PRINTED: 05/26/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:			X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345232	B. WING _			C <b>04/24/2015</b>	
	ROVIDER OR SUPPLIER	ск		3031	ET ADDRESS, CITY, STATE, ZIP CODE TATE BOULEVARD SE CORY, NC 28602	1 04/	2-1/2010
(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 159 SS=E	PERSONAL FUNDS  Upon written authoriz facility must hold, safe account for the perso deposited with the facility must deposited with facility must deposited in excess of \$5 account (or accounts) the facility's operating all interest earned on account. (In pooled a separate accounting to the facility must main funds that do not except the facility must extend that assures a full and accounting accounting principles funds entrusted to the behalf.  The system must previously must previously entrusted to the behalf.  The individual financial through quarterly stat the resident or his or the facility must notif Medicaid benefits who	nal funds of the resident cility, as specified in of this section.  posit any resident's personal on in an interest bearing that is separate from any of accounts, and that credits resident's funds to that accounts, there must be a for each resident's personal end \$50 in a non-interest rest-bearing account, or ablish and maintain a system of complete and separate of the generally accepted of each resident's personal end facility on the resident's clude any commingling of cility funds or with the funds than another resident.  The general separate of the general separate of the second must be available ements and on request to the legal representative.	F1	59			5/22/15
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

Electronically Signed 05/22/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

Any denciency statement ending with an asterisk (\*) denotes a denciency 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED					
		345232	B. WING _			C <b>04/24/2015</b>		
	ROVIDER OR SUPPLIER	ск		STREET ADDRESS, CITY, STATE, 3 3031 TATE BOULEVARD SE HICKORY, NC 28602	ZIP CODE	0412412010		
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F 159	section 1611(a)(3)(B) amount in the account the resident's other na reaches the SSI reso resident may lose elig	one person, specified in of the Act; and that, if the t, in addition to the value of onexempt resources, urce limit for one person, the gibility for Medicaid or SSI.	F1	159				
	by: Based on resident in staff interviews, the far fund accounts access of 3 sampled resident and #70).  The findings included  1. Resident #63 was 11/24/14. Her admiss dated 12/03/14 coded intact.  Resident #63 stated of at 12:05 PM that the faccount for her. She access her money affanytime on Sundays, get money from her adoor has been closed stated that she had to out a day or two befo wanted money over the litterview with the Bustiers.	admitted to the facility on sion Minimum Data Set I her as being cognitively during interview on 04/20/15 facility held a personal fund stated that she could not the roon on Saturdays or She stated she had gone to occount on Sundays but the land locked. She further or remember to get money the the weekend if she the weekend.		F 159  1. Corrective action of accomplished for the all practice with regard to #63, and #70 by ensuring access to their funds on the account have the affected by the same all practice. Therefore, the Manager has implement provide access to reside on the weekends. An all trust account roster has by the Business Office has provided these resinformation on how to a second to the alleged deficient recurred include: the Admin Director of Nursing will in-service/re-education office Manager and We Nurses regarding the praccessibility of resident weekends. The Pasido	lleged deficient Residents # 41, ng that they have the weekends. Who have a resid potential to be lleged deficient the Business Office the a process to lent trust account udit of the reside to been complete Manager and shidents with access their fund place to ensure the practice does inistrator and conduct for the Business the process for the funds on	ent ent control ts ent d d ee s. not		
	Resident #63 had a p the facility. Per BOM	t 3:16 PM confirmed that ersonal funds account with residents wishing to methods their personal funds		weekends. The Reside meet in the month of M residents; right to acce funds. The facility;s An	lay to review the ess their persona			

IDENTIFICATION NUMBER:	ON NUMBED:		2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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345232	B. WING _			04/24/2015		
•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
HICK		30	31 TATE BOULEVARD SE			
nick		HI	CKORY, NC 28602			
NCY MUST BE PRECEDED BY FULL	ID PREFI TAG	х	•		(X5) COMPLETION DATE	
e to the office themselves or mourse aide to the office and e resident. She stated money the resident. She stated money the further stated no one was the weekends and that are they could get their money the reded it over the weekend.  We with Resident #63 on the reded that she was unhappy the reded that resident to not having the residents have not as about not being able to get weekends in resident council rems. He stated that residents greating money over the reded her with intact cognition.  In the reded to the facility that as admitted to the facility red as a f	F	159	conduct visits at least weekly for two months with assigned residents to include questions regarding access to their resident trust account, if applicable. Ne admissions will have information regarding resident trust accounts provide to them or their responsible party as party of their admission paperwork. The Administrator will review concerns during the morning stand up meeting to identify issues with funds availability and ensure prompt follow up with concerned individuals. On a monthly basis, the Administrator will review Resident Courneeting minutes to identify concerns regarding funds availability to ensure continued compliance.  4. The Administrator or Director of Nursing will review data obtained during audits of concerns and resident council meetings, analyze the data and report patterns/trends to the QAPI committee every other monthly for six months. To QAPI committee will evaluate the	w ded int ng y e ncil		
The south of the state of the s		A BUILDING  I HICK  STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  age 2  The to the office themselves or menurse aide to the office and the resident. She stated money ween 8 AM and 6 PM Monday She further stated no one was the weekends and that the tare they could get their money the eded it over the weekend.  The work of the weekend of the weekend of the recently could not go mily member due to not having the edes to recently could not go mily member due to not having the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident council the sabout not being able to get the weekends in resident the sabout not being able to get the weekends in resident council the sabout not being able to get the sabout not being	A BUILDING  B. WING  STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)  age 2  The to the office themselves or minurse aide to the office and he resident. She stated money ween 8 AM and 6 PM Monday She further stated no one was the weekends and that are they could get their money needed it over the weekend.  The work of the weekend of the weekend of the weekends on the weekend of the with intact cognition.  The weekend of the wee	I HICK  STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE HICKORY, NC 28602  STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL TAG  STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE HICKORY, NC 28602  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  F 159  CONDUCT VISITS at least weekly for two months with assigned residents to inclu questions regarding access to their resident trust account, if applicable. Ne administrator and that are they could get their money needed it over the weekend. Be with Resident #63 on severated that she was unhappy the each of the money on the led she recently could not go mily member due to not having ey.  Administrator on 04/24/15 at that residents have not as about not being able to get a weekends in resident council rms. He stated that residents getting money over the  are admitted to the facility uding 12/20/14. Her most ata Set, a 60 day assessment ded her with intact cognition.  and during interview on 04/21/15 e had a personal fund account dould not get her money on follow up interview was sident #70 on 04/23/15 at hich she stated she wanted to money on the weekends if she ther stated if was her money	A SOLUMNS  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  3331 TATE BOULEVARD SE HICKORY, NC 28602  ID RICY MUST BE PRECEDED BY FULL PRICY MUST BE PRECEDED BY FULL PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 159  CONDUCT visits at least weekly for two months with assigned residents to include questions regarding access to their resident trust account, if applicable. New admissions will have information regarding resident trust account, if applicable. New admissions will have information regarding resident trust account, if applicable. New admissions will have information regarding resident trust account, if applicable. New admissions will have information regarding resident trust account, if applicable. New admissions will have information regarding resident trust account, if applicable. New admissions will have information regarding resident trust account, if applicable. 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F 159	(BOM) on 04/23/15 a Resident #70 had a p the facility. Per BOM withdrawal money fro account could come send a request from staff would go to the was available betwee through Fridays. Sho in the office during th residents were aware on Fridays if they nee  Interview with the Ad 1:14 PM revealed tha expressed concerns their money on the w or via grievance form were probably not ge weekends.  3. Resident #41 was recently on 06/23/14 data Set, a quarterly having intact cognition On 04/21/15 at 9:53 had a personal fund could not get money stated that she had to Fridays if she wanted weekend.  Interview with the Bu (BOM) on 04/23/15 at Resident #41 had a p the facility. Per BOM	siness Office Manager at 3:16 PM confirmed that bersonal funds account with I, residents wishing to om their personal funds to the office themselves or nurse aide to the office and resident. She stated money en 8 AM and 6 PM Monday e further stated no one was e weekends and that e they could get their money ended it over the weekend.  ministrator on 04/24/15 at at residents have not about not being able to get eekends in resident council as. He stated that residents etting money over the  admitted to the facility most Her most recent Minimum dated 02/20/15 coded her as	F 15	9			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 159 F 171 SS=D	send a request from r staff would go to the r was available betwee through Fridays. She in the office during the residents were aware on Fridays if they need Interview with the Adr 1:14 PM revealed that expressed concerns a their money on the wo	o the office themselves or nurse aide to the office and resident. She stated money in 8 AM and 6 PM Monday of further stated no one was a weekends and that they could get their money aded it over the weekend.  In the state of the interval of the state	F 15		5/22/15
	communications, included communications, included access to stationery, implements at the result of	ident's own expense.  is not met as evidenced  and staff interviews the facility I day out of 6 days that mail		F 171  1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #97 by ensuring that he/she receives mail tha addressed to him/her on Saturdays.  2. Facility residents have the potenti be affected by the same alleged defici practice; therefore the Activities Mana, has established a process for delivery mail on Saturdays via the Manager on	t is al to ent ger of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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				HICKORY, NC 28602			
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F 171	PM with Resident #97 delivered to the facility receive it on Saturday received her Saturday received her mail on I An interview was cone PM with the Activity D delivered the resident through Friday and th Saturday was locked Monday.  An interview was cone PM with the Director of stated the resident mathrough Friday and the in an office and delivered to the stated the resident mathrough Friday and the in an office and delivered.	ducted on 04/23/15 at 2:30 7. She stated if she had mail y on Saturday she would like 7. Resident #97 stated she 9 mail at the same time she Mondays.  ducted on 04/23/15 at 2:58 birector. He stated he 1 mail at the facility Monday in an office and delivered on in an office and delivered on ducted on 04/24/15 at 3:51 of Nursing (DON). She 1 mail was delivered Monday in e Saturday mail was locked in each of the pool of the p	F 1	Duty.  3. Measures put into put that the alleged deficient recur include: The Admiconduct in-service/re-ed Activities Manager, Activates Manager,	at practice does inistrator will ducation for the vities Assistant, am regarding the mail to residents and Council meet month of May t ght to have their he facility is suct visits at leas with assigned estions regarding nistrator will revirning stand up as concerning massis, the vities and the vities and the vities of the above erns/trends to the other month for committee will ass of the above onal intervention ds/outcomes to	e s tting to r tt g riew nail ncil ith	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPC ALLEGATIONS/INDI\	PRT	F 2	· ·		5/22/15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 225	been found guilty of mistreating residents had a finding entered registry concerning a of residents or misar and report any know court of law against a indicate unfitness for other facility staff to or licensing authorities. The facility must ensinvolving mistreatme including injuries of misappropriation of rimmediately to the act to other officials in act through established State survey and certifications are thoroup revent further poter investigation is in profit to the administrator of representative and to with State law (included certification agency) incident, and if the administrator of the administrato	employ individuals who have abusing, neglecting, or a by a court of law; or have dinto the State nurse aide abuse, neglect, mistreatment oppopriation of their property; ledge it has of actions by a can employee, which would a service as a nurse aide or the State nurse aide registry es.  For the state nurse aide or the state nurse aide	F 2	25		
	by:	T is not met as evidenced view and staff interviews, the		F 225		

		IDENITIEICATION NITIMPED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
						С	
		345232	B. WING		0	4/24/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
		014		3031 TATE BOULEVARD SE			
BRIANCI	R HEALTH & REHABI HI	CK		HICKORY, NC 28602			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 225	Continued From page	e 7	F 22	25			
	facility failed to report	to the state allegations of		Corrective action could not	ot be		
	abuse and investigati	on results within the		accomplished for Resident #8	2 as no		
	required time frames	for 1 of 5 sampled residents		24-hr or 5-Working Day report	was		
	(Residents #82) and	failed to investigate an		located for the allegation of 11	/3/2014.		
	allegation of misappro	opriation of property for 1 of		Resident # 201 was discharge	d from the		
	5 sampled residents (	(Resident #210).		facility; therefore, no corrective	e action		
				could be accomplished for this	resident		
	The findings included	the following:		with regard to missing jewelry.			
				Administrator and Director of N			
		readmitted to the facility on		were educated by the District			
		sion Minimum Data Set		Director regarding the requirer			
		d her with long and short		reporting allegations according			
		, having no behaviors, being		facility¿s Abuse Prohibition Po			
	nonambulatory, and r			2. Facility residents have the	•		
		of her activities of daily		be affected by the same allege			
	living skills (ADLs).			practice therefore, the Adminis			
				conducted an audit of the last	-		
		revealed that on 11/03/14,		concerns and last 30 days of r			
	•	filed a written grievance		allegations to ensure that repo	-		
		t #82 stated that nurse aide		investigation occurred timely a	ina		
		while changing her or		appropriately.	0.000.00		
		The grievance also stated ent #82 that "she was a cry		Measures put into place to that the alleged deficient pract			
		An additional note written		recur include: The District Clin			
		n, from the former Assistant		will conduct in-service/re-educt			
	_	ADON), stated this occurred		the Interdisciplinary Team, inc			
		the specified nurse aide		Administrator, Director of Nurs	•		
		t the wall & twisted her legs,		Services Director, Activities M	-		
	called her Ms. Priss &			Rehab Manager, Care Manag	-		
				Director, and Nurse Managers			
	Attached to the grieva	ance were interviews with 3		the facility¿s policy on Abuse			
	_	erview with Resident #82,		Prohibition, specifically, that w	-		
		the family who initially		allegation of this nature is rece			
		There was no evidence that		Abuse Coordinator is to be no			
	T	e was reported to the state		immediately, an investigation i			
		hours of the allegation and		and proper reporting is to be	<b>3</b> .		
