DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OR MEDICARE & MEDICAID SERVICES			"A" FOI					
	F ISOLATED DEFICIENCIES WHICH CAUSE H ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	MULTIPLE CONSTRUCTION A. BUILDING:	DATE SURVEY COMPLETE:					
OK SINFS AND	ML2	345080	B. WING	3/16/2017					
	VIDER OR SUPPLIER TER HEALTH & REHAB HICKORY VIEWMON	STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC							
D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES								
F 514	483.70(i)(1)(5) RES RECORDS-COMPLET	E/ACCURATE/A	CCESSIBLE						
	(i) Medical records.(1) In accordance with accepted professional records on each resident that are-	standards and prac	ctices, the facility must maintain medical						
	(i) Complete;								
	(ii) Accurately documented;								
	(iii) Readily accessible; and								
	(iv) Systematically organized	(iv) Systematically organized							
	(5) The medical record must contain-	(5) The medical record must contain-							
	(i) Sufficient information to identify the resident;								
	(ii) A record of the resident's assessments;								
	(iii) The comprehensive plan of care and services provided;								
	(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;								
	(v) Physician's, nurse's, and other licensed pr	ofessional's progr	ess notes; and						
	This REQUIREMENT is not met as evidence	d review and staff interviews the facility failed to document ostomy care for 2 of 2 residents							
	The findings included:	The findings included:							
	1. Resident #4 was admitted to the facility on disease.	Resident #4 was admitted to the facility on 05/18/16 with diagnoses including diabetes and Alzheimer's lisease.							
	Review of Resident #4's physician orders reve pouching system.	Review of Resident #4's physician orders revealed no order for colostomy care and no order for changing the pouching system.							
	Review of Resident #4's Treatment Administr no record of colostomy care or evidence that		R) from 12/01/16 through 03/16/2017 revealed em had been changed.						

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

The above isolated deficiencies pose no actual harm to the residents

AH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	MEDICARE & MEDICAID SERVICES			"A" FORM
STATEMENT OF IS	OLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WITH O	ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:
FOR SNFs AND NF	5	345080	D WINC	3/16/2017
			B. WING	
NAME OF PROVID	ER OR SUPPLIER	STREET ADDRESS, C 220 13TH AVENU	TTY, STATE, ZIP CODE	
BRIAN CENTE	ER HEALTH & REHAB HICKORY VIEWMON	HICKORY, NC	E PLACE INW	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
F 514	Continued From Page 1 On 03/16/17 at 12:42 PM an interview with N assistants (NA) were responsible for emptying change the pouching system. Nurse #1 stated system was changed so that "we could keep up that they documented on the TAR that routine and the surrounding skin. Nurse #1 stated she the stoma every 3 to 4 days. She stated the Nu the bag if it needed to be changed. She further change the wafer. On 03/16/17 at 1:33 PM an interview was con- she worked with Resident #4 on the 7:00 AM colostomy bag two times a shift and more offe 3 to 4 days. On 03/16/17 at 3:57 PM an interview with the that residents with ostomies wore a pouching the pouching bag should be emptied or change documented on the TAR and they would also that all staff knew when it was due to be chan- the policy when they logged into the electroni if they had any questions. The DON stated tha have written an order that read "ostomy care e into the electronic medical record and that wa required care. The DON was not aware that F appear on the TAR that staff was providing th 2. Resident #3 was admitted to the facility on Resident #3's diagnoses included: polyp of co Review of Resident #3's Treatment Administr- no record of ileostomy care or evidence that the assistants (NA) were responsible for emptying change the pouching system. Nurse #1 stated system was changed so that "we could keep up that they documented on the TAR that routine	g Resident #4's cold that the staff would p with it every 3 da costomy care was of changed Resident urse Aides (NAs) k r stated Resident #4 nducted with Certiff to 3:00 PM shift a en if needed. She st e Director of Nursin system would be c ed at least daily. TI be keeping up with ged next. The DOP ic medical record a at when Resident # every day and as ne s how the staff woo Resident #3 did not e required care or p a 12/14/16 and disc lon with ostomy st aled no order for ile ration Record (TAR he pouching system furse #1 was condu p with it every 3 da	ostomy pouch and she as the nurse would d document on the TAR when the pouchi ays as the policy stated." Nurse #1 also st done, because they had to assess the storn #4's wafer and pouching system and asse ept her bag emptied and clean and chang 4 always reminded when it was time to "ied Medication Aide/Nurse Aide #4 reve t least 5 times a week and she emptied he tated the nurse changed the system out even ing (DON) was conducted. The DON stat hanged every 3 to 5 days per the policy a ne DON stated that the ostomy care shou in the pouching system changes on the TA N stated that each staff member had access ind were familiar with where to find the p 4 was admitted to the facility someone sl beeded." The order would have been enter- uld have been prompted to perform the have an order for ostomy care nor did it pouching system changes. tharged from the facility on 02/02/17. atus. eostomy care and no order for changing to a had been changed.	ing tated ma essed ged ealed er very ted and fild be AR so ss to policy hould red the aled

AH

EDADTMENT OF HEATTH AND HIMAN SERVICES

ENTERS FO	NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES			A "A" FOI						
	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY						
IO HARM WIT OR SNFs AND	'H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:						
JK SINFS AIND	INFS	345080	B. WING	3/16/2017						
AME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE							
RIAN CEN	TER HEALTH & REHAB HICKORY VIEWM	ON 220 13TH AVEN HICKORY, NC	UE PLACE NW							
D	1	Inckoki, Ne								
D REFIX AG	SUMMARY STATEMENT OF DEFICIENC	IES								
	Continued From Page 2									
F 514		r stated that Resident :	#3's pouching system was changed much m	lore						
	and the surrounding skin. Nurse #1 further stated that Resident #3's pouching system was changed much more frequently but the nurses tried their best to leave in on for at least 3 days so his skin would not get irritated or									
	before reapplying the pouch to Resident #	red. Nurse #1 also stated that the NAs would routinely empty Resident #3's pouch and rinse the pouch out before reapplying the pouch to Resident #3.								
			ng (DON) was conducted. The DON stated							
			changed every 3 to 5 days per the policy an							
			he DON stated that the ostomy care should							
	-		h the pouching system changes on the TAR N stated that each staff member had access							
			and were familiar with where to find the po							
			⁴ 3 was admitted to the facility someone sho	-						
			eeded." The order would have been entered							
	into the electronic medical record and that									
	required care. The DON was not aware the		-							
	appear on the TAR that staff was providin	g the required care of	pouching system changes.							

	-	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		PLETED
		345080	B. WING _				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	220 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA			ŀ	HICKORY, NC 28601		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT OR I	Lise identify find information)	TAG		DEFICIENCY)	AIE	
					1		
F 000	INITIAL COMMENTS		FC	000			
	1. 483.25 (F323) at J						
		began on 02/16/17 when					
	-	om the facility without staff's					
	knowledge that she w						
		t #4 had crossed the parking					
		feet in a straight path from					
	, , , , , , , , , , , , , , , , , , ,	to the postal box across the					
	-	t back to the facility by a					
		oss the road. The speed					
		35 miles per hour and the					
	-	ne low 50's and overcast.					
		ring a long sleeve cotton					
		nd shoes and was assessed					
	-	njuries noted. Immediate					
		ed on 03/16/17 when the					
		mplemented a credible					
		nce. The facility remains out					
	-	wer scope and severity level					
		pring of systems put in place					
	and completion of em	ipioyee training.					
	2. 483.75 (F520) at J						
		began on 02/16/17 when					
		om the facility without staff's					
	knowledge that she w						
		t #4 had crossed the parking					
	-	feet in a straight path from					
		to the postal box across the					
		t back to the facility by a					
		oss the road. The speed					
		35 miles per hour and the					
		ie low 50's and overcast.					
	· ·	ring a long sleeve cotton					
		nd shoes and was assessed					
		njuries noted. Immediate					
		ed on 03/16/17 when the					
		mplemented a credible					
LABORATORY	LINECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITLE		(X6) DATE

Electronically Signed

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.

04/10/2017

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/201 FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 03/16/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		20 13TH AVENUE PLACE NW IICKORY, NC 28601	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	allegation of complian of compliance at a low of D to ensure monito place. A partial extended su of the facility's compli	e 1 nce. The facility remains out wer scope and severity level oring of systems were put in rvey was conducted as part aint investigation from 16/17. Event ID# 546311.	F 000		
F 241 SS=D	the State Survey Age F-323 and F-520. Eve 483.10(a)(1) DIGNIT	vided to the facility because ncy made revisions to tags ent ID# 546311.	F 241		4/18/17
	resident in a manner promotes maintenand her quality of life reco individuality. The faci promote the rights of This REQUIREMENT by:	the resident. is not met as evidenced iew, resident and staff		Preparation, submission and implementation of this Plan of Correctic	'n
		:		does not constitute an admission of or agreement with the facts and conclusio set forth on the survey report. Our Plan Correction is prepared and executed as means to continuously improve the qua of care and to comply with all applicable state and federal regulatory requirement	n of s a llity e
	diagnoses that includ heart failure, hyperter	admitted on 10/05/15 with ed coronary artery disease, nsion, diabetes mellitus type r disease, arthritis, anxiety ion.		F 241 Criteria #1 On 3/16/17 the Director of Nursing validated that Resident #8 received	

Facility ID: 923004

If continuation sheet Page 2 of 49

		MEDICAID SERVICES	(X2) MUU TU	וסו ר	CONSTRUCTION	OMB NC	
	CORRECTION	IDENTIFICATION NUMBER:	· /			· /	LETED
				_			C
		345080	B. WING			03/	16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH & REHA	B HICKORY VIEWMONT			20 13TH AVENUE PLACE NW IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 241	Continued From page	e 2	F 24	241			
					incontinent care following an episode of	of	
		#8's quarterly MDS dated			bowel incontinence. A skin assessme	nt	
		at he was cognitively intact			was completed for Resident #8 by the		
	-	ve to total assistance of 1 to			Charge Nurse on 3/14/17 and skin		
	totally dependent on	except eating and was			integrity remains intact. Nursing Staff I been re-educated regarding providing	lave	
		stall for battling.			incontinent care with dignity and respe	ct	
	Review of Resident #	#8's CAA summary dated			by the Director of Nursing or Nurse		
		e was frequently incontinent			Managers by 4/18/17.		
		ncontinent of bowel and			Criteria #2		
	-	or extensive to total care for			Residents receiving incontinent care h		
	all ADL.				the potential to be affected by the alleg		
	Dovious of Decident f	49 a core plan dated $02/10/17$			deficient practice. The Nurse Manage conducted an audit and interview of	rs	
		#8's care plan dated 02/10/17 an ADL self-care deficit			current residents to evaluate care is be	ina	
		mobility and required			provided with dignity. This audit was	Jing	
		ance to total dependence for			completed by 4/18/17. Opportunities v	vere	
	all ADL.				corrected as identified.		
					Criteria #3		
		t 9:08 AM with nurse aide			Nursing Staff have been re-educated k	ру	
		t residents did not get			the Director of Nursing or Nurse		
	NA #4 stated it was r	ery 2 hours as they should. 9000 9.10 AM and			Managers on providing incontinent car with dignity and respect. This educati		
		id not been provided for the			was completed by 4/18/17. The Direct		
		She stated that with 2 NAs			of Nursing or Nurse Managers will mal		
		t with breakfast there was			10 random observations of residents		
		et incontinence care done			receiving incontinent care, per week for	or	
		got to them some of the			12 weeks, to validate residents are		
	residents were really	wet and solled.			receiving incontinent care with dignity		
	Interview 03/16/17 of	t 9:20 AM with Resident #8			respect. Opportunities will be corrected daily as identified.	eu	
		waited several times for			Criteria #4		
		issistance with incontinent			The Director of Nursing will report the		
	care. He further state	ed that approximately 2			results of these observations to the QA	PI	
		ng shift, he laid with bowel			committee weekly for 12 weeks then		
		f for an hour and 10 minutes			monthly. The facility utilizes the Plan,		
		to assist him with incontinent			Study, Act method for Quality Assuran		
	care. He stated "can				and Performance Improvement Progra	(11)	
	numinating and degra	ading it is to lay in your own			including scheduling, identification of		

Facility ID: 923004

If continuation sheet Page 3 of 49

			0.00		OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345080	B. WING		03/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601	
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 241	Continued From page	e 3	F 24	1	
	stool for an hour and to do anything about call light response tim Resident Council me nothing had changed Interview 03/16/17 at	0 minutes and be helplesstrends or patterns, submission of data, and initiation of quality improvement pl related to identified areas of opportunit The committee will evaluate effective of the plan and make recommendation as required.		provement plans of opportunity. te effectiveness	
	would wait for inconti shift because there w stated that evening si with NAs and that NA staying over and NAs coming in early to con	nence care on the evening vas not enough help. She hift was always short staffed as from day shift were s from night shift were ver evenings. NA #4 stated est that they could with the			
	revealed that most da evening shifts. She s enough NAs on even schedule. Nurse #2 s best that they could fi they were given. She medication aides wer had their duties to co sometimes could not	stated they had done the or the residents with the help e stated that the nurses and re assisting the NAs but they mplete and all the care get done. She stated that nd incontinence care were			
	Nursing (DON) revea change residents whe every 2 hours or as n she would have expe Resident #8 out of his time than an hour and that it was her expect	4:10 PM with the Director of aled she expected the NAs to o needed incontinence care needed. She further stated ected the NAs to change s soiled brief in much less d 10 minutes. She stated tation that all residents were nd respect and that no			

