should have pr	ut it on a soiled field "			outcomes identified to ensure	ro	1
Ī	She stated she was aske	ed by other staff to help		İ	continued compliance.	! 1	
	pass meal trays to other	residents and she would		;	priantee.	İ	- 1
!	go back after lunch to fini	ish cleaning Resident		!		į	- 1
1	#1's room.		!	Ĺ		!	1
į		į		ĺ		Ī	
i	During an interview with I	Resident #1 on 06/22/11		!		!	1
			į	ĺ		!	1
4 CMS-2567/	(02-99) Province Marsiana Oberes			_			ľ

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2011 FORM APPROVED

CENTERS FOR STATEMENT OF DEFI	RMEDICARE (& MEDICAID SERVICES		T -			F	ORM APPROV NO. 0938-03	
AND PLAN OF CORRE	CTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		345128		B. WING			C 06/22/2011		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	1	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
During (DON) should overbe have ir	5 p.m. he state dirty linens or athe him or cle an interview w on 06/22/11 a not put soiled d table. She funmediately not	d most of the time the staff in his overbed table when ean him up. with the Director of Nursing t 4:00 p.m. she stated staff linens on a resident's inther stated NA #2 should iffied housekeeping staff to ble after she removed the		F 44	11				