	no evidence that a 5			accomplished. In addition, the			
	investigation was rep			Administrator and Director of N			
	required.			conduct in-service/re-educatio	-		

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		345232	B. WING			C	
NAME OF F	ROVIDER OR SUPPLIER	040202	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		04/24/2015	
				3031 TATE BOULEVARD SE			
BRIAN CT	TR HEALTH & REHABI H	ICK		HICKORY, NC 28602			
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F 225	An interview was con Administrator and the Education on 04/23/1 Administrator stated to ensure that the reside abuse was removed would be conducted questions of who, where the stated that a 24 heart to the state with the inwithin 5 days. The DE Education stated there sent to the state ager On 04/24/15 at 10:10 (DON) stated all report the Administrator who piece. The DON stated instructions of the Administrator who piece. The DON stated instructions of the Administrator who piece in the allegation her findings with the properties of the allegation her findings with the properties and the former Administrator instruction interviews in the morn interviews concluded the resident had a his family did not believe was unsubstantiated. Director present during former Administrator and was responsible	ducted with the interim a Division Director of Clinical 5 at 1:50 PM. The that initially the facility would ent making an allegation of from threat and interviews of appropriate staff, covering at where, when and why. our report would be sent to other report would be sent to other report would be sent nvestigation information ivision Director of Clinical re was no 24 or 5 day report ncy as required.  AM, the Director of Nursing orts of abuse were given to or initiated the investigation ed she followed the ministrator and if asked to viewed the resident and off that was on duty at the a. She then followed up with Administrator. Regarding dent #82, DON stated the the DON at home to report d she in turn reported it to ator. The former ted the DON to conduct ning. DON stated her there were inconsistencies, story of delusions, and the these allegations, so abuse	F 2	staff regarding the facility as A Neglect Prohibition policy. The Administrator will review continued the morning stand up meeting potential reportable issues and that reporting and investigation completed per policy. On a mather Administrator and Director will review any reports to the to ensure that all components report are present to ensure compliance.  4. The Administrator or Director Nursing will review data obtate concern and report audits; and data and report patterns/trens QAPI committee every other six months. The QAPI commevaluate the effectiveness of plan, and will add additional in based on identified trends/outensure continued compliance.	cerns during g to identify and ensure on is nonthly basis, or of Nursing State Agency s of the continued ector of ined during halyze the ds to the month for ittee will the above interventions utcomes to		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED				
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F 225	Continued From page	ge 9	F 22	5			
	02/11/14. Review of investigations reveal submitted to the state #201 reported that who lock bag of jewelry on 03/02/14.	vas admitted to the facility on if the facility's abuse aled a 24 hour report te which indicated Resident while she was at church, a zip went missing from her room					
	former Administrato the police had been searched, staff on the	bmitted to the state by the r on 03/07/14 indicated that contacted, the room was he unit were interviewed and usion to the missing bag.					
	included pearl earri	report revealed items missing ngs, diamond earrings, gold n bumble bee earrings, crystal all earrings.					
	to who searched the were working on the interviewed, what si with the police durin	able to provide information as the resident's room, what staff at unit, what staff were that said and or any follow uping the investigation to assure a on had been completed.					
	the District Clinical I AM revealed all rep the Administrator who piece. The DON standard instructions of the A investigate, she interestigate, she interestigate, she interestigate was on due the She then followed up Administrator. DON incident, the former	Director of Nursing (DON) and Director on 04/24/15 at 10:10 orts of abuse were given to no initiated the investigation ated she followed the dministrator and if asked to erviewed the resident and any ty at the time of the allegation. In with her findings with the stated that at the time of this Administrator took over the pecific notes regarding the					

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F 225 F 226	did not conduct any i missing jewelry. 483.13(c) DEVELOP	e located. DON stated she nterviews related to the	F 2			5/22/15	
SS=D	policies and procedu mistreatment, neglec	elop and implement written					
	by: Based on record revision facility failed to follow procedures for report investigations of abut failed to investigate a misappropriation of presidents (Residents) The findings included The facility policy "Atwith a revision date of *The facility administ Coordinator. *The facility will condalleged abuse/negled or misappropriation of accordance with stat *The facility will repostate, in accordance *The facility will repostate, in accordance *The facility will repostate.	se to the state agency and an allegation of property for 2 of 5 sampled #82 and #210).  If the following:  Duse & Neglect Prohibition" of June 2013 included: rator is the Abuse Prevention of the Abuse Prevention of the Abuse of unknown origin, of resident property in the law. It such allegations to the		F226  1. Corrective action could no accomplished for Resident #82 24-hr or 5-Working Day report located for the allegation of 11. Resident # 201 was discharge facility; therefore, no corrective could be accomplished for this with regard to missing jewelry. Administrator and Director of N were educated by the District Obirector regarding the requiren reporting allegations according facility is Abuse Prohibition Po 2. Facility residents have the be affected by the same allege practice therefore, the Adminis conducted an audit of the last concerns and last 30 days of reallegations to ensure that repoinvestigation occurred timely a appropriately.  3. Measures put into place to	2 as no was /3/2014. d from the e action for resident The new Nursing Clinical ment for g to the blicy. e potential ted deficient strator has 30 days of eported orting and		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345232	B. WING			1	24/2045
NAME OF D	ROVIDER OR SUPPLIER	0.40202	1	С.	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	24/2015
NAME OF PI	ROVIDER OR SUPPLIER						
BRIAN CT	R HEALTH & REHABI H	ICK			031 TATE BOULEVARD SE		
				Н	ICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	Continued From page 1. Resident #82 was 10/10/14. The Admis dated 10/17/14 code term memory deficits nonambulatory, and assistance with most living skills (ADLs).  Review of grievances Resident #82's family which stated Resider (NA) #3 "beat on her interacting with her." that NA #3 told Resided by (verbal abuse), on the grievance forn Director of Nursing (Aaround breakfast that against the wall & tw. Priss & a cry baby."  Attached to the griev staff members, an interacting within 24 no evidence that a 5 investigation was reprequired.  An interview was continued to the continued to the griev staff members, and a reinterview with reported the abuse.	readmitted to the facility on ssion Minimum Data Set d her with long and short a, having no behaviors, being requiring extensive of her activities of daily  servealed that on 11/03/14, y filed a written grievance at #82 stated that Nurse Aide while changing her or  The grievance also stated dent #82 that "she was a cry " An additional note written in, from the former Assistant ADON), stated this occurred at NA #3 "slammed her isted her legs, called her Ms.  ance were interviews with 3 terview with Resident #82, in the family who initially There was no evidence that is was reported to the state hours of the allegation and day report of the		2226	that the alleged deficient practice does recur include: The District Clinical Direct will conduct in-service/re-education for the Interdisciplinary Team, including the Administrator, Director of Nursing, Soci Services Director, Activities Manager, Rehab Manager, Care Management Director, and Nurse Managers regarding the facility is policy on Abuse & Neglect Prohibition, specifically, that when an allegation of this nature is received, the Abuse Coordinator is to be notified immediately, an investigation is to begin and proper reporting is to be accomplished. In addition, the Administrator and Director of Nursing we conduct in-service/re-education for faci staff regarding the facility is Abuse & Neglect Prohibition policy. The Administrator will review concerns during the morning stand up meeting to identify potential reportable issues and ensure that reporting and investigation is completed per policy. On a monthly base the Administrator and Director of Nursing will review any reports to the State Age to ensure that all components of the report are present to ensure continued compliance.  4. The Administrator or Director of Nursing will review data obtained during concern and report audits; analyze the data and report patterns/trends to the	not ctor e e e e e e e e e e e e e e e e e e e	DATE
	ensure that the residabuse was removed would be conducted	that initially the facility would ent making an allegation of from threat and interviews of appropriate staff, covering lat where, when and why.			QAPI committee every other month for six months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventio based on identified trends/outcomes to ensure continued compliance.	e ns	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345232	B. WING			C 4/24/2015	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602	•	4/24/2015	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	the state and then and to the state with the inwithin 5 days. The DEducation stated their found in the facility wow. On 04/24/15 at 10:10 (DON) stated all reports the Administrator who piece. The DON statinstructions of the Adinvestigate, she interfollow up with any statime of the allegation her findings with the artificial former ADON called family's allegation and the former Administrator instruction interviews in the morninterviews concluded the resident had a his family did not believe was unsubstantiated. Director present during former Administrator and was responsible day reports with the state of the s	our report would be sent to aother report would be sent investigation information ivision Director of Clinical re was no 24 or 5 day report ith the grievance.  AM, the Director of Nursing orts of abuse were given to a initiated the investigation red she followed the ministrator and if asked to viewed the resident and aff that was on duty at the action. She then followed up with Administrator. Regarding ident #82, DON stated the the DON at home to report d she in turn reported it to	F 2:				
	02/11/14. Review of investigations revealed submitted to the state #201 reported that will	the facility's abuse					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345232	B. WING		C	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602	04/24/2015	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
	The 5 day report subinformer Administrator of the police had been of searched, staff on the there was no conclus. A copy of the police roundled pearl earring hoop earrings, Avon I earrings and gold bal. The facility was unabto who searched the were working on that interviewed, what stawith the police during thorough investigation. Interview with the District Clinical Diam AM revealed all report the Administrator who piece. The DON statinstructions of the Administrator who piece. The DON statinstructions of the Administrator. DON staff that was on duty She then followed up Administrator. DON sincident, the former Amovestigation. No specially investigation could be did not conduct any immissing jewelry.	mitted to the state by the on 03/07/14 indicated that contacted, the room was a unit were interviewed and ion to the missing bag.  eport revealed items missing us, diamond earrings, gold bumble bee earrings, crystal learrings.  The to provide information as resident's room, what staff unit, what staff were ff said and or any follow up the investigation to assure an had been completed.  Exector of Nursing (DON) and rector on 04/24/15 at 10:10 its of abuse were given to initiated the investigation	F 22		5/22/15	
SS=E	The resident has the	right to choose activities, n care consistent with his or				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345232	B. WING _				C <b>24/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/	24/2010
				303	31 TATE BOULEVARD SE		
BRIAN CT	R HEALTH & REHABI H	ICK		HI	CKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD  PREFIX  TAG  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)					(X5) COMPLETION DATE
F 242	interact with member inside and outside the	ments, and plans of care; rs of the community both e facility; and make choices or her life in the facility that	F2	242			
	by: Based on observation resident and staff into accommodate food or reviewed for food chromatic food control food that the staff into accommodate food or reviewed for food chromatic food of the sident #51) and thresidents with their pa week for 2 of 2 resident #78, #200.  The findings included 1. Resident #20 was 11/28/06 with diagnor reflux and quadripled Data Set (MDS) date Resident #20 was control for eating Review of the facility through 04/2015 reversively grievances related to being honored.  An observation was PM of Resident #20 Aide (NA) #7 assisted lunch. Resident #20 of baked chicken was resident #20	admitted to the facility on ses of diabetes, esophageal gia. The quarterly Minimum of 02/28/15 revealed signitively intact and was .			F 242  1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents #20 a #51 by interviewing the residents to identify food preferences and documenting the information in the diet tray card system. Resident # 78 has be interviewed regarding preferences for showers and this information has been added to the shower schedule to accommodate for the resident ¿s choice Resident #200 has been discharged from the facility.  2. Facility residents have the potential be affected by the same alleged deficie practice; therefore, the Social Services Director and Assistant Director of Nursinave completed an audit of current residents ¿ preferences to include choice related to showers. The Dietary Managhas audited the current resident population to identify that food preferences are documented and honored.  3. Measures put into place to ensure that the alleged deficient practice does recur include: The Social Services Director and Dietary Manager will conditions.	ess. om al to ent ing ce ger	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	
		345232	B. WING _			04/	24/2015
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	031 TATE BOULEVARD SE		
BRIAN CT	R HEALTH & REHABI H	ICK		Н	IICKORY, NC 28602		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			COMPLETION DATE
F 242	42 Continued From page 15		F:	242			
		his lunch tray in case he			nursing staff regarding the resident¿s		
		and onions and she wrote it			right to make choices consistent with the	neir	
		#7 called the kitchen and			interests, specifically, honoring choices		
	•	#20's side of baked chicken			related to food preferences and showe		
	•	to his room 15 minutes later.			schedules. The Administrator will revie		
					concerns during morning stand up		
	An interview was con	ducted on 04/22/15 at 9:52			meeting to identify opportunities related	d to	
	AM with Nurse Aide (	(NA) #9. She stated she			providing for resident choices and ensu		
		plaints from her residents			timely follow up. The Dietary Manager		
	regarding not receiving	ng what they ask for on their			Registered Dietician will obtain food		
	trays. She stated if a	resident asked for a			likes/dislikes/preferences during the		
	sandwich or a snack	throughout the day they are			admission assessment and document	the	
	told the kitchen was	out of what they wanted. NA			information in the medical record and		
	#9 stated she has a r	esident that asked for 2			dietary tray card system. During the		
	cups of coffee with ea				72-hour Care Conference, the Social		
		ray card for 2 cups but she		Services Director or Social Services			
	received 1 cup of cof	fee with each meal.			Assistant will inquire as to preferences	for	
					baths/showers and provide the		
		ducted on 04/22/15 at 3:43			information to the Director of Nursing for		
		he stated the kitchen ran out			documentation on the shower schedule	€.	
		on a daily basis. NA #3			The facility is Ambassadors (team		
		anted a sandwich the kitchen			members who visit with residents routing	-	
		ble to provide it due to			to identify concerns/needs) will conduc	τ	
	running out of food u	sed to make it.			visits at least weekly for 4 weeks to		
	An intorviou was son	ducted on 04/23/15 at 8:52			include questions regarding preference		
		O. He stated if he didn't like			such as food and shower choices. The Administrator will review the minutes from		
		o. He stated if he didn't like nu and asked for a sandwich				OIII	
		he didn't receive it most of			Resident Council monthly to identify concerns related to food or shower		
		told the kitchen was out of			preferences and provide a timely		
	-	stated the kitchen ran out of			response to ensure continued		
	food all of the time.	otates the attenentian out of			compliance.		