Facility ID: 923004

If continuation sheet Page 4 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 04/18/201 ORM APPROVEI 3 NO. 0938-039
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345080	B. WING				C 03/16/2017
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT	L	:	STREET ADDRESS, CITY, STATE, ZIP CODE 220 13th Avenue place NW Hickory, NC 28601	I	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	Continued From page		F	241			
F 278 SS=D	483.20(g)-(j) ASSES	umiliated or degraded. SMENT DINATION/CERTIFIED	F	278	3		4/18/17
		ssments. The assessment ct the resident's status.					
	(h) Coordination A registered nurse me each assessment wit participation of health						
	(i) Certification(1) A registered nurse the assessment is co	e must sign and certify that mpleted.					
		ho completes a portion of the n and certify the accuracy of sessment.					
	(j) Penalty for Falsific (1) Under Medicare a who willfully and know	nd Medicaid, an individual					
		l and false statement in a is subject to a civil money nan \$1,000 for each					
	and false statement in	idividual to certify a material n a resident assessment is ey penalty or not more than ssment.					
	material and false sta	nent does not constitute a itement. is not met as evidenced					

Facility ID: 923004

If continuation sheet Page 5 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/18/201 MAPPROVE D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		STRUCTION		PLETED
		345080	B. WING				C 16/2017
NAME OF PF	ROVIDER OR SUPPLIER	·		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			TH AVENUE PLACE NW DRY, NC 28601		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From page by:		F 2				
	Based on record revi facility failed to accurs set to reflect the resid 3 residents (Resident The findings included 1. Resident #3 admitt and discharged from diagnoses that includ ostomy status. Review of the admiss minimum data set (M revealed that Resider and required extensiv of daily living. The MI Resident #3 had an of continent of bowel. On 03/15/17 at 4:29 F Nurse #1 was conduc had been completing many years. The MD resident had an ostor ileostomy, or colostor section H of the MDS that if a resident had the bowel status wou continent." MDS Nurs interview and indicate that she did not think be coded as "always reviewed the Resider	ted to the facility on 12/14/16 the facility on 02/02/17 with ed: polyps of colon with sion comprehensive DS) dated 12/21/16 nt #3 was cognitively intact we assistance with activities DS further revealed that ostomy and was always PM an interview with MDS cted and revealed that she MDS assessments for S Nurse #1 stated that if a my including urostomy, my that would be coded in c. The MDS Nurse #1 stated one of those ostomies then Id be coded as "always se #2 was present during the ed by shaking her head "no" that the bowel status should continent." MDS Nurse #1 nt Assessment Instrument		im do ag see Co mo of sta F2 Cr Co thu #3 reve ac ap as to Cr All aff Ar Mi wa so co ap as to cr co thu as co co thu a sec co thu as co thu as co co thu as to thu as co thu as co thu as co thu as co thu as co thu as co thu as co thu as co thu as co thu as co thu as co thu as co thu as co co thu as co thu thu as co thu thu thu as co thu thu thu thu thu thu thu thu thu thu	reparation, submission and plementation of this Plan of Correct res not constitute an admission of of preement with the facts and conclus- t forth on the survey report. Our Ple prection is prepared and executed eans to continuously improve the q care and to comply with all applica ate and federal regulatory requirem 278 iteria 1 prrective action was accomplished to a alleged deficient practice for Resi 6 MDS with ARD 12/21/16 to accurate flect bowel continence status and esident #6 with ARD 2/20/17 to courately reflect bladder and bowel opliances. Modifications of these sessments were completed on 3/20 correct MDS coding errors.	or sions lan of as a uality ble ents. for dent ately D/17 e. tice. an ys ate	
	should have been coo	Resident #3's bowel status ded as "not rated" instead of id she would correct the		4/8	idelines .This audit was completed 8/2017. iteria 3	by	

Facility ID: 923004

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 03/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER HEALTH & REH	AB HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601	
				·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 278	Continued From page	ge 6	F 278	3	
				The District Director of Care Mana	igement
		PM an interview with Director		(DDCM) re-educated the Resident	
		as conducted and revealed		Management Director (RCMD) and	
		e MDS to be completed the resident's current status.		staff on accurate MDS coding rela bowel continence and bladder and	
		admitted to the facility on		appliance per the RAI manual. Th	
		nitted on 04/12/16 with		RCMD will randomly review 5 com	
	diagnoses that inclu	ded dementia.		MDSs weekly for 12 weeks to veri	
	D : (4) (accurate coding of bowel continen	ce and
		erly Minimum Data Set (MDS) aled that Resident #6 was		bladder and bowel appliances.	
	cognitively intact and			Opportunities will be corrected as identified as a result of these audit	łe
		vities of daily living. The MDS			
		sident #6 was coded as		Criteria 4	
	having an ostomy ar	nd was always incontinent of		The results of these audi	
	bowel and bladder.			be presented by the Resident Car	
	Interview on 02/16/1	7 at 5:00 DM with MDS purse		Management Director monthly for	
		7 at 5:00 PM with MDS nurse sident #6 did not have an		months at Facility QAPI meeting. committee will make changes or	The
		MDS nurse #2 stated that		recommendations as indicated.	
		of Resident #6 while working			
	as a nurse on the ha	all and knew that she did not		Date of compliance 4/18/2017	
		I had been coded incorrectly			
		y by MDS nurse #1. MDS			
		uring the interview and stated and they would correct the			
	MDS right away.				
	On 03/16/17 at 5.19	PM an interview with the			
		(DON) was conducted and			
	revealed that she ex	spected the MDS to be			
		ly to reflect the resident's			
F 000	current status.		FOO		
F 282 SS=D	483.21(b)(3)(II) SER PERSONS/PER CA	VICES BY QUALIFIED RE PLAN	F 282	2	4/18/17
	(b)(3) Comprehensiv The services provide	ve Care Plans			

Event ID: 546311

Facility ID: 923004

If continuation sheet Page 7 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 03/16/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		20 13TH AVENUE PLACE NW IICKORY, NC 28601	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 282	Continued From page	e 7	F 282		
		mprehensive care plan,			
	care.	alified persons in resident's written plan of is not met as evidenced			
	provide restorative nu splint management a exercises as outlined	erviews, the facility failed to ursing care for ambulation, nd passive range of motion in the care plan for 1 out of t #6) reviewed for care		Preparation, submission and implementation of this Plan of Correct does not constitute an admission of c agreement with the facts and conclus set forth on the survey report. Our P Correction is prepared and executed means to continuously improve the q of care and to comply with all applica	or sions lan of as a uality
	The findings included	:		state and federal regulatory requirem	ients.
	diagnoses which inclu	itted on 01/12/16 with uded cerebral infarction, he right side, difficulty		F 282 Criteria #1 Resident #6 was evaluated by the Re Staff by 4/18/17 and a treatment plan developed to include splinting, range motion and development of a Restora	of
	02/20/17 for Resident cognitively intact and	Im Data Set (MDS) dated t #6 revealed that she was required extensive to total tivities of Daily Living.		Nursing Program for ongoing management Criteria #2 Residents with care planned interven for restorative nursing are at risk of b	tions
	Resident #6 was care restorative care splint passive range of mot extremity and ambula goal was for the resid level of optimal functi The interventions for	an dated 03/02/17 revealed e planned for receiving t/brace assistance, gentle ion to the right upper ation 7 days a week. The lent to achieve the highest oning over the next 90 days. the resident included: allow t periods and do not rush,		affected by this alleged deficient prac The Director of Nursing and Nurse Managers completed an audit of resi with care planned interventions for restorative nursing to evaluate ongoin needs and accuracy. This audit was completed by 4/18/17. Opportunities corrected as identified. Criteria #3	dents

Facility ID: 923004

If continuation sheet Page 8 of 49

CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLF	CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
							С
		345080	B. WING			03	/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT					
				н	CKORY, NC 28601		1
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	Continued From page	e 8	F 28	82			
	weakness, stiffness,	and pain and inform nurse,			Managers will re-educate Nursing Sta	ff on	
	÷ .	en goal is accomplished or			implementation of care planned		
		progress every month and as			restorative nursing to include the		
		isks using terms, gestures			Restorative Nursing Aide to complete		
		erstand, perform restorative			planned Restorative Nursing intervent	ions	
	care per order and do	o not force of fush.			daily as assigned. In the event a Restorative Aide is unavailable to		
	A review of Resident	#6's restorative care service			complete the assigned tasks the		
		led she received restorative			Administrator will be notified and		
	-	ary (care was ordered to			alternative staffing will be secured for		
		done 7 days a week) and			completion of these interventions. Th	is	
	-	record for March revealed			education was completed by 4/18/17.		
	that she had received 16 days, and missed	d restorative care 10 out of 6 days.			The Director of Nursing or Nurse Managers will randomly observe 10 residents weekly for 12 weeks to verif		
	Interview 03/16/17 at	8:37 AM with Resident #6			care planned interventions are in plac	-	
		tting restorative nursing but			Opportunities will be corrected as		
	she was not getting it				identified as a result of these audits		
		the restorative aides were			Criteria #4		
		s nurses aides (NAs) and			The Director of Nursing will report the		
	could not get to her e	every day.			results of these observations to the Q	API	
	Intonviow 02/15/17 at	2:34 PM with Restorative			committee weekly for 12 weeks then monthly. The facility utilizes the Plan,	Do	
		aled they were pulled to the			Study, Act method for Quality Assurar		
		out of 7 days per week and			and Performance Improvement Progra		
		ative nursing care was not			including scheduling, identification of		
	being provided. They	y stated that they were aware			trends or patterns, submission of data	,	
		eir list not getting care and			and initiation of quality improvement p		
		storative orders for Resident			related to identified areas of opportuni	•	
	reporting their inabilit	on these days they were			The committee will evaluate effectiver of the plan and make recommendation		
		no was also the MDS nurse			as required.	15	
		4:10 PM with the Director of					
	Nursing (DON) revea						
		lents get restorative care as					
	ordered. She stated t were expected to rep	hat the restorative aides					

Facility ID: 923004

If continuation sheet Page 9 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/18/2017 RM APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345080	B. WING _			C 03/16/201	
NAME OF P	ROVIDER OR SUPPLIER	•	•	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
	NTER HEALTH & REHA			220	0 13TH AVENUE PLACE NW		
BRIAN CE				HI	CKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 282			F 2	282			
F 312 SS=D			F 3	312			4/18/17
	activities of daily living services to maintain of personal and oral hyo This REQUIREMENT by: Based on observatio and staff interviews, t showers and bed bat incontinent care for 3 Activities of Daily Livi and #8). The findings included 1. Resident #6 was a 09/09/13 and was re- diagnoses that includ cerebrovascular accid affecting right side, ty anxiety disorder, considerent dementia without beh Review of Resident #6 assistance of 1 to 2 p Review of Resident #7 revealed that she was	is not met as evidenced ins, record reviews, resident the facility failed to provide hs as scheduled and of 4 residents reviewed for ng (ADL) (Residents #6, #7 differentiation of the facility on admitted to the facility on admitted on 04/12/16 with led fractured right femur, dent (CVA), and hemiplegia vpe 2 diabetes mellitus, gestive heart disease, and haviors. 6's quarterly Minimum Data 20/17 revealed an cognition. The MDS 6 required extensive to total bersons with all ADL. 6's care plan dated 03/02/17 s dependent on staff _ related to her diagnoses of			Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusion set forth on the survey report. Our Pla Correction is prepared and executed a means to continuously improve the qua of care and to comply with all applicable state and federal regulatory requireme F312 Criteria 1 On 3/17/17 the Director of Nursing validated that Residents #6 received a shower according to her preference. On 3/17/17 the Director of Nursing validated that Resident #7 receiving a shower according her preference. On 3/16/17 the Director of Nursing validated that Resident #8 received incontinent care following an episode of bowel incontinence. On 3/17/17 the Director of Nursing validated that Resident #8 received a shower accord to his preference on. Criteria 2 Current residents requiring assistance	ons n of s a ality le nts.	

