RS FOR MEDICARE & OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		OMB I	NO. 0938-0391
	. ,	(Y2) MULT			
D PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		TE SURVEY MPLETED
	345232	B. WING _			C )3/10/2016
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	θE	
	014		3031 TATE BOULEVARD SE		
IR HEALTH & REHABI HI	CK		HICKORY, NC 28602		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
		F 1	76		4/5/16
the interdisciplinary te	eam, as defined by				
by: Based on record revi interviews, the facility residents for the abilit leaving medications a swallow at a later time The findings included Resident #61 was add diagnoses which inclu cognition, Alzheimer's confusion, hypertensi and congestive heart Resident #61's most to (MDS) dated 12/17/19 moderately cognitivel short term memory lo resident #61 was inde	ew, observation and staff failed to assess 1 of 1 y to self-medicate prior to at bedside for the resident to e (Resident #61). : mitted to the facility with uded depression, decreased a disease, muscle atrophy, on, coronary artery disease failure. recent Minimum Data Set 5 assessed him as being y impaired with long and ss. The MDS indicated ependent with activities of		Deemed Safe. This plan of Correction is the credible allegation of complia It is the policy of this facility to residents who wish to self ad drugs will be assessed by the Interdisciplinary team. Resid evaluated on 3/7/16 by the Interdisciplinary team includir Director of Nursing and was of unable to safely self- adminis medications. This resident w have a licensed nurse admini medication or ordered by the Residents who are able to se medications have the potentia affected by this alleged defici Director of Nursing, Unit Man Social Workers completed int	facility □'s nce. o ensure minister e dent #61 was ng the deemed ter ill continue to ster his physician. If-administer al to be ency. The agers and erviews with	
that at 9:45 AM Nurse medications in his roo resident stated he wo minute. Nurse #1 tolo them back later. The them, I will take them	e #1 took the resident's om in medicine cups. The uld take his medications in a d him that she would bring resident stated, no leave in a minute, and told Nurse		administer medications to der willingness, those residents v self- administer were assesse Interdisciplinary Team includi Director of Nursing and care accordingly. These interview assessments were completed	termine their vishing to ed by the ng the planned s and d on 3/16/16.	(X6) DATE
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I 483.10(n) RESIDENT DRUGS IF DEEMED An individual resident the interdisciplinary te §483.20(d)(2)(ii), has practice is safe. This REQUIREMENT by: Based on record revi interviews, the facility residents for the abilit leaving medications a swallow at a later time The findings included Resident #61 was add diagnoses which inclu- cognition, Alzheimer's confusion, hypertensi and congestive heart Resident #61's most to (MDS) dated 12/17/11 moderately cognitivel short term memory lo resident #61 was inde daily living with one p Nurse's notes on 3/4/ that at 9:45 AM Nurse medications in his roo resident stated he wo minute. Nurse #1 tole them back later. The them, I will take them #1 to leave the room.	TR HEALTH & REHABI HICK         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE         An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.         This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to assess 1 of 1 residents for the ability to self-medicate prior to leaving medications at bedside for the resident to swallow at a later time (Resident #61).         The findings included:         Resident #61 was admitted to the facility with diagnoses which included depression, decreased cognition, Alzheimer's disease, muscle atrophy, confusion, hypertension, coronary artery disease and congestive heart failure.         Resident #61 was independent with long and short term memory loss. The MDS indicated resident #61 was independent with activities of daily living with one person assist.         Nurse's notes on 3/4/16 at 10:00 AM revealed that at 9:45 AM Nurse #1 took the resident's medications in his room in medicine cups. The resident stated he would take his medications in a minute. Nurse #1 told him that she would bring them back later. The resident stated, no leave them, I will take them in a minute, and told Nurse #1 to leave the room. Nurse #1 left them on the	Image: Control of the second state	TR HEALTH & REHABI HICK         3331 TATE BOULEVARD SE HICKORY, NC 28602           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION)         ID PROVIDERS PLAN OF CC (EACH OFRECTIVE ACTION CROSS REPRENCED TO THE DEFICIENCY)           483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE         F 176           An individual resident may self-administer drugs if the interdisciplinary team, as defined by \$483.20(d)(2)(ii), has determined that this practice is safe.         F 176: Resident Self-Adminis Deemed Safe.           This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility tailed to assess 1 of 1 residents for the ability to self-medicate prior to leaving medications at bedside for the resident to swallow at a later time (Resident #61).         F 176: Resident Self-Adminis Deemed Safe.           The findings included:         The findings included:         The findings included to the facility with diagnoses which included depression, decreased conguistion, Alzheimer's disease, muscle atrophy, confusion, hypertension, coronary artery disease and congestive heart failure.         The sesident #61's most recent Minimum Data Set (MDS) dated 12/17/15 assessed him as being moderately cognitively impaired with long and short term memory loss. The MDS indicated resident #61 was independent with activities of daily living with one person assist.         Resident was have the potent affected by this alleged defici Director of Nursing and was to unable to safely sesiments were assessed interdisciplinary team includi Director of Nursing and take his medications in a minute. Nurse's notes on 3/4/16 at 10:00 AM revealed that at 9:45 AM Nurse #1 took the resident S	REQUIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SUMMARY STREEMENT OF DEFICIENCIES (RACH DEFICIENCY)     STREET ADDRESS, CITY, STATE, ZIP CODE       SUMMARY STREEMENT OF DEFICIENCIES (RACH ORDER) FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID (RACH ORDER) FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE     F 176       An individual resident may self-administer drugs if the interdisciplinary team, as defined by \$433.20(4)(2)(ii), has determined that this practice is safe.     F 176: Resident Self-Administer Drugs if Deemed Safe.       This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to assess 1 of 1 residents for the ability to self-medicate prior to leaving medications at bedside for the resident to swallow at a later time (Resident #61).     F 176: Resident Self-Administer Drugs if Deemed Safe.       The findings included: Resident #61 was admitted to the facility with diagnoses which included depression, dccreased cognition, Altheimer's disease, muscle atrophy, confusion, hypertension, coronary artery disease and congestive heart failure.     F 176: Resident Self-Administer This resident wito continue to have a licensed nurse administer medications in the recent Minimum Data Set (MDS) dated 12/17/15 assessed him as being moderately cognitively impaired with long an short term memory loss. The MDS indicated resident #61 was independent with activities of daily living with one person assist.     Resident #61 wave the potential to self- administer medications have the potential to self- administer medications have the potential to self- administer mere completed on 3/16/16. The Director of Nursing, Unit Managers

