	-	ND HUMAN SERVICES				FORI	M APPROVED
							D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDI	ING.			
		345115	B. WING				R-C
	ROVIDER OR SUPPLIER	343113			STREET ADDRESS, CITY, STATE, ZIP CODE	05	/06/2017
NAME OF PI	ROVIDER OR SUPPLIER						
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY			635 STATESVILLE BOULEVARD		
					SALISBURY, NC 28144		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFI	IV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
			ſ				
F 000	INITIAL COMMENTS	3	F	000			
	A follow-up complair	nt and new complaint					
		nducted from 5/3/17 through					
	5/6/17.	C C					
	Immediate Jeopardy	was identified at:					
	CFR 483.15 at tag F204 at a scope and severity						
	(J) CEP 483 70 at tag E	251 at a scope and severity					
	(J)	251 at a scope and sevenity					
		284 at a scope and severity					
	(J)						
		323 at a scope and severity					
	(J)						
	-	490 at a scope and severity					
	(J)						
	-	520 at a scope and severity					
	(J)						
	Immediate Jeonardy	began on 2/25/17 at tags					
		0 for Resident #13 and on					
		F251, F284, F490 and F520					
		mediate Jeopardy was					
		An extended survey was					
	conducted.						
F 204			F :	204	L _		6/7/17
SS=J	SAFE/ORDERLY TR	ANSFER/DISCHRG					
		T (D:					
		Transfer or Discharge					
		e and document sufficient ntation to residents to ensure					
		sfer or discharge from the					
		on must be provided in a					
	form and manner that						
	understand.						
		Γ is not met as evidenced					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						05/29/2017

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.

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/2017 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	CON	E SURVEY IPLETED
		345115	B. WING			R-C 5/06/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				635 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		SALISBURY, NC 28144		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 204	Continued From page	e 1	F 2	04		
	Health Care staff, phy interviews, and facility record reviews, the facility record reviews, the facility record reviews, the facility allows a curved tube windpipe to open a re- breathing), resident a on tracheostomy care tracheostomy supplier resident (Resident #9 from the facility with a resulted in a lack of the discharge; and, the re- diagnosed with neck potentially serious bar requiring treatment w Immediate jeopardy to Resident #9 was disc his home. The resider multiple co-morbiditier resident had not beer Health care agency to tracheostomy care up expected. The resider own at home. He ret and was immediately Emergency Department and treatment of the diagnosed with neck an oral and topical ar from the hospital ED facility on 4/6/17.	es for 1 of 1 sampled a) who was discharged home a tracheostomy. This racheostomy care after esident was subsequently cellulitis (a common and acterial skin infection) with antibiotics. began on 4/1/17 when charged from the facility to ent had a tracheostomy and es (chronic conditions). The n accepted by a Home o receive assistance with his bon discharge, as he had ent did not have the training e tracheostomy care on his urned to the facility on 4/6/17 r sent to the hospital ent (ED) for an evaluation tracheostomy. He was cellulitis and prescribed both htibiotic. He was released and re-admitted to the		 Brian Center Health and Rehabilitation/Salisbury acknow receipt of the Statement of De and purpose of this Plan of Co the extent that the summary of factually correct in order to ma compliance with applicable rul provisions of quality of care of The Plan of Correction is subm written allegation of compliance Preparation and submission of Correction is in response to th 2567 from the survey conducts 3-6, 2017. Brian Center Health Rehabilitation/Salisbury's resp Statement of Deficiencies and Correction does not denote ag with the Statement of Deficien does it constitute an admission deficiency is accurate. Furthe Brian Center Health and Rehabilitation/Salisbury reserv to refute any deficiency on tha of Deficiencies through Inform Resolution, formal appeal and administrative or legal procedu F204 Corrective action accomplishe residents found to have been a the deficient practice: Resident #9 was discharged to from Brian Center Health and Rehabilitation/Salisbury on 4/1 	ficiencies prrection to f findings is aintain es and residents. nitted as ce. f this Plan of e CMS ed on May n and onse to the Plan of greement cies nor n that any rmore, the ves the right t Statement al Dispute /or other ures. d for those affected by	
	The immediate jeopa	rdy was removed on 5/6/17		request of the resident and his		