Event ID: 546311

Facility ID: 923004

If continuation sheet Page 10 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/2017 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345080	B. WING				C /16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	20 13TH AVENUE PLACE NW		
	NTER HEALTH & REHA	B HICKORT VIEWMONT		н	IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Interview 03/16/17 at revealed that she was times weekly. She st shower per week bed staff to provide them Review of the ADL ba February, 2017 revea received only 4 baths and 1 bath from Marc 2017. Interview 03/15/16 at (NA) #1 revealed that staffed and showers of Interview 03/15/17 at revealed that they we staffed and this had b Nurse #3 stated that done as scheduled. Interview 03/16/17 at Nursing (DON) revea for all residents to red scheduled. Interview 03/16/17 at Administrator reveale that all residents rece according to their sch 2. Resident #7 was a	 10:18 AM with Resident #6 s not getting her showers 2 ated she maybe got 1 ause there was not enough 2 times a week. athing documentation for led that Resident #6 for the month of February th 1 through March 16, 9:00 AM with nurse aide they often worked short were not done as scheduled. 11:53 AM with nurse #3 tre almost always short been a problem for months. showers were not being 4:10 PM with the Director of led that her expectation was the their showers as 5:15 PM with the d that her expectation was the assistance with ADL ledule for showers. dmitted to the facility on 	F	312	with incontinent care and showers had the potential to be affected by this alle deficient practice. The Director of Nu and Nurse Managers conducted an at of residents requiring assistance with incontinent care and showers to valida current preferences and completion of showers as required according to the preferences. This audit was complete 4/18/17 and opportunities were correct as identified. Criteria 3 Nursing Staff were re-educated by 4/7 by the Director of Nursing and Nurse Managers on the expectation of provi- residents with assistance of completion ADLs with a focus on completion of showers according to the resident's preference and completion of incontin- care as required. The Nurse Managers will randomly observe 10 residents per week, who require assistance with showers and incontinent care for 12 weeks, to valid completion of ADL assistance including showers and incontinent care. Opportunities will be corrected as identified during these audits. Criteria 4	eged rsing udit ate f se ed by cted 18/17 ding on of eent late	
	again on 11/28/16 wit atrial fibrillation, heart type 2 and obstructive	on 03/29/16 and readmitted h diagnoses that included failure, diabetes mellitus e sleep apnea. 7's annual MDS dated			The Director of Nursing will report the results of these observations to the Q committee weekly for 12 weeks then monthly. The facility utilizes the Plan, Study, Act method for Quality Assurar and Performance Improvement Progr	API Do, nce	
L	I						1

Event ID: 546311

Facility ID: 923004

If continuation sheet Page 11 of 49

		MEDICAID SERVICES	a		OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	、 <i>,</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		345080	B. WING		03/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE IENCY)
F 312	Continued From page	e 11	F 31	12	
		assessment of intact		including scheduling, id	entification of
	cognition. The MDS	indicated Resident #7		trends or patterns, subr	
		ssistance of 1 person with		and initiation of quality	
		dependent on staff for		related to identified are The committee will eva	
F	bathing.			of the plan and make re	
	Review of Resident #	7's care plan dated 01/29/17		as required.	
		uired staff assistance and			
	intervention for comp	letion of all ADL needs.			
	intervention for completion of all ADL needs. Interview 03/16/17 at 8:56 AM with Resident #7 revealed that she was not getting her bed baths 2 times per week as she was scheduled. She stated that the staff worked hard but there was just not enough to meet the needs of the residents. She stated that she had told the Administrator that there was not enough help to get all the residents bathed and showered, but nothing had changed.				
	Review of the ADL bathing documentation for February, 2017 revealed that Resident #7 received only 4 baths for the month of February and 2 baths from March 1 through March 16, 2017.				
	showers and bed bat scheduled. She state	ten work short staffed and ths are not done as ed that it was hard to get irst shift and to assist in the			
	revealed that they we staffed and especially hard to get all the wo residents who had re	: 11:53 AM with nurse #2 ere almost always short y with NAs and it made it rk done. There were quested 3 showers per week good to get 1 or 2. The			

Facility ID: 923004

If continuation sheet Page 12 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345080	B. WING				C 16/2017	
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT			20 13TH AVENUE PLACE NW IICKORY, NC 28601	w		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 312	Director of Nursing (E residents were not re requested. Interview 03/16/17 at Nursing (DON) revea for all residents to rec scheduled. Interview 03/16/17 at Administrator reveale that all residents rece according to their sch 3. Resident #8 was a 06/28/11 and was re- diagnoses that includ heart failure, hyperter 2, peripheral vascular disorder and depress Review of Resident # 01/27/17 revealed that and required extensiv 2 persons for all ADL totally dependent for Review of Resident # revealed that he had related to his limited r assistance to total de Interview 03/16/17 at revealed he was not g week. He stated he g had time to give him of regularly attended the and they had discuss	200N) was aware that ceiving showers as they had 4:10 PM with the Director of led that her expectation was ceive their showers as 5:15 PM with the d that her expectation was vived assistance with ADL redules for showers. dmitted to the facility on admitted on 10/05/15 with ed coronary artery disease, nsion, diabetes mellitus type disease, arthritis, anxiety ion. 8's quarterly MDS dated at he was cognitively intact ve to total assistance of 1 to except eating and was	F	312				

Facility ID: 923004

If continuation sheet Page 13 of 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 03/16/2017
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
RIAN CE	NTER HEALTH & REH	AB HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE
F 312	problem. Review of the ADL I February, 2017 reve received only 5 bath	ge 13 tration was aware of the bathing documentation for ealed that Resident #8 ns for the month of February rch 1 through March 16,	F 31	2	
	revealed that they c showers and bed ba scheduled. She sta	at 9:08 AM with NA #4 often worked short staffed and aths were not done as ated that it was hard to get first shift and assist in the meals.			
	revealed that they w staffed and especia hard to get all the w residents who had r and they were doing Director of Nursing	at 11:53 AM with nurse #2 vere almost always short Ily with NAs and it made it vork done. There were requested 3 showers per week g good to get 1 or 2. The (DON) was aware that receiving showers as they had			
	Nursing (DON) reve	at 4:10 PM with the Director of ealed that her expectation was eceive their showers as			
F 318	that all residents red	led that her expectation was ceive assistance with ADL chedule for showers. REASE/PREVENT	F 31	8	4/18/17

If continuation sheet Page 14 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 03/16/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT		20 13TH AVENUE PLACE NW IICKORY, NC 28601	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 318	Continued From page (c) Mobility.	2 14	F 318		
		treatment and services to tion and/or to prevent further			
	appropriate services, to maintain or improve practicable independent mobility is demonstra	ited mobility receives equipment, and assistance e mobility with the maximum ence unless a reduction in bly unavoidable. is not met as evidenced			
	Based on observatio resident and staff inte provide restorative nu management and pas	ssive range of motion 1 resident (Resident #6)		Preparation, submission and implementation of this Plan of Correct does not constitute an admission of o agreement with the facts and conclus set forth on the survey report. Our Pla Correction is prepared and executed a means to continuously improve the qu	r ions an of as a Jality
	The findings included Resident #6 was adm 09/09/13 and re-admi	itted to the facility on		of care and to comply with all applicat state and federal regulatory requirement F318	
	diagnoses which inclu	uded cerebral infarction, he right side, difficulty		Criteria 1 Resident #6 was evaluated by the Re Staff by 4/18/17 and a treatment plan	
	02/20/17 for Resident	m Data Set (MDS) dated #6 revealed that she was required extensive to total DL.		developed to include splinting, range motion and development of a Restora Nursing Program for ongoing management. Criteria 2	
	Resident #6 revealed for restorative care fo motion to right upper	an dated 01/29/17 for that she was care planned r gentle passive range of extremity 7 days a week. care planned for right		Residents with contractures have the potential to be affected by this alleged deficient practice. An audit of current residents with contractures was conducted by the Rehab Staff by 4/18	

Facility ID: 923004

If continuation sheet Page 15 of 49

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB (X3) DA	TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;	CC CC	MPLETED
						С
		345080	B. WING)3/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 318	Continued From page	e 15	F 31	8		
	wrist/hand/finger splir 6 hours daily 7 days a	nt and increase splint use to a week.		Based on the results o individualized treatmen developed to include s	nt plan was plinting and range	
		8:37 AM with Resident #6 tting restorative nursing but every day like it was		of motion where clinica Ongoing Restorative N will be developed and	Iursing Programs implemented as	
		the restorative aides were s nursing aides (NAs) and very day.		therapy treatment plan Criteria 3 Licensed Nurses were Staff Development Coo	re-educated by the	
	delivery record revea	#6's restorative care service led she received restorative ary (care was ordered to		the assessment of residecreased range of mo contractures to include	idents with otion and	
	missed 6 days. The	done 7 days a week) and record for March revealed I restorative care 10 out of		evaluation and ongoing Restorative Nursing. was completed by 4/18	The re-education 8/17. The Rehab	
	16 days, and missed	-		Manager or Nurse Man audit 5 residents week	ly for 12 weeks with	
	(NA) #1 who was also	9:00 AM with nurse aide o responsible for the at there is not enough staff		and splinting is comple indicated. Opportunitie	eted as clinically	
	to cover the schedule	-		as identified. Criteria 4		
	worked as NAs 5 out	of 7 days and restorative rovided to the residents.		The Rehab Director wi of these audits and mo QAPI committee for th	onitoring to the	
	revealed the Restora	11:53 AM with Nurse #2 tive Aides were being pulled NAs and residents were not nursing care.		quarterly, and then as committee will evaluate and amend as needed	needed. The QAPI e the effectiveness	
	Aides #1 and #2 reven hall to work as NAs 5	2:34 PM with Restorative aled they were pulled to the out of 7 days per week and ative nursing care was not				
	being provided. They they were reporting the	y both stated on these days neir inability to do care to the no was also the MDS nurse				

Facility ID: 923004

If continuation sheet Page 16 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED C
		345080	B. WING		03/16/2017
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COD	•
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT	-	13TH AVENUE PLACE NW KORY, NC 28601	
(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)	SHOULD BE COMPLETION
F 318	Continued From page	e 16	F 318		
F 323 SS=J	residents because the #2 had been pulled to Interview 03/16/17 at Nursing (DON) revea expectation that resid ordered. 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu (1) The resident envir from accident hazard (2) Each resident rec and assistance device (n) - Bed Rails. The fa appropriate alternativ bed rail. If a bed or s must ensure correct i maintenance of bed r to the following element (1) Assess the reside from bed rails prior to (2) Review the risks a the resident or reside informed consent prior	care had not been done for e restorative aides #1 and b work the halls as NAs. 4:10 PM with the Director of led that it was her lents get restorative care as -(3) FREE OF ACCIDENT SION/DEVICES ure that - ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use res prior to installing a side or ide rail is used, the facility nstallation, use, and rails, including but not limited ents.	F 323		4/18/17
	(3) Ensure that the be appropriate for the re	ed's dimensions are sident's size and weight.			

Facility ID: 923004

If continuation sheet Page 17 of 49

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 04/18/20 ² / APPROVE). 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345080	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		22	20 13TH AVENUE PLACE NW		
BRIANCE				H	ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 17	F 3	222			
. 020	-	Γ is not met as evidenced	1.5	525			
	by:	i is not met as evidenced					
	-	ons, record review and staff			Preparation, submission and		
		failed to prevent 1 of 9			implementation of this Plan of Correct	tion	
	cognitively impaired i				does not constitute an admission of c		
		t risk for elopement, from			agreement with the facts and conclus		
	exiting the facility and	C F			set forth on the survey report. Our P		
	grounds (Resident #4	+).			Correction is prepared and executed means to continuously improve the q		
	Immediate Jeonardy	began on 02/16/17 when			of care and to comply with all applica		
		rom the facility without staff's			state and federal regulatory requirem		
	knowledge that she v						
	-	t #4 had crossed the parking			F323		
	lot approximately 135	5 feet in a straight path from					
	-	to the postal box across the					
		nt back to the facility by a			1. Resident #4 was assessed as be	•	
		ross the road. The speed			at risk for elopement and a Wandergi		
		35 miles per hour and the			was initiated on 08/21/16 . On 2/16/		
		he low 50's and overcast. aring a long sleeve cotton			approximately 5:30pm Resident #4 w assisted back into the facility at the	as	
		nd shoes and was assessed			building s front door by Nurse #3. A	e	
		injuries noted. Immediate			Resident #4 re-entered the facility, in		
	•	ed on 03/16/17 when the			wheel chair, the wander guard she w		
		implemented a credible			wearing sounded and the door		
		nce. The facility remains out			immediately locked. A visitor reported	d to	
		wer scope and severity level			Nurse #3 that she observed Residen		
		oring of systems put in place			cross the street, in her wheel chair ar		
	and completion of en	nployee training.			rolled herself back into the facility par	-	
	The findings included	4.			lot, prior to being assisted back into t facility.	ne	
					Nurse #3 immediately completed a H	ead	
	Review of the facility	's "Resident Elopement"			to Toe Assessment of Resident #1wit		
	-	e with release/revision date			injuries noted. An updated Elopeme		
	of June 2007 specifie				Assessment was completed for Resid		
		de a safe environment and			#4 and the care plan was reviewed a		
	preventive measures	for elopement. Nursing			updates by the Director of Nursing or	n	
		rt and investigate all reports			2/16/17. The Director of Nursing		
	of missing residents.				validated the placement and function	of	
	"It is the responsibilit	y of all personnel to report			the Wanderguard for Resident #4.		