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

TITLE

03/31/2016

PRINTED: 04/13/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**Electronically Signed** 

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · ·	NO. 0938-039 ATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CC	OMPLETED
		345232	B WING			С
		345232		STREET ADDRESS, CITY, STATE, ZIP CO		03/10/2016
NAME OF P	ROVIDER OR SUPPLIER			3031 TATE BOULEVARD SE	JDE	
BRIAN CI	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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 176	Continued From page	e 1	F 170	6		
	table. The nurse's no Nurse #1 went back i resident had taken th were not in the cups. Review of the Medica for the month of Marc resident's morning m Flonase, Plavix, isord Zoloft, metoprolol, Ne and Pepcid. On 3/8/16 at 10:00 Al of the resident lying in The resident was ale questions appropriate An interview was con AM with Nursing Assi that the resident was answer simple questi he wanted. On 3/9/16 at 11:30 Al took the medications and he wanted her to get out of the room. St the room because the treating him like a chi later, the resident had She further stated that a candidate for self-m confusion and forgetf An interview was con PM with the Director	be also stated that later, nto the room and the e medications. The pills ation Administration Record ch revealed that the edications were: Aricept, fil, potassium, Namenda, eurontin, Tylenol arthritis, M an observation was made n bed with his clothes on. rt, but unable to answer ely and acted confused. ducted on 3/10/16 at 10:00 stant (NA) #3 who stated confused at times, but could ons and could tell you what M, Nurse #1 stated that she in the room that morning leave them and told her to She left the medications in e resident told her she was id. When she went back d taken the medications. at the resident would not be nedication due to his ulness at times. ducted on 3/10/16 at 1:00		<ul> <li>and Area Staff Development re-educated Licensed Nurse techniques for administration medication to residents, inco assessed to safely self- administration medications. In-service Educompleted on 3/16/16.</li> <li>Unit Managers and/or the D Nursing will monitor medicate administration on units for a randomly picking 10 resider unit for 4 weeks, then 10 reised unit for 4 weeks, then 10 reised medication administration to the Nurse and Residents with administering medications.</li> <li>5/27/16.</li> <li>The Director of Nursing will new admissions in morning residents who have a desired medicate. Assessments with performed and Care Plans with Interdisciplinary Team inclued Director of Nursing as requited Director of Nursing and Administer medicate the of the above plan and will a interventions based on idemitter trends/outcomes to ensure compliance.</li> <li>Date of Completion 5/27/16</li> </ul>	es on proper on of luding those minister ucation was Director of tition all shifts, nts on each sidents veeks. These lidation of echniques by ho are self- Completion report on all meeting of e to self II be updated by the ding the fred. ministrator will g facility audits ta and report committee The QAPI effectiveness dd additional tified continued	