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 06/08/2017 DRM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		345115	B. WING				R-C 05/06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	Y	00/00/2011
				6	35 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		s	ALISBURY, NC 28144		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 204		ided an acceptable credible	F	204	Resident #9 required home health		
	out of compliance at	nce. The facility will remain a scope and severity level of ith the potential for more at is not immediate			services for nursing, oxygen and sup to manage tracheostomy care at hor The facility Administrator completed referral to the home health agency o	ne. a	
		ity to complete staff training ring systems put into place			3/28/17, prior to discharge from the facility. Home health agency informe staff nurse prior to discharge that the were unable to provide service for the servi	ey (
	The findings included				resident. This nurse has received education form the Area Staff		
	revealed he was hos	ent #9 's medical records pitalized on 12/17/16 for			Development Coordinator regarding discharge policy and procedure on 5		
	acute on chronic resp				The oxygen provider delivered oxyge	en but	
	-	the hospital, the resident			was unable to provide tracheostomy		
		nd a tracheostomy (also			supplies. No arrangements for DME		
	-	esident #9 was discharged			confirmed prior to discharge. Reside		
	cumulative diagnoses	ne facility on 2/7/17. His			was returned to facility by his family 4/6/17, was assessed and determine		
		y disease, respiratory failure,			need for care for his trach, due to	a	
	and diabetes.	y disease, respiratory failure,			drainage and odor, was sent to ER f	or	
	and diabetes.				eval and returned to facility where he		
		#9 ' s admission Minimum essment dated 2/14/17			readmitted to Brian Center Health ar Rehabilitation/Salisbury on 4/6/17, a	nd	
		ct cognitive skills for daily			treated for infection. Resident #9 rel		
	decision making. He				a current resident. At time of discha	•	
	assistance for bed m				there was no validation of home hea	lth	
	-	tance for transfers and			admitting resident, what care was		
		d, supervision from staff for			necessary to maintain stable health,		
	locomotion on the un				consequences of not providing this c		
	-	ing. Section O of the MDS d Resident #9 received			for the resident and his family/caregi	ver.	
		y (OT) and Physical Therapy			Section Q of the MDS was complete	d for	
	(PT) services. It also				Resident #9 on 4/13/17 and indicate		
	. ,	ceived oxygen therapy while			resident expects to remain in the fac		
	he was a resident. S						
		I the resident and his family			Throughout the discharge planning		
		sessment process. The			process for Resident #9 the facility w	/as	
	MDS reported his over	erall goal about returning to			without a Qualified Social Worker.		

Facility ID: 953007

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/20 FORM APPROVE OMB NO. 0938-039	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING		R-C 05/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				635 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		SALISBURY, NC 28144		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 204	Continued From page	o 2				
F 204	Continued From page		F 204			
		Inknown or uncertain; and,		Facility's full-time Social Service Di		
		ning was not occurring for to the community. Section		resigned without notice on 1/26/17. Facility went without a Qualified So		
		ed the resident did not want		Worker form 1/26/17 until a Qualifie		
		pout the possibility of leaving		Social Worker was retained on 3/30		
		ing to live and receive		Qualified Social Worker remains		
		nunity at the time of the		employed. The administrator had a	an	
		er, Section Q of the MDS		active role in the discharge		
	also indicated the res	sident wanted to be asked		process/planning for Resident #9.		
	about returning to the	e community on all				
	subsequent assessm	ients.		Corrective action accomplished for	those	
				residents having the potential to be		
	following areas of foc			affected by the deficient practice:		
		has a tracheostomy related		All residents discharging from the fa	-	
		mechanics" (Initiated		have the potential to be affected by		
	2/7/17; Revised on 2	-		alleged deficient practice. The nurs		
		his area of focus was for the		managers conducted an audit of re		
		igns/symptoms of infection		who have discharged from the facil	•	
		ate (Initiated on 2/7/17;		since 4/1/17 to validate each reside	ent	
	Revised on 3/16/17).	tlined to meet this goal		received sufficient preparation and orientation to ensure a safe and or	dorby	
	included:	lined to meet this goal		discharge. This was validated by	-	
		cheostomy ties (the bands		reviewing the resident record for		
		eck and hold the trach tube in		documentation of coordination of he	ome	
	-	trach collars) are secured at		care services and conducting phon		
	all times." (Initiated 2	,		interviews with the resident or their		
	-	respiratory rate, depth and		responsible party to validate succes		
	quality. Check and d	locument every shift or as		discharge. This audit was complete		
	ordered (Initiated 2/7			5/5/17.		
	Suction as necessa					
] wishes to be discharged to		Measures put into place or systemi		
		iated on 3/8/17; Revised on		changes made to ensure that the d	eficient	
	3/8/17).			practice will not occur:		
	-	his area of focus was for the				
		verbalize/communicate the		The Area Staff Development Direct		
		need post-discharge and the neet his needs before		completed re-education on 5/5/17 c		
	discharge (Initiated o			the interdisciplinary team involved i		
	uischarge (milialed o				11	