Facility ID: 923004

If continuation sheet Page 18 of 49

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	OMB NO	SURVEY
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG			LETED
		345080	B. WING			02/	C 16/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2017
					20 13TH AVENUE PLACE NW		
BRIAN CE	ENTER HEALTH & REHA	B HICKORY VIEWMONT		Н	ICKORY, NC 28601		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 323	Continued From page	e 18	F 32	23			
		ing to leave the premises, or	1 0.	20	Increased supervision was initiated for		
		nissing, to the charge nurse			Resident #4 to include every 15 minute		
	and document the oc				checks to monitor location. These		
				checks were completed by the Nursing			
		nitted to the facility on			Assistants and documented on the flow		
	-	ses including diabetes and			record by the Charge Nurse for 72 hour	rs	
	Alzheimer's disease.				following the incident. Nurse #3 notified Resident #4□s		
	Review of the quarte	rly Minimum Data Set (MDS)			Responsible Party and Physician		
	dated 02/17/17 revea	•			regarding Resident #4 exiting the facilit	v,	
	severely cognitively i	mpaired. The MDS further			physical assessment following the ever	-	
		1 had wandering behavior 1			and plan for increased monitoring on		
	to 3 days during the a	assessment period.			2/16/17. No new Physician □s Orders		
	Dovious of the sere of	lan with a greation data of			were received. An Incident report was	a n	
	-	lan with a creation date of dated date of dated date of 02/17/17			completed by Nurse #3 on 2/16/17 and investigation was completed by the	an	
	revealed Resident #4				Director of Nursing on 2/16/17 who		
		related to being disoriented			interviewed Resident #4 and determine	d	
	to place, impaired sa	fety awareness and			that she exited the Facility via the front		
		rred on 02/16/17. The goal			door by entering the Wanderguard code	e	
		be maintained through the			into the key pad.		
		erventions included: identify			Since 2/16/17 the Restorative Aides ha		
		: is wandering purposeful, ? Is resident looking for			validated the placement and function of Resident #4 s Wanderguard daily and		
		ndicate the need for more			documented on the Wanderguard Log.		
	-	as appropriate. Wander alert			On 3/16/17 Incident and Accident repor	ts	
	checks daily.				for the last 90 days were reviewed by the		
					Director of Nursing and Administrator a	nd	
	Review of Nurse's no	otes:			it was determined there were no other	- 1	
	08/21/16 /05 014 0-	sident #4 observed by this			unsupervised exits reported for Resider		
		esident #4 observed by this go out front door of facility.			#4. There were no other unsupervised exits reported for other residents		
		vith diagnoses of dementia.			assessed at risk for elopement during t	he	
		is nurse, "I'm going home."			last 90 days. To the knowledge of Facil		
	Resident was easily	redirected." Wanderguard			Staff and Leadership, Resident #4 has	-	
		sident for elopement risk			had no other instances of exiting the		
	and safety. Will conti	nue to monitor.			facility without supervision since 2/16/1	7.	
	00/07/46 0:40 DM D	aident placently confirmed			2. The code for the Wanderguard		
	U8/27/16 2:16 PM Re	esident pleasantly confused.			System was changed by the Maintenar	ice	

Facility ID: 923004

If continuation sheet Page 19 of 49

		MEDICAID SERVICES	0			<u>). 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	SURVEY PLETED
		345080	B. WING			C
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP COD		/16/2017
	NOVIDER OR SOLT EIER			220 13TH AVENUE PLACE NW	-	
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		HICKORY, NC 28601		
(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)	SHOULD BE	(X5) COMPLETIC DATE
F 323	Continued From page	e 19	F 32	3		
		ented to place, time and	1 02	Director on 2/16/17 and again	on 3/15/17	
		from exit doors multiple		The Maintenance Director cor		
	times. No distress not	•		review of the Wanderguard Sy		
				including validation of properly		
		sident placed herself on the		Wanderguard keypads and al		
		neelchair and began to cut		facility doors on 2/16/17 and a		
	-	with a pair of nail clippers.		3/15/17. The Maintenance Di		
	She was placed back			Administrator will continue to		
		placed and nail clippers were juries were noted from her		Wanderguard System for all fa daily and document on the Wa		
	cutting off the wander	-		Log.	anuerguaru	
		guaru.		The Director of Nursing and N	urse	
	09/16/16 2:36 PM Re	sident is alert with		Managers completed an audit		
	confusion, attempts to			current residents with Wander		
		r until she gets it open. She		validated placement and func	-	
	-	ng herself on the floor from		device on 2/16/17 and again of		
	her wheelchair.			On 2/17/17 and 3/16/17 the D		
				Nursing and Nurse Managers		
		sident continually wandering		an audit of all current resident		
		esident walking around with and. Resident knows how to		elopement to include a review Elopement Assessments for a		
	-	Asked therapy to reassess		validation of Wanderguard pla	-	
	her for independent s			operation as required, validati		
				Physician s Orders to include		
	02/16/17 5:30 PM Re	sident, in a wheelchair, was		placement of current Wanderg	-	
	brought into the facilit	ty building by a staff		shift and function of current		
		s following close behind and		Wanderguards daily. These of		
		t across the road and I had		placement and function will be		
		ow her to cross back into the		documented by the Charge N		
		sident entering into building,		Medication Administration Re		
		d at the door immediately stated, "If you wait long		Elopement care plans were re validated on 2/17/17 by the N		
		open the door for you."		Managers.		
		assessment with no injury		All care plans of Residents wi	th	
		verbal, disoriented to time		Wanderguard were updated o		
	-	e elopement protocol placed		and on 3/16/17 to reflect requ		
	-	g resident's location every		interventions based on the re-		
	15 minutes, to continu	ue for 72 hours.		Elopement assessments by the	ne Nurse	
				Managers.		1

Facility ID: 923004

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/201 M APPROVE D. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345080	B. WING				C / 16/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				22	0 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		н	CKORY, NC 28601		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 20	F 3	23			
					Beginning on 3/16/17, the Admissions		
	Review of the facility	Incident/Accident Report			Director will review referrals for poten		
		0 PM revealed Resident #4			admissions with identified exit seeking		
	exited the facility, elo				behaviors with the Director of Nursing	-	
	Investigation follow-u				Administrator prior to offering placem	ent	
	wheelchair and seen	by mailbox, a visitor			to ensure proper placement. The Dire	ector	
	observed resident cro			of Nursing and Nurse Managers will			
		n the facility on entry alarm			continue to review new admissions an	nd	
	-	rd functioning properly.			readmission daily during the Clinical		
		was going to check mail.			Morning Meeting to validate accurate		
		she was able to get out of			elopement assessments and care pla as required. The Director of Nursing		
	someone will open th	"You just have to wait and			Nurse Managers will review current	anu	
		ed - Sign on door for visitors			residents assessed at risk for elopem	ent	
		lents - do not open door for			monthly to validate accurate assessm		
		ndations - New elopement			and care plans.		
		ed. Wanderguard checked			Beginning on 3/16/17 any Resident		
	for proper functioning	. All doors checked by			elopement will be reported immediate	ly to	
		r. Code to wanderguard			the Facility s Administrator or Director		
	• • •	Resident placed on every			Nursing and an Incident and Accident		
		72 hours than 1 hour until			report will be completed.		
	placement can be fou	und at a locked unit.			3. On 3/16/17 The Director of Nursi	ng	
	An interview and the	ad an 02/15/17 at 11:20 ANA			and Nurse Managers re-educated all	ilit.	
		ed on 03/15/17 at 11:38 AM ed on 02/16/17 she was			current Facility Staff regarding the fac policy for Elopement. On 3/15/17 the	-	
		s desk in the front lobby and			Director of Nursing and Nurse Manag		
	saw a visitor pushing				educated all current facility staff regar		
		king lot toward the front door			changing the code on the Wandergua	•	
		ated she immediately went			System and keeping this code discret		
	-	esident #4 was outside.			which includes not sharing with famili	es,	
		visitor told her she was			visitors or residents and to report any		
		and had to stop her car in			deviations from this process to the		
	front of the facility, on				Administrator or the Director of Nursin	•	
		ick across the road to the			On 3/15/17 the Maintenance Director		
		d she parked her car and			changed the code for the Wandergua		
1	prought Resident #/			1	System. On 3/15/17 the Administrato	r	
	-	back to the facility. She			-	•	
	stated Resident #4 ha	ad gone approximately 135 across the street and 135			and the Maintenance Director implemented a process for changing		

Facility ID: 923004

If continuation sheet Page 21 of 49

STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345080	B. WING _		a	C 3/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				220 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 323	had on a long sleeve tennis shoes. Nurse a approached the front Resident #4's wande to unlock the door to she assessed Reside placed her on elopen informed the Adminis building and called th Administrator's order did not hear Residem off and was not awar until she saw her out she went out without An interview was con PM with Restorative a worked on 02/16/17 v PM to 11:00 PM shift #4 eating supper in th 5:00 PM and did not not know she had go stated Resident #4 w supper and wasn't ar the dining room. He s in the front lobby afte and she would wand and would tell him sh stated she had gone before and her alarm right back into the bu some of the alert and	the low 50's and Resident #4 d cotton shirt, slacks and #2 stated when they door it locked due to r guard and staff inside had let them in. Nurse #2 stated ent #4 and found no injuries, nent precautions protocol, strator, who was in the ne Director of Nursing per . Nurse #2 further stated she t #4's wanderguard alarm go e she was out of the building side and did not know how the alarm sounding. Adducted on 03/15/17 at 3:15 Aide (RA) #2 revealed he with Resident #4 on the 3:00 . He stated he saw Resident the main dining room around hear an alarm go off and did ne out of the building. RA #2 ras her baseline during nxious or in a hurry to leave stated Resident #4 would sit er supper and watch the news er throughout the building ut the front door with visitors ie wanted to go home. RA #2 out the front door one time went off and he brought her ilding. RA #2 further stated I oriented residents that sat w the code and would let	F 3	 monthly or as needed a part of the staff education No staff shall work after receiving this education has been added to the P program for all new hire to be completed prior to after 3/15/17. The Administrator, Direc Nurse Manager will range staff members 3 times p weeks to ensure the Wa kept discrete. The Adm monitor the Door logs w weeks to ensure the Wa System is monitored at proper function. The Di and Nurse Managers wi residents with wandergu 12 weeks to validate do effective placement and wandergurds. 4. The Administrator results of these audits w weeks during the QAPI monthly thereafter. The review these results and recommendations as results of the second second	on. a 3/15/17 before b. This education Facility Orientation es and agency staff b beginning work ctor of Nursing or domly interview 5 ber week for 12 anderguard code is hinistrator will weekly for 12 anderguard each door daily for irector of Nursing ill monitor uards weekly for boumentation of d function of the will report the weekly for 12 Meeting and then a committee will d make	
		with the DON at 3:46 PM on e was not in building on				

If continuation sheet Page 22 of 49

	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IE SORVET MPLETED
			A BOILDING			С
		345080	B. WING		0	3/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
				220 13TH AVENUE PLACE NW		
BRIAN CE	NIER HEALIH & REHA	B HICKORY VIEWMONT		HICKORY, NC 28601		
(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) COMPLETIO DATE
F 323	Continued From page	a 22	F 32	22		
1 020			Г 52			
		lent #4 eloped but she was Nurse #1 and came to the				
	-	ing. The DON stated she				
		and Resident #4 about the				
	incident the following	day. She stated Resident #4				
	told her she was goir	ig to check the mail and				
		how she got out the door				
y C p		if you watched long enough				
	-	e buttons and go out. The				
		imed she had watched staff				
	-	ard staff telling visitors and				
		e knew how to go out				
		Inding. The DON stated she nd none of them heard the				
	alarm go off when Re					
	-	she called the Maintenance				
	-	e in and reset the code for				
	the front door. The D	OON stated there was no one				
	at the reception desk	in the evenings after supper				
	but the nurses were i	n and out of the nurse's				
		o observe the residents that				
	liked to sit in the front	t lobby in the evenings.				
	During an interview c	onducted on 03/15/17 at				
	5:00 PM the Adminis					
	0	ence room on 02/16/17				
		M when Nurse #2 came in				
		sident #4 had eloped,				
		was pushed back to the				
		ne Administrator stated she ne DON and complete an				
		Administrator stated she was				
	-	4 had tried to exit the				
		She stated the investigation				
		staff would tell other staff or				
		nlock the front door and				
	Resident #4 had to k	now the code to exit without				
	the alarm from her wa	andor guard counding. The				
		Resident #4's wanderguard				

