### Statement of Deficiencies and Plan of Correction

**Date Survey Completed:** 04/01/2016

#### Facility Information
- **Name of Provider or Supplier:** BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE
- **Address:** 520 VALLEY STREET, STATESVILLE, NC 28677

#### Summary of Deficiencies

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<tr>
<th>ID</th>
<th>Prefix</th>
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<th>Summary</th>
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<tr>
<td>F 253</td>
<td>SS=E</td>
<td>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</td>
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This **Requirement** is not met as evidenced by:

- Based on observation and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood on 4 of 5 halls, failed to repair smoke barrier doors with broken and splintered laminate and wood on 1 of 5 halls, and paint the door of a nourishment room. The facility also failed to clean an arm trough on a resident's wheelchair (Resident #1), and failed to cover a plunger in a shared bathroom on 1 of 5 halls.

The findings included:

1. Observations of Room 224 on 03/29/16 at 1:11 PM revealed the door of the residents' room had a dime-sized area with broken and splintered laminate on the edges of the door just above the bottom door hinge. The bottom edge of the bathroom door had broken and splintered laminate.

2. Observations of Room 227 on 03/29/16 at 1:11 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the door above and below the door jam. The bottom edge of the bathroom door had broken and splintered laminate.

3. Observations of Room 304 on 03/29/16 at 3:40 PM revealed the door of the residents' room had

#### Plan of Correction

- **Criteria 1:**
  - The Maintenance Director repaired, painted or stained doors for Rooms 224, 227, 304, 307, 302, 138, 301, 303, 134, and 403 by 4-25-16. The Maintenance Director removed the toilet plunger from Resident # 1's bathroom by 4-25-16. Resident #1's arm trough was cleaned.

- **Criteria 2:**
  - All Resident's with Rooms having damaged door are at risk of being affected by this alleged deficient practice.

- **Criteria 3:**
  - Every Resident door and every bathroom door and every smoke containment door was repaired, painted or stained as needed. These repairs, painting and staining were completed by 4-25-16. The Maintenance Director completed an audit of Resident Bathrooms to remove other toilet plungers. This audit and removal was completed by 4-25-16. The administrator will audit the building weekly for dirty equipment and see that it is cleaned x 4 weeks.

- **Criteria 4:**
  - Nursing Staff and Housekeeping Staff were re-educated by the Administrator regarding the process for completion of maintenance request forms when repair needs are identified and storage of toilet plungers.

#### Laboratory Director's or Provider/Supplier Representative's Signature

- **Date:** 04/25/2016
- **Signature:** Electronically Signed

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*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.*
### Summary Statement of Deficiencies

#### F 253

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<td>broken and splintered laminate on the edges of the door above the kick plate. The bottom half of the bathroom door had an approximately 1/4 inch strip of laminate missing from the edge of the door with rough edges noted.</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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<td>F 253</td>
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<td>had broken and splintered laminate on the edges at the bottom half of the door. A quarter-sized hole with splintered edges was noted half way down the inside of the bathroom door.</td>
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j. Observations of Room 403 on 03/30/16 at 6:33 PM and 03/31/16 at 12:35 PM revealed the door of the residents' room had broken and splintered laminate on the edges of the bottom half of the door near the hinges.

An interview with the Maintenance Supervisor on 04/01/16 at 3:43 PM revealed he and his assistant painted doors and door frames one day each week but he did not maintain any documentation of the painting. The Maintenance Supervisor further stated the room doors and bathroom doors were constantly being bumped into by wheelchairs and resident care equipment which made it difficult to keep up with painting and repairs.

An interview with the Administrator on 04/01/16 at 3:55 PM revealed she was aware there were some bathroom doors that needed attention but had not compiled of a list of which doors needed repairs.

During an environmental tour on 04/01/16 beginning at 4:04 PM the Maintenance Supervisor and Administrator observed the doors for rooms 134, 138, 224, 227, 301, 302, 303, 304, 307, and 403 with broken and splintered laminate.

An interview was conducted with the Maintenance Supervisor and the Administrator on 04/01/16 at 4:33 PM. The Administrator and Maintenance Supervisor confirmed the doors with broken and
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<td>splintered laminate would need to be repaired and the facility had a Divisional Manager they could consult with regarding repairs.</td>
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<td>2. Observations of the smoke prevention doors on 200 hall near Room 227 on 03/29/16 at 1:11 PM revealed the doors had broken and splintered laminate on the edges of the bottom half of the door.</td>
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<td>During an environmental tour and interview on 04/01/16 at 4:09 PM the Maintenance Supervisor and Administrator observed the smoke prevention doors on 200 hall near Room 227. The Maintenance Supervisor stated he had caulked and painted the edges of the door a few months ago and was not aware the edges of the door were rough again. The Administrator and the Maintenance Supervisor both stated the smoke prevention doors would be repaired.</td>
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<td>3. Observations of the metal door to the nourishment room on the courtyard hall on 03/29/16 at 12:29 PM revealed the door had black scuff marks and scratches over the entire surface of the door.</td>
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<td>During an environmental tour and interview on 04/01/16 at 4:01 PM the Maintenance Supervisor and Administrator observed the metal door to the nourishment room on the courtyard hall. The Maintenance Supervisor stated he and his assistant painted doors and door frames one day each week but he did not maintain any documentation of the painting. The Maintenance Supervisor further stated he had missed this door and agreed the door needed to be painted.</td>
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<td>4. Observations of Resident #1 on 03/30/16 at</td>
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### F 253

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11:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. Five areas of dried brown matter the size of a pencil eraser were noted just in front of her right hand on the arm trough. The entire visible surface of the arm trough was covered with a dried white film.