Facility ID: 922986

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TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. 0938-03
		345232	B. WING		C 03/10/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CT	R HEALTH & REHABI H	ск		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
F 176	expectation that the r medications in the ro self-medicate. An ass self-medicate should	urse would not leave the om for the resident to essment for competency to be done on any resident re left in the room for a	F 17	6	
F 253 SS=D	483.15(h)(2) HOUSE MAINTENANCE SEF	KEEPING &	F 25	3	4/5/16
	sanitary, orderly, and	s necessary to maintain a comfortable interior. is not met as evidenced			
	by: Based on observatio facility failed to label a	ns and staff interviews the and properly store personal resident care equipment on		F253 Housekeeping and Maintena Services This plan of Correction is the facility credible allegation of compliance. 1a. On 3/10/16 Room 210 and 211	y⊡'s
		: the shared bathroom for n 03/08/16 at 11:25 AM		emesis basin, toothbrush, toothpas two disposable razors were discard new supplies given to residents with name on these items by the Charge	led and h their
	revealed an emesis b tank cover that conta toothbrush, a tube of disposable razors. N	asin on top of the commode ned an uncovered		Nurse. Items are to be stored in ro bedside table. 1b. On 3/10/16 Rooms 301 and 30 wash basins were discard by the C Nurse. New wash basins have bee	om in )2 gray harge
	Observations of the s 210 and 211 on 03/09 emesis basin on top of that contained an uno toothpaste, and two of	hared bathroom for rooms 0/16 at 2:16 PM revealed an of the commode tank cover rovered toothbrush, a tube of isposable razors. None of d with a resident name or		replaced to store in resident⊡s room name on them by the Charge Nurse Plunger on the bathroom floor next toilet was removed by the Maintena Director on 3/10/16. All residents have the potential to b affected by the same alleged deficient practice. The Unit Managers comp	m with e. The to the ance ent

Facility ID: 922986

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/13/2016 MAPPROVED O. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345232	B. WING		C 03/10/2016			
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHABI H	іск			031 TATE BOULEVARD SE ICKORY, NC 28602			
						N	0(5)	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 253	Continued From page	e 3	F 2	253				
					an audit of all resident rooms and			
1	Observations of the s	shared bathroom for rooms			bathrooms, discarding unlabeled per	sonal		
		0/16 at 8:14 AM revealed an			care equipment and replacements w			
		of the commode tank cover			labeled with the resident⊡s name. T	his		
	that contained an uncovered toothbrush, a tube of toothpaste, and two disposable razors. None of the items were labeled with a resident name or room number.				audit was completed on 3/16/16. The Director of Nursing , Unit Manag	oro		
					and Area Staff Development Coordin			
					re-educated Nursing, Housekeeping			
					Maintenance staff on labeling and st			
	An interview with Nur	rse #1 on 03/10/16 at 8:18			of resident care equipment and stora	ge of		
		basins, wash basins, and			toilet plungers. This education was			
	personal hygiene pro				completed on 3/18/16.			
	•	I drawers. Nurse #1 stated			The Housekeeping Manager will insp			
		f the facility labeled these nt's name and suggested l			10 random resident rooms and bathr weekly for 4 weeks and then 10 rand			
	check with a nurse ai				rooms twice per month for 2 months			
					include observation of plungers store			
	During an interview of	of 03/10/16 at 8:24 AM NA #1			bathrooms without plastic bags.			
	stated residents' pers	sonal hygiene products were			The nursing management team will			
		ed with the resident's name			conduct a audit and inspect 10 room			
		ght stand. NA #1 further			weekly for 4 weeks and then 10 room			
		and wash basins were			random rooms 2x/ month for 2 month			
		lent's name and stored either the sink or their night stand.			validate labeling and storage of perso care equipment. Completed Date: J			
	An interview was con	ducted with the Director of			1, 2016 The Administrator, Housekeeping Di	ector		
		9/10/16 at 8:40 AM. The			and Director of Nursing will review da			
		ected residents' personal			obtained during facility audits and ro	unds;		
		be placed in bags labeled			analyze the data and report			
		me and stored in their night			patterns/trends to the QAPI committee			
		further revealed personal			every month for 2 months. The QAP			
		ld be labeled with the stand.			committee will evaluate the effective of the above plan and will add addition			
		stored in their hight stand.			interventions based on identified	niai		
		210 and 211 on 03/10/16 at			trends/outcomes to ensure continued	ł		
		firmed the emesis basin,			compliance.			
		te, and razors should not be						
		m. The DON further stated						
	staff should have place	ced the personal hygiene						