Facility ID: 923004

If continuation sheet Page 23 of 49

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 345080 B. WING 03/16/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW	CENTER	RTMENT OF HEALTH AN ERS FOR MEDICARE &		(X2) MULTIF	PLE CONSTRUCTION		FORM	0: 04/18/2017 1 APPROVED 0. 0938-0391 SURVEY
345080 B. WING 03/16/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT 220 13TH AVENUE PLACE NW				· ,			COMP	LETED
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT			345080	B. WING		_		
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	NAME OF PF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HICKORT, NG 28601	BRIAN CE	CENTER HEALTH & REHAI	3 HICKORY VIEWMONT		220 13TH AVENUE PLACE HICKORY, NC 28601	NW		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	ECTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
F 323 Continued From page 23 was functioning properly because it the locked the door when they tried to re-enter the building and the Maintenance Director checked it that evening and the alarm sounded when the code for the door wasn't put in first. On 03/15/17 at 5:20 PM an interview with Resident #8, who was allert and oriented, was conducted. During this interview Resident #8 stated he was aware of the code to unlock the facility's front door to exit the facility. The resident stated he knew the facility front door exit code by hearing staff yell the code ou lock the facility's front door to the stuft facility. The resident stated he current code to unlock the facility's front door to the surveyor. Observations made on 03/15/17 at 8:35 AM, 03/15/17 at 3:30 PM and 03/16 17 at 4:30 PM revealed Resident #4 in her room talking with her roommate and watching television. Her wanderguard was observed on her left ankle each observation. The Administrator and DON were informed of Immediate Jeopardy on 03/15/17 at 6:33 PM. On 03/16/17 at 6:35 PM, the facility provided the following Credible Allegation of Compliance: 1. Resident #1 was assessed as being at risk for elopement and a Wanderguard was initiated on 08/21/16. On 21/61/7 at 6:35 PM. On 03/16/17 at 6:35 PM, the facility provimately 5:30pm Resident #1 was assisted back into the facility at the building's front door by Nurse #3. As Resident #1 re-entered the facility. In her wheel chair, the wander guard she was wearing sounded and the door immediately locked. A	F 323	 was functioning proper the door when they tr and the Maintenance evening and the alarm for the door wasn't put On 03/15/17 at 5:20 F Resident #8, who was conducted. During thi stated he was aware facility's front door to stated he knew the faby hearing staff yell th During this interview I provided the current of front door to the surver. Observations made on 03/15/17 at 3:30 PM arevealed Resident #4 roommate and watchi wanderguard was obseach observation. The Administrator and Immediate Jeopardy of On 03/16/17 at 6:35 F following Credible Aller 1. Resident #1 wrisk for elopement and initiated on 08/21/16. 5:30pm Resident #1 re-en wheel chair, the wand 	erly because it the locked ied to re-enter the building Director checked it that in sounded when the code it in first. PM an interview with a alert and oriented, was is interview Resident #8 of the code to unlock the exit the facility. The resident icility's front door exit code the code out to each other. Resident #8 correctly code to unlock the facility's eyor. In 03/15/17 at 8:35 AM, and 03/16 17 at 4:30 PM in her room talking with her ing television. Her served on her left ankle d DON were informed of on 03/15/17 at 6:38 PM. PM, the facility provided the egation of Compliance : vas assessed as being at d a Wanderguard was On 2/16/17 at approximately was assisted back into the 's front door by Nurse #3. tered the facility, in her der guard she was wearing	F 32	23			

Facility ID: 923004

If continuation sheet Page 24 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/2017 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345080	B. WING				C / 16/2017
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	220 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		ŀ	HICKORY, NC 28601		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	and rolled herself back prior to being assisted Nurse #3 immediately Assessment of Reside completed for Reside reviewed and updates on 2/16/17. The Dire placement and function Resident #1. Increase for Resident #1 to increase for 72 hours for Nurse #3 notified Res Party and Physician resident Nurse #3 on 2/16/17. No new Phy received. An Incident Nurse #3 on 2/16/17 completed by the Dire who interviewed Resis she exited the Facility entering the Wanderg Since 2/16/17 the Res validated the placement #1's Wanderguard da Wanderguard Log. On 3/16/17 Incident at last 90 days were rev Nursing and Administ there were no other up for Resident #1. The	e street, in her wheel chair ck into the facility parking lot, d back into the facility. y completed a Head to Toe ent #1 with no injuries Elopement Assessment was and #1 and the care plan was s by the Director of Nursing ctor of Nursing validated the on of the Wanderguard for ued supervision was initiated fude every 15 minute ation. These checks were rsing Assistants and ow record by the Charge llowing the incident. sident #1's Responsible regarding Resident #1 exiting ssessment following the creased monitoring on vsician's Orders were t report was completed by and an investigation was ector of Nursing on 2/16/17 ident #1 and determined that v via the front door by guard code into the key pad. storative Aides have ent and function of Resident illy and documented on the and Accident reports for the riewed by the Director of trator and it was determined insupervised exits reported re were no other	F	323			
	unsupervised exits re assessed at risk for e	ported for other residents lopement during the last 90 ge of Facility Staff and					

Facility ID: 923004

If continuation sheet Page 25 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/2017 MAPPROVED O. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345080	B. WING			03	C 8/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				22	20 13TH AVENUE PLACE NW		
BRIAN CE	NIER HEALIH & REHA	B HICKORY VIEWMONT		н	ICKORY, NC 28601		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	since 2/16/17. 2. The code for the changed by the Main and again on 3/15/17 completed a review of including validation of Wanderguard keypace doors on 2/16/17 and Maintenance Director continue to monitor thall facility doors daily Wanderguard Log. The Director of Nursin completed an audit of Wanderguards and validation of each device 3/15/17. On 2/17/17 and 3/16/ and Nurse Managers current residents at ria a review of current El accuracy, validation of and operation as requered physician's Orders to of current Wanderguards and set of current Wanderguards are set of current Wanderguards and set of current Wanderguards are set of current Wanderguards and set of current Wanderguards are set of the set of current Wanderguards are set of current wanderguards	t #1 has had no other ne facility without supervision Wanderguard System was tenance Director on 2/16/17 The Maintenance Director of the Wanderguard System f properly functioning as and alarms for all facility again on 3/15/17. The r or Administrator will ne Wanderguard System for and document on the ang and Nurse Managers f all current residents with alidated placement and ce on 2/16/17 and again on 17 the Director of Nursing conducted an audit of all sk for elopement to include opement Assessments for of Wander guard placement	F	323			
	the Charge Nurse on Administration Recor- were reviewed and va Nurse Managers. All care plans of Resi were updated on 2/17	d. Elopement care plans alidated on 2/17/17 by the idents with Wanderguard 7/17 and on 3/16/17 to rentions based on the review					

Facility ID: 923004

If continuation sheet Page 26 of 49

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345080	B. WING		C 03/16/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW	1
				HICKORY, NC 28601	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION DATE ICLENCY)
F 323	Beginning on 3/16/17 will review referrals for identified exit seeking of Nursing and Admir placement to ensure Director of Nursing and continue to review new readmission daily dur Meeting to validate and assessments and car Director of Nursing and review current reside elopement monthly to assessments and car Beginning on 3/16/17 will be reported immer Administrator or Direct Incident and Accident 3. On 3/16/17 The Nurse Managers re-et Staff regarding the fa On 3/15/17 the Direct Managers educated a regarding changing th System and keeping includes not sharing vendors or residents	 the Admissions Director proper placement. The head Nurse Managers will we admissions and ring the Clinical Morning ccurate elopement the plans as required. The head Nurse Managers will we admissions and ring the Clinical Morning ccurate elopement the plans as required. The head Nurse Managers will head Nurse Wanderguard head Nurse Wanders will he	F 3	23	
	Director changed the System. On 3/15/17 Maintenance Director changing the code fo monthly or as needed the staff education. No staff shall work aff this education. This e	On 3/15/17 the Maintenance code for the Wanderguard the Administrator and the implemented a process for r the Wanderguard System d and included this as part of ter 3/15/17 before receiving ducation has been added to n program for all new hires			

Facility ID: 923004

If continuation sheet Page 27 of 49

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION		E SURVEY PLETED
		345080	B. WING				C / 16/2017
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT		220	REET ADDRESS, CITY, STATE, ZIP CODE 0 13TH AVENUE PLACE NW CKORY, NC 28601	1 00	10,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 323 F 333 SS=E	6:35 PM when intervi administrative staff ar confirmed they had re the facility's Elopeme the code to the front of 483.45(f)(2) RESIDED SIGNIFICANT MED E 483.45(f) Medication The facility must ensu (f)(2) Residents are fr medication errors. This REQUIREMENT by: Based on record revi facility failed to admin physician orders for 2 medication administra #11). The findings included 1. Resident #1 was a 07/01/13 with diagnos anxiety and depressio	e completed prior to 3/15/17. was removed on 03/16/17 at ews with direct care staff, nd non-nursing staff eccived in-service training on nt Policy and not giving out door. NTS FREE OF ERRORS Errors. ure that its- ree of any significant is not met as evidenced iew and staff interviews the hister medication per of 5 residents reviewed for ation (Resident's #1 and : dmitted to the facility on ses of Alzheimer's disease,		323	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusion set forth on the survey report. Our Pla Correction is prepared and executed a means to continuously improve the qua of care and to comply with all applicable state and federal regulatory requireme F333 Criteria 1	ons n of s a ality le	4/18/17
	Review of the annual dated 01/24/17 revea severely cognitively ir antianxiety medicatio assessment period.	led Resident #1 was npaired and received			Criteria 1 The Director of Nursing completed Medication Variance Reports for orderer medications with missing signatures related to Residents #1 and #11. The Physician was notified as required. The		

Event ID: 546311

Facility ID: 923004

If continuation sheet Page 28 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/18/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345080	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	20 13TH AVENUE PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		н	ICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	Resident #1 required psychoactive medica Resident #1 to receiv continued to be effect included: observe for observe for potential reviews for potential Review of the physicit following: 10/27/14 Valium 1 minisht and 1 mg every anxiety. 12/20/16 Clarification take ½ a tablet (1 mg mg (1/2 tablet) by moneeded for anxiety. 01/24/17 1. Discontin regarding gradual dos Valium 2mg tablet give every other night and needed for anxiety. Review of the monthl revealed a recomment 12/22/16 to decrease	an dated 02/04/17 revealed administration of tion. The goal was for e the smallest dosage that tive. The interventions medication effectiveness, side effects and periodic dose reduction. an order's revealed the lligram (mg) by mouth every 8 hours as needed for order: Valium 2 mg tablet) by mouth every night and 1 outh every 8 hours as use all current Valium orders se reduction attempt. 2. re ½ tablet (1 mg) by mouth 1 mg every 8 hours as	F	333	DEFICIENCY) was completed by 4/18/17. Criteria 2 All residents receiving medications has the potential to be affected by this alle deficient practice. The Director of Nu and Nurse Managers conducted an ai of current resident s Medication Administration Records to validate accurate transcription of Physician s Orders and accurate documentation of administration of ordered medications from the last 30 days. This audit was completed by 4/18/17. Medication Variance Reports will be completed as opportunities are identified. Criteria 3 The Director of Nursing or Nurse Managers will re-educate all Licensect Nurses on transcription of Physician orders including the process for Moni End verification of accurate transcripti of Physician s Orders and the documentation of administration of medications as ordered by the physic This education was completed by 4/18 The Director of Nursing or Nurse Managers will review the Order Listing report and the Medication Administrat Audit report via Point Click Care 4 tim per week for 12 weeks to verify accur- transcription to the Medication Administration Record and documenta of medication administration. Opportunities will be corrected daily ai identified.	eged rsing udit of s s th ion ian. 8/17. g ion les ate ation	
	Review of the Medica (MAR) revealed the fe	ation Administration Record ollowing:			Criteria 4 The Director of Nursing will report the		
	The December 2016	MAR revealed Resident #1			results of these audits and monitoring	to	

Event ID: 546311

Facility ID: 923004

If continuation sheet Page 29 of 49

		MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY IPLETED	
						С	
		345080	B. WING		0:	3/16/2017	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CE	ENTER HEALTH & REHA	B HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601				
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE	
F 333	Continued From page	e 29	F 33	3			
	received 1 mg Valiun from 12/01/16 throug	n every evening at 6:30 PM h 12/20/16 and she began ose of Valium 1 mg at 9:00		the QAPI committee for three n quarterly, and then as needed. committee will evaluate the effe and amend as needed.	The QAPI		
	received 1 mg Valiun and 9:00 PM from 01 She received 1 mg V PM from 01/11/17 thr received 1 mg Valiun through 01/31/17 and every other night from Review of the Februa Resident #1 received	AR revealed Resident #1 n every evening at 6:30 PM /01/17 through 01/10/17. 'alium at 6:30 PM and 10:00 rough 01/23/17 and she n at 10:00 PM from 01/24/17 d 1 mg Valium at 7:00 PM n 01/24/17 through 01/31/17. ary 2017 MAR revealed d Valium 1 mg every other					
	with the Director of N was not aware of the Resident #1. She sta received it was the m put it in the computer previous order that w stated the order put i should not have in be she stated it was just the current valium or order in it caused Re dose of valium every on 01/24/17 was put that entered the order	ed on 03/14/17 at 3:30 PM lursing (DON) revealed she medication error for ted when an order was urse on duty responsibility to and discontinue any vas being replaced. The DON n the computer on 12/20/16 een put in as a new order, an updated prescription for der and by putting a second sident #1 to receive an extra night. She stated the order in correctly but the nurse or into the computer system e of the valium 1 mg every					
	night order and not b nurse should have go make sure all previou cancelled. The DON	oth orders. She stated the one through the MAR to us valium orders had been further stated she and the wed the monthly MARs to					