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	M APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345115	B. WING				R-C 5/06/2017
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	IR HEALTH & REHAB/SA	ALISBURY			5 STATESVILLE BOULEVARD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 204	3/16/17). The interventions out included: Establish a pre-disc resident/family/careg revise the plan as ner- need for assistance w and Activities of Daily (Initiated on 3/8/17; F Evaluate the resider the community (Initian A review of the resider included Respiratory 2/7/17, 2/8/17, 2/14/1 3/21/17. One addition No notations were maindicate the RT provious resident on the care of A review of Resident revealed a home visit by OT and PT in antion from the facility. Rec the home visit included chair, hand held show shower, and oxygen basis. The notes rec PT, and Speech Ther A review of the resided orders (as of 3/31/17 Tracheostomy: Cha every night shift ever 2/7/17); Oxygen saturation (be checked every shift	dined to meet this goal charge plan with the ivers, evaluate progress, and eded with the resident 's with his tracheostomy care (Living (ADL) assistance Revised on 3/8/17); and, nt 's motivation to return to ted on 3/8/17). ent 's medical record Therapist (RT) notes dated 7, 2/23/17, 3/14/17, and nal RT note was not dated. ade on the RT notes to ded education/training for the of his tracheostomy. #9 's therapy notes t was conducted on 3/27/17 cipation of his discharge commendations made from ed the need for a shower wer head, grab bar in the on an as needed (PRN) ommended follow up OT, rapy (ST) upon discharge. ent 's current physician) included the following: ange tubing and equipment y Wednesday (Initiated falso known as an O2 Sat) to fit and notify the Medical 2 Sat is less than 88%	F2	204	 discharge planning to include the Administrator, Director of Nursing, Nu Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physicia This education includes the facility por regarding transfer and discharge procedures as follows: A. The Social Services Director coordinates the preparation of the resident to ensure safe and orderly transfer or discharge from the facility a) informing the resident where he or is going; b) involving the resident and/or the responsible party in selecting the new residence; c) providing a home visit for the resid to the new location, if possible; d) making appropriate referrals; i.e.: Home Health, DME, O2 Supplies B. Nursing staff completes the Resid Transfer form if the resident is transfer to an acute health care facility or ano nursing facility. C. The Post-Discharge Care Plan is completed by the Interdisciplinary Tea for all planned discharges from the fa lf a resident is discharged home, nursing facility. 	an. blicy by: she v ent ent erring ther	

Event ID: H58611

Facility ID: 953007

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		ATE SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		
		245445				R-C
		345115	B. WING			05/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
BRIAN CT	R HEALTH & REHAB/S	ALISBURY		635 STATESVILLE BOULEVARD		
				SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 204	Continued From pag	je 5	F 2	04		
		unt of oxygen carried in the		staff reviews the plan with the	ne resident	
		d oxygen levels are typically		and/or the resident's legal r		
	considered to be 95-			prior to discharge.		
		ng (referring to the inner				
		of the tracheostomy tube):		D. The physician provides	discharge	
		to be completed every shift		order.	5	
	and as needed (Initia					
	Oxygen (O2) at 5 li	iters (referring to the oxygen		No licensed nurses shall we	ork after 5/5/17	
		every shift (Initiated 3/2/17).		before receiving this educat	ion. This	
				education has been added		
	A review of the resid	ent 's medical record		orientation program for all n	ew hires and	
	included a Respirato	ory Therapist (RT) note dated		agency staff to be complete	d prior to	
	3/31/17. The respira	atory assessment note		beginning work after 5/5/17		
	revealed Resident #	9 was sitting up in the chair				
	with a pleasant dem	eanor. Tracheostomy care		District Care Management I	Director (MDS	
	was done and the R	T noted there was no change		educated the facility MDS d	epartment and	
	in the stoma (surgica	al opening) site at that time.		Social Services Director on	completion of	
	Resident #9 was not	ed to be scheduled for		Section Q on 5/6/17.		
		n 4/1/17. There was no				
	notation on the RT n	ote to indicate the resident		The Administrator, Director	of Nursing or	
	was trained on care	of the tracheostomy.		Nurse Manager will review i	residents	
				planned for discharge three	times per	
		ent 's medical record		week for 12 weeks to ensur		
		's note dated 3/31/17 at		orderly discharge has been		
		ician noted Resident #9 was		meeting with the resident ar	-	
		summary. The notation		and completing the Post Dis		
	read as follows, in pa			of Care, providing a home v		
		is seen today in anticipation		possible and validating the	completion of	
	-	n the facility this weekend.		appropriate referrals.		
		the [Name of Facility] on				
	-	ospitalized for acute on		District Director of Care Ma	•	
		ailure and pneumonia		audit five MDSs weekly for		
	subsequently requiri			validate accurate completio	in or Section Q.	
	-	e his admission he has done			tod as	
		on and with trach care. For		Opportunities will be correct	ieu do	
	-	eks he has been seen		identified.		
	_	he facility without any SOB or not been requiring oxygen		Monitoring Process:		
	when walking"	ior been requiring oxygen		Monitoring Flocess.		

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/