Facility ID: 922986

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/13/2016 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345232	B. WING				C / <b>10/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2010
BRIAN CI	R HEALTH & REHABI HI	ск		303	31 TATE BOULEVARD SE		
BRIANCI	R HEALTH & REHADI HI			HI	CKORY, 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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 253		e 4 esis basin in bags labeled	F 2	53			
		me and stored them in their					
	rooms 301 and 302 o revealed 2 grey wash other on the floor und	the shared bathroom for n 03/08/16 at 9:04 AM basins stacked inside each er the sink. The basins					
		a resident's name and there idue noted in the bottom of					
	301 and 302 on 03/09 grey wash basins stat the floor under the sir labeled with a resider	hared bathroom for rooms 0/16 at 9:16 AM revealed 2 cked inside each other on k. The basins were not it's name and there was a oted in the bottom of wash					
	301 and 302 on 03/09 grey wash basins stat the floor under the sir labeled with a resider dried green residue n	hared bathroom for rooms //16 at 3:19 PM revealed 2 cked inside each other on k. The basins were not it's name and there was a oted in the bottom of wash ere was a plunger on the o the toilet.					
	301 and 302 on 03/10 grey wash basins star the floor under the sir labeled with a resider dried green residue n basin. In addition, the bathroom floor next to	hared bathroom for rooms b/16 at 8:37 AM revealed 2 cked inside each other on ik. The basins were not it's name and there was a oted in the bottom of wash ere was a plunger on the b the toilet. se #1 on 03/10/16 at 8:18					

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		ND HUMAN SERVICES	_		FO	ED: 04/13/201 RM APPROVEI NO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345232	B. WING		0	C 03/10/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CT	R HEALTH & REHABI H	ICK		3031 TATE BOULEVARD SE HICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 253 F 312 SS=D	personal hygiene pro residents' night stand she was not certain it items with the residen check with a nurse ai During an interview of stated residents' pers placed in bags labele and stored in their nig stated emesis basins labeled with the resid in the cabinet under t An interview was con Nursing (DON) on 03 DON stated she pers be labeled with the resid their night stand. The plungers should be p stored in residents' ba accompanied to the s 301 and 302 on 03/10 confirmed the 2 wash floor under the sink. wash basins should be name and placed in a bathroom or stored in The interview further have been placed in bathroom and remov had used it to plunge 483.25(a)(3) ADL CA	basins, wash basins, and ducts were stored in d drawers. Nurse #1 stated f the facility labeled these int's name and suggested I ide (NA). of 03/10/16 at 8:24 AM NA #1 sonal hygiene products were ed with the resident's name ght stand. NA #1 further and wash basins were then's name and stored either the sink or their night stand. nducted with the Director of 8/10/16 at 8:40 AM. The sonal care equipment should esident's name and stored in e DON further stated laced in a bag if they were athrooms. The DON was shared bathroom for rooms 0/16 at 8:54 AM and the n basins should not be on the The DON further stated the be labeled with a resident's a bag if stored in the n the resident's night stand. revealed the plunger should a bag if stored in the ed from the bathroom if staff the toilet. WE PROVIDED FOR	F 25			4/5/16
		able to carry out activities of he necessary services to				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 04/13/2016 RM APPROVED IO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345232	B. WING			0	C 3/10/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CT	R HEALTH & REHABI H	ск			ITE BOULEVARD SE RY, NC 28602			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 312	Continued From page maintain good nutritic and oral hygiene.	e 6 on, grooming, and personal	F	312				
	by: Based on observatio interviews the facility showers every week resident for 2 of 5 deg for activities of daily li #178). The findings included 1. Resident #34 was 07/21/09 with diagnos disorder, cerebrovasc hemiplegia. Review of the annual dated 01/15/16 revea was intact and there noted. The annual M Resident #34 was tot bathing. Review of the Care A Summary for Activitie Functional dated 01/2 had diagnoses includ disorder. The CAA S was pleasant and coor required limited to ext Review of an ADL car revealed Resident #3	admitted to the facility on ses including seizure cular accident (CVA), and Minimum Data Set (MDS) iled Resident #34's cognition was no rejection of care IDS further revealed ally dependent on staff with rea Assessment (CAA) s of Daily Living (ADL) 29/16 revealed Resident #34		Real Thi cree 1. two the 2. well 3/1 AD by The and all AD cor sch cor 3/1 Edu reg acco sch sho 3/1 The res well	A12 ADL Care Provided for Depension sidents. Is plan of Correction is the facilit dible allegation of compliance. Resident # 34 has been schedo b showers per week per his choi Unit Manager on 3/11/16. Resident # 178 this residents is re cleaned by the Charge Nurse 0/16. residents requiring assistance w Ls have the potential of being a this alleged deficient practice. e Director of Nursing, Unit Mana d Charge Nurses completed and residents requiring assistance w Ls to confirm showers are being mpleted according to their prefer nedule and validate nail care wa mpleted. This audit was comple 6/16. ucation was given to all Nursing parding the completing of shower bedule and on providing nail care owers and as needed. Complete 6/16 e Unit Mangers will randomly au idents per shift, 3 times a week eks, to ensure nails are clean an owers are being completed. mpletion Date: April 7, 2016	y' s duled for ce by nails on vith ffected agers audit of vith g rred s ted on g Staff rs e during ed Date: ndit 3 for 4		

