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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(C1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

345080

(C2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(C3) DATE SURVEY COMPLETED

06/13/2013

NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT

STREET ADDRESS, CITY, STATE, ZIP CODE
220 13TH AVE PLACE NW
HICKORY, NC 28601

(C4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSI IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

F 164 SS=D
483.10(e), 483.75(l)(4) PERSONAL
PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and
confidence of his or her personal and clinical
records.

Personal privacy includes accommodations,
medical treatment, written and telephone
communications, personal care, visits, and
meetings of family and resident groups, but this
does not require the facility to provide a private
room for each resident.

Except as provided in paragraph (e)(3) of
this section, the resident may approve or refuse the
release of personal and clinical records to any
individual outside the facility.

The resident's right to refuse release of personal
and clinical records does not apply when the
resident is transferred to another health care
institution; or record release is required by law.

The facility must keep confidential all information
contained in the resident's records, regardless of
the form or storage methods, except when
release is required by transfer to another
healthcare institution; law; third party payment
contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observations, resident review, and
resident and staff interviews the facility failed to
provide privacy for 1 of 2 residents observed
during provision of care.

Preparation, submission
and implementation of
this Plan of Correction
does not constitute an
admission of or
agreement with the
facts and conclusions
set forth on the survey
report. Our Plan of
Correction is prepared
and executed as a means
to continuously improve
the quality of care and
to comply with all
applicable state and
federal regulatory
requirements.

F 164 Personal
Privacy/confidentiality of
Records

Criteria 1
The Privacy Curtain Track in
Room 217 was repaired to allow
the curtain to move freely on the
track and to allow the door to be
closed completely in order to
provide privacy during personal
care.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Original Signature Date: 7/01/13

FORM CMS-2567(02-09) Previous Versions Obsolete
Event ID: NVZ311
Facility ID: 923004
If continuation sheet Page 1 of 11
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 164</td>
<td>Continued From page 1</td>
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<td>The findings included:</td>
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<td></td>
<td>Resident #5 was admitted to the facility 04/05/13 with diagnoses which included diabetes and benign prostate hypertrophy. The most recent Admission Minimum Data Set (MDS) dated 05/10/13 assessed Resident #5 as being able to be understood and able to understand. The MDS assessed Resident #5 as having moderate cognitive impairment and needing extensive assistance with personal hygiene and bathing.</td>
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<td>An observation was made on 06/13/13 at 3:55 PM. The door to Resident #5's room was open and the curtain partially pulled as it had been on earlier observations that day. Upon knocking and entering the room it was observed that Resident #5 was receiving incontinence care provided by Nursing Assistant (NA) #1. There was a large gap in the curtain leaving Resident #5 in full view of anyone in the room. Resident #5's room contained three beds. The curtain to the second bed was not pulled and the curtain to the third bed was only partially pulled. There was a family member visiting the resident in bed #3. No one was in bed #2 at the time.</td>
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<td>On 06/13/13 at 4:00 PM an interview was conducted with NA #1. NA #1 stated he had been providing incontinence care for Resident #5 as he had a bowel movement. NA #1 further stated he was &quot;in a rush&quot; and did not take the time to close the door or fully pull the curtains around Resident #5's bed. He stated he should have fully pulled the curtains and closed the door to provide privacy for Resident #5.</td>
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<tr>
<td></td>
<td>On 06/13/13 at 4:05 PM an interview was</td>
<td></td>
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</tbody>
</table>

**Criteria 2**

All residents have the potential to be affected by this alleged deficient practice. An audit of Privacy Curtains maintained throughout the facility will be conducted by the Administrator or Designee to verify proper function and repair as required. These audits will be completed by July 11, 2013.

**Criteria 3**

The Director of Nursing or Designee will re-educate Nursing Staff on Privacy requirements, to include the use of privacy curtains when providing personal care. This education will be completed by July 11, 2013. The Director of Nursing or Designee will randomly monitor 5
Resident Care Specialists while providing personal care weekly for 4 weeks and monthly for 2 months to ensure compliance with privacy requirements. Opportunities will be corrected as identified.

Criteria 4
The results of the audits will be reported in monthly Quality Assurance Performance Improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.

Date of Compliance:
July 11, 2013
**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**

**F 242 Self Determination Right to make Choices**

**Criteria 1**
Resident #5 was interviewed regarding his preference for bathing and his schedule was changed to meet his preferences.

**Criteria 2**
All residents have the potential to be affected by this alleged deficient practice. An audit of residents has been conducted by the Director of Nursing or Designee to verify their preferences with regards to...
bathing and bathing schedules were adjusted as required based on results of these interviews. The audit will be completed by July 11, 2013

Criteria 3

The Director of Nursing has developed an additional interview tool for use during the admission process to identify resident preferences related to bathing schedules. Licensed Nursing Staff will be educated by the Director of Nursing or Designee on completion of the interview regarding bathing preferences upon admission.

Nursing Staff has been re-educated by the Director of Nursing or Designee on adhering to resident preferences regarding bathing schedules and communicating a resident’s request for change in bathing schedules to the Director of Nursing or Unit Manager. The education will be completed by July 11, 2013. The Director of Nursing or Designee will randomly interview 5 residents
F 242 Continued From page 5

2. On 06/13/13 at approximately 11:45 AM observations were made of food on the lunch tray line. Food items prepared for the lunch meal included puree tuna, puree potato salad and puree peaches. Food was observed plated for Resident #8 with a diet order for puree food. Food items served to Resident #8 included puree tuna. Review of the tray card of Resident #8 included a dislike of tuna. Dietary notes dated 05/31/13 in the medical record of Resident #8 also included tuna as a dislike.