Facility ID: 923004

If continuation sheet Page 30 of 49

	SUPPLIER/CLIA TION NUMBER: 345080 WMONT CIENCIES	· ,	NG		(X3) DATE COMP	0. 0938-0391 SURVEY LETED
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB HICKORY VIE (X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PRECE	CIENCIES	B. WING _				;
BRIAN CENTER HEALTH & REHAB HICKORY VIE (X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PRECE	CIENCIES				03/16/2017	
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PRECI	CIENCIES		~	TREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PRECE	CIENCIES		22	20 13TH AVENUE PLACE NW		
PREFIX (EACH DEFICIENCY MUST BE PRECI			н	IICKORY, NC 28601		
	INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333 Continued From page 30		F 3	222			
make sure they were correct and m	issed the					
medication errors in Dec. 2016 and						
During an interview conducted on 0 4:06 PM the facility Physician state	d it was his					
expectation that all medication order followed. The Physician stated the						
have happened and 2 mg of valium						
was a larger dose than what Resident #1 needed but it wasn't harmful for her.						
An interview conducted with Nurse 03/15/17 at 8:45 AM revealed Resid						
always alert in the mornings and at						
the dining room. She stated Reside						
take a nap around 1:00 or 1:30 PM never seemed over medicated or se						
An interview conducted on 03/15/17						
with the facility Pharmacy Consulta she reviewed resident records once						
stated her reviews consisted of med						
review, new and existing orders, lab						
gradual dose reductions and inform						
staff on the residents status. She st stopped reviewing resident MARs v						
facility changed to computer MARs						
was too time consuming. The Phar						
she was not aware Resident #1 had						
double the dose of valium in Dec. 2						
2017 and she would have caught th had reviewed the MAR but didn't ca						
physician order sheet. She stated s						
have reviewed the MARs for all res						
During an interview conducted on 0						
11:55 AM Nurse #3 stated she took 01/24/17 to discontinue all valium o						
valium 1 mg every other night and p						

Facility ID: 923004

If continuation sheet Page 31 of 49

CENTER	MENT OF HEALTH AN IS FOR MEDICARE & I	MEDICAID SERVICES			CONSTRUCTION		FORM	0: 04/18/2017 APPROVED 0: 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,				` '	LETED
		345080	B. WING					_ 16/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP	CODE		
BRIAN CE	INTER HEALTH & REHAR	B HICKORY VIEWMONT			20 13TH AVENUE PLACE NW ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BI		(X5) COMPLETION DATE
F 333	computer. She stated the valium 1 mg every realize there were two every night in the syst discontinue medication the MAR until you found discontinue and clicked An interview conducter Nurse #4 revealed it w clarification order for w dated 12/20/16. He st taking the order but h- computer as a new or the current valium ord An interview conducter 03/16/17 at 5:45 PM r expectation for all phy as written and discont 2. Resident #11 initial 02/09/17 and most re- facility on 02/28/17 ar facility on 03/08/17. R included: infection of ft (diskitis) and kidney d Review of Resident # comprehensive minim 02/16/17 revealed that moderately impaired ft and required only set transfers, ambulation, use. The MDS also re- received 7 days of an	she did discontinue one of a night orders but she didn't b orders for valium 1 mg tem. She stated to n orders you looked through nd the order you wanted to ed discontinue order. ed on 03/16/17 at 4:10 PM vas his signature on the valium 1 mg every night ated he did not remember e must have put it in the der and didn't discontinue ler. ed with the Administrator on evealed it was her visician orders to be followed tinued as ordered. ly admitted to the facility on cently readmitted to the ad was discharged from the esident #11's diagnoses the intervertebral disc isease stage 2. 11's most recent hum data set (MDS) dated tt Resident #11 was for daily decision making	F 3	33				

Facility ID: 923004

If continuation sheet Page 32 of 49

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB N (X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	. ,	IPLETED
						С
		345080	B. WING		0	3/16/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 333	Continued From pag	e 32	F 33	33		
	Review of a facility d	ocument titled "Hospital				
		for Resident #11 dated				
	02/28/17 read in part					
	milligrams (mg) IV ev	very day.				
	Review of medication	n administration record dated				
		/31/17 revealed that on				
		11 received vancomycin 1500				
	mg IV at 9:53 AM an	d again at 8:48 PM.				
	Review of Jaboratory	report dated 03/02/17 of a				
	complete blood coun					
	-	abolic panel (CMP) were				
	present in the chart a medical doctor (MD)	and been reviewed by the				
	Interview with Nurse	#1 on 03/16/17 at 12:42 PM				
		d been off for a few days and				
		03/03/17 and had seen that omycin had been placed on				
		d that when she went to				
	Resident #11's room					
	medication she noted	d that an old bag of				
	-	nging but not infusing. So				
		1 #1 and they began to				
		nd that was when they dent #11 had gotten 2 doses				
		mg IV on 03/01/17. Nurse #1				
	stated she was not s	ure what UM #1 did after the				
		r and was not sure if there				
	-	orders. Nurse #1 stated that				
		ere checking Resident #11's il it was less than 20 and that				
		g once he was off of the				
	vancomycin.	-				
	Attempts to reach the	e MD on 03/16/17 at 6:01 PM				
	were unsuccessful.					

If continuation sheet Page 33 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/18/2017 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345080	B. WING				C / 16/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				220 1	13TH AVENUE PLACE NW		
	INTER HEALTH & REHA	B HICKORY VIEWMONT		HICI	KORY, NC 28601		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	03/16/17 at 6:15 PM i out on leave and had 03/08/17 and was ma error involving Reside that the report she rec computer glitch that e not show up on the M entered and the nurse orders appeared on the medication was admin stated she had not has but to her knowledge transpired. The DON the staff to administer and in this case it was day. Interview with the Nur 03/16/17 at 6:40 PM is stated she did recall F the medication error is stated that the facility errors" lately and this stated that Resident # mobile and had a diag stage 2. The NP state been more elderly an have worsened his kin of his younger age ar affect his kidney funct ultimately Resident # Interview with Nurse a 03/16/17 at 6:45 PM. working on 03/01/17 a Resident #11's orders hospital stay and in th	ector of Nursing (DON) on revealed that she had been returned to work on ade aware of the medication ent #11. The DON stated ceived was that there was a evening and one order did IAR so another order was e did not realize that both he MAR, therefore the nistered twice. The DON ad time to fully investigate that was what had further stated she expected r the medication as ordered s once a day and not twice a rse Practitioner (NP) on was conducted. The NP Resident #11 and did recall with his vancomycin. The NP r had "some medication was one of them. The NP #11 was ambulatory and gnoses of kidney disease ed that if Resident #11 had d bedridden this error could dney function but because nd mobility it really did not tion to her knowledge and 11 was discharged home.	F	333			

Facility ID: 923004

If continuation sheet Page 34 of 49

	-	ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVI NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345080	B. WING			C	C 3/16/2017
AME OF PF	ROVIDER OR SUPPLIER		•		EET ADDRESS, CITY, STATE, ZIP CODE		
RIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		_	13TH AVENUE PLACE NW KORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 333	Continued From page	e 34	Ĺ	333			
1 000		hat he had to reboot the		333			
		e system came back up there					
		system cue (where they					
	,	Nurse #4 stated he had					
		and did not realized that the					
		place. So Resident #11 got 2 1500 mg IV that day, one in					
	the morning and one						
		urse #5 on 03/16/17 at 6:55 ful. Nurse #5 was the nurse					
		e extra dose of vancomycin					
	on 03/01/17.						
	03/16/17 at 7:00 PM	it Manager (UM) #1 on revealed that Nurse #1 had					
		omycin error and reported it					
		ated that she had gone down ident #11 and he was his					
		1 stated she then called the					
	NP and made her aw	are of the error and also					
		and made them aware of the					
	-	nacy was dosing Resident ne UM #1 also stated that the					
		BC and CMP (laboratory test)					
		n as ordered. The UM #1					
		ed the Director of Nursing of					
F 959	the error.			252			4/40/47
F 353 SS=E	STAFF PER CARE F	FICIENT 24-HR NURSING PLANS		353			4/18/17
	483.35 Nursing Servi	ices					
	-	e sufficient nursing staff with					
		petencies and skills sets to					
		related services to assure					
		ttain or maintain the highest					

Facility ID: 923004

If continuation sheet Page 35 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP		
		345080	B. WING				_ 16/2017	
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT			220 13TH AVENUE PLACE NW HICKORY, NC 28601			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 353	 well-being of each restresident assessments and considering the n diagnoses of the facilit accordance with the f at §483.70(e). [As linked to Facility A be implemented begin (Phase 2)] (a) Sufficient Staff. (a) (1) The facility must sufficient numbers of of personnel on a 24-nursing care to all restresident care plans: (i) Except when waive this section, licensed (ii) Other nursing perstimited to nurse aides (a)(2) Except when w this section, the facilit nurse to serve as a cluty. (a)(3) The facility must nurses have the spect sets necessary to care identified through residence in the plan (a)(4) Providing care fasters in the plan 	sident, as determined by a and individual plans of care umber, acuity and ity's resident population in acility assessment required assessment, §483.70(e), will nning November 28, 2017 at provide services by each of the following types hour basis to provide idents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not aived under paragraph (e) of y must designate a licensed harge nurse on each tour of et ensure that licensed ific competencies and skill e for residents' needs, as dent assessments, and	F	353				

If continuation sheet Page 36 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/18/2017 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345080	B. WING				C 16/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	NTER HEALTH & REHA			2	20 13TH AVENUE PLACE NW		
DIVIAN OF				ŀ	HICKORY, NC 28601		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	Continued From page	36	F	353			
		is not met as evidenced		555			
	by:						
	Based on observatio and staff interviews, t sufficient nursing staf bed baths not being p of 4 residents reviewed #8), incontinence care 4 residents reviewed	eing provided as ordered for			Preparation, submission and implementation of this Plan of Correct does not constitute an admission of of agreement with the facts and conclusi set forth on the survey report. Our Pla Correction is prepared and executed a means to continuously improve the qu of care and to comply with all applicat state and federal regulatory requirement	- ons an of as a iality ble	
	interviews, the facility and bed baths as sch reviewed for Activities (Residents #6, #7 and	F-312. Based on reviews, resident and staff failed to provide showers reduled for 3 of 4 residents s of Daily Living (ADL) d #8).			F353 Criteria 1 On 3/17/17 the Director of Nursing validated that Residents #6 received a shower according to her preference. Resident #6 was evaluated by the Re Staff by 4/18/17 and a treatment plan developed to include splinting, range motion and development of a Restora	hab of	
	review, resident and s failed to maintain a re him in a soiled brief for residents reviewed for (Resident #8). 3. Cross refer to tag F observation, record re	-318. Based on eviews and resident and			Nursing Program for ongoing management On 3/17/17 the Director of Nursing validated that Resident #7 receiving a shower according her preference. On 3/16/17 the Director of Nursing validated that Resident #8 received incontinent care following an episode bowel incontinence. On 3/17/17 the		
	and passive range of of 1 resident (Residen restorative care (Resi	nre for splint management motion exercises for 1 out nt #6) reviewed for ident #6). 9:00 AM with nurse aide			Director of Nursing validated that Resident #8 received a shower accord to his preference. Criteria 2 All residents have the potential to be affected by this alleged deficient pract Criteria 3 The Administrator will secure a contra	ice.	
	schedule revealed that	at there is not enough staff			for agency staffing by 3/17/17 to fill		

Facility ID: 923004

		ND HUMAN SERVICES				FOR	D: 04/18/20 M APPROVE
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION			0. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>			(X3) DATE SURVEY COMPLETED	
		345080	B. WING _				C / 16/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	1 00	
				220 13TH AVENUE	PLACE NW		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		HICKORY, NC 2	8601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 353	Continued From page	a 37	F3	53			
					de ee required		
		e. She stated that the development of the development of the development of the state of the development of			ds as required. strator and Director of N	lursing	
		of 7 days and restorative			erdisciplinary Team inclu		
		rovided to the residents. NA			lursing Staff completed		
	÷ ·	n 1st shift were being asked			sis regarding ongoing s		
		stay over to assist with 2nd		-	nent needs by 4/13/17.	•	
		s being asked to come in			ysis and ongoing feedb		
		ift. She stated that there			g staff the following plai		
	-	positions on 2nd shift for		have been o			
		hat the Director of Nursing			/13/17 and "All Hands of	n	
	and the Administrator	r were aware that the			bach will be implemente		
	schedule was short s	taffed.		include all a	vailable facility staff to a	assist	
				during meal	s to provide additional		
	Interview 03/15/17 at	11:35 AM with Nurse #3		assistance a	and support to meet res	ident	
	revealed Administrati	on was aware of the staffing		ADL needs.			
	problem and had said	d that they were working on		Nursing Sta	ff were re-educated by	4/18/17	
		urse #3 further stated that all		-	tor of Nursing and Nurs		
		b being on call 1 extra shift			on the expectation of pro		
		d that she was on call the			ith assistance of comple		
		k. Nurse #3 also stated that			focus on completion of		
		Il staff had been put on the			cording to the resident's		
		o one to call in the event of a		·	and completion of incom		
	staff member calling	out for the shift.			uired. Nursing Staff will report to the Administration		
	Interview 03/15/17 at	11:53 AM with Nurse #2			Nursing when unable to		
	revealed the Restora	tive Aides were being pulled			DLs for assigned reside	nts and	
		NAs and residents were not			e plan will be secured		
	receiving restorative	nursing care.		·	itional assistance.		
		0.50 DM			Licensed Nurses were		
	Interview 03/15/17 at				I by the Staff Developm		
		ot take any breaks or a lunch			regarding the assessm		
		some of the work done but if			ith decreased range of i		
		preaks then they could not			tures to include therapy		
	get the residents' inco				evaluation and ongoing y Restorative Nursing.	In the	
	Interview 03/16/17 at	9:08 AM with NA #4		-	storative Aide is unavaila		
		arted with getting residents			e assigned tasks the		
	up and dressed and t				or will be notified and		
		NA from each hall had to go			staffing will be secured f	or	