Facility ID: 922986

If continuation sheet Page 7 of 14

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/13/2016 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345232	B. WING				C 10/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHABI HI			30	031 TATE BOULEVARD SE		
BRIANCI				н	ICKORY, NC 28602		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 312	Continued From page	27	F	312			
	_	d showers two times a week			The Administrator, and Director of Nur- will review data obtained during facility audits and rounds; analyze the data ar		
		aide care guide revealed			report patterns/trends to the QAPI		
		heduled for showers every			committee every month for 2 months.	The	
	3:00 PM shift.	rday during the 7:00 AM to			QAPI committee will evaluate the effectiveness of the above plan and wi	11	
					add additional interventions based on		
	Review of Resident #				identified trends/outcomes to ensure		
		owers from 02/10/16 through			continued compliance.		
	03/10/16 revealed the	07/16 there was one shower					
	documented on 02/10						
		14/16 there was one shower					
	documented on 02/17						
	showers documented						
		28/16 there was one shower					
	stated he was suppos week but usually only	n 03/07/16 Resident #34 sed to get two showers a received one shower a					
	week.						
		sident #34 on Wednesday,					
	03/09/16 at 4:57 PM r						
	received his schedule	a snower.					
	An interview was con-	ducted with Nurse Aide (NA)					
		4 AM. During the interview					
		ts' showers were recorded in ocumentation system. NA #1					
		d given Resident #34 his					
		out may have forgotten to					
	record it in the NAs el system because she	lectronic documentation					
	yesterday.	was running bening					