Subsequent observations of Resident #1 on 03/31/16 at 12:49 PM, 03/31/16 at 5:53 PM, and 04/01/16 at 7:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. Five areas of dried brown matter the size of a pencil eraser were noted just in front of her right hand on the arm trough. The entire visible surface of the arm trough was covered with a dried white film.

An interview was conducted with the Director of Nursing (DON) on 04/01/16 at 11:05 AM. The DON stated the housekeeping department had a schedule for cleaning residents' wheelchairs but she expected the staff to clean the surfaces of residents' wheelchairs anytime they were soiled. The DON observed Resident #1's arm trough on 04/01/16 at 11:08 AM which still had the dried brown matter and dried white film and stated it would be cleaned immediately.

5. Observations of the shared bathroom for rooms 302 and 304 on 03/29/16 at 3:40 PM revealed a plunger on the floor beside to the toilet which was making hissing sound.

Observations of the shared bathroom for rooms 302 and 304 on 03/30/16 at 10:38 AM revealed a plunger on the floor beside the toilet which was making a hissing sound. NA #7 was in room 302 at the time of the observation and was asked if
The toilet was functioning properly. NA #7 came in the bathroom and proceeded to plunge the toilet and then place the plunger on the floor beside the toilet. Subsequent observations of the shared bathroom for rooms 302 and 304 on 03/31/16 at 8:35 AM and 04/01/16 at 7:15 AM revealed the plunger remained on the floor beside the toilet.

During an interview on 04/01/16 at 3:45 PM the Environmental Services Accounts Manager stated the housekeepers should have put the plunger in a bag if it needed to be stored in the residents' bathroom.

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
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<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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<tr>
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<td>Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</td>
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This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and resident and staff interviews, the facility failed to complete a Care Area Assessment that addressed the underlying causes, contributing factors, and risk factors for 3 of 5 residents (Residents #13, #72 and #145) reviewed for psychotropic medication.

The findings included:

1. Resident #13 had diagnoses which included, schizophrenia and anxiety disorder. The annual Minimum Data Set (MDS) dated 12/19/15, indicated the resident was moderately cognitively impaired. The MDS also indicated Resident #13 had received antipsychotic and antianxiety medication for 7 of 7 days, and had reported feeling depressed or hopeless during the assessment period.

Criteria 1
The Resident Care Management Director (RCMD) updated and submitted the Care Area Assessments for Residents #13, #72 and #145 to reflect the Resident's psychosocial well-being, diagnosis, medications, underlying causes, contributing factors, and risk factors as it is related to the Psychotropic Medications prescribed to these Residents by 4-29-16.

Criteria 2
All Residents requiring a CAA are at risk for being affected by this alleged deficient practice. The RCMD will review all comprehensive assessments completed during the 30 days prior to 4/4/16 for complete Care Area Assessments. New MDSs will be opened if need is identified.
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<td>F 272</td>
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<td>Review of Resident #13's Care Area Assessment (CAA) for Psychotropic Drug Use dated 12/19/15, revealed the diagnoses and medications received, but there was no documentation in the summary/analysis of contributing factors, or risk factors related to the care area. The CAA did not indicate if there was any behavior monitoring, adverse drug reaction or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health rehab services had seen the resident.</td>
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<td>Resident #13's Care Plan (most recently updated on 3/30/16) indicated the resident had the potential to be verbally aggressive, resist care, and was at risk for falls. It indicated the problem of Resident 13's verbally aggressive behavior was first addressed in the Care Plan on 9/25/15.</td>
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<td>On 4/1/16 at 12:03 PM, MDS Coordinator #2 said she thought she had completed the Psychotropic Drug Use CAA summary for Resident #13 and said, &quot;I must not have clicked save on the things that I wrote.&quot;</td>
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<td>During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident.</td>
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<td>2. Resident #72 was admitted to the facility on 2/20/15 and had diagnoses which included, anxiety, major depression, and unspecified psychosis. The annual Minimum Data Set (MDS) dated 2/10/16, indicated the resident was cognitively intact but had exhibited some verbal behavioral symptoms directed toward others. The MDS also indicated Resident #72 had received</td>
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<td>by 4-29-16. Criteria 3 The Resident Care Management Director (RCMD) re-educated the MDS Coordinators and Social Services Director regarding completion of Care Area Assessment related to Psychotropic Medication to include the Resident's psychosocial well-being, diagnosis, medications, underlying causes, contributing factors, and risk factors. This education included instructions on documenting descriptive Care Area Assessments in all areas according to the RAI Manual. The RCMD will randomly audit 10 completed Comprehensive Assessments weekly for 12 weeks to validate descriptive CAAs. Opportunities will be corrected as identified by the RCMD as a result of these audits. Criteria 4 The results of these audits will be presented by the RCMD to the QAPI monthly for 3 months. The committee will make changes or recommendations as needed.</td>
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### Statement of Deficiencies and Plan of Correction

#### Event ID: SMY711

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**Deficiency F 272** continued from page 8:

Antipsychotic, antidepressant and antianxiety medication for 7 of 7 days during the assessment period.