					The Administrator and Dietary		
	An interview was con	iducted on 04/24/15 at 10:13			Manager will review data obtained duri	na	
		Manager (DM). She stated			food/shower preference audits, concern		
	•	esidents on admission about			and Ambassador rounds; analyze the o		
		s and choices for their tray			and report patterns/trends to the QAPI		
	cards and inputs the				committee every other month for six		
		ed on the card. She stated if			months. The QAPI committee will		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		E SURVEY IPLETED
		345232	B. WING _			04	C 4/24/2015
	ROVIDER OR SUPPLIER	ICK		303	REET ADDRESS, CITY, STATE, ZIP CODE  31 TATE BOULEVARD SE  CKORY, NC 28602	1 0-	1/24/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 242	choose the alternate them. She stated if a coffee with every mentheir tray card they she coffee with every mentheir tray card they she coffee with every menthey have never rand short if there were new they have never rand short if there were new they have never rand short if there were new they have never	at the regular meal they could and it should be available to resident wanted 2 cups of all and it was documented on hould receive 2 cups of all. The DM further stated but of food but might run awadmissions to the facility.  Iducted on 04/24/15 at 1:45 rator. He stated he was not receiving what they leal trays and was currently to improve the issue. He is choices should be  admitted to the facility on sees of hypertension and ray Minimum Data Set dated lesident #51 was cognitively  grievances from 11/2014 lealed there were 7 resident food choices not  a on 04/22/15 at 9:45 AM of fast tray revealed she had 1 tray card indicated she was	F 2	242	evaluate the effectiveness of the above plan, and will add additional intervent based on identified trends/outcomes ensure continued compliance.	ions	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345232	B. WING			C <b>04/24/2015</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3031 TATE BOULEVARD SE HICKORY, NC 28602	•	04/24/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	were told the kitchen wanted. NA #9 stated cups of coffee with eadocumented on her treceived 1 cup of coff.  An interview was con AM with Resident #5′ spoken with the DM recups of coffee with eatray card and underline everyday but continue. She stated she should cup of coffee every day and interview was con AM with the Dietary Market interviewed the retheir likes and dislikes cards and inputs the incomputer to be printed a resident didn't want choose the alternate at them. She stated if a coffee with every mean card they should be rewith every mean. The never ran out of food there are new admission.  An interview was con PM with the Administrative was con PM with the Administrative of residents no requested on their means.	Resident #51 asked for 2 and meal and it was ay card for 2 cups but she see daily.  ducted on 04/22/15 at 10:12  I. She stated she had many times about getting 2 and to neal and wrote it on her red it on her red it on her red it on her tray card at to receive 1 cup of coffee. In the card in the card in the card in the card. She stated if the regular meal they could and it should be available to resident wanted 2 cups of all and it was on their tray exceiving 2 cups of coffee DM further stated they have but they might run short if ions to the facility.  Inducted on 04/24/15 at 1:45 attor. He stated he was to receiving what they all trays and was currently to improve the issue. He	F2	242		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345232	B. WING _			C <b>04/24/2015</b>
	ROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP COD 3031 TATE BOULEVARD SE HICKORY, NC 28602	E	04/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 242	Continued From page	e 18	F 2	42		
	09/08/14. His diagno	admitted to the facility on oses included dementia, action, diabetes, right sided rascular accident and				
	09/15/14 coded him v cognition, requiring e most activities of dail	num Data Set (MDS) dated with severely impaired xtensive assistance with y living skills (adls), and not th during this assessment				
	with long and short to	ated 12/05/14 coded him erm memory impairment, decision making skills and ance with bathing.				
		ated 03/03/15 coded him d cognition and requiring bathing.				
	04/21/15 at 1:23 PM, that the resident did r	riew conducted by phone on the responsible party stated not receive showers per his me he would have showered				
	9:29 AM revealed that up according to room manager and Director resident requested at tried to fit it in with the	Aide (NA) #1 on 04/24/15 at at a shower schedule was set numbers by the unit of Nursing (DON). If a nextra shower then they eir regular schedule. If a lest more than 2 showers				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C <b>04/24/2015</b>	
	PROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602	<b> </b>	04/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 242	weekly on a regular beforwarded to the DOI  Interview with the Un  9:32 AM revealed that two showers per week change to a different day, then a switch we accommodate that rest that upon admission responsible party was schedule.  The Social Worker we at 10:05 AM. She stacked residents and preferences for shown.  The Activity Director 04/24/15 at 11:13 AM preference section of the resident or responsible to the resident or responsible bath. He stated the did not direct him to a baths they preferred.  Interview with the Dir 04/24/15 at 1:17 PM hour meeting with all family and the reside going. At that time prefered discussed.  Follow up interview we 04/24/15 at 3:22 PM or responsible party of the responsible party of the presence of the party of the presence	pasis, that request would be N or unit manager.  It Manager #1 on 04/24/15 at at there was a schedule for ex. If there was a request to day or a different time of buld be made to equest. She further stated the resident and or informed of the set  as interviewed on 04/24/15 at at the MDS nurses responsible parties their vers.  It stated during interview on that when he completed the in the MDS, he only asked insible party how important it then a bed bath, shower or the MDS preference section ask how many showers or to receive each week.  The extension of the set of the MDS preference section ask how many showers or to receive each week.  The extension of the set of the MDS preference section ask how many showers or to receive each week.  The extension of the set of the MDS preference section ask how many showers or to receive each week.  The extension of the set of the MDS preference section ask how many showers or to receive each week.	F 2	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345232	B. WING _			C <b>04/24/2015</b>		
		пск		STREET ADDRESS, CITY, STATE, ZIP ( 3031 TATE BOULEVARD SE HICKORY, NC 28602	CODE	0.12.1.20.10		
(X4) ID PREFIX TAG	OF CORRECTION  A 345232  F PROVIDER OR SUPPLIER  CTR HEALTH & REHABI HICK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE			
F 242	of this interview inter added to the schedu	jected that showers were le if a resident asked for	F	242				
	diagnoses that including high blood pressure, Review of the admis (MDS) indicated he resident #200 requimost activities of dai person assist, was not transfers, and was of with staff assistance be incontinent of uring the best of the best of the best of the most activities of dai person assist, was not transfers, and was of with staff assistance be incontinent of uring the best of the best of the best of the best of the care participated in the control of the best of the care participated in the control of the best of the care participated in the care participated	ded gout, kidney disease, stroke, and dizziness. sion Minimum Data Set was cognitively intact. red extensive assistance with ly living (ADL's) with 1 to 2 oted to not be steady with may able to transfer safely. He was revealed to always he and frequently incontinent indicated Resident #200 had in and received therapy 5 ent #200 was noted to have completion of the MDS as very important for him to ath he received.						
	On 04/22/15 at 8:30 Resident #200, he in	wer 2 times weekly.  AM during an interview with dicated he would like to take He stated he took a shower						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVE COMPLETED		
		345232	B. WING _	B. WING		C <b>04/24/2015</b>	
	ROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP COD 3031 TATE BOULEVARD SE HICKORY, NC 28602		04/24/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 242	Continued From page	e 21 vas at home and he would	F 2	242			
	prefer to have a show now. He indicated he what type of bath he revealed he was told	ver more often than he does was not asked how often or would prefer. Resident #200 by a nurse he would take a and he could get a bed bath					
	Resident #200 receives She revealed he had	e Aide #6 (NA#6). She stated yed a shower 2 times a week. a shower in his room, as did 00 Hall. NA #6 indicated					
	staff did initial assess they were admitted to revealed that residen receive 2 showers a days were. The resid alright with them. Sho not asked how many a shower. Nurse #3 i an extra shower they them. She stated the	PM an interview was e #3. She indicated nursing sments on residents when to the facility. Nurse #3 ats were told they would week and what their shower ents were asked if that was e revealed residents were days a week they would like indicated if a resident wanted would try to accommodate re were no baths on the 500 got a shower or a bed bath.					
	are not asked now m would like. She state their shower days wo	PM an interview was 7. She indicated residents any showers a week they d residents were told what ould be and if they requested would try to accommodate					
	On 04/23/15 at 1:35 conducted with NA #	PM an interview was 8. She revealed residents					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •	' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345232	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602		4/24/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 256 SS=D	were given a shower a bed bath on the oth resident wanted anotton their own, the staff NA #8 indicated if a rewithout assistance, the On 04/24/15 at 1:55 F conducted with Nurse activities department their preferences. Nu were told they would scheduled days. She bed bath on the non-acknowledged reside many days a week the shower.  On 04/24/15 at 2:25 F conducted with the D She stated the facility hours after a resident includes the entire teasocial work personne preferences are discuresidents were told were to be given, and day or shift the staff we them. The DON acknet told when they would not asked how often to	2 times a week and offered er days. She stated if a her shower and could do it is would assist with set-up. Esident could not shower ey were offered a bed bath.  PM an interview was effected a bed bath.  PM and interview was a week on the revealed residents get a shower days. Nurse #4 effected hat were not asked how ey would like to receive a effected hat am including activities and effected hat day their 2 showers effected hat day their 2 showers effected another would try to accommodate by wedged residents were receive a shower, but were hey would like a shower.  ATE & COMFORTABLE	F 2:			5/22/15	
	acknowledged reside many days a week th shower.  On 04/24/15 at 2:25 F conducted with the D She stated the facility hours after a resident includes the entire teasocial work personne preferences are discuresidents were told wwere to be given, and day or shift the staff with them. The DON acknowled to to the day of the	PM and interview was rector of Nursing (DON). conducts a meeting 72 has been admitted that am including activities and l. She revealed resident issed. The DON indicated that day their 2 showers if they preferred another would try to accommodate owledged residents were receive a shower, but were hey would like a shower. ATE & COMFORTABLE	F 2:	56		5/22/1	

OLIVILIY	OT OIL MEDIO, ILL G	· · · · · · · · · · · · · · · · · · ·				<del></del>	. 0000 0001
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345232	B. WING				24/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
DDIAN OT	DUEALTH & DEHADIN	lok.		30	031 TATE BOULEVARD SE		
BRIANCI	R HEALTH & REHABI H	ick		Н	IICKORY, NC 28602		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 256	Continued From page 23		F	256			
	· -	is not met as evidenced	•				
	by:	13 Hot met as evidenced					
	-	ns and staff and resident			F 256		
	interviews the facility	failed to provide adequate			Corrective action has been		
		a resident's room for 1 of 1			accomplished for the alleged deficient		
		lighting levels (Resident			practice with regard to Resident #24 by	/	
	#24).				providing a reading lamp for the		
	The findings included				resident¿s need for additional lighting.		
		mitted to the facility on			2. Facility residents have the potentia		
		the annual Minimum Data			be affected by the same alleged deficie	ent	
		vealed Resident #24 was			practice; therefore, the Maintenance		
		indicated reading books			Director and Maintenance Assistant ha		
	was very important to	vas conducted on 04/20/15			completed an audit of the facility to enst that adequate lighting is provided in ea		
		nt #24 reported that she had			room.	CII	
		s Maintenance Director and			Measures put into place to ensure		
		lighting by her bed so that			that the alleged deficient practice does		
	· · ·	comfortably but none had			recur include: the Administrator will		
	been provided.	•			conduct in-service/re-education for the		
	An observation of Re	sident #24's room was			Maintenance Director and Maintenance	Э	
		15 at 11:28 AM. The lighting			Assistant regarding adequate and		
		y was limited to only one			comfortable lighting levels, specifically		
		supplemental lighting was			that each room should include an		
	available by Resident				over-bed light or other supplemental		
		ducted on 04/23/15 at 11:18  Maintenance Director. The			lighting source. The Maintenance Director will conduct rounds weekly for		
		e Director reported that			four weeks, then at least monthly as pa		
	_	ially asked him to provide			of the preventive maintenance progran		
		pproximately one month ago			identify that adequate lighting is preser		
		lent #24 had also reminded			each room. The Administrator will cond		
		e previous week. The			rounds weekly for four weeks then at le		
		verbalized that he had not			monthly for 3 months to monitor that		
	taken any action to p	rovide Resident #24 with			lighting is adequate in residents; room	S	
		ecause he had forgotten			to ensure continued compliance.		
	about Resident #24's	•			4. The Administrator and Maintenand	-	
		conducted with the DON on			Director will review data obtained durin	g	
		The DON verbalized that it			facility audits and rounds; analyze the		
	-	that each resident would			data and report patterns/trends to the		
	have adequate lightin	ng in their room for reading.			QAPI committee every other month for	SiX	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _				C <b>24/2015</b>
	ROVIDER OR SUPPLIER	ск	'	STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602			2-1/2010
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F 256	Continued From page			256	months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventio based on identified trends/outcomes to ensure continued compliance.	ns	
F 272 SS=E	a comprehensive, acc reproducible assessment functional capacity.  A facility must make a assessment of a resideresident assessment by the State. The assessment by the State. The assessment of a resident assessment contification and dent customary routine; Cognitive patterns; Communication; Vision; Mood and behavior personal moderation of sur conditions; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sur the additional assessing the session of the se	duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information;  atterns; ng; and structural problems; d health conditions; status;	F?	272			5/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NI IMBED:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	0.0202		STREET ADDRESS, CITY, STATE, ZIP CODE		04/24/2015	
				3031 TATE BOULEVARD SE			
BRIAN CT	R HEALTH & REHABI H	ICK		HICKORY, NC 28602			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 272	Continued From page Documentation of pa	e 25 rticipation in assessment.	F 27	72			
	by: Based on record rev facility failed to analy weaknesses, and hor residents' functionalit assessments for 7 of (Residents #11, #57, #135).  The findings included  1. Resident #63 was 11/24/14 with diagnos chronic pain, anxiety, The admission Minim 12/03/14 coded her v exhibiting other beha disrupted care or the and nearly every day things, feeling down, issues, having trouble or speaking so slowly  The Care Area Asses 12/05/14 and written did not analyze the re weaknesses, and hor	y in the care area 26 sampled residents. #63, #78, #108, #109, and It:  admitted to the facility on ses including diabetes, and depressive disorder. It with intact cognition, viors that significantly living environment of others, having little interest in doing being tired, having appetite expenses concentrating and moving of others may notice.  Sesments (CAA), dated by the Social Worker (SW), sesident's strengths, or these affected the		F 272  1. Corrective action has been accomplished for the alleged def practice with regard to Residents #63, #78, #108, and #109 by rea the Care Area Assessments (CA making addendum documentation support the findings. Action could taken for Residents #11 and #13 are discharged from the facility.  2. Residents who have compressessments completed have the potential to be affected by the same alleged deficient practice; therefore Resident Care Management Direct MDS Coordinator have reviewed 30 days of comprehensive assessments of comprehensive assessments and CAAs to ensure that triggeres have information present that deather resident as strengths, weakness and functionality.  3. Measures put into place to esthat the alleged deficient practice recur include: The District Director Management has conducted in-service/re-education for the Resident Care with the Resident Care action for the Resident Care with the Resident Care action for the Resident Care with the Resident Care action for the Resident Care with the Resident Care action for the Resident Care with the Resident Care action for the Resident Care with the Resident Care action for the Resident Care with the Care with	s # 57, ssessing As) and on to d not be 5 as they chensive e me ore, the ector and the last esments ed areas scribes esses, ensure e does not or of Care esident		
	resident's functionalit a. Cognition CAA not diagnoses of anxiety	y as follows: ed the resident had a		Care Management Director, MDS Coordinator, and Social Services regarding CAA completion expec	S Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C <b>04/24/2015</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	04/24/2013	
				3031 TATE BOULEVARD SE			
BRIAN CT	R HEALTH & REHABI I	HICK		HICKORY, NC 28602			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE DED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 272	Resident #63 was ye care plan decision were developed and staff redirection when beto. Psychosocial Wester resident was adding was independed CAA reiterated the Mood issues. There had mood issues. There had mood issues, we was affected by their was no care plan we would continue to in socials and assist heattend.  C. Mood CAA repeated Psychosocial Well-Emade to not proceed were going to invite d. Behavior CAA not anxiety disorder and 11/28/14 she was yell plan was going to be continue to provide arose.  Interview with SW or revealed she had part on the computer related the corporation to as responsibilities inclusible said she normal notes for information information she four that she will gather it.	aurses noted on 11/28/14 that belling and screaming. The was no care plan would be would continue to provide haviors arise.  Il-Being CAA noted the date mitted, her diagnoses, that bele to make her needs know in the decision making. This MDS information related to expect was no analysis of why she hat caused them, or how she in. The care plan decision build be developed as staff wite her to activities and for to activities if she chose to ded what was written in the decision was downthen a care plan as staff to activities. The decision was downthen a care plan as staff to activities. The decision was downthe a care plan as staff to activities. The decision was downthe had the diagnoses of a lithat in the nursing notes on belling and screaming. No care decivities at 2:54 PM articipated in company training and steed to completion of CAA's. The decision was directed to completion of CAA's. The decision was developed as staff were to redirection when behaviors.	F2	as described in the F Resident Care Mana audit at least 5 comp assessments and CA months to ensure the present according to the individual and the addresses the analy- strengths, weakness	agement Director will brehensive AAs per month for six at information is the assessment of at the information sis of the resident; sees, and how these dent; s functionality to impliance. are Management data obtained during essment audits, direport e QAPI committee or six months. The evaluate the above plan, and will entions based on comes to ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C <b>04/24/2015</b>	
	ROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP COD 3031 TATE BOULEVARD SE HICKORY, NC 28602	E	04242010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 272	Continued From pag	e 27	F 2	772			
	she found in the nurs	of repeated what information sing notes on the CAA. She ow she needed to put more A.					