Facility ID: 922986

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/13/2016 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345232	B. WING		_	03/ <sup>,</sup>	; 10/2016
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
BRIAN CT	R HEALTH & REHABI HI	ск		031 TATE BOULEVARD S IICKORY, NC 28602	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	10:48 AM revealed sh recalled she did not g on 03/09/16 and had a resident that had a day. NA #1 stated Re provided a shower too An interview was com Nursing (DON) on 03 DON stated NAs were residents' showers in documentation syster Resident #34's nurse showers from 02/10/1 the interview and con recorded 5 showers of DON confirmed Resid recall if he had receiv wanted 2 showers a w provided to him. The the facility did not cur	with NA #1 on 03/10/16 at ne had thought about it and ive Resident #34 a shower switched out his shower for doctor's appointment that esident #34 would be day, 03/10/16. ducted with the Director of /10/16 at 1:15 PM. The e expected to record their electronic n. The DON reviewed aide documentation of 6 through 03/10/16 during firmed the nurse aides had luring this time frame. The dent #34 would be able to ed a shower or not and if he veek they should be interview further revealed rently review the nurse aide wers to see if they were	F 312				
	12/04/15 with diagnos weakness, anxiety, hy others. The admission dated 12/14/15 specif and long term memor moderately impaired of making. The MDS als not have behaviors bu	cognitive skills for decision so specified the resident did					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345232	B. WING				C 10/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHABI HI	ск			031 TATE BOULEVARD SE IICKORY, NC 28602		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 312	The Care Area Asses 12/14/15 read in part, extensive assistance plan] to provide neede Resident #178's ADL indicated the resident assistance for comple The following observa Resident #178: - On 03/07/16 at 2 in her bed eating choo Observations of her ri- nails were approxima black debris imbedde - On 03/08/16 at 1 sitting in her wheelch Wing nurses' station. resident's right hand ri- debris imbedded under the observation, Resident's right hand ri- debris imbedded under the observation, Resident's right hand ri- debris imbedded under the observation, Resident's right hand ri- debris imbedded under the observation for ri- had black debris imbed - On 03/10/16 at 9 observed in therapy. Resident #178 was in the nurses' station. Complexity of the resident's resident with the rest to her mouth.	sment (CAA) dated "Resident requires for ADL. Proceed [to care ed assistance." care plan dated 12/15/15 required extensive etion of ADL. ations were made of :04 PM Resident #178 was colates from a box. ight hand revealed that her tely 1/8 inch long but had d underneath the nails. 0:44 AM Resident #178 was air across from the East Observations of the revealed her nails had black erneath her nails. During dent #178 had her hand up :28 PM Resident #178 was her skin with her right hand. ight hand revealed the nails edded underneath the nails. :15 AM Resident #178 was After her therapy session, her wheelchair across from Observations of the revealed her fingernails had d under the nails.	F	312			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER.       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       345232       B. WING       C         BRIAN CTR HEALTH & REHABI HICK       STREET ADDRESS, CITY, STATE, ZIP CODE 3031 TATE BOULEVARD SE HICKORY, NC 28602       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 PREFIX TAG       PROVIDER SPLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       VSI (COMPLETED 0001012016         F 312       Continued From page 10 Interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.       F 312       F 312         On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed an explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident tup, then the resident ate breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 by the cause night shift got the resident up, then the resident ate breakfast and went to therapy. NA #3 observed Resident #178 by       Here and the refused care. NA #3 observed Resident #178 by		-	ID HUMAN SERVICES					FORM	D: 04/13/2016 MAPPROVED D. 0938-0391
345232     B. WING     03/10/2016       NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       3031 TATE BOULEVARD SE HICKORY, NC 28602       IND PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 312     Continued From page 10 interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.     F 312     F 312     F 312       On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed and explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident #178 yet because night shift got the resident up, then the resident ate breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 but did not think she refused care. NA #3 observed Resident #178's     IIII (IIIII (IIIIII)	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •				(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BRIAN CTR HEALTH & REHABI HICK     331 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 PREFIX TAG     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 312     Continued From page 10 interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.     F 312       On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed and explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident #178 yet because night shift got the resident up, then the resident ate breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 but did not think she refused care. NA #3 observed Resident #178's			345232	B. WING			_		
BRIAN CTR HEALTH & REHABI HICK     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 PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     C/(S) COMPLETIC DATE       F 312     Continued From page 10 interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.     F 312     F 312       On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed and explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident #178 yet because night shift got the resident up, then the resident ate breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 but did not think she refused care. NA #3 observed Resident #178's     Image: Complexity of the care of the	NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	1 00/	10/2010