Review of Resident #72’s Care Area Assessment (CAA) for Psychotropic Drug Use dated 2/10/16, revealed only the diagnoses and medications received. There was no documentation in the summary/analysis of contributing factors, or risk factors related to the care area. The CAA did not indicate if there was any behavior monitoring, adverse drug reaction or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health rehab services had seen the resident.

On 3/29/16 at 12:15 PM, Resident #72 was observed eating lunch in the dining room. She was sitting at a table with other residents and also interacted positively with staff.

During an interview on 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she was unaware the risk factors and behavior monitoring should be considered for inclusion in the Psychotropic Drug Use CAA summary.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident.

3. Resident #145 was admitted to the facility on 08/10/15 with diagnoses of generalized anxiety disorder, major depressive disorder, and unspecified psychosis.

Record review of nurse’s notes on 02/24/16 revealed the Resident’s condition had worsened, showing signs of increased confusion, decreased...
F 272 Continued From page 9

Review of the Minimum Data Set (MDS) Care Area Assessment (CAA) Summary dated 02/24/16 revealed Resident #145 received scheduled antidepressant and antianxiety medications. Orders were signed on 02/18/16 to place the Resident on Hospice Care with Resident #145 being prescribed additional as needed antidepressant and antianxiety medications. No documentation was noted describing the impact of the prescribed psychotropic medications being used by the resident. Additionally, there were no rationales provided for the care plan decisions/interventions that were put in place. The CAAs failed to identify the Resident's condition, weaknesses, complications, strengths, and overall progress.

During an interview on 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she was unaware the risk factors and behavior monitoring should be considered for inclusion in the Psychotropic Drug Use CAA summary.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be complete for each resident.

F 278

483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
### F 278 Continued From page 10

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set for 7 of 17 sampled residents (Residents #1, #13, #24 #72, #73, #86, and #157).

The findings included:

1. Resident #13 had diagnoses which included, schizophrenia and anxiety disorder.

The resident’s annual Minimum Data Set (MDS) dated 12/19/15 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or

Criteria 1

The MDS for Resident #1 was corrected by the RCMD to reflect an active diagnosis of Hemiplegia.

The MDS for Resident #13 was corrected by the RCMD to accurately reflect the Level II PASRR and the assessment for the Oral/Dental section.

The MDSs for Residents #24, #72, #73, #86 and #157 were corrected by the RCMD to accurately reflect the assessments of the Residents for the Oral/Dental section.

Criteria 2

All Residents have the potential of being...
F 278 Continued From page 11

intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.

A review of the facility's list of Level II PASRR residents, provided on 3/29/2016, revealed Resident #13 was included among the residents named on the list.

During an observation and interview on 3/29/16 at 4:39 PM, Resident #13 indicated she had an upper denture but no natural teeth.

On 4/1/16 at 12:01 PM, MDS Coordinator #1 and MDS Coordinator #2 were interviewed. MDS Coordinator #1 indicated she was new to the position and was unsure how the Level II PASRR status was communicated, but that it should be accurate on the MDS. MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.
F 278 Continued From page 12
2. Resident #72 was admitted to the facility on 2/20/15. The annual Minimum Data Set (MDS) dated 2/10/16, was reviewed. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.

During an observation and interview on 3/30/16 at 1:56 PM, Resident #72 stated she no longer had any of her own teeth.

On 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.

3. Resident #73 had diagnoses including diabetes mellitus.

Record review of a Dental Care Progress note dated 9/30/13 revealed, “Patient is now edentulous.”

Resident #73’s annual Minimum Data Set (MDS) dated 7/1/15, was reviewed. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural
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<td>teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.</td>
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On 3/29/16 at 3:45 PM, Resident #73 was in her room. The resident did not have any upper or lower natural teeth and was not wearing dentures.

On 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.

During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.

4. Resident #86 was admitted to the facility on 7/6/12. The annual Minimum Data Set (MDS) dated 3/10/16, was reviewed. The Oral/Dental assessment section of the MDS was coded as none of the above present, which had questions about broken or ill-fitting dentures, no natural teeth or tooth fragments, abnormal mouth tissue, cavities or broken natural teeth, inflamed or bleeding gums, mouth or face pain, discomfort or difficulty chewing. Because the Oral/Dental section indicated no concerns, the Dental Care Area Assessment (CAA) did not trigger for further assessment.