Facility ID: 923004

If continuation sheet Page 38 of 49

S FOR MEDICARE &	MEDICAID SERVICES				0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		COMP	LETED
	345080	B. WING			C 16/2017
ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
NTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
Continued From page	e 38	F 35	53		
to the dining room to stated the NA that rer	assist with breakfast. She nained on the hall had to		completion of these interven		
not gone to the dining room for breakfast. She stated that sometimes on night shift there were only 2 to 3 NAs in the building and that was not enough help to meet the needs of the residents. NA #4 stated that recently on a Sunday (could not		will review the Nursing scheo plan ahead and prepare for s opportunities. The Nurse Managers will rar	dule daily to staffing ndomly		
room and there was r trays and the residen they should have with	no one in there to pass out ts had not gotten drinks as n their meal. She stated that		require assistance with show incontinent care for 12 week completion of ADL assistanc	vers and s, to validate e including	
asked to work over to staff was getting burn they had told the Ass	o cover the schedule and the led out. NA #4 stated that istant Director and the		Opportunities will be corrected identified during these audits The Rehab Director will rand	ed as s. lomly audit 5	
Interview 03/16/17 at	4:10 PM with the Director of		contractures to ensure range and splinting is completed as	e of motion s clinically	
She stated that they I and tried to cover the	nad used some agency NAs schedule with current staff.		Director of Nursing will hold	a meeting	
the halls until 5:00 PM and coming in early to She stated that it was	A and staff were staying late to try to cover the schedule. ther expectation that		review and discuss facility st based on resident care need activity and planned hiring an	affing needs s, recruitment	
-			The Administrator will report these observations to the QA weekly for 12 weeks then mo facility utilizes the Plan, Do,	API committee onthly. The Study, Act	
			Performance Improvement F including scheduling, identifi trends or patterns, submission	Program cation of on of data,	
	Continued From page to the dining room to stated the NA that rer pass breakfast trays in not gone to the dining stated that sometime only 2 to 3 NAs in the enough help to meet NA #4 stated that rec recall date) there wer room and there was n trays and the residen they should have with every time they turne asked to work over to staff was getting burn they had told the Ass Director of Nursing burn they had told the Ass Director of Nursing burn they construct the She stated that they fand the cover the The DON stated that the halls until 5:00 PM and coming in early to She stated that it was residents get restorat incontinence care at	AF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A345080 ROVIDER OR SUPPLIER NTER HEALTH & REHAB HICKORY VIEWMONT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 to the dining room to assist with breakfast. She stated the NA that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that sometimes on night shift there were only 2 to 3 NAs in the building and that was not enough help to meet the needs of the residents. NA #4 stated that recently on a Sunday (could not recall date) there were residents in the dining room and there was no one in there to pass out trays and the resident had not gotten drinks as they should have with their meal. She stated that every time they turned around they were being asked to work over to cover the schedule and the staff was getting burned out. NA #4 stated that they had told the Assistant Director and the Director of Nursing but nothing had changed. Interview 03/16/17 at 4:10 PM with the Director of Nursing (DON) revealed that she had not talked with the residents about their issues with staffing. She stated that they had used some agency NAs and tried to cover the schedule with current staff. The DON stated that managers had worked on the halls until 5:00 PM and staff were staying late and coming in early to try to cover the schedule. She stated that it was her expectation that residents get restorative care as ordered and incontinence care at least every 2-3 hours and as	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING ROVIDER OR SUPPLIER 345080 B. WING	predeneuscies CORRECTION (X1) PROVIDERSUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING 345080 B WING BOUDER OR SUPPLIER STREET ADDRESS, CITY, STREE, ZIP COL 220 13TH AVENUE PLACE NW INCORVY, NC 28601 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CO 220 13TH AVENUE PLACE NW INCORVY, NC 28601 Continued From page 38 to the dining room to assist with breakfast. She stated the NA that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated the NA that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that sometimes on high shift there were only 2 to 3 NAs in the building and that was not enough help to meet the needs of the residents. NA #4 stated that recently on a Sunday (could not trays and there was no one in three to pass out trays and there was no one in three to pass out trays and the residents ahot gotten drinks as they should have with their meal. She stated that every time they turned around they were being asked to work over to cover the schedule and the Director of Nursing but nothing had changed. The Rehab Director will rand residents weekly for 12 week contractures to ensure range and splinting is completed as indicated. Opportunities will as identified. She stated that they had used some agency NAs and tried to cover the schedule. She stated that they had used some agency NAs and tried to cover the schedule. She stated that they had used some agency NAs and tried to the sensore as ordered and incontinence care at least every 2-3 hours and as needed. </td <td>PF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COMPO 345080 B WING 00 STREET ADDRESS, CITY, STATE, ZIP CODE 201 3TH AVENUE PLACE NW HICKORY, NC 28601 00 SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY WIST PE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETIX (READ COMPRECTIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PROVIDER'S NEW OCCORRECTION (READ COMPRECTIVE ACTION SHOLD DE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Continued From page 38 to the dining room to assist with breakfast. She stated the X that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that A that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that recently on a Sunday (could not recail date) there were residents in the dining room and there was no one in there to pass out trays and the residents had not gotten drinks as they should have with their meal. She stated that they had ubd the Assistant Director and the birector of Nursing but nothing had changed. The Nurse Managers will randomly observe 10 residents with staffing. She stated that they had used some agency NAs and tried to cover the schedule and the staff was getting burned out, NA #4 stated that they had ubl the Sistent Director of Nursing (DON) revealed that she had not talked with the residents about their issues with staffing. She stated that they had used some agency NAs and tried to cover the schedule with staffing. She stated that twas her expectation that residents get restorativ</td>	PF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE COMPO 345080 B WING 00 STREET ADDRESS, CITY, STATE, ZIP CODE 201 3TH AVENUE PLACE NW HICKORY, NC 28601 00 SUMMARY STATEMENT OF DEFICIENCIES (READ DEFICIENCY WIST PE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETIX (READ COMPRECTIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PROVIDER'S NEW OCCORRECTION (READ COMPRECTIVE ACTION SHOLD DE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Continued From page 38 to the dining room to assist with breakfast. She stated the X that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that A that remained on the hall had to pass breakfast trays for the residents who had not gone to the dining room for breakfast. She stated that recently on a Sunday (could not recail date) there were residents in the dining room and there was no one in there to pass out trays and the residents had not gotten drinks as they should have with their meal. She stated that they had ubd the Assistant Director and the birector of Nursing but nothing had changed. The Nurse Managers will randomly observe 10 residents with staffing. She stated that they had used some agency NAs and tried to cover the schedule and the staff was getting burned out, NA #4 stated that they had ubl the Sistent Director of Nursing (DON) revealed that she had not talked with the residents about their issues with staffing. She stated that they had used some agency NAs and tried to cover the schedule with staffing. She stated that twas her expectation that residents get restorativ

Facility ID: 923004

If continuation sheet Page 39 of 49

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		345080	B. WING				C 03/16/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0/10/2011
				22	20 13TH AVENUE PLACE NW		
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT			ICKORY, NC 28601		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 353	Continued From page	- <u>30</u>		252			
1 333	Continued From page	e 39		353			
					of the plan and make recommendation	IS	
					as required.		
F 425 SS=E		RMACEUTICAL SVC - DURES, RPH		425			4/18/17
	(a) Procedures. A fa						
		ces (including procedures					
		ate acquiring, receiving,					
		inistering of all drugs and he needs of each resident.					
	(b) Service Consultat	ion. The facility must					
	employ or obtain the	services of a licensed					
	pharmacist who						
	(1) Provides consulta	tion on all aspects of the					
		y services in the facility;					
		is not met as evidenced					
	by:						
		iew and staff interviews the			Preparation, submission and		
	facility's Pharmacy C	onsultant failed to identify a			implementation of this Plan of Correcti	on	
		of 5 residents reviewed for			does not constitute an admission of or		
	unnecessary drug us	e (Resident #1).			agreement with the facts and conclusion		
	The findings included	l:			set forth on the survey report. Our Pla Correction is prepared and executed a		
					means to continuously improve the qu		
	Resident #1 was adm	nitted to the facility on			of care and to comply with all applicab	-	
		ses of Alzheimer's disease,			state and federal regulatory requireme		
	anxiety and depression						
					F425		
		Minimum Data Set (MDS)					
	dated 01/24/17 revea				1. Medications for Resident #4 have		
	, , ,	mpaired and received			been reviewed by the pharmacist by		
	antianxiety medicatio assessment period.	ns daily during the			4/18/17 to ensure the regimen is free of errors and unnecessary medications.	ונ	
					-		
		an dated 02/04/17 revealed			Residents receiving Psychoactive medications have to the potential to be		
	Resident #1 required administration of						

Event ID: 546311

Facility ID: 923004

If continuation sheet Page 40 of 49

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURV	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETE	D
		345080	B. WING		C 03/16/2	017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•	017
BRIAN CE	ENTER HEALTH & REHA	B HICKORY VIEWMONT		220 13TH AVENUE PLACE NW HICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COM O THE APPROPRIATE	(X5) MPLETIC DATE
F 425	Continued From page	e 40	F 42	25		
	 F 425 Continued From page 40 psychoactive medication. The goal was for Resident #1 to receive the smallest dosage that continued to be effective. The interventions included: observe for medication effectiveness, observe for potential side effects and periodic reviews for potential dose reduction. Review of the physician order's revealed the following: 10/27/14 Valium 1 milligram (mg) by mouth every night and 1 mg every 8 hours as needed for anxiety. 12/20/16 Clarification order: Valium 2 mg tablet take ½ a tablet (1 mg) by mouth every night and 1 mg (1/2 tablet) by mouth every 8 hours as needed for anxiety. 01/24/17 1. Discontinue all current Valium orders regarding gradual dose reduction attempt. 2. Valium 2mg tablet give ½ tablet (1 mg) by mouth every other night and 1 mg every 8 hours as 			 affected by this alleged of The Consultant Pharmace an audit of all residents of Psychoactive medication regimen is free of errors medications. This audit by 4/18/17. 3. The Pharmacy Manage the Consultant Pharmace procedures for completion regimen review for reside Psychoactive drugs to in identification of medication use of unnecessary medication education will be complet The Pharmacy Manager monthly review of the Consultant Pharmacists of unnecessary medications residents receiving Psych medications to validate an identification of errors or unnecessary medications will be corrected as identification 	sist will conduct eceiving is to ensure their and unnecessary will be completed er will re-educate ist on the proper ig a monthly drug ents receiving clude the on errors and the ications. This ted by 4/18/17. will conduct a onsultant en reviews for 10 hoactive iccurate usage of s. Opportunities	
	night for anxiety. The accept dated 01/24/1 Review of the Medica (MAR) revealed the for The December 2016 received 1 mg Valium from 12/01/16 through	ndation was made on valium to 1 mg every other physician's response was to 7. ation Administration Record ollowing: MAR revealed Resident #1 n every evening at 6:30 PM h 12/20/16 and she began ose of Valium 1 mg at 9:00		4. The Director of Nursin results of these observat committee weekly for 12 monthly. The facility utili Study, Act method for Qu and Performance Improvi including scheduling, ide trends or patterns, subm and initiation of quality in related to identified areas The committee will evalue of the plan and make rece as required.	ions to the QAPI weeks then zes the Plan, Do, uality Assurance rement Program ntification of ission of data, nprovement plans s of opportunity. ate effectiveness	

Facility ID: 923004

If continuation sheet Page 41 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345080	B. WING				C 16/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT			20 13TH AVENUE PLACE NW IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page	÷ 41	F	425			
	received 1 mg Valium and 9:00 PM from 01. She received 1 mg Va PM from 01/11/17 thr received 1 mg Valium through 01/31/17 and every other night from Review of the Februa Resident #1 received night at 7:00 PM. An interview conducte with the Director of Ni was not aware of the Resident #1. She stat received it was the nu to put it in the comput previous order that was stated the order put in should not have in be she stated it was just the current valium orco order in it caused Resides of valium every stated the Pharmacy Managers reviewed this sure they were correct errors in Dec. 2016 and During an interview co 4:06 PM the facility P expectation that all m followed. The Physici have happened and 2	n 01/24/17 through 01/31/17. ry 2017 MAR revealed Valium 1 mg every other ed on 03/14/17 at 3:30 PM ursing (DON) revealed she medication error for ted when an order was urse on duty's responsibility ter and discontinue any as being replaced. The DON in the computer on 12/20/16 en put in as a new order, an updated prescription for der and by putting a second sident #1 to receive an extra night. The DON further Consultant, she and the Unit he monthly MARs to make et and missed the medication and Jan. 2017.					