BRAN CTR HEALTH & REHABI HICK       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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETIC DATE         F 312       Continued From page 10 interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.       F 312       F 312         On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed and explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident #178 yet because night shift got the resident up, then the resident ate breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 but did not think she refused care. NA #3 observed Resident #178's       HICKORY, NC 28602									
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETIC DATE         F 312       Continued From page 10 interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.       F 312       F 312         On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed and explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident #178 yet because night shift got the resident up, then the resident at breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 but did not think she refused care. NA #3 observed Resident #178's       F 312	BRIAN CT	R HEALTH & REHABI HI	СК				-		
<ul> <li>interviewed and reported that nail care was to be performed by the nurse aides as needed. Nurse #2 observed Resident #178's right hand and stated her nails needed to be trimmed and cleaned.</li> <li>On 03/10/16 at 9:48 AM nurse aide (NA) #3 was interviewed and explained that nail care was performed as needed. She stated that she was assigned to Resident #178 but she had not made a "round" (offer/provide ADL care) to Resident #178 yet because night shift got the resident up, then the resident ate breakfast and went to therapy. NA #3 stated she was not very familiar with Resident #178 but did not think she refused care. NA #3 observed Resident #178's</li> </ul>	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		COMPLETION
fingernails and cleaned them. On 03/10/16 at 9:55 AM the Director of Nursing (DON) was interviewed and reported that nurse aides were expected to routinely check residents' nails and provide nail care as needed. She observed Resident #178's nail after NA #3 had attempted to clean and observed that the nails still had black debris imbedded. On 03/10/16 at 10:29 AM NA #2 was interviewed on the telephone and reported that she was assigned to care for Resident #178 on 03/07/16, 03/08/16 and 03/09/16 from 7 AM to 3 PM. The NA explained that Resident #178 did not refuse care and was "easy to care for." The NA added that Resident #178 was a diabetic and therefore she could not trim or clean the resident's nails. She stated that she had observed Resident #178's nails to be "very dirty." NA #2 added that she had observed Resident #178 scratching her skin and leaving red marks and notified a nurse	F 312	interviewed and repor performed by the nurs #2 observed Residen stated her nails needed cleaned. On 03/10/16 at 9:48 A interviewed and expla- performed as needed assigned to Resident a "round" (offer/provid #178 yet because nig then the resident ate therapy. NA #3 state with Resident #178 b care. NA #3 observed fingernails and cleaned On 03/10/16 at 9:55 A (DON) was interviewed aides were expected nails and provide nail observed Resident #7 attempted to clean ar still had black debris in On 03/10/16 at 10:29 on the telephone and assigned to care for F 03/08/16 and 03/09/1 NA explained that Re care and was "easy to that Resident #178 w she could not trim or She stated that she h #178's nails to be "ve she had observed Resident #1	AM nurse aide (NA) #3 was ained that nail care was to be t #178's right hand and ed to be trimmed and AM nurse aide (NA) #3 was ained that nail care was I. She stated that she was #178 but she had not made de ADL care) to Resident th shift got the resident up, breakfast and went to d she was not very familiar ut did not think she refused d Resident #178's ed them. AM the Director of Nursing ed and reported that nurse to routinely check residents' care as needed. She 178's nail after NA #3 had nd observed that the nails imbedded. AM NA #2 was interviewed reported that she was Resident #178 did not refuse o care for." The NA added as a diabetic and therefore clean the resident's nails. ad observed Resident ery dirty." NA #2 added that esident #178 scratching her	F	312		DEFICIENCY)		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO.	APPROVE	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C 03/10/2016		
		345232	B. WING				
NAME OF PR	ROVIDER OR SUPPLIER	•	STR	EET ADDRESS, CITY, STATE, ZIP COD			
	R HEALTH & REHABI H	ICK	303 <sup>,</sup>	1 TATE BOULEVARD SE			
DRIANCI	R HEALTH & REHADIT		HIC	KORY, 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	(X5) COMPLETION DATE	
F 312	Continued From page	a 11	F 312				
1 012		ame of a nurse but there was	F 312				
	· ·	me working in the facility).					
		e made attempts on 03/08/16					
		s nails but could not get					
		oris imbedded underneath					
E 404	the nails.		<b>F</b> 404			1514.0	
F 431	483.60(b), (d), (e) DF	GS & BIOLOGICALS	F 431		4.	/5/16	
SS=D	LABEL/STORE DRU	GS & BIOLOGICALS					
	The facility must emp	loy or obtain the services of					
	•	t who establishes a system					
	of records of receipt a						
	-	ifficient detail to enable an					
		n; and determines that drug and that an account of all					
		aintained and periodically					
	reconciled.						
	Drugs and biologicals	s used in the facility must be					
		e with currently accepted					
	professional principle	<b>,</b>					
	appropriate accessor						
	instructions, and the	expiration date when					
	applicable.						
	In accordance with S	tate and Federal laws, the					
		drugs and biologicals in					
		s under proper temperature					
		only authorized personnel to					
	have access to the ke	zy5.					
	The facility must prov	vide separately locked,					
		compartments for storage of					
	•	d in Schedule II of the					
		Abuse Prevention and					
		nd other drugs subject to					
		the facility uses single unit ution systems in which the					
		ation systems in which the					