Observations were made of Resident #8 being assisted with the lunch meal in the main dining room. Resident #8 did not eat the tuna and reported he did not like tuna. Staff assisting Resident #8 requested an alternate to the tuna after it was brought to their attention.

On 06/13/13 at 12:50 PM the Food Service Director (FSD) stated Resident #8 should not have received the puree tuna. The FSD stated pimento cheese or cream soup should have been served to Resident #8 as a substitute for the tuna. The FSD could not explain why puree tuna had been served to Resident #8.

F 333 483.25(m)(2) RESIDENT'S FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on record reviews and staff interviews, the facility failed to administer routine medications on two shifts, and administered seven doses of a weekly for 4 weeks and then monthly for 2 months to verify bathing preferences are being followed. Opportunities will be corrected as identified.

Criteria 4

The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting for 3 months. The committee will evaluate and make further recommendations as indicated.

Date of Compliance:
July 11, 2013

F 242 CONTINUED

Resident #8 and Related Food Preference Concern

Criteria 1

Issue for resident # 8 was resolved on date of survey by providing appropriate substitute for the tuna. Additionally a new Dietary History / Food Preference form was completed.
F 333 Continued From page 6

discontinued "as needed" narcotic pain medication (Percocet), for 1 of 3 residents reviewed for unnecessary medications (Resident #2).

The findings include:

Resident #2 was originally admitted to the facility on 1/31/13 and readmitted on 4/26/13. Resident #2's diagnoses included anemia, history of gastrointestinal bleeding, history of deep vein thrombosis, chronic pain and acute renal failure. A review of the medication orders dated 4/26/13 included:

- Bupropion XL 300 mg (milligram) once daily
- Vitamin D3 1000 IU (international units) once daily
- Synthroid 175 mcg (microgram) once daily
- Multivitamin once daily
- Vitamin B-6 100 mg once daily
- Xarelto 15 mg once daily to start on 4/26/13
- Carafate 1 G (gram) (in liquid form) three times daily before meals and at bedtime
- Fibercon 1250 mg two times daily
- Calcium 600 mg once daily
- Atorvastatin 40 mg once daily
- Protonix 40 mg once daily
- Oxycodone with Acetaminophen (5 mg/325 mg) tablet as needed and not continued on 4/26/13

A further review of the Medication Administration Record (MAR) for the month of May 2013 revealed that none of these medications were documented to have been given on 5/6/13 during the first and second shift medication administration. Resident #2 was sent to the hospital on 5/7/13 for an evaluation and no

F 333 to assure future accuracy of his preferences on same date as survey.

Criteria 2

All residents have the potential to be affected by this alleged deficient practice. A Dietary History / Food Preference form will be completed for each resident by the FSM or designee. All tray cards will be updated to assure their accuracy for each resident by July 3, 2013 again completed by the FSM or designee. All food service staff and additional staff involved in feeding or food delivery will be educated on reviewing tray card against actual tray for accuracy and assurance that food preferences are met. Education will be completed by July 3, 2013.

Criteria 3

The food service director or designee will complete audits comparing the tray card preferences against actual food plated and served. This will be completed both in the kitchen as
### Continued From page 7

Explanation was found why these doses of medications were not administered on 5/6/13. Further review of the narcotic log for Oxydodone with Acetaminaphen (5/325 mg) (Percocet) revealed that seven doses of this narcotic ‘as needed for pain’ medication was administered after it was discontinued on 4/25/13. Further, the administration of Percocet was not documented in the MAR. No explanation or no other documentation of these medication errors was available in the medical records.

An interview with Nurse #2 on 6/13/13 at 6:20 PM revealed that Nurse #2 had administered five of the seven doses of Percocet and did not remember why she had administered the doses without a proper physician order and also could not explain why nurse #2 did not have any documentation in the May 2013 MAR. Nurse #2 also had no explanation related to the medications not administered for Resident #2 on 5/6/13 during the second shift.

A telephone interview with Nurse #3 on 6/13/13 at 8:30 PM revealed that early morning medications had no explanation why medications were not administered to Resident #2 during the morning medication administration on 5/6/13 prior to the resident's return to the hospital the following day.

An interview with the Director of Nursing (DON) on 6/13/13 at 5:15 PM revealed that it was her expectation to document all medication administrations and if there was no initial in MAR, they were administered. DON had no explanation for these medication errors and all nurses were expected to bring medication errors to her attention. DON also stated that all

### Criteria 4

The results of the audits will be reported in the Quality Assurance Performance Improvement meeting for 4 months then quarterly. The committee will evaluate and make further recommendations as indicated.

Date of Compliance:
July 11, 2013
**F 333 Residents Free of Significant Med Errors**

**Criteria**  
Medication Variance Reports were completed for ordered medications with missing signatures related to Resident #2. The Physician was notified as required.
Criteria 2

All residents receiving medications have the potential to be affected by this alleged deficient practice. An audit of current resident’s Medication Administration Records from the last 30 days will be completed by July 11, 2013 and Medication Variance Reports completed as required.

Criteria 3

The Director of Nursing or Designee will re-educate Licensed Nurses and Certified Medication Aides on Medication Administration and Documentation, including accurately signing the Medication Administration Record following medication...
administration. The education will be completed by July 11, 2013. The Director of Nursing or Designee will perform 5 random audits of Medication Administration Records 3 times a week for 4 weeks, then weekly for 8 weeks, to verify accurate medication administration and documentation. Opportunities will be corrected as identified.

**Criteria 4**

The results of the audits will be reported in the Quality Assurance Performance Improvement meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated.

Date of Compliance:
July 11, 2013