Facility ID: 923004

If continuation sheet Page 42 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04 FORM APP OMB NO. 093	PROVE		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345080	B. WING		C 03/16/2	017		
	ROVIDER OR SUPPLIER	B HICKORY VIEWMONT	220	STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVENUE PLACE NW HICKORY, NC 28601				
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) MPLETION DATE		
F 425	Continued From page	e 42	F 425					
F 520 SS=J	with the facility Pharm she reviewed residen stated her reviews co review, new and exisi gradual dose reduction staff on the residents stopped reviewing resi- facility changed to co was too time consum she was not aware R double the dose of va 2017 and she would I had reviewed the MA physician order sheet have reviewed the MA physician order sheet have reviewed the MA An interview conducto 03/16/17 at 5:45 PM i expectation for the far to review the entire re- medication errors. 483.75(g)(1)(i)-(iii)(2)) COMMITTEE-MEMB QUARTERLY/PLANS (g) Quality assessme (1) A facility must mail and assurance comm- minimum of: (i) The director of nur- (ii) The Medical Direct	ting orders, labs, need for ons and information from the status. She stated she sident MARs when the mputer MARs because it ing. The Pharmacist stated esident #1 had received alium in Dec. 2016 and Jan. have caught the error if she R but didn't catch it from the t. She stated she should ARs for all residents. ed with the Administrator on revealed it was her cility Pharmacy Consultant esident medical record for (i)(ii)(h)(i) QAA ERS/MEET on t and assurance.	F 520		4/18	\$/17		

Facility ID: 923004

If continuation sheet Page 43 of 49

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/18/2017 FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345080	B. WING		C 03/16/2017		
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	INTER HEALTH & REHA	B HICKORY VIEWMONT		20 13TH AVENUE PLACE NW IICKORY, NC 28601			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 520	staff, at least one of v administrator, owner, individual in a leaders (g)(2) The quality ass committee must : (i) Meet at least quart coordinate and evalu- identifying issues with assessment and assu- necessary; and (ii) Develop and imple action to correct iden (h) Disclosure of infor Secretary may not re- records of such comr such disclosure is rel- such committee with section. (i) Sanctions. Good fa committee to identify deficiencies will not b sanctions. This REQUIREMENT by: Based on record rev facility's Quality Asse committee failed to m procedures and moni committee put into pla was for a recited defie of 2016 and subsequ	who must be the a board member or other ship role; and sessment and assurance terly and as needed to ate activities such as in respect to which quality urance activities are ement appropriate plans of tified quality deficiencies; rmation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this aith attempts by the and correct quality e used as a basis for T is not met as evidenced iews and staff interviews the ssment and Assurance naintain implemented tor interventions that the ace on July 8, 2016. This ciency originally cited in July ently recited in March of complaint investigation	F 520	Preparation, submission and implementation of this Plan of Correct does not constitute an admission of a greement with the facts and conclus set forth on the survey report. Our P Correction is prepared and executed means to continuously improve the co of care and to comply with all application	or sions lan of as a juality		

Facility ID: 923004

If continuation sheet Page 44 of 49

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 04/18/2017 DRM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345080	B. WING				C 03/16/2017
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHAI			220 ⁻	13TH AVENUE PLACE NW		
BRIAN OL				HIC	KORY, NC 28601		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	2 44	F 52	20			
	continued failure durin	ng two federal surveys of of the facility's inability to	1 02		F520		
	sustain an effective C Immediate Jeopardy I Resident #4 eloped fr knowledge that she w supervision. Immedia on 03/16/17 when the implemented a credib The facility remains o scope and severity le monitoring of systems completion of employ The findings included This tag was cross re F 323: Based on obse staff interviews the fa cognitively impaired r assessed as being at exiting the facility and grounds (Resident #4 The facility was recite prevent a resident fro F323 was originally ci recertification survey adequate supervision falling during indepen wheelchair.	Availity Assurance Program. began on 02/16/17 when from the facility without staff's vas outside without te Jeopardy was removed a facility provided and ble allegation of compliance. ut of compliance at a lower vel of D to ensure is put in place and ee training. ferred to: ervations, record review and cility failed to prevent 1 of 9 esidents, who were risk for elopement, from I leaving the facility's b). ed for F323 for failing to m eloping from the facility. ited in July 2016 on the for failing to provide to prevent a resident from ident transfers from bed to onducted on 03/15/17 at rator stated she was ence room on 02/16/17 M when Nurse #2 came in			 On 3/16/17, the Area Staff Development Coordinator conducted re-education for the Administrator on facility s policy and procedures for assembling a QAPI committee, colled data and analyzing trends, and development and implementation of a plan to improve with ongoing monitor sustain compliance. The facility utiliz the the Plan, Do, Study, Act method Quality Assurance and Performance Improvement Program including scheduling, identification of trends or patterns, submission of data, and init of quality improvement plans related identified areas of opportunity. The committee has met monthly in the pa monitor ongoing compliance with F323 Supervision to prevent Accidents with focus on the review and monitoring o audits being conducted to correct and maintain the elopement managemen process and to evaluate systems for effectiveness of the facility Is overall compliance with F323 Supervision to prevent Accidents. 2. On 3/16/17 the Administrator, Di of Nursing and Facility Interdisciplina Team including the Social Services Director, Admission Coordinator and Maintenance Director conducted a ro cause analysis regarding facility processes for elopement prevention. Based on the results of this root cause 	the cting a ing to res for iation to st to 23 vill n a f d t t rector ry	

Facility ID: 923004

If continuation sheet Page 45 of 49

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(¥2) MI II TI			OMB NO. 0938-03	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
						С	
345080		B. WING			03/16/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI			
				220 13TH AVENUE PLACE NW			
BRIAN CE	RIAN CENTER HEALTH & REHAB HICKORY VIEWMONT			HICKORY, NC 28601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETIC DATE	
F 520	Continued From page	e 45	F 52	20			
	crossed the road and was pushed back to the			analysis a QA plan was	developed to		
		ne Administrator stated she		include re-education of a	-		
		ne DON and complete an		staff regarding the Elope	-		
	· ·	Administrator stated she was		management of the War			
		4 had tried to exit the		System. A review of elop			
		She stated the investigation		assessments and care p			
		staff would tell other staff or		at risk for elopement we			
		nlock the front door and now the code to exit without		updated by the Nurse M Residents with Wanderg			
		ander guard sounding. The		observed for validation of			
	Administrator stated Resident #4's wander guard			function of the Wanderg			
		erly because it locked the		system was implemente			
		to re-enter the building and		Wanderguard door code	-		
	the Maintenance Dire	ector checked it that evening		needed. All current facil	ity staff were		
		ed when the code for the		re-educated regarding th			
		t. The Administrator further		complete an Incident Re			
		Performance Improvement		elopements and to imme	•		
		17 for elopement for the		elopements to the Admir			
		sment and Assurance (QA) eviewing at the meetings.		Director of Nursing. The Nursing will implement i			
	-	continue to monitor and audit		supervision for the Resid			
	-	supervision to prevent		immediately to establish			
	accidents at morning meetings and QA meetings			continue until the investi			
	on an ongoing basis.			completed and required			
				have been implemented	. Incident		
		d DON were informed of		Reports will be reviewed			
	Immediate Jeopardy	on 03/15/17 at 6:38 PM.		Interdisciplinary Team da			
	0-00/10/17 -+ 0:05 1			morning Stand Up meeti			
		PM, the facility provided the egation of Compliance:		Administrator. The Inter will determine acceptable			
				and ensure the care plan			
	1. On 3/16/17, the Area Staff Development			Administrator will conduc			
		ed re-education for the		of the Incident report and			
	Administrator on the facility's policy and			completion. The District			
	procedures for assembling a QAPI committee,			Clinical Services will con			
	collecting data and a	nalyzing trends, and		all Incident reports with t			
		plementation of a plan to		and Director of Nursing	-		
		monitoring to sustain		to validate completion of			
	compliance The fac	ility utilizes the Plan, Do,		and implementation of re	auired	1	

Facility ID: 923004

If continuation sheet Page 46 of 49

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
	345080		B. WING			C 03/16/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL			0,10,2011	
				22	20 13TH AVENUE PLACE NW			
BRIAN CE	NTER HEALTH & REHA	B HICKORY VIEWMONT		Н	ICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 520	Continued From page	- 46	Í – –					
F 520	Continued From page		F 5	20				
		r Quality Assurance and ement Program including			interventions.			
		tion of trends or patterns,			The results of this meeting and QA F	Plan		
	submission of data, a				were shared with the Facility Medical			
	improvement plans re			Director on 3/16/17 and he was in				
	opportunity. The committee has met monthly in				agreement.			
	the past to monitor or	ngoing compliance with F323						
		nt Accident but will begin			3. On 3/16/17, the Administrator an	d the		
		16/17 to increase monitoring			Quality Assurance Committee were			
		n to prevent Accidents with a			retrained on the Quality Assurance &			
		ind monitoring of audits			Performance Improvement Program			
	-	orrect and maintain the			the Area Staff Development Coordina	ator.		
		ent process and to evaluate ness of the facility's overall			The Quality Assurance committee consists of:			
	-	3 Supervision to prevent			" Administrator			
	Accidents.				" Director of Nursing			
		dministrator, Director of			" Dietary Manager			
	Nursing and Facility I				" Rehabilitation Manager			
		Services Director, Admission			" Maintenance or Environmental			
	-	ntenance Director conducted			Representative			
	a root because analy	sis regarding facility			" Activities Director			
		nent prevention. Based on			" Social Services Director			
		t cause analysis a QA plan			" Human Resource Designee			
	-	lude re-education of all			" Business Office Director			
		egarding the Elopement			Resident Care Management Director	ector		
		ent of the Wander guard			Medical Director			
		elopement assessments and			" Infection Preventionist			
	were reviewed and u	nts at risk for elopement						
		Residents with Wander			A New Admission and readmission	n will		
	-	d for validation of placement			be monitored by the Director of Nursi			
		ander guards. A new			and Nurse Managers daily during the	•		
		nted to change the Wander			morning clinical meeting for accurate			
		thly and as needed. All			assessments and care planned			
		ere re-educated regarding			interventions as required.			
	-	complete an Incident Report			Current Residents at risk for elopeme	ent		
	-	d to immediately report			will be monitored by the Director of			
		ministrator and Director of			Nursing and Nurse Managers weekly	and		
	Nursing The Direct	or of Nursing will implement			as needed to review the accuracy of		1	

Facility ID: 923004

If continuation sheet Page 47 of 49

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	COMPLETED			
			С				
		B. WING		03/16/2017			
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· ·		
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT				220 13TH AVENUE PLACE NW HICKORY, NC 28601			
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO		
F 520	Continued From page	e 47	F 52				
	4) ID SUMMARY STATEMENT OF DEFICIENCIES IEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)			assessments and care plans for or interventions. The Maintenance Director Administrator will continue to moni Wanderguard System for al doors daily and document on the Wanderguard Log The Administrator and the Director Nursing will present the results of monitoring of the Elopement Proce Wanderguard System to the Quali Assurance & Performance Improve committee weekly for 12 weeks ar monthly thereafter. The next Qua Assurance & Performance Improve meetings will be conducted weekly weeks, then monthly with oversigh District Director of Clinical Service three months .	or tor the I facility of this ess and ty ement d then lity ement / for 12 t by		

Facility ID: 923004

If continuation sheet Page 48 of 49

	FORM APPROVED							
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION							OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		345080	B. WING			C 03/16/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			10/2017	
BRIAN CE	NTER HEALTH & REHA			2	20 13TH AVENUE PLACE NW			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 520	Continued From page	2 48	F	520				
	Infection Prevent			020				
		and readmission will be ector of Nursing and Nurse						
	Managers daily during	g the morning clinical						
		assessments and care						
	planned interventions as required. Current Residents at risk for elopement will be							
	monitored by the Director of Nursing and Nurse Managers weekly and as needed to review the accuracy of assessments and care plans for ongoing interventions. The Maintenance Director or Administrator will continue to monitor the Wander guard System for all facility doors daily and document on the							
	Wander guard Log.							
	The Administrator and	d the Director of Nursing will						
	present the results of this monitoring of the							
	the Quality Assurance	IND Wander guard System to e & Performance						
	Improvement commit	tee weekly for 12 weeks and						
	then monthly thereaft Assurance & Perform	-						
		lucted weekly for 12 weeks,						
	-	ersight by District Director of						
	Clinical Services for t	nree months.						
	Immodiate Issue							
	-	was removed on 03/16/17 at ews with direct care staff,						
	administrative staff ar	nd non-nursing staff						
		eceived in-service training on nt Policy and not giving out						
	the code to the front of							

Facility ID: 923004

If continuation sheet Page 49 of 49