	02/20/15 with diagno hypertension, encepl depression. He sust	as admitted to the facility on ses including alcohol abuse, nalopathy, anxiety, and ained a head injury from e he lost consciousness per					
	02/27/15 coded him a skills, having inattent alerted level of consoretardation, having pubehavioral symptoms and others at signific injury and interfered and intruded on the pull in addition, the MDS feeling down, depres	mum Data Set (MDS) dated as having intact cognitive ion, disorganized thinking, ciousness, psychomotor hysical, verbal and other is which put both the resident ant risk for physical illness or with Resident #135's care privacy or activity of others. coded the resident as sed or hopeless, having little					
	The Care Area Assessments (CAA), dated 03/04/15 and written by the Social Worker (SW), did not describe the extent of the issue, analyze the resident's strengths, weaknesses, and how these affected the resident's functionality as follows:  a. Cognitive CAA noted he had short term memory problems and repeated his answers from the brief interview for mental status as stated on the MDS. The decision to not proceed with a care plan was made as staff were to continue to provide orientation as needed.  b. Psychosocial Well-Being CAA listed his						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345232	B. WING _			C <b>04/24/2015</b>		
	ROVIDER OR SUPPLIER	lick		STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602		0412412010		
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F 272	and kicking staff on anxious and combat noted he received mand a psychiatry cor There was no analys. The decision to not cand staff were to corwhen behaviors aros c. Behavioral CAA o anxiety and the nurs 02/25/15 documentind decision was made that staff were to continual behaviors arose.  Interview with SW or revealed she had paranthe computer relations to as responsibilities included the corporation to as responsibilities included that she will gather in able but for most thin	gnoses, nursing vas combative, threatening 02/23/15 and he was very ive on 02/25/15. The CAA iedication for this agitation issult had been ordered. Sis of the facts presented. Care plan this area was made intinue to provide redirection isse. Inly listed his diagnoses of ing notes of 02/23/15 and ing combative behaviors. The ion oot care plan this area as ie to provide redirection when  In 04/24/15 at 2:54 PM Intricipated in company training inted to completion of CAA's. Interes was no oversight from itsist her with social work ding the completion of CAA's. Illy looked at the nursing	F 2	72				
	CAA. She stated she put more information  3. Resident #78 was 09/08/14 with diagnor chronic airway obstruccident and depres  The admission Minim	e did not know she needed to a in the CAA.  s admitted to the facility on oses including dementia, uction, cerebral vascular						

i '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602	<u> </u>	04/24/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 272	cognitive skills, exhib extensive assistance living skills and weigh. The Care Area Asses analyze the resident's and how these affects as follows:  a. Cognition CAA dats. Social Worker (SW) still diagnoses of dementi impairments and was year, month, or day of analysis of this inform on the resident. The not develop a care plate to provide orientation. Interview with SW on revealed she had part on the computer related. She further stated the the corporation to assist responsibilities included She said she normally notes for information information she found that she will gather in able. She stated she put more information b. Nutrition CAA date former dietary employ admission and diagnor gastro esophageal realization and condition and diagnor gastro esophageal realization and condition and diagnor gastro esophageal realization. Instead of the received a responsibilities and diagnor gastro esophageal realization and diagnor gastro esophageal realization and diagnor gastro esophageal realization and condition averaging 62 percent weight, listed laborated.	ting no behaviors, requiring for most activities of daily ing 142 pounds.  sments (CAA) did not strengths, weaknesses, ed the resident's functionality and 09/18/14 written by the stated the resident had a a with short term memory unable to recall the correct of the week. There was no station and what affect it had care plan decision was to an as staff was to continue as needed.  04/24/15 at 2:54 PM sticipated in company training ed to completion of CAA's. For ewas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's. For evas no oversight from sist her with social work ing the completion of CAA's.	F 2	72				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345232	B. WING _			C <b>04/24/2015</b>		
	ROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP COI 3031 TATE BOULEVARD SE HICKORY, NC 28602	DE	04/24/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 272	There was no analys and contributing factor this information impa Interview with the MI at 2:54 PM revealed analyze the informatiskinny since admission chose to do so.  4. Resident #57 was 10/29/11 with diagnoencephalopathy, den Disease.  The significant change 06/07/14 coded her woognitive skills (missibrief interview for medid not analyze the reweaknesses, and hor resident's functionality a. Cognition CAA not diagnoses of dement problems, and was ure year, month and day information describin was or how it affected.	and his creatine was high. is which included causes ors and risk factors and how oted his nutritional status. OS coordinator on 04/24/15 that this nutrition CAA did not on. She stated he'd been on and can feed himself if he admitted to the facility on ses including metabolic mentia, and Alzheimer's  ge Minimum Data Set dated with severely impaired ing all the questions on the ental status).  sements (CAA), dated by the Social Worker (SW), esident's strengths, w these affected the	F	272				
	revealed she had part on the computer rela	04/24/15 at 2:54 PM rticipated in company training ted to completion of CAA's. ere was no oversight from						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345232	B. WING _			C <b>04/24/2015</b>		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 272	-	sist her with social work	F	272				
	She said she normal notes for information information she found that she will gather in	d in the CAA. She stated formation from a resident if did not know she needed to						
	04/11/11. her diagno	is admitted to the facility on ses included altered mental order and depressive						
	09/26/14 coded her a scoring a 9 out of 15	Data Set (MDS) dated as being cognitively intact, on the brief interview for aving behaviors of rejecting						
	10/03/14 and written did not analyze the re weaknesses, and ho resident's functionalit a. Cognition CAA not dementia with delusic problems and was ur year or day of the we information describin was or how it affected. The decision was mas staff were to contineeded.	w these affected the y as follows: ed she had a diagnosis of ons, short term memory hable to recall the correct ek. There was no g how severe the dementia d her day to day function. Indee to not care plan this area nue to provide orientation as						
	dementia and the me records for September medication on 9/20/1	ed she had a diagnoses of edication administration er 2014 showed she refused 4 and 9/22/14. It was also behavior form for September						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			
		345232	B. WING		C 04/24/2015		
	ROVIDER OR SUPPLIER	ніск	;	STREET ADDRESS, CITY, STATE, ZIP CODE 8031 TATE BOULEVARD SE HICKORY, NC 28602	1 04/24/2010		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 272	2014 she had 5 epis delusions and parar information as to he The decision was make to continue to arose and to encounted to arose.	sodes of hallucinations, noia. There was no we this affected the resident. nade not to care plan as staff redirect when behaviors	F 272				
	revealed she had part on the computer rel She further stated the corporation to a responsibilities inclusive said she normal notes for information information she found that she gathered in able but for most the Resident #109 she she found in the number of the computer	articipated in company training ated to completion of CAA's. here was no oversight from ssist her with social work uding the completion of CAA's. ally looked at the nursing n and put whatever and in the CAA. She stated information from a resident if tings such as the case with just repeated what information rising notes on the CAA. She eeded to analyze the					
	03/23/11 with diagn accident, diabetes a significant change Mated 03/27/15 reveseverely cognitively revealed Resident #	vas admitted to the facility on oses of cerebrovascular and Alzheimer's disease. The Vinimum Data Set (MDS) ealed Resident #108 was impaired. The MDS further #108 required extensive mobility, transfers, personal g.					
	dated 04/01/15 reveildentified and how t	Area Assessments (CAA) ealed no analysis of the areas hey affected Resident #108's ection the care plan would					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345232	B. WING			C <b>04/24/2015</b>	
	NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK			30	REET ADDRESS, CITY, STATE, ZIP CODE 31 TATE BOULEVARD SE CKORY, NC 28602	0-47	24/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	the facility for long tenter diagnoses. The owas that she was on was written by the MIPressure Ulcer reveal readmitted to the facing rehabilitation and a light additional information interventions and treatulcer. This was written the MDS nurse was an interview was comply with the MDS Coccan comply with the MDS coccan should contain a resident was doing but the resident and expessated she would war Resident #108 in the and pressure ulcers. The Resident #11 was 02/11/14 with diagnoral Disease (ESR and respiratory diseate annual Minimum 01/27/15 revealed she required extensive as of daily living (ADL's) vision, and was on a Review of the Care Adated 01/27/15 indicate areas for further asset to include ADL's, president was on a present the content of the care and th	ent #108 was readmitted to rm rehabilitation and a list of only additional information the therapy caseload. This DS Nurse.  Iled Resident #108 was lity for long term st of her diagnoses. The only n was a list of the atment for the pressure in by the MDS Nurse.  Unavaliable for interview.  Iducted on 04/24/15 at 2:54 ordinator. She stated the asummary of how the efore admission, goals for ected outcomes. She further int more information about analysis of findings for falls  admitted to the facility on ses that included End Stage D), heart failure, diabetes, se among others. Review of Data Set (MDS) dated e was cognitively intact, sisistance with most activities had moderately impaired	F	272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345232 B. WING		B. WING		C 04/24/2015	
	ROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 309 SS=D	the care area of nutri Resident #11's comp direction the care pla is as follows: Nutritional status indi stable weight for the dialysis well, was not would continue to be nutritional analysis of needs were discusse MDS Coordinator. On 04/24/15 at 3:25 I conducted with the M revealed she realized care issues. She stat analysis contained lit Resident #11's stable Coordinator acknowled other care issues that CAA. 483.25 PROVIDE CAHIGHEST WELL BEI  Each resident must reprovide the necessar or maintain the higher mental, and psychosolaccordance with the dand plan of care.  This REQUIREMENT by: Based on observation interviews, and reconschedule a follow-up	cion did not fully describe lex nutritional needs, or what in should follow. An example  cated Resident #11 had loast 6 months, tolerated on fluid restrictions, and monitored. No further Resident #11's complex d. This was written by the  PM an interview was DS Coordinator. She I Resident #11 had multiple led the reason the CAA cle information was due to le weight. The MDS ledged Resident #11 had let were not addressed in the  IRE/SERVICES FOR NG  Receive and the facility must by care and services to attain st practicable physical,	F 272		5/22/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _	B. WING		C <b>04/24/2015</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3(	031 TATE BOULEVARD SE		
BRIAN CT	R HEALTH & REHABI H	ICK		Н	IICKORY, NC 28602		
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F 309	Continued From page	e 35	F:	309			
F 309	residents on dialysis implement physician interventions to addreshand plasticity for 1 of skin impairment issue. The findings included 1. Resident #11 was 02/11/14 with diagnosfailure, high blood pre Review of the annual dated 01/27/15 indicated sintact and required exmost activities of daily to receive dialysis, and Review of Resident #01/27/15 indicated should be care planning for dialyoned to have included the dialysis center and her drug regimen for Review of Resident #101/23/14. Her cate postponed due to Respressure and it was mare scheduled after her more stable. Review medication regimen in treatment for her blood	(Resident #11) and failed to orders and care planned less edema, skin tears and if 3 residents sampled for es (Resident #121).  It is admitted to the facility on ses of renal disease, heart lessure, and diabetes.  Minimum Data Set (MDS) and the ses was cognitively extensive assistance with a privilege yield it is on oxygen therapy.  It is care plan dated the received assessment and a privilege is expected assessment and grist treatment which is extend communication between the facility, and monitoring drug interactions.  It is medical record the due to be sident #11's unstable blood to ted that she was to be blood pressure became	F;	309	completing a therapy screening for the use of a hand splint, high-back wheelchair, dycem, and half lap tray. Resident #121¿s orders for an edema control sleeve to his left arm are implemented per the MD orders. Refus are documented in the medical record. Resident #11 has been discharged from the facility.  2. Residents who require adaptive equipment for the purposes of position and/or skin protection and residents who have consultations with community medical resources have the potential to be affected by the same alleged deficies practice. The Rehab Program Manage and Director of Nursing have complete an audit of current residents who require adaptive equipment to ensure that equipment is available and in use per to MD order and/or care plan. The Director of Nursing has completed an audit of current residents who required manages are consultations within last 30 days with outside medical records to identify that recommendations and/or orders from consultations within last 30 days with outside medical resources has been followed up and implemented as appropriate.  3. Measures put into place to ensure that the alleged deficient practice does recur include: The Director of Nursing a Rehab Program Manager will conduct in-service/re-education for nursing staf regarding the provision of services to	ing no ent r d re he or	
	Assistant (PA) to find nephrologist at the di	out from Resident #11's alysis center if she was safe avenous sedation for her			maintain wellbeing, specifically, resider who require adaptive/protective equipment are to have this equipment place per care plan and/or MD order, the equipment meets the needs of the	in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
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F 309	Continued From p	age 36	F3	309		