On 3/31/16 and 12:06 PM, Resident #86 was observed eating lunch in the dining room. The resident did not have any upper or lower natural teeth and was not wearing dentures.
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<tr>
<td>On 4/1/16 at 12:01 PM, MDS Coordinator #2 indicated she thought if the person had dentures then was not considered edentulous.</td>
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<tr>
<td>During an interview on 4/1/16 at 12:46 PM, the Director of Nursing stated she expected the assessments to be accurate for each resident.</td>
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<td>5. Resident #1 was admitted to the facility on 07/19/13. Review of the medical record revealed hemiplegia was listed as diagnosis.</td>
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<td>Review of the annual Minimum Data Set (MDS) dated 11/15/15 revealed hemiplegia was not checked as an active diagnosis.</td>
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<td>Review of a care plan dated 02/29/16 revealed Resident #1 had an activities of daily living self-performance deficit related to a stroke, limited range of motion, hemiplegia, limited mobility, and impaired balance. Interventions included a right resting arm trough when up in wheelchair.</td>
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<td>Observations of Resident #1 on 03/30/16 at 11:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. A self gripping strap was observed over her lower right arm which was attached to both sides of the arm trough.</td>
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<td>Subsequent observations of Resident #1 on 03/31/16 at 12:49 PM, 03/31/16 at 5:53 PM, and 04/01/16 at 7:15 AM revealed she was self propelling in the hallway in her wheelchair with her right arm resting in an arm trough. A self</td>
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gripping strap was observed over her lower right arm which was attached to both sides of the arm trough.

An interview was conducted MDS Coordinator #1 on 04/01/16 at 2:54 PM. During the interview MDS Coordinator #1 reviewed Resident #1’s annual MDS dated 11/15/15 and stated this assessment had been completed by a nurse who worked 2 days a week assisting with MDS assessments. MDS Coordinator #1 confirmed Resident #1’s annual MDS should have been coded to include hemiplegia as an active diagnosis. The interview further revealed MDS Coordinator #1 was responsible for reviewing the MDS assessments completed by the nurse who assisted 2 days a week but she could not recall if she had reviewed Resident #1’s annual MDS.

6. Resident #24 was admitted on 07/19/14 with diagnoses including dementia and dysphagia.

Review of an annual Minimum Data Set (MDS) dated 06/27/15 revealed Resident #24 was coded in the dental status section as not having and dental problems during the 7-day look back period. Possible options for coding in the dental status section included no natural teeth or tooth fragment(s) (edentulous).

Observations of Resident #24 on 03/31/16 at 9:29 AM revealed the tray card on her meal tray noted she received a pureed diet with nectar thick liquids. No natural teeth were visible at the time of the observation. Nurse Aide #7 was feeding Resident #24 at the time of the observation and confirmed the Resident #24 did not have any teeth.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 278</td>
<td>Continued From page 16 An interview was conducted with MDS Coordinator #1 on 04/01/16 at 9:19 AM. During the interview MDS Coordinator #1 reviewed Resident #24's annual MDS dated 06/27/15 and stated this assessment had been completed by a nurse who worked 2 days a week assisting with MDS assessments. MDS Coordinator #1 explained she was not employed by the facility when Resident #24's annual MDS was completed. MDS Coordinator #1 confirmed Resident #24 was edentulous and the annual MDS should have been coded as edentulous in the dental status section.</td>
<td>F 278</td>
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<td></td>
<td>7. Resident #157 was readmitted to the facility on 02/16/16. Resident #157's most recent Minimum Data Set (MDS) dated 02/23/16 indicated that he was cognitively intact and required total assistance of one staff member for personal hygiene. The MDS did not indicate that Resident #157 did not have any natural teeth or tooth fragments and was edentulous. Review of admission nursing assessment dated 02/16/16 revealed that Resident #157 had a full set of upper and lower dentures. Edentulous was not checked on this assessment. Interview with Resident #157 on 03/30/16 at 9:06 AM revealed that he had lost his dentures about 3 weeks ago and he confirmed that he was edentulous. Resident #157 further stated that he had no trouble chewing or swallowing. Observation of Resident #157 on 03/30/16 at 9:11 AM revealed Resident #157 was edentulous and had no dentures in his mouth. Observation of Resident #157 on 03/31/16 at</td>
<td></td>
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</tbody>
</table>
F 278 Continued From page 17
6:41 PM revealed Resident #157 was edentulous and had no dentures in his mouth.

Observation of Resident #157 on 04/01/16 at 9:00 AM revealed Resident #157 was edentulous and had no dentures in his mouth.

Interview with MDS Coordinator #1 on 04/01/16 at 12:42 PM revealed that she had 2 other nurses that helped her complete Minimum Data Sets. MDS Coordinator #1 stated that she spot checked their work and then signs off on the assessment. MDS Coordinator #1 further stated when they completed Minimum Data Sets they go and talk to the resident to gather the information needed to complete the assessment. MDS Coordinator #1 confirmed the MDS for Resident #157 should have been coded as edentulous and she would make the correction.

On 04/01/16 at 12:46 PM the DON stated she expected the assessments to be complete and accurate for each resident.

F 312 SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and resident and staff interviews the facility failed to provide oral care and nail care for 3 of 6
### Statement of Deficiencies and Plan of Correction

#### A. BUILDING ________________________

** Provider/Supplier/CLIA Identification Number: **

<table>
<thead>
<tr>
<th>ID</th>
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</table>

#### B. WING _____________________________

** Statement of Deficiencies and Plan of Correction **

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<th>PREFIX</th>
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</table>

** Date Survey Completed:**

C 04/01/2016

** Name of Provider or Supplier:**

** Brian Center Health & Rehabilitation/Statesville **

** Street Address, City, State, Zip Code:**

520 Valley Street

Statesville, NC  28677

---

** Summary Statement of Deficiencies **

Each deficiency must be preceded by full regulatory or LSC identifying information.