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 04/13/2016 I APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345232		(X1) PROVIDER/SUPPLIER/CLIA	, <i>i</i>	PLE CONSTRUCTION G	COMPI	(X3) DATE SURVEY COMPLETED	
		B. WING		C 03/10/2016			
NAME OF PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP CODI	•		
				3031 TATE BOULEVARD SE			
BRIAN CTR HEALTH & REHABI HICK				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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	Continued From page quantity stored is min be readily detected.	e 12 imal and a missing dose can	F 43	31			
	<ul> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on observations, staff interviews and review of facility policy and procedure the facility failed to: maintain medications and medical solutions within expiration dates in 3 of 7 medication carts and 2 of 4 medication rooms. Findings included:</li> <li>The Facility Policy for Storage and Expiration of Medications, Biologicals, Syringes and Needles, dated 12/01/2007 was reviewed. The procedure reads under number 4. Facility should ensure that medications and biologicals: are not retained longer than recommended by manufacturer guidelines.</li> <li>1. a. On 3/10/16 at 10:30 am Hall 100 medication room #1 observed with 3 bottles of Povidone iodine solution expired 2/2016. Interview with unit manager #1 and assistant DON on 3/10/16 at 11:54 am revealed the solution should have been discarded.</li> <li>b. On 3/10/16 at 11:159 am revealed the solution should have been discarded.</li> <li>c. On 3/10/16 at 11:159 am revealed the solution carts (2) and medication room observed with Math Pacification cart #5 with Folic Acid expired 2/2016. Interview with nurse #1 on 3/10/16 at 11:159 am revealed the solution expired 2/2016. Interview with nurse #1 on 3/10/16 at 11:59 am revealed the solution carts (2) and medication room observed with Medication cart #5 with Folic Acid expired 2/2016. Interview with unit manager #2 on 3/10/16 at 12:02 pm revealed the medication should have been discarded.</li> <li>c. On 3/10/16 at 11:30 am Hall 500 medication cart and medication room observed with Zinc</li> </ul>			F431 Drug records, Label/Sto and Biological. This plan of Correction is the f credible allegation of complian a. Hall 100 medication room Povidone lodine Solution that on 2/2016 were removed and on 3/10/16 by the Director of N b. Hall 200 medication room Povidone lodine Solution that on 2/2016 was removed and o 3/10/16 by the Director of Nur c. Hall 300 medication carts medication room with Folic Ac 2/2016 has been removed and on 3/10/16 by the Director of N d. Hall 500 medication cart a medication room with Zinc Su Nicotine Transdermal System expired 2/2016 have been rem discarded on 3/10/16 by the D Nursing All resident have the potential affected by this alleged deficie The Unit Managers conducted medication storage rooms to v other expired drugs were press audit was completed on 3/16/ The Director of Nursing and A Development Coordinator re-e Licensed Nurses on the Facili	facility 's face. a 3 bottles of was expired discarded Nursing. a 1 bottle of was expired discarded on sing. and id expired d discarded Nursing. and lfate and Patches noved and birector of to be ent practice. d an audit of arts and validate no sent. This 16. rea Staff educated		

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		MEDICAID SERVICES				NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345232			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 03/10/2016		
		345232						
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	05/10/2010			
				3031 TATE BOULEVARD SE				
BRIAN C	R HEALTH & REHABI HI	СК						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		IOULD BE	(X5) COMPLETIO DATE		
F 431	Continued From page	e 13	F 43					
Γ 431	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 43'	for storage and labeling of media include discarding expired media Completed 3/16/16. The Unit Managers will audit eau medication cart and medication room weekly for 12 weeks to en- labeling and dating of medicatio according to the Facility policy, a expired drugs will be discarded a identified. The Pharmacy Tech will audit m carts monthly and report to the I Nursing any findings. Audit com 3/24/16 and ongoing monthly. The Administrator, Director of Nu Pharmacy Consultant will review obtained during facility audits an analyze the data and report patterns/trends to the QAPI com every month The QAPI committ evaluate the effectiveness of the plan and will add additional inter based on identified trends/outco ensure continued compliance.	cations. ch storage sure ns any as edication Director of opleted on ursing and v data d rounds; umittee ee will above ventions			

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