1 309	Further review of Resident #11 was on 03/10/15. Opto Resident #11 was lenses due to her Resident #11 was and she wanted to as she was cleared On 04/21/15 at 4: made of Resident her television. She to see anything or she was supposed was canceled due stated it was supposed was canceled. She inded to her surgery unnot talked to anyocanceled.  On 04/23/15 at 2:3 conducted with Noremember when Fourgery postponed blood pressure, but been addressed seen addressed seen addressed seen and request to have cataract sonephrologist. Nursignal was written on 01/10/16/16/16/16/16/16/16/16/16/16/16/16/16/	the medical record revealed seen by the facility optometrist metry records indicated not a candidate for corrective cataracts. He revealed still waiting for cataract surgery proceed with surgery as soon ed.  10 PM an observation was #11 sitting 8 to 10 inches from e stated she had to sit so close in the TV. Resident #11 revealed do to have cataract surgery, but it is to her blood pressure. She posed to be rescheduled, but if anything since it had been icated the eye center would not till she was cleared, but she had ne since the surgery was  30 PM an interview was surse #1. She stated she could Resident #11 had her cataract do due to her issue with high but she did not know if it had ince.  10 PM an interview was surse #1. She stated due to hal failure, the facility medical ed the decision for her release urgery be left up to her se #1 acknowledged the order		resident, and that the such equipment is deproper appropriately. If a result equipment, then the documented. Repeated be reported to the plintervention or disconsideration of Nursing with the process of Nursing with the process of Nursing, will conduct care round the pr	ocumented sident refuses such instance is ated refusals should hysician for possible ontinuation. The will review consultation forning clinical that any new ations are on the MD orders. Sing, Assistant and Unit Coordinator ands twice weekly for weekly for weekly for 4 weeks to exprotective equipment are plan and/or MD is Director of Nursing or will review twice weekly for four week for four weeks, see months during ers to validate that place for equipment. Nursing will review g care rounds and dits; analyze the data trends to the QAPI for month for six committee will eness of the above diditional interventions trends/outcomes to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER TR HEALTH & REHABI H	иск		STREET ADDRESS, CITY, STATE, ZIP CO 3031 TATE BOULEVARD SE HICKORY, NC 28602	DE	0.12.020.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	by her nephrologist a approval for cataract she did not know if the dialysis center.  On 04/24/15 at 10:00 dialysis center and shurse #2 acknowled the dialysis center has Resident #11 to be effected the orderenter. She stated shout the nurse on duty.  On 04/24/15 at 10:20 conducted with the Fivrote an order for a expectation that the consultation. The Pawith complex medical specialist consult to an esthesia.  On 04/24/15 at 2:25 conducted with the Effective She stated it was he staff would take those fax them to the dialy acknowledged the outobe evaluated by have cataract surger dialysis center was reconsult.  2. Resident #11 with diagnor failure, high blood presidents.	esident #11 to be evaluated at the dialysis center for the surgery. The PA revealed those orders were sent to the DO AM Nurse #2 called the spoke with the Charge Nurse. Iged the Charge Nurse stated and not received a request for evaluated for surgery. Nurse for was not sent to the dialysis the was not present that day, by that day missed the order.  DO AM an interview was PA. She stated when she consult it was her nurses schedule the an indicated for any resident at issues she would request a clear the resident for  PM an interview was Director of Nursing (DON). In expectation that the nursing the orders for the consult and	F	309			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		345232	B. WING		04/24/2015
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 309	intact and required of most activities of dat to receive dialysis at Review of Resident 01/27/15 indicated scare planning for dianoted to have including the dialysis center at her drug regimen for Review of Resident revealed an order with pharmacy exchange medication Renvela Acetate. On 04/17/1 communication she center to the facility be discontinued and The facility was requenter for further clarecord from the dialycharge nurse at the notation on the comfacility took off the orequest.	extensive assistance with a control of the control	F 309		
	dialysis center was on a Dialysis Comm filled out by the facil medications taken, information pertinen care. Nurse #1 indic a resident went for o	ween the facility and the completed by documentation nunication Record that was lity with vital signs, meals provided, and any other at to the resident and their cated this was done each time dialysis treatment. She dialysis center responded with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		345232	B. WING			C <b>04/24/2015</b>
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK  (X4) ID PREFIX TAG  Continued From page 39 information and orders concerning the resident after dialysis was completed. This information included any changes to the resident's medication regimen. Nurse #1 indicated the sheet was reviewed by the nurse when the resident returned from dialysis and orders were processed.  On 04/23/15 at 2:25 PM Nurse #1 contacted the dialysis center to discuss Resident #11's medication order for Renvela. Nurse #1 stated she was instructed by the charge nurse at the dialysis center that the nephrologist and the		STREET ADDRESS, CITY, STATE, ZIP COD 3031 TATE BOULEVARD SE HICKORY, NC 28602		CODE	· · · · · · · · · · · · · · · · · · ·	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	information and orde after dialysis was cor included any change regimen. Nurse #1 in reviewed by the nurs from dialysis and ord  On 04/23/15 at 2:25 dialysis center to disc medication order for she was instructed by dialysis center that the dietician requested the 04/17/15 due to the eCalcium Acetate, whin need. Nurse #1 indic would contact the ne Calcium Acetate coul Renvela.  On 04/23/15 at 3:35 conducted with Nurse just received a call from instructions to discontant restart the Renvette nephrologist did not restart the received and receive	rs concerning the resident impleted. This information is to the resident's medication dicated the sheet was element when the resident returned ers were processed.  PM Nurse #1 contacted the class Resident #11's Renvela. Nurse #1 stated by the charge nurse at the renephrologist and the charge on excess calcium in the char	F	309	CY)	
	(PA). She indicated if that Resident #11 to she should receive. The aresident returned from the written orders, the known so she can revistated the order conclude the dialysis center.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345232	B. WING _			C <b>04/24/2015</b>	
	ROVIDER OR SUPPLIER	lick		STREET ADDRESS, CITY, STATE, ZIP COD 3031 TATE BOULEVARD SE HICKORY, NC 28602	E	04/24/2010	
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F 309	Continued From pag	e 40	F3	809			
	would re-check Resi her levels were norm lab performed at the revealed her calcium limits.  On 04/24/15 at 2:25 conducted with the E She stated she had a concerning the commander the facility and the dindicated there was a orders are sent from the facility. She reversetter system in place transferred correctly was her expectation orders received from	ion. The PA indicated she dent #11's calcium to be sure hal. Review of Resident #11's dialysis center on 04/22/15 helevels were within normal.  PM an interview was Director of Nursing (DON). Spoken with the PA nunication issues between alysis center. The DON a breakdown in how resident the center and received by aled there needed to be a see to assure information is. The DON acknowledged it that the nurses take off the the dialysis center and seen by the medical staff.					
	05/14/12 with diagnor vascular accident, he syndrome, chronic p stress.  Review of physician #121 was to have a 8 hours per day since dycem to keep arm fordered on 08/12/12 arm and hand every 08/12/13; and high be	as admitted to the facility on uses including cerebral emiplegia, neurologic neglect ain, and post traumatic orders revealed Resident left resting hand splint on 6 to e ordered on 07/29/13; from sliding every shift since; edema control sleeve left shift since ordered on ack wheelchair with left half nce ordered on 01/14/14.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1.0002	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602	<u> </u>	04/24/2015	
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F 309	Continued From pag	e 41	F3	09			
	therapy and/or physi	evealed that occupational cal therapy had not seen 01/15/14 when he was seen nent.					
	02/27/15 coded Resi cognitively intact, har extensive assistance living skills (ADLs) ar was coded also as h human assistance to surface transitions ar	n Data Set (MDS) dated ident #121 as being ving no behaviors, requiring with most activities of daily and being nonambulatory. He aving no skin tears, needing a stabilize during surface to and being unsteady but able to an moving from a seated to a					
	ADLs stated he was to voice all needs an year, it has become to a standing position						
	identified the problem required staff assistate completion of ADL no supervision, limited a assistance of 1 staff have ADL needs identified assistance and interphighest level of indepinctude standing at hincluded the use of a left half lap tray and	ince and intervention for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345232	B. WING		04/24/2015		
	NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 309  Continued From page 42 hours a day.  There was also a care plan dated 03/03/15 related to the potential for skin impairment issues with the goal for Resident #121 to be free of further skin impairment related to risk factors through 90 days. The interventions were to observed skin weekly and document findings as indicated and to document observations of any non-pressure related skin impairments on facility non pressure ulcer wound documentation form.  Review of recent skin assessments revealed on 04/06/15 there were no skin tears; on 04/12/15		STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602				
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
F 309	hours a day.  There was also a carelated to the potentiwith the goal for Resfurther skin impairment through 90 days. The observed skin weeklindicated and to doc non-pressure related non pressure ulcer were ulcer were there were 2 small harm; on 04/20/15 the scabs on bilateral and descriptions of these Toe skin checks, no skin tears and no not the skin tears.  There were no nursing record which indicate were no physician public arm edema, flactions are flactions are flactions. Place the flatting flattin	re plan dated 03/03/15 al for skin impairment issues ident #121 to be free of ent related to risk factors be interventions were to y and document findings as ument observations of any laskin impairments on facility yound documentation form.  In assessments revealed on no skin tears; on 04/12/15 ealing areas on the left upper ere were no skin tears but ms. there were no skin tears but ms. there were no eskin tears on the Head to incident reports related to in pressure reports related to in pressure reports related to on pressure sin that addressed arm or skin integrity  Observed on 04/20/15 at rt sleeve shirt on, and wrist area and his left elbow ible under the bandage. He nor any edema sleeves in st was a hard plastic with no sat 3:13 PM, when asked eskin tears, Resident #121 is hand and arm on the	F 309				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3031 TATE BOULEVARD SE HICKORY, NC 28602	CODE	04/24/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE THE APPROPRIA	DATE
F 309	upper arm as the are was not wearing a hahis arms and he was shirt. At this time he hand to extend the firm The arm rest was with the arm rest was with the dining room, in the pulled himself upstanding position. He shirt and had no hand and no dycem or packed his utilized his right had standing position. He with no sleeve or har his wheelchair on 04/12/15 at 10:17 Alvin the hall and at 9:43 Alvin the hall out of his with his right hand to had no sleeves in pladycem or padding on An interview was cor #1 on 04/22/15 at 10 #121 had very soft sk propelled himself dow to a standing position would bump his arm further stated staff triarms but he complain them off.	andages on his left wrist or as were scabbed over. He and splint or any sleeves on wearing a short sleeved was observed using his right negers of his left flaccid hand. hout dycem or padding.  AM, Resident #121 was by we hall at the hand rails and from the wheelchair to a was wearing a short sleeved splint or sleeves in place liding over the left arm rest. Hand to pull himself to a we continued to be observed and splint when observed in (22/15 at 9:03 AM while in AM while in his room. On the was observed standing wheelchair at the hand rail pull himself up. He again ace, any hand splint, and no	F3	309		
	Once he reseated hir	mself, he left using the on his wheelchair which he				

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	was observed by the half tray. Again he was plint or sleeves and He was observed state holding to the hand reduced the tray of the wheelchair what the stated he freely move in place at will. She cushion on it. She full state has the freely for the wheelchair what the tray of the wheelchair what the tray of the wheelchair what the freely move in place at will. She cushion on it.	If. This was the first time he surveyor using the padded as not wearing the hand had on short sleeved shirt. Inding again independently ail in the hall on 04/22/15 at adducted with NA #11 revealed craped his arms on the side ere the half tray hangs. She ed the half tray up and down stated he would not allow a urther stated that as he stood accid left arm against the	F 30	09			
	room in his wheelcha and no hand splint in edematous and appe on the outer side of hot in place and the ahard plastic and theron the arm rest. The padded. He stated at the facility was going arm rest because he rest when he stood. If accid arm resting diplastic arm rest. Wh sleeve to protect his him once in awhile.  On 04/23/15 at 10:26 wheelchair was cover material but no obvious to wearing a arm sleeped.	AM Resident #121 was in his air. He had no sleeves on place. His left arm was red, eared to have a new abrasion his forearm. The lap tray was arm rest was noted to be a e was no dycem or padding to other arm rest was slightly this time that he was told to find something to pad the scraped it against the arm He was observed to have his rectly against the hard en asked about wearing a arm, he stated staff put it on the left arm rest of the red in a thin gerisleeve hus padding. He again was seeve or hand splint. He is the left arm rest of the red in awhile they put his hand					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		345232	B. WING		C 04/24/2015