#### F 312

Continued From page 18

dependent residents reviewed for activities of daily living (Residents #82, #16, and #68).

The findings included:

1. Resident #82 was admitted on 05/28/15 with diagnoses including dementia and muscle weakness.

Review of the quarterly Minimum Data Set (MDS) dated 01/05/16 revealed Resident #82 had moderately impaired cognition and required extensive assistance with personal hygiene. The quarterly MDS also noted Resident #82 had impaired range of motion of both upper extremities and one lower extremity.

Review of a care plan dated 01/11/16 revealed Resident #82 had an activities of daily living self-performance deficit related to dementia, limited mobility, confusion, and a right below the knee amputation. Interventions included:

- extensive assistance with transfers, gather and provide needed supplies, and provide cueing with tasks as needed.

During an interview on 03/30/16 at 9:35 AM Resident #82 stated it had been a while since anyone had assisted her with brushing her teeth. Observations during the interview revealed Resident #82 did not have any top teeth and her bottom teeth were covered with white matter.

A follow up interview was conducted with Resident #82 on 03/31/16 at 10:49 AM after she had returned to her room after a group exercise activity. Resident #82 stated no one had assisted her with brushing her teeth last night or this morning. Observations during the interview

---

Residents #82, 16 and 68 by the Director of Nursing and Unit Managers on 4/1/16.

Criteria 2

Resident requiring assistance with Activities of Daily Living (ADLs) have the potential to be affected by this alleged deficient practice. An audit of Residents requiring assistance with ADLs was completed by the DON, SDC and Unit Managers by 4-29-16 to validate Oral Care and Nail Care was provided as needed. Opportunities were corrected by the DON and Unit Managers as identified.

Criteria 3

Nursing Staff were re-educated by Director of Nursing (DON) and Staff Development Coordinator (SDC) on providing assistance with ADLs to include Oral Care and Nail Care. The DON, SDC, and Unit Managers will audit at least 10 residents weekly for 12 weeks to validate completion of Oral Care and Nail Care. Opportunities will be corrected as identified by the DON, SDC and Unit Managers.

Criteria 4

The DON will report the results of the audits to the QAPI committee monthly for 3 months. The committee will make changes or recommendations as indicated.
### F 312

Continued From page 19

revealed Resident #82 did not have any top teeth and her bottom teeth were covered with white matter.

An interview was conducted with Nurse Aide (NA) #5 on 03/31/16 at 2:30 PM. NA #5 confirmed she was assigned to Resident #82 and had washed her up and assisted her out of bed this morning. NA #5 stated she had not brushed Resident #82's teeth this morning because she was in a rush.

Observations of Resident #82's teeth on 04/01/16 at 3:05 PM revealed she did not have any top teeth and her bottom teeth were clean with no white matter noted. NA #6 was interviewed during this observation and stated she had brushed Resident #82's teeth that morning and Resident #82 was cooperative.

During an interview on 04/01/16 at 3:15 PM the Director of Nursing stated she expected NAs to brush residents' teeth while providing morning and evening care.

2. Resident #16 was admitted to the facility on 12/10/2014 with diagnosis which included history of hypertension, anoxic brain damage and osteoarthritis.

Review of the Quarterly Minimum Data Set (MDS) dated 02/23/16 specified Resident #16 had moderately impaired cognition and required extensive assistance with activities of daily (ADL) including personal hygiene.

On 03/29/16 at 10:22 AM Resident #16 was in his room and his mouth was observed and noted to...
F 312 Continued From page 20

have heavy accumulation of white debris covering the surface of and in between all visible teeth. On 03/30/16 at 9:26 AM Resident #16 was observed sitting in his wheelchair in the lobby and noted to have a similar appearance of heavy accumulation of white debris covering the surface of and in between all visible teeth.

On 03/30/16 at 10:19 AM a family interview was conducted. During the interview Resident #16's family member stated that Resident #16 was not capable of brushing his teeth and the staff did not brush his teeth and they should be brushed frequently.

On 04/01/16 at 7:38 AM NA#1 stated she had worked with Resident #16 and was familiar with his care needs. NA#1 stated Resident #16 required extensive assistance with bathing, dressing, personal hygiene and supervision with eating. During the interview, NA#1 stated she had not provided oral care on Resident #16 and she had not offered to provide oral care. She stated she was taught oral care was part of daily care of a resident. NA#1 acknowledge she should have provided oral care.

An interview was conducted on 04/01/16 at 9:42 AM with NA#2. She stated oral care should be offered in the morning before breakfast and in the evening. She further stated, she did not provide oral care because it was her understanding oral care was provided by third shift staff before breakfast and she did not provide or offer Resident #16 oral care.