	ROVIDER OR SUPPLIER	ніск	3	STREET ADDRESS, CITY, STATE, ZIP CODE 8031 TATE BOULEVARD SE HICKORY, NC 28602	1 04/24/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 309	10:41 AM revealed resident for awhile a splint for Resident # not offer the edema asked about yesters she attempted to pu would not keep ther off. At 1:18 PM on in his wheelchair at edema sleeves to b  The nurse on duty, 04/23/15 at 1:22 PM obtained a set of ed Resident #121. She treatments yesterdamaking sure his edes she got busy and di She stated the slee from skin tears. She the hand splint and splint. She was unawas not on the arm  On 04/2415 at 8:25 room drinking coffee place. He was not wand stated they hur wearing the hand splint and stated they hur wearing the hand splint and stated she could no not wear it anyway half tray that was pahad been a couple of Resident #121 wear	w with NA #1 on 04/23/15 at she had worked with this and had never seen a hand #121. She stated that she did sleeve this morning. When day, she did not answer say at them on, she stated he m on and he just took them 04/23/15, Resident #121 was the end of the hall wearing oth arms.  Nurse #5, was interviewed on M. Nurse #5 stated that she dema sleeves this morning for the stated even though she did any and was responsible for the ema sleeves were in place, do not put the sleeves on him. Wes would protect his skin the further stated she looked for was unable to find the hand able to explain why the dycem rest.  AM Resident #121 was in his the with the half lap tray in wearing the edema sleeves this hands. He was not blint. At 9:00 AM Nurse #5 this hands. He was not blint. At 9:00 AM Nurse #5 thind the splint and he would and he should be using the added. She further stated it of weeks since she had seen	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		345232	B. WING			C <b>4/24/2015</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3031 TATE BOULEVARD SE HICKORY, NC 28602	•	4/24/2015	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	An interview was Occupational The Therapist (PT) on stated she had we times for positioni a hand contracture dema and spasti was noncompliant multiple sleeves a stated this date thin his room. They discharged to rest splint and edema per day. PT state would allow the spremove it a short inconsistently conthat Resident #12 sleeve and hand short period of timbeneficial devices the wheelchair ye caught in the whe came to ask for so wheelchair and shmaterial with stick rest. Both stated Resident #121 was wheelchair which bolster.  On 04/24/15 at 11 observed in his will wearing edema sl	conducted with the rapist (OT) and the Physical 04/24/15 at 9:47 AM. OT orked with the resident manying. She stated he did not have the that it was flaccid and he had city in his hand. They stated he that and they have given him and splints that disappear. They they found 4 sleeves and a splint stated that in July 2013 he was corative wearing a left hand glove tolerating for 6 to 8 hours did restorative related that he olint to be applied and then time later. Staff reported he was appliant. OT and PT both stated 1 would benefit from the edema splint even if he only wore for a see and that these was still. The lap tray was placed on ars ago as his arm would get els. Yesterday maintenance omething to pad the arm of the segave him a thin sleeve type by backing to apply to the arm they were unaware that its getting skin tears from the could be addressed by trying a could be addressed on the late of the page that the polint.	F3	309			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		345232	B. WING _			C <b>24/2015</b>
	ROVIDER OR SUPPLIER	СК		STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602	<u>,                                    </u>	- 112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323 SS=D	applied to Resident # documented on the tr applied. With the skii wheelchair, she expe see what could be ad protection. She furth reports would trigger tears but confirmed th reports relating to Re  On 04/24/15 at 2:09 F stated she did not know skin tears, but admitted when he stood up frought stated the staff and of maintenance to look a skin tears.  483.25(h) FREE OF A HAZARDS/SUPERVITTHE facility must ensure environment remains as is possible; and each applied.	eves and splints were being 121 since they were reatment records as being in tears coming from the cted maintenance to look to ded to the wheelchair for er stated that incident a need to address the skin here were no incident sident #121.  PM the unit manager #1 bw how he got his recent ed that he scraped his arm in his wheelchair. She ir nurses should alert at the wheelchair to prevent  ACCIDENT SION/DEVICES  ure that the resident as free of accident hazards	F3			5/22/15
	by: Based on observatio interviews the facility	is not met as evidenced  ns, record review and staff failed to secure loose bed campled residents (Resident		F 323  1. Corrective action has been accomplished for the alleged deficient practice with regard to Residents #108 and #28 by evaluating the beds for rep When repair was not satisfactory, the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG	` '	(X3) DATE SURVEY COMPLETED	
		345232	B. WING			С	
NAME OF B	20//050 00 01/001/50	343232	D. WING_	OTDEET ADDRESS OFFV STATE 70		1/24/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
BRIAN CT	BRIAN CTR HEALTH & REHABI HICK			3031 TATE BOULEVARD SE			
			HICKORY, NC 28602				
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 48	F 3	23			
F 323	1. Resident #108 was 03/23/11 with diagnos accident and Alzheim change Minimum Data revealed Resident #1 impaired and required bed mobility and tran Observations of Resiside rails were as foll - On 04/20/15 at 3:45 loose and leaned awa approximately 2 incheloose and leaned awa approximately 3 incheloose and leaned awa approximately 2 incheloose and leaned awa approximately 2 incheloose and leaned awa approximately 3 incheloose and leaned awa approximately 2 incheloose and leaned awa approximately 2 incheloose and leaned awa approximately 3 incheloose and leaned awa approximately 3 incheloose and leaned awa approximately 3 incheloose and leaned awa approximately 2 incheloose and leaned awa approximately 2 incheloose and leaned awa approximately 3 incheloose and leaned awa appr	s admitted to the facility on ses of cerebrovascular er's disease. The significant as Set (MDS) dated 03/27/15 08 was severely cognitively dextensive assistance for sfers.  Ident #108's bilateral full bed ows: I PM the left side rail was any from the bed es. The right side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. The right side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. The right side rail was any from the bed es. The right side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was bed. I PM the left side rail was any from the bed es. Resident #108 was any f	F 3	beds were replaced.  Residents who requiside rails have the potent by the same alleged deficit therefore, the Maintenance completed an audit of bear repair or replacement need side rails.  Measures put into plath the alleged deficient recur include: The Direct conduct in-service/re-edunursing and maintenance the provision of a hazard to the extent possible, spaside rails should be report Maintenance as soon as reduce the potential for incannot be repaired, then should be provided. The Nursing, Assistant Direct Unit Coordinator will concurred to side rail repairs Maintenance Director will weekly for four weeks to monitor related to side rail repairs Maintenance Director will weekly for four weeks the monthly to include evaluates part of the preventive program to ensure continuals; analyze the data patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns/trends to the QA every other month for six QAPI committee will evaluated to side rail and the patterns and the pat	tial to be affected cient practice; ce Director has ds to determine eds related to acce to ensure practice does not or of Nursing will acation for estaff regarding free environment ecifically; loose red to possible to poss		
	AM with Nurse Aide (	NA) #1. She stated staff of needed repairs by writing		effectiveness of the abov	e plan, and will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345232	B. WING			C 04/24/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 3031 TATE BOULEVARD SE HICKORY, NC 28602	•	14/24/2015	
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	desk or by calling the #1 stated she checke providing care to her	nce book at the nurse's Maintenance Director. NA	F3	identified trends/outcomes continued compliance.	to ensure		
	AM with NA #2. She s #108's bed side rails she called the mainte the Maintenance Dire	ducted on 04/23/15 at 10:39 stated she noticed Resident were loose that morning and nance director. NA #2 stated actor came and looked at and tried to tighten the side					
	Director and the Director accompanied to Resi examined the left and Maintenance Director side rails were loose down. He stated he h #108's side rails earli trying to find new part side rails could not be parts. He further state new beds but they we August 2015.	AM the Maintenance ctor of Nursing (DON) were dent #108's room and I right bed side rails. The rand the DON confirmed the and needed to be tightened ad looked at Resident er that morning and was ts to repair them as the bed at tightened with the existing ed the facility was getting 70 buldn't have them until					
		rails fit properly and NAs to to to maintenance to be s possible.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	, ,	OATE SURVEY COMPLETED
		345232	B. WING _			C 04/24/2015
	ROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP CODI 3031 TATE BOULEVARD SE HICKORY, NC 28602	E	04/24/2010
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	e 50	F3	323		
	04/16/09 with diagno accident, seizure disc quarterly Minimum D 03/31/15 revealed Re cognitively impaired a assistance for bed m	esident #28 was severely and required extensive obility and transfers.				
	side rails were as foll - On 04/20/15 at 3:48 loose and leaned aw approximately 3 inch loose and leaned aw approximately 3 inch observed lying in the - On 04/21/15 at 4:20 loose and leaned aw approximately 3 inch loose and leaned aw approximately 3 inch observed lying in the - On 04/22/15 at 9:50 loose and leaned aw approximately 3 inch loose and leaned aw approximately 3 inch loose and leaned aw approximately 3 inch observed lying in the - On 04/23/15 at 8:50 loose and leaned aw approximately 3 inch loose and leaned aw	ay from the left side rail was ay from the bed es. The right side rail was ay from the bed es. Resident #28 was bed.  Define PM the left side rail was ay from the bed es. The right side rail was ay from the bed es. Resident #28 was bed.  AM the left side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. Resident #28 was bed.  AM the left side rail was ay from the bed es. Resident #28 was bed.  AM the left side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. Resident #28 was				
		nducted on 04/23/15 at 9:10 (NA) #1. She stated staff				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C <b>04/24/2015</b>
	ROVIDER OR SUPPLIER	СК		STREET ADDRESS, CITY, STATE, ZIP 3031 TATE BOULEVARD SE HICKORY, NC 28602	CODE	04/24/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	them in the maintena desk or by calling the #1 stated she checke providing care to her	of needed repairs by writing nce book at the nurse's Maintenance Director. NA	F3	323		
	AM with NA #2. She s #28's bed side rails w she called the Mainte stated the maintenan	ducted on 04/23/15 at 10:39 stated she noticed Resident vere loose that morning and mance Director. NA #2 ce director came and looked and tried to tighten the side				
	Director and the Director accompanied to Resi examined the left and Maintenance Director side rails were loose down. He stated he had side rails earlier that find new parts to repart could not be tightene further stated the facility.	AM the Maintenance ctor of Nursing (DON) were dent #28's room and it right bed side rails. The rand the DON confirmed the and needed to be tightened ad looked at Resident #28's morning and was trying to air them as the bed side rails d with the existing parts. He lity was getting 70 new beds e them until August 2015.				
F 360	3:51 PM with the DO expectation that side report loose side rails repaired as quickly as	rails fit properly and NAs to to maintenance to be	F3	360		5/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` '		(X3) DATE SURVEY COMPLETED	
		345232	345232 B. WING			C 4/24/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	•	4/24/2013
DDIAN OT	DUEALTH & DELIAD	II IIIOK		3031 TATE BOULEVARD SE		
BRIANCI	R HEALTH & REHAB	II HICK		HICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 360	Continued From p	age 52	F 3	60		
SS=D	EACH RESIDENT	•				
	nourishing, palata	rovide each resident with a ble, well-balanced diet that itritional and special dietary ident.				
	by: Based on observaresident and staff follow the tray care for food allergies ( The findings included Resident #51 was 02/17/14 with diagonal resident #51 was 02/17/14 with with with with with with with with	ded: admitted to the facility on process of chronic obstructive		F 360  1. Corrective action has be accomplished for the alleged of practice with regard to Reside providing her with meals that the tray card in relation to food all resident does not receive food she is allergic.  2. Residents who have doce	deficient ent #51 by follow the ergies. The ds to which	
	Minimum Data Se revealed Resident Review of Resider Medication Admini	e and diabetes. The quarterly t (MDS) dated 01/09/15 #51 was cognitively intact.  In #51's allergies on the istration Record for April 2015 allergic to chicken, eggs and r.		food allergies have the potent affected by the same alleged of practice; therefore, the Dietary has completed an audit of cur residents to validate food aller information is present in the traystem and entered into the assection to prevent these items printing on the meal tickets.	deficient y Manager rent rgy ay card dislike¿	
	04/24/15 revealed poultry and artificial An observation marevealed Resident her breakfast tray.	ade on 04/23/14 at 9:15 AM : #51 received French toast on Resident #51's tray card allergic to eggs and should		3. Measures put into place that the alleged deficient practice recur include: the Dietary Marconduct in-service/re-education staff regarding the provision of meet the needs of residents, such at tray cards should be followed residents are not to receive for have been listed an allergy. Manager will post a list of residents.	tice does not nager will on for dietary of foods that specifically, wed and loods that	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C <b>04/24/2015</b>	
	ROVIDER OR SUPPLIER	ск	'	STREET ADDRESS, CITY, STATE, ZI 3031 TATE BOULEVARD SE HICKORY, NC 28602	IP CODE		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 363 SS=E	AM with Resident #5 allergic to chicken and both on her tray 3 to a #51 stated she receive of the lasagna on her when they sent it back told she received the lasagna had an egg is spoken to the Dietary chicken or eggs and numerous times.  An interview was con AM with the Dietary of the resident's food all tray cards and should make the trays. The Is several in services with read the tray card and resident's did not received to.  An interview was con PM with the Administ expectation that resident they were allergic to a followed as written. 483.35(c) MENUS MI ADVANCE/FOLLOW Menus must meet the residents in accordant dietary allowances of Board of the National	ducted on 04/22/15 at 10:12  1. She stated she was degs and she received 4 times a week. Resident red a chicken patty in place flunch tray on 04/21/15 and ket to the kitchen they were chicken patty because the nit. She stated she had a Manager about receiving being allergic to them  ducted on 04/24/15 at 10:13 Manager (DM). She stated tergies were written on the libe observed when staff DM stated she has had the staff regarding how to do it was her expectation that their foods they were allergic ducted on 04/24/15 at 1:45 rator. He stated it was his lent's did not receive food and the tray cards be  EET RES NEEDS/PREP IN ED		food allergies at the tray and will update the listin and discharges. The Die assigned dietary staff metray accuracy in a rotation daily for two weeks, there times per week for four weeks weekly for four weeks, there weeks weekly for four weeks, there weeks weekly for four weeks, there weeks, the	g with admissions etary Manager or ember will monitor on of meal times in at least three weeks, then at eks.  Forected at the time of a Manager or ember will monitor on of meal times in at least three weeks, then at eks.  Forected at the time of a Manager of a Mana	5/22/15	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		<b>345232</b> B. WING			C <b>04/24/2015</b>
NAME OF PI	ROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/24/2010
				3031 TATE BOULEVARD SE	
BRIAN CTR HEALTH & REHABI HICK			HICKORY, NC 28602		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
F 363	Continued From page	e 54	F 36	3	
	This REQUIREMENT by:	is not met as evidenced			
	_	ns, record review and		F 363	
		erviews the facility failed to		Corrective action has been	
		I menu for 2 of 3 residents		accomplished for the alleged deficier	ıt
		g menus (Resident #134 and		practice with regard to Residents #13	
	Resident #51).	,		and #51 by providing meals accordin	
	,			the pre-planned menu. Food supplies	
	The findings included	l:		replenished twice weekly and as nee  2. Facility residents have the poten	ded.
	1. Resident #134 was	s admitted to the facility on		be affected by the same alleged defic	
	02/20/13 with diagnos			practice; therefore, the Dietary Mana	ger
	non-Alzheimer's dem	entia and Parkinson's		has completed an audit of the inventor	
	disease. The quarterl	y Minimum Data Set (MDS)		food items and increased the par leve	els
	dated 01/23/15 revea	lled Resident #134 was		on staple items.	
	moderately cognitivel	ly impaired but was able to		Measures put into place to ensure	
	understand and be u	nderstood.		that the alleged deficient practice doe recur include: The new Dietary Service	
		grievances from 11/2014		Manager will conduct	
	through 04/2015 reve			in-service/re-education for the dietary	
		food concerns. Resident		regarding the adherence to pre-planr	
		er filed food grievances on		menus and providing a menu that me	eets
	01/25/15, 03/12/15, 0	04/08/15 and 04/13/15.		the residents; needs, specifically,	
	Λ m imtom de	dusted an 04/00/45 -t 0:50		production sheets and recipes are to	De
		iducted on 04/22/15 at 9:52		followed and if discrepancies are	
		NA) #9. She stated she plaints from her residents		identified, then the Dietary Manager i	5
	· · · · · · · · · · · · · · · · · · ·	plaints from her residents hat was on their tray card		made aware immediately in order to provide appropriate substitution. The	
	_	the alternate or a sandwich		Dietary Manager provides production	
	they were told the kite			sheets and scaled recipes in advance	
	andy word told the kitt	onon was out.		the staff for daily use. The Dietary	
	An interview was con	ducted on 04/22/15 at 3:07		Manager will conduct an inventory of	food
		34's family member. She		supplies twice weekly, implement foc	
		ne facility every day and		deliveries twice weekly, and increase	
		4 with lunch and supper. She		levels of staple items to provide for	
		not follow the preplanned		residents; needs. The Dietary Mana	ger
	_	f food on the weekends. The		and Administrator will conduct Food	
		d on 04/11/15 Resident		Committee meetings weekly with	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345232	B. WING _	B. WING		C <b>04/24/2015</b>	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADD	RESS, CITY, STATE, ZIP CODE	1 04/	24/2013
				3031 TATE B	OULEVARD SE		
BRIAN CT	R HEALTH & REHABI H	ICK		HICKORY,			
(X4) ID PREFIX TAG			ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	N SHOULD BE COMPLE APPROPRIATE	
F 363	Continued From page	e 55	F3	63			
	#134's tray card reve dog in a bun with chil cup of cole slaw and apples and he receive piece of white bread a beans and showed the tray to the survey no eggs or breakfast She further stated she Dietary Manager, the corporate office sever improvements to the  An interview was con PM with Nurse #3. So received a hot dog with bread and pork and be tray card indicated he bun, cole slaw and cin Nurse #3 stated the kand it was worse on the a resident wanted the tell them they were on of items to make sand staff have gone out a residents before due items from the kitchel.  An interview was con AM with the Cook. She of food every weeken altered. She stated the truck a week on Mone could not be cooked and they had been was on the tray cards what they had. She s	aled he was to receive a hot i, ½ cup of baked beans, ½ ½ cup cinnamon baked ed a hot dog with chili on 1 and ½ cup of pork and he tray card and a picture of or. She reported there were meats by Sunday morning. He had spoken with the Administrator and the ral times with no food.  ducted on 04/22/15 at 3:43 he stated Resident #134 hith chili on 1 piece of white he he had spoken with the heans on 04/11/15 and his he should have received a mnamon baked apples. Witchen ran out of food a lot he weekends. She stated if he alternate the kitchen would but and at times they ran out dwiches. She further stated and bought dinner for to not being able to obtain		residen meal de related review Residen monthly meal se complia 4. Th Adminis during i meeting analyze pattern every of QAPI ceffectiv add addidentifie	ats to identify concerns related to elivery, menus, or other concern to meals. The Administrator withe Food Committee minutes a nt Council meeting minutes by to identify concerns related to ervice to ensure continued ance.  The Dietary Manager and strator will review data obtained inventory audits, food committee gs, and resident council minute at the data and report soften month for six months. The committee will evaluate the eness of the above plan, and we ditional interventions based on additional interventions based on the definition of the compliance.	ns II nd dee s;	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK				STREET ADDRESS, CITY, STATE, ZIP COI 3031 TATE BOULEVARD SE HICKORY, NC 28602	•	14/24/2013
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 363	AM with the Dietary Manager of the placed a food or delivered to the facility she was not aware of every weekend. She of an item on the presubstituted with anoth nutritional value. The expectation for the profollowed and further sof food but might run admissions to the factor of the profollowed and further sof food but might run admissions to the factor of the profollowed and further sof food but might run admissions to the factor of the profollowed and further sof food but might run admissions to the factor of the profollowed and further sof food but might run admissions to the factor of the profollowed and had be improve service.  2. Resident #51 was 02/17/14 with diagnor diabetes. The quarter 01/09/15 revealed Resintact.  Review of the facility through 04/2015 revealed to An observation made Resident #51's lunch bowl of corn and a minute of the facility through of corn and a minute of the facility through 04/2015 revealed to An observation made Resident #51's lunch bowl of corn and a minute of the facility through of corn and a minute of the facility through 04/2015 revealed to the f	ducted on 04/24/15 at 10:13 Manager (DM). She stated der on Friday and it was y on Monday morning and ever running out of items stated if the kitchen ran out blanned menu they her item with the same DM stated it was her eplanned menus to be stated they had never ran out short if there were new ility over the weekend.  ducted on 04/24/15 at 1:45 rator. He stated he was of receiving what was on the defood shortages on the een working with dietary to  admitted to the facility on ses of hypertension and ry Minimum Data Set dated esident #51 was cognitively  grievances from 11/2014 haled there were 29 food concerns.  on 04/22/15 at 1:00 PM of tray revealed she had a ashed potatoes on her plate. ard indicated she should	F 3	63		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345232	B. WING		C		
NAME OF PI	ROVIDER OR SUPPLIER	0.10202		STREET ADDRESS, CITY, STATE, ZIP COD		14/24/2015	
				3031 TATE BOULEVARD SE			
BRIAN CT	R HEALTH & REHABI H	ICK		HICKORY, NC 28602			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 363	Continued From pag	e 57	F 36	53			
	AM with Nurse Aide received a lot of com about not receiving wand if they asked for they were told the kit						
	PM with Resident #5 her tray card against trays daily and it very #51 stated she was a and on days chicken plate of vegetables with chicken even tho Resident #51 further food every weekend, pancakes for breakfar	st last week but they didn't hey are out of the alternate					
	AM with the Cook. So of food every weeker altered. She stated the truck a week on Mon could not be cooked unloaded due to not Cook further stated the worry about what was make the trays with a stated there were a likitchen for wrong food. An interview was cor AM with the Dietary I she placed a food or delivered to the facility.	nducted on 04/24/15 at 9:23 the stated the kitchen ran out and and the menus had to be the facility received 1 food day mornings and breakfast until the truck had been thaving food to cook. The they had been told not to s on the tray cards but to what they had. She further tot of plates returned to the they had a lot of complaints.  Inducted on 04/24/15 at 10:13 Wanager (DM). She stated der on Friday and it was ty on Monday morning and f ever running out of items					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _		C 04/24/2015	
	ROVIDER OR SUPPLIER	ск	STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 364 SS=E	of an item on the prepulsational value. The expectation for the profollowed and further sof food but might run admissions to the factor of the profollowed and further sof food but might run admissions to the factor of the fact	e stated if the kitchen ran out planned menu they her item with the same DM stated it was her eplanned menus to be stated they had never ran out short if there were new ility over the weekend.  ducted on 04/24/15 at 1:45 rator. He stated he was streceiving what was on the drood shortages on the een working with dietary to RITIVE VALUE/APPEAR, R TEMP  es and the facility provides shods that conserve nutritive rearance; and food that is and at the proper		364	5/22/15	
	by: Based on observatio interviews with staff a failed to serve food a 5 of 6 resident's revie (Resident's #134, #20  The findings included  1. Resident #134 was	o, #51, #63 and #57).  admitted to the facility on sees of hemiplegia and		F 364  1. Corrective action has been accomplished for the alleged de practice with regard to Resident #20, #51, #63, and #57 by provi meals that are palatable and at appropriate temperatures.  2. Facility residents have the pube affected by the same alleged practice; therefore, the Dietary Mas completed interviews with the	s #134, ding  potential to I deficient Manager	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		<b>345232</b> B. W			C 04/24/2015
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/24/2010
				3031 TATE BOULEVARD SE	
BRIAN CTR HEALTH & REHABI HICK				HICKORY, NC 28602	
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	
F 364	Continued From pag	e 59	F 36	4	
	Minimum Data Set (I	MDS) dated 01/23/15		residents who are deemed intervie	wable
	revealed Resident #	134 was moderately		to identify concerns related to food	
		but was understood and was		temperatures and palatability. Any	
	able to understand.			concerns identified were addresse	d at the
				time of discovery.	
		grievances from 11/2014		3. Measures put into place to en	
	through 04/2015 rev			that the alleged deficient practice of	
	grievances related to	1000 concerns.		recur include: The Dietary Manage	r and
	Observations of lunc	h trays being taken to		Director of Nursing will conduct in-service/re-education for dietary	and
		e 100 and 500 halls on		nursing staff regarding palatability	
		ays were taken to the		including use of the plate warmer a	
		oon as they arrived on the		pellet system and timely meal tray	
	halls.	•		to reduce the potential for receiving	
				that are not warm/cold according to	
	On 4/22/15 at 12:21	PM a test tray was placed		menu. The Cook will record tempe	ratures
	12th on the 100 Hall	tray cart. The cart stopped		of foods being served prior to meal	
	_	om where residents in the		service to ensure the temperatures	
	_	rved from the cart and at		within guidelines. The Dietary Man	-
		nder of the cart left for the		has posted a guide for Cooks to ac	l l
		M the last tray was served		regarding food temperatures in the	
		the test tray was observed		temperature log book. The Dietary	
		ager (DM) as follows: 9.7 degrees, corn 123.8		Manager will monitor test trays, on	
		degrees, com 123.8 degrees.		time rotation, five times per week for weeks, then four times per week for	
		es were warm but the corn,		weeks, then three times a week for	
		e described as luke warm by		weeks, and weekly thereafter for the	
	the surveyor and the	•		months. The Dietary Manager and	
				Administrator will conduct a Food	
	An interview was cor	nducted on 04/22/15 at 9:05		Committee meeting weekly to iden	tify
	AM with NA #2. She	stated residents complained		concerns related to meal service.	-
	daily about the food	and the coffee being cold and		facility¿s Ambassadors will conduc	t
	she reheated it daily	for them.		rounds at least weekly for three mo	onths to
				identify concerns related to food	
		nducted on 04/22/15 at 3:07		temperatures and palatability. The	
		34's family member. She		Ambassadors will report findings to	
		e facility every day during		Administrator during the morning s	-
		d 6 days out of 7 she had to		meetings. The Administrator will re	
	warm up Resident #	134's food and coffee before		minutes from the Resident Council	to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345232	B. WING			C <b>4/24/2015</b>
NAME OF P	ROVIDER OR SUPPLIER	1 - 1 - 1 - 1		STREET ADDRESS, CITY, STATE, ZIP COL		4/24/2013
				3031 TATE BOULEVARD SE		
BRIAN C	r health & rehabi h	ICK		HICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 364	Continued From page	e 60	F 36	64		
	he could eat. She als received grilled chees grilled with butter spr tater tots. Resident # she had spoken to th (DON) and the Admir there had been no im  An interview was con PM with Nurse #6. Sl cold in the evenings adaily basis for resider had voiced concerns dietary but it hasn't g.  An interview was con AM with the DM. She resident's had complestated the food was wand shouldn't be cold received it. She state the tray if the resident An interview was con PM with the Administ aware of the food cor had spoken with the solution. The Administ should not receive con have their food reheat 2. Resident #20 was 11/28/06 with diagnose esophageal reflux. The Set dated 02/28/15 recognitively intact.	so stated Resident #134 had se sandwiches that were not ead on both sides and frozen 134's family member stated e DM, Director of Nursing histrator several times and aprovement in the food.  Iducted on 04/22/15 at 3:43 he stated the food is always and she had to reheat it on a hts. She further stated staff about food being cold to otten any better.  Iducted on 04/24/15 at 10:13 e stated she was aware ained about cold food. She warm when it left the kitchen when the resident's at the kitchen would warm up it requested.  Iducted on 04/24/15 at 3:51 frator. He stated he was incerns in the building and DM multiple times to find a strator stated resident's old food or need to ask to ated.  Idudted to the facility on sees of diabetes and the quarterly Minimum Data devealed Resident #20 was grievances from 11/2014	F 3t	identify concerns related to for palatability or temperature or basis to ensure continued co.  4. The Dietary Manager an Administrator will review data during temperature log audits Ambassador rounds, Food Comeetings, and Resident Couranalyze the data and report patterns/trends to the QAPI cevery other month for six mo QAPI committee will evaluate effectiveness of the above pladd additional interventions is identified trends/outcomes to continued compliance.	n a monthly mpliance. d a obtained s, committee ncil meetings; committee nths. The e the an, and will based on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION  IG	(X3	OMPLETED
		345232	B. WING _			C <b>04/24/2015</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602	<u> </u>	04/24/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SHORT) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 364	resident rooms on the 04/20/15 revealed transident rooms as so halls.  On 4/22/15 at 12:21 12th on the 100 Hall in the Main Dining rodining room were set 12:32 PM the remain 100 Hall. At 12:39 Fon the 100 Hall and with the Dietary Marmashed potatoes 12 degrees, liver 118.4 The mashed potatoes liver and coffee were the surveyor and the An interview was con AM with NA #2. She daily about the food reheated it daily for the An interview was con PM with Resident #2 overcooked or under was not hot. He stated daily basis but the for further stated he had food 3 to 4 times a wind an interview was con PM with Nurse #6. So cold in the evenings	ch trays being taken to the 100 and 500 halls on ays were taken to the poon as they arrived on the con where residents in the rived from the cart and at onder of the cart left for the con the control of the con the control of	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345232	B. WING				C <b>24/2015</b>	
	ск		3031	1 TATE BOULEVARD SE	1 04/	24/2013	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE	
had voiced concerns dietary but it hasn't go An interview was con AM with the DM. She resident's had comples tated the food was wand shouldn't be cold received it. She state the tray if the resident An interview was con PM with the Administraware of the food cor had spoken with the I solution. The Administraware food receive co have their food reheat 3. Resident #51 was 02/17/14 with diagnost diabetes. The quarter 01/09/15 revealed Resintact.  Review of the facility through 04/2015 revergievances related to Observations of lunch resident rooms on the 04/20/15 revealed traresident rooms as socialls.  On 4/22/15 at 12:21 Fe 12th on the 100 Hall for the sident room the 100 Hall for the sident room the 100 Hall for	about food being cold to obten any better.  ducted on 04/24/15 at 10:13 stated she was aware ained about cold food. She warm when it left the kitchen when the resident's did the kitchen would warm up to requested.  ducted on 04/24/15 at 3:51 rator. He stated he was incerns in the building and DM multiple times to find a strator stated resident's lid food or need to ask to ted.  admitted to the facility on sees of hypertension and resident #51 was cognitively grievances from 11/2014 aled there were 29 food concerns.  In trays being taken to be 100 and 500 halls on ys were taken to the on as they arrived on the DM a test tray was placed tray cart. The cart stopped	F	364				