Interview conducted on 04/01/16 at 11:30 AM with the Director of Nursing (DON). She stated her expectation was that all residents receive oral
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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 312</td>
<td>Continued From page 21 care daily and as frequently as needed.</td>
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<td>Interview conducted on 04/01/16 at 11:38 AM with the Administrator and she stated her expectation was for staff to provide oral care daily and as needed.</td>
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<td>3. Resident #68 was readmitted to the facility on 03/02/16 with diagnoses diabetes mellitus and partial amputation of foot. Resident #68 most recent minimum data set (MDS) dated 02/06/16 indicated that he was cognitively intact and required extensive assistance of one staff member for personal hygiene. No rejection of care was identified.</td>
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<td>Observation of Resident #68 on 03/30/16 at 8:56 AM revealed all 10 fingernails were approximately ¼ inch long and had brown substance under them.</td>
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<td>Observation of Resident #68 on 03/31/16 at 8:36 AM revealed all 10 fingernails were approximately ¼ inch long and had brown substance under them.</td>
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<td>Observation of Resident #68 on 04/01/16 at 10:43 AM revealed all 10 fingernails were approximately ¼ inch long and had brown substance under them.</td>
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<td>Interview with Resident #68 on 03/30/16 at 9:00 AM revealed that he used to trim his own nails but since he had been sick he had not been able to do so. Resident #68 indicated that he had never asked the staff to trim them but they sure needed to be trimmed because they were longer than what he liked.</td>
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### Statement of Deficiencies and Plan of Correction

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<th>ID Prefix</th>
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<th>ID Prefix</th>
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<th>Provider's Plan of Correction</th>
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<tr>
<td>F 312</td>
<td></td>
<td>Interview with Nursing Assistant (NA) #4 on 04/01/16 at 3:15 PM revealed that she was talking care of Resident #68 and that she was aware his nails needed to be trimmed but stated she had been &quot;running around like a chicken&quot; and had not had time to do it. NA #4 further stated that she had not reported to the nurse that his nails needed to be trimmed.</td>
<td>F 312</td>
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<tr>
<td>F 356</td>
<td>SS=C</td>
<td>483.30(e) POSTED NURSE STAFFING INFORMATION</td>
<td>F 356</td>
<td></td>
<td>4/29/16</td>
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The facility must post the following information on a daily basis:
- Facility name.
- The current date.
- The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
  - Registered nurses.
  - Licensed practical nurses or licensed vocational nurses (as defined under State law).
  - Certified nurse aides.
- Resident census.

The facility must post the nurse staffing data.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345128

#### MULTIPLE CONSTRUCTION

A. BUILDING ____________________________

B. WING ____________________________

#### DATE SURVEY COMPLETED

04/01/2016

<table>
<thead>
<tr>
<th>ID</th>
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<td>F 356</td>
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<td>Continued From page 23 specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</td>
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<td>o In a prominent place readily accessible to residents and visitors.</td>
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<td>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</td>
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<td>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observations, record reviews and staff interviews the facility failed to accurately post the daily staffing sheet for 4 of 4 days of the recertification survey conducted on 03/29/16, 03/30/16, 03/31/16, and 04/01/16.</td>
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<td>The findings included:</td>
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<td>Observation made on initial tour of facility on 03/29/16 at 9:00 AM revealed the daily staffing sheet was posted at the entrance of facility and contained the date, the census of the facility, and the actual hours worked for all 3 shifts. The daily staffing sheet for first shift indicated that they had 6 registered nurses (RN), 4 license practical nurses (LPN), 13 nursing assistants (NA), and 2 medication aides (MA). For second shift the daily staffing sheet indicated that they had 2 RN's, 5 LPN's, 16 NA's, and 2 MA's. The daily staffing sheet for third shift indicated that they had 0 RN, 4 LPN's, 13 NA's, and 8 MA's.</td>
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<td>F356 Criteria 1 The Staffing Posting was corrected by the Director of Nursing on 4-2-16. Criteria 2 All residents have the potential to be effected by this alleged deficient practice. Criteria 3 On 4/20/2016 The DON, re-educated the Scheduler on the requirements for Regulation F356 regarding the daily staffing posting requirements and the maintenance and filing of these records. The Scheduler will be responsible for ensuring the staffing posting daily. The DON, SDC or Unit Managers will monitor the posting daily for 7 days, then 3 times a week for 3 weeks, then weekly for 8 weeks to ensure the posting is timely and accurate. Opportunities will be corrected as identified by the DON.</td>
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</table>
Review of the daily assignment sheet dated 03/29/16 indicated that for first shift they had 1 RN, 4 LPN's, 9 NA's, and 1 MA. The daily assignment sheet for second shift indicated that they had 0 RN's, 2 LPN's, 9 NA's, and 2 MA's. The daily assignment sheet for third shift indicated that they had 0 RN, 4 LPN's, 5 NA's, and 0 MA.

Observation made of the daily staffing sheet on 03/30/16 at 8:00 AM which was posted at the entrance of the facility and contained the date and actual hours worked for all 3 shift. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 12 NA's, and 2 MA's. The daily staffing sheet for second shift indicated that they had 0 RN's, 3 LPN's, 11 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 0 RN, 3 LPN's, 10 NA's, and 0 MA.

Review of the daily assignment sheet dated 03/30/16 indicated that for first shift they had 1 RN, 4 LPN's, 12 NA's, and 2 MA's. The daily assignment sheet for second shift indicated that they had 1 RN, 3 LPN's, 10 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN's, 3 LPN's, 9 NA's, and 0 MA.