	ROVIDER OR SUPPLIER  R HEALTH & REHABI HI  SUMMARY ST, (EACH DEFICIENC' REGULATORY OR LE  Continued From page had voiced concerns dietary but it hasn't go  An interview was con AM with the DM. She resident's had complestated the food was wand shouldn't be cold received it. She state the tray if the resident'  An interview was con PM with the Administration aware of the food cor had spoken with the I solution. The Administration should not receive con have their food reheat  3. Resident #51 was a 02/17/14 with diagnost diabetes. The quarter 01/09/15 revealed Resintact.  Review of the facility through 04/2015 reversident rooms on the 04/20/15 revealed trains resident rooms on the 04/20/15 revealed trains resident rooms as soon halls.  On 4/22/15 at 12:21 Fe 12th on the 100 Hall the Main Dining rooms.	ROVIDER OR SUPPLIER  R HEALTH & REHABI HICK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 62 had voiced concerns about food being cold to dietary but it hasn't gotten any better.  An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.  An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated.  3. Resident #51 was admitted to the facility on 02/17/14 with diagnoses of hypertension and diabetes. The quarterly Minimum Data Set dated 01/09/15 revealed Resident #51 was cognitively intact.  Review of the facility grievances from 11/2014 through 04/2015 revealed there were 29 grievances related to food concerns.  Observations of lunch trays being taken to resident rooms on the 100 and 500 halls on 04/20/15 revealed trays were taken to the resident rooms as soon as they arrived on the	ROVIDER OR SUPPLIER  R HEALTH & REHABI HICK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 62 had voiced concerns about food being cold to dietary but it hasn't gotten any better.  An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.  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The cart stopped in the Main Dining room where residents in the	ROVIDER OR SUPPLIER  R HEALTH & REHABI HICK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 62 had voiced concerns about food being cold to dietary but it hasn't gotten any better.  An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.  An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated.  3. 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She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen wall of the odd concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. The Administrator stated resident's should not receive cold food or need to ask to have their food reheated.  3. Resident #51 was admitted to the facility on 02/17/14 with diagnoses of hypertension and diabetes. The quarterly Minimum Data Set dated 01/109/15 revealed there were 29 grievances related to food corerns.  Conservations of lunch trays being taken to resident rooms on the 100 and 500 halls on 04/20/15 revealed thrays were taken to the resident rooms as soon as they arrived on the halls.  Cn 4/22/15 at 12:21 PM a test tray was placed 12th on the 100 Hall tray cart. The cart stopped in the Main Dining prom where residents in the	A BUILDING  345232  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  331 TATE BOULEVARD SE  RHALTH & REHABI HICK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 62 had voiced concerns about food being cold to dietary but it hasn't gotten any better.  An interview was conducted on 04/24/15 at 10:13 AM with the DM. She stated she was aware resident's had complained about cold food. She stated the food was warm when it left the kitchen and shouldn't be cold when the resident's received it. She stated the kitchen would warm up the tray if the resident requested.  An interview was conducted on 04/24/15 at 3:51 PM with the Administrator. He stated he was aware of the food concerns in the building and had spoken with the DM multiple times to find a solution. 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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345232	B. WING				24/2015
	ROVIDER OR SUPPLIER	L		3	TREET ADDRESS, CITY, STATE, ZIP CODE  031 TATE BOULEVARD SE  IICKORY, NC 28602	1 04//	24/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364	on the 100 Hall and the with the Dietary Manamashed potatoes 129 degrees, liver 118.4 of The mashed potatoes liver and coffee were the surveyor and the An observation was not appeared to be congring in the oatmeal and the An interview was conformed and to reheat it for An interview was conformed and the An interview was conformed and to reheat it for An interview was conformed and to reheat it for An interview was conformed and voiced concerns dietary but it hasn't go An interview was conformed and eggs we had to ask staff to rehad to have her coffer food reheated 3 to 4 to An interview was conformed and with the DM. She resident's had complete the complete th	der of the cart left for the of the last tray was served the test tray was observed ager (DM) as follows: 0.7 degrees, corn 123.8 legrees, coffee 138 degrees. It was warm but the corn, described as luke warm by DM.  In ade on 04/24/15 at 8:36 breakfast tray. The oatmeal ealed, the butter did not melt be eggs looked runny.  Inducted on 04/22/15 at 9:05 stated residents complained and the coffee being cold and for them.  Inducted on 04/22/15 at 3:43 the stated the food is always and she had to reheat it on a lats. She further stated staff about food being cold to obten any better.  Inducted on 04/24/15 at 9:55 the stated her coffee, are cold this morning and she leat them. She stated she leat them. She stated she leat them. She stated she leat them was aware alined about cold food. She warm when it left the kitchen	F	364			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		PLETED
		345232	B. WING		l	C <b>24/2015</b>
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK				STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC 28602	04/24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 364	An interview was cor PM with the Administ aware of the food co had spoken with the solution. The Adminis	ed the kitchen would warm up at requested.  Inducted on 04/24/15 at 3:51 trator. He stated he was incerns in the building and DM multiple times to find a strator stated resident's bild food or need to ask to	F 36	4		
	11/24/14. Her admis (MDS) dated 12/03/1 dated 02/20/15 code	admitted to the facility on sion Minimum Data Set 4 and her quarterly MDS d her as having intact ndependent for eating with				
	Resident #63 describ "pitiful." She stated s was overcooked and	on 04/20/15 at 11:34 AM, bed the food as "slop" and she got very small portions, it was always cold when she her stated she usually ate in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C <b>04/24/2015</b>
	ROVIDER OR SUPPLIER	ICK		STREET ADDRESS, CITY, STATE, ZIP CO 3031 TATE BOULEVARD SE HICKORY, NC 28602	DDE	04/24/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 364	Continued From page	e 65	F;	364		
	observed with her tra appeared congealed cold. She tried the so were very cold and the "putrid" due to being.  On 04/22/15 at 9:05 at (NA) #2 revealed, since the food not being go on 04/22/15 at 9:52 revealed, since the food not being go on 04/22/15 at 9:52 revealed, since the coresidents constantly or regarding combination the tray cards and about the part of the	AM interview with Nurse Aide ace the change in dietary in November 2014, the da a lot of complaints about and served cold.  AM interview with NA #9 hange in dietary companies, complain about the food an of food items, not following about portion sizes.  PM Nurse #6 stated the food ad cold and they have to by basis. She further stated ad complaints.  Inducted on 04/24/15 at 10:13 a stated she was aware ained about cold food. She warm when it left the kitchen it when the resident's in November 2014, and the kitchen would warm up				
	solution. The Adminis	DM multiple times to find a strator stated resident's old food or need to ask to steed.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345232	B. WING _			C 04/24/2015
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK			STREET ADDRESS, CITY, STATE, ZIP C 3031 TATE BOULEVARD SE HICKORY, NC 28602		04/24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 364	Continued From page	e 66	F:	364		
	02/14/14. Her most r dated 02/06/15 coded	admitted to the facility on ecent Minimum Data Set I her as having intact ndependently with set up				
	at bedside eating bre was usually cold. Sh warm but the scramb She stated she would	AM Resident #57 was sitting akfast. She said the food e stated today the grits were led eggs were "ice cold." I like them warmer but did e staff by asking them to				
	(NA) #2 revealed, sin companies occurred	AM interview with Nurse Aide ce the change in dietary in November 2014, the d a lot of complaints about od and served cold.				
	revealed, since the cl residents constantly	AM interview with NA #9 nange in dietary companies, complain about the food n of food items, not following out portion sizes.				
	and coffee was serve	PM Nurse #6 stated the food d cold and they have to y basis. She further stated d complaints.				
	AM with the DM. She resident's had comple stated the food was v and shouldn't be cold	d the kitchen would warm up				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345232	B. WING		04/24/2015	:
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK				STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602	1 04/24/2010	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLE	TION
F 364 F 371 SS=E	PM with the Administ aware of the food cor had spoken with the I solution. The Administ should not receive con have their food reheat 483.35(i) FOOD PROSTORE/PREPARE/S  The facility must - (1) Procure food from considered satisfactor authorities; and	ducted on 04/24/15 at 3:51 rator. He stated he was incerns in the building and DM multiple times to find a strator stated resident's Id food or need to ask to ted. ICURE, ERVE - SANITARY  sources approved or rry by Federal, State or local	F 30		5/22/15	5
	by: Based on observation facility failed to ensur stored ready for use.  The findings included An initial tour of the k 04/20/15 at 9:30 AM. for use in the dry storn Observations of cannot (4) 5 ½ pound dented 1/2 pound can of peace approximately a 3 incompact of the second can be	itchen was made on Canned goods stored ready age area were observed. ed food items revealed four cans of pears and one (1) 5		F 371  1. Corrective action has been accomplished for the alleged deficipractice with regard to dented cansive removing them at the time of discolor. No residents were identified; however, facility residents have the potential to be affected by the same alleged deficient practice; therefore Dietary Manager has completed an of current inventory items to ensure dented cans are removed from sto be returned.  3. Measures put into place to entitled the alleged deficient practice of the complete deficient practice of the complete dented the alleged deficient practice of the complete dented the alleged deficient practice of the complete dented t	s by very. e e e, the n audit e that ck to sure	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3	) DATE SURVEY COMPLETED
		345232	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	343232	B: Willo	STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	04/24/2015
TVAINE OF T	NOVIDER OR GOLF EIER			3031 TATE BOULEVARD SE	<u>-</u>	
BRIAN CT	R HEALTH & REHABI HI	СК		HICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 371	Continued From page	e 68	F3	371		
	upper side of the can had a 2 ½ inch dent of can of peaches had a the can and the top of the can and the can and the top of the can and inspecting cans fremoved. The DM stars	near the rim, the 4th can the side of the can. The 2 inch dent on the side of the can was protruding out.  ducted on 04/20/15 at 10:00 Manager (DM). She the dented food items. She decived every week and staff stocking the shelves. She re trained on the proper ding and stocking canned ded rotating canned goods or dents which were to be atted the dented cans should dry storage room ready for		recur include: The Dietary Maconduct in-service/re-educative staff regarding food storage, that dented cans are to be pladesignated area to be returned vendor and not put into stock Dietary Manager will conduct room audits to identify that deare not in stock rotation three week for four weeks, then twifer four weeks, then at least week three months. The District Diemonthly to ensure continued and the stock room for dented and the stock room for dented and the stock room and the stock room and the stock room and the stock room and the sanitation audits; and and report patterns/trends to committee every other month months. The QAPI committee evaluate the effectiveness of plan, and will add additional in based on identified trends/ou ensure continued compliance.	on for dietary specifically, aced in a ed to the rotation. The storage ented cans times per ce per week weekly for etary conduct clude review cans at least compliance. view data udits and lyze the data the QAPI for six e will the above interventions tcomes to	

CENTERS FU	OR MEDICARE & MEDICAID SERVICES			A FORM				
STATEMENT OF	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WITI	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs AND		345232	B. WING	4/24/2015				
	VIDER OR SUPPLIER HEALTH & REHABI HICK		STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE	IES						
F 514	483.75(l)(1) RES RECORDS-COMPLET	E/ACCURATE/ACCI	ESSIBLE					
	The facility must maintain clinical records standards and practices that are complete; organized.							
	The clinical record must contain sufficient assessments; the plan of care and services the State; and progress notes.		fy the resident; a record of the resident's of any preadmission screening conducted by	1				
	This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interview, the facility failed to accurately document physician ordered devices on the treatment record of 1 of 4 sampled residents who's treatment records were reviewed. (Resident #121).							
	The findings included:							
	Resident #121 was admitted to the facility on 05/14/12 with diagnoses including cerebral vascular accident, hemiplegia, neurologic neglect syndrome, chronic pain, and post traumatic stress.							
	Review of physician orders revealed Resident #121 was to have a left resting hand splint on 6 to 8 hours per day since ordered on 07/29/13; dycem to keep arm from sliding every shift since ordered on 08/12/12; and an edema control sleeve left arm and hand every shift since ordered on 08/12/13.							
	The annual Minimum Data Set (MDS) dated 02/27/15 coded Resident #121 as being cognitively intact and requiring extensive assistance with most activities of daily living skills (ADLs) and being nonambulatory.							
	The care plan for ADLs originating 03/03/assistance and intervention for completion extensive assistance of 1 staff member. Th assistance and intervention while maintain standing at hand rails. Interventions included and splint 6 to 8 hours a day and dycem is	n of ADL need due to reduce to reduce and was to have AI ning highest level of inded the use of an eden	needing supervision, limited assistance and DL needs identified and met with staff idependent function possible to include na sleeve to left arm as ordered, and a left					
	Resident #121 was observed as follows wi wheelchair arm rest and no edema sleeve i *on 04/20/15 at 12:42 PM; *on 04/21/15 at 8:39 AM; *on 04/22/15 at 8:15 AM; *on 04/22/15 at 9:03 AM; *on 04/22/15 at 9:43 AM;	•	•					

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF I	SOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WITH	ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs AND N	Fs	345232	B. WING	4/24/2015				
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHABI HICK			STREET ADDRESS, CITY, STATE, ZIP CODE  3031 TATE BOULEVARD SE  HICKORY, NC					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	TIES						
F 514	Continued From Page 1 *on 04/22/15 at 10:17 AM; *on 04/22/15 at 11:53 AM; *on 04/23/15 at 8:47 AM  Review of the treatment administration shand splint, dycem and left resting hand of the obvious padding. He again was not wear they put his hand splint on.  A follow up interview with NA #1 on 04/2 awhile and had never seen a hand splint for this morning. When asked about yesterdate he would not keep them on and he just too the nurse on duty, Nurse #5, was interview set of edema sleeves this morning for Reswas to ensure his edema sleeves were in patted she looked for the hand splint and the dycem was not on the arm rest. She stadevices were in place.  The Director of Nursing (DON) stated on sleeves and splints were being applied to as being applied. She confirmed the treat	neets revealed that in Fesplint were in place. The wheelchair was covering a arm sleeve or hands  23/15 at 10:41 AM reverse or Resident #121. She may, she did not answer sook them off.  The weed on 04/23/15 at 1:20 expected blace, she got busy and was unable to find the hated she should have got 04/24/15 at 1:20 PM d  Resident #121 since the	ered in a thin gerisleeve material but no d splint. He stated that every once in awh ealed she had worked with this resident for stated that she did not offer the edema sled ay she attempted to put them on, she state 2 PM. Nurse #5 stated that she obtained a even though she did treatment yesterday a did not put the sleeves on him. She further and splint. She was unable to explain whome back and circled the initials indicating turing interview, that she expected that the ey were documented on the treatment reco	r eve d a a and er y the				