Observation made of the daily staffing sheet on 03/31/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. Census was 130. For first shift the daily staffing sheet indicated that they had 4 RN's, 4 LPN's, 11 NA's, and 2 MA's. The daily staffing sheet for second shift indicated that they had 0 RN, 4 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 4 RN's, 4 LPN's, 11 NA's, and 2 MA's.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Completion Date</th>
</tr>
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</table>
| F356 | Continued From page 25 | **F356**

shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA.

Review of the daily assignment sheet dated 03/31/16 indicated that for first shift they had 1 RN, 3 LPN's, 11 NA's, and 2 MA's. The daily assignment sheet for second shift indicated that they had 0 RN, 4 LPN's, 11 NA's, and 1 MA. The daily assignment sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA.

Observation made of the daily staff sheet on 04/01/16 at 8:00 AM which was posted at the entrance of the facility contained the date and actual hours worked for all 3 shifts. No census was present on the sheet. For first shift the daily staffing sheet indicated that they had 4 RN's, 5 LPN's, 10 NA's, and 3 MA's. The daily staffing sheet for second shift indicated that they had 2 RN's, 5 LPN's, 10 NA's, and 1 MA. The daily staffing sheet for third shift indicated that they had 0 RN, 3 LPN's, 6 NA's, and 0 MA.

Review of the daily assignment sheet dated 04/01/16 indicated that for first shift they had 1 RN, 4 LPN's, 10 NA's, and 1 MA. The daily assignment sheet for second shift indicated that they had 1 RN, 3 LPN's, 9 NA's, and 1 MA. The daily assignment sheet indicated that they had 0 RN, 3 LPN's, 5 NA's, and 0 MA.

Interview with MA #1 on 04/01/16 at 12:14 PM revealed that she had worked at the facility for 11 years and was responsible for completing the daily staffing sheets up until last Thursday when she was relieved of her duties by the Director of Nursing (DON). MA #1 indicated that she would complete the daily staffing sheets daily by 11:00 AM and would go by the daily assignment sheet.
F 356 Continued From page 26

to report the numbers on the daily staffing sheet.  
MA #1 also indicated that she only put the nurses  
and NA's that were direct care staff, the DON or  
the Minimum Data Set (MDS) nurse were not  
included in the numbers on the daily staffing  
sheets. MA #1 further stated that she was never  
instructed to update the daily staffing sheet as  
census or staffing changed and on the weekend  
she would fill them out on Friday and leave them  
for the weekend staff to hang up.

Interview with the DON on 04/01/16 at 4:31 PM  
confirmed that she had relieved MA #1 of her  
duties of the completing the daily staffing sheets  
and was in the process of realigning staff and  
was not sure who would be completing the daily  
staffing sheets going forward. The DON stated  
that she had completed them this week during  
the survey and was aware that the numbers were  
incorrect because she was misinformed of which  
staff was included on the daily staffing sheets.  
The DON further stated that the expectation was  
that the daily staffing sheets would be accurate  
reflection of the direct care staff that was present  
in the facility throughout the 24 hour period.

F 431 4/29/16

483.60(b), (d), (e) DRUG RECORDS,  
LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of  
a licensed pharmacist who establishes a system  
of records of receipt and disposition of all  
controlled drugs in sufficient detail to enable an  
accurate reconciliation; and determines that drug  
records are in order and that an account of all  
controlled drugs is maintained and periodically  
reconciled.

Drugs and biologicals used in the facility must be
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<tr>
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<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 27 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from 3 of 4 medication carts and failed to remove expired medication from 1 of 1 central supply closet. The findings included: A review of the facility's policy &quot;Storage and Expiration of Medications, Biologicals, Syringes, and Needles&quot; dated 12/01/07 read in part that the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or</td>
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<tr>
<td>Criteria 1</td>
<td>The Director of Nursing discarded all identified expired drugs on 4-2-16.</td>
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<tr>
<td>Criteria 2</td>
<td>All residents have the potential to be affected by this alleged deficient practice. An audit of all medication storage rooms, refrigerators and medication carts was conducted and completed by 4-29-16 by the DON, SDC and Unit Managers. All expired and unlabeled items were discarded immediately.</td>
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<td>Criteria 3</td>
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### Summary Statement of Deficiencies

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<th>STATEMENT OF DEFICIENCIES</th>
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<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 28</td>
<td>biologicals in accordance with Pharmacy return/destruction guidelines.</td>
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<tr>
<td>1 a.</td>
<td>Observation of the 200 hall Medication cart 1 on 03/30/16 at 2:00 PM revealed a bottle of Levemir insulin that contained no date indicating when it had been opened.</td>
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<tr>
<td>b.</td>
<td>Observation of the 100 hall Medication cart 1 on 03/30/16 at 3:45 PM revealed a bottle of ibuprofen that contained an expiration date of 08/15.</td>
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<td>c.</td>
<td>Observation of the Courtyard Medication cart 1 on 04/01/16 at 11:30 AM revealed a bottle of Humalog insulin that had an open date of 03/04/16 and an expiration date of 03/31/16.</td>
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<td>d.</td>
<td>Observation of the central supply closet on 04/01/16 at 2:30 PM revealed 2 bottles of iron elixir that contained an expiration date of 03/16 and a bottle of milk of magnesia that contained an expiration date of 02/15.</td>
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</table>

### Provider's Plan of Correction

The DON re-educated the Central Supply Clerk and Licensed Nurses regarding storage and labeling of medications. This education was completed by 4-29-16. On-going the 3rd shift Nurses will be responsible for the nightly audit of the medication carts for expired meds, Unit Managers will audit the carts weekly and the pharmacy consultant will audit them monthly. The DON, SDC, or a Unit Manager will audit all medication storage rooms and refrigerators weekly to verify medication storage per policy on a on-going basis. Opportunities will be corrected as identified. The Central Supply Clerk has completed an inventory sheet that includes expiration dates for all over-the-counter meds in her supply room. She will check this inventory monthly to discard expired meds timely.

### Criteria 4

Results of audits and inventories will be presented to the QAPI committee monthly for 3 months by the DON. The committee will make changes or recommendations as indicated.

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**Event ID:** SMY711  
**Facility ID:** 922999  
**If continuation sheet Page:** 29 of 33
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
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<td>F 520</td>
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<td>483.75(o)(1) QAA</td>
<td>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</td>
<td>F 520</td>
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### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 345128

**Date Survey Completed:** 04/01/2016

**Name of Provider or Supplier:** Brian Center Health & Rehabilitation/Statesville

**Street Address, City, State, Zip Code:** 520 Valley Street, Statesville, NC 28677

### Summary Statement of Deficiencies

#### F 520

Continued From page 30

and assurance activities are necessary; and
develops and implements appropriate plans of
action to correct identified quality deficiencies.

A State or the Secretary may not require
disclosure of the records of such committee
except insofar as such disclosure is related to the
compliance of such committee with the
requirements of this section.

Good faith attempts by the committee to identify
and correct quality deficiencies will not be used as
a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

- Based on observations, record reviews, and staff
  interviews the facility’s Quality Assessment and
  Assurance Committee failed to maintain
  implemented procedures and monitor the
  interventions the committee put into place in July
  2015. This was for two recited deficiencies that
  were originally cited in June 2015 and
  subsequently cited in April 2016 on the current
  recertification survey. The repeated deficiencies
  were in the area of resident assessment. The
  continued failure of the facility during two federal
  surveys of record show a pattern of the facility’s
  inability to sustain an effective Quality Assurance
  Program.

The findings included:

- The tags were cross referred to:

  - F 272: Comprehensive Assessment. Based on
    observations, record review, and resident and
    staff interviews, the facility failed to complete a

### Provider’s Plan of Correction

**Criteria 1**

Corrective action was accomplished for
the alleged deficient practice by the
Administrator holding an Ad Hoc QAPI
meeting on 4-25-16 to discuss the
outcomes of the annual survey and repeat
citations of F272 related to Resident Care
Area Assessments and F278 related to
accurate coding of the MDS. The
Interdisciplinary Department Head Team
reviewed the previous plans of correction
related to accurate CAA and coding for
the MDS.

**Criteria 2**

Residents requiring a Comprehensive
MDS Assessment are at risk for being
affected by this alleged deficient practice.

**Criteria 3**

The RCMD will review all comprehensive
assessments completed during the 30
days prior to 4/4/16 for complete Care
### Summary Statement of Deficiencies

**F 520** Continued From page 31  
Care Area Assessment (CAA) that addressed the underlying causes, contributing factors, and risk factors for 3 of 5 residents (Residents #13, #72 and #145) reviewed for psychotropic medication.

The facility was recited for F 272 for failing to complete CAAAs that addressed the underlying causes, contributing factors, and risk factors for 3 residents reviewed for psychotropic medications.  
F 272 was originally cited during the June 2015 recertification survey for failing to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors when completing comprehensive MDS assessments 2 residents in the following areas: ADL Functional/Rehabilitation Potential, Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, and Pressure Ulcer.

**F 278: Accuracy of Assessment.** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set for 7 of 17 sampled residents (Residents #1, #13, #24 #72, #73, #86, and #157).  
The facility was recited for F 278 for failing to accurately code the Minimum Data Set for Preadmission Screening and Resident Review (PASRR), Oral/Dental Status, and Active Diagnoses.  F 278 was originally cited during the June 2015 recertification survey for failing to code the Minimum Data Set accurately to reflect Hospice care and Behaviors.  
During an interview on 04/01/16 at 6:42 PM the Administrator stated accuracy of MDS had not been monitored or discussed in the facility's monthly Quality Assurance meeting since she came to work at the facility the middle of November 2016.  The Administrator further stated a corporate representative had been conducting Area Assessments.  Opportunities for correction were identified and correction was begun by the RCMD by 4-29-16.  
The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F272 Resident Care Area Assessment and F278 accurate MDS coding.  This education was completed by 4-29-16.  
The Administrator will hold a weekly Ad Hoc QAPI committee meeting for the next 4 weeks to review F272 Resident Care Area Assessment and F278 accurate MDS coding to ensure compliance with these regulations. Opportunities will be corrected as identified.

**Criteria 4**

Measures to ensure that corrections are achieved & sustained include: The results of these weekly meetings will be submitted to the QAPI Committee by the Administrator for review by IDT members at the next 6 meetings. The QAPI committee will evaluate the effectiveness and amend as needed.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 520</td>
<td>Continued From page 32 weekly conference calls with the MDS Coordinators the last month which included a review of MDS assessments for accuracy.</td>
<td>F 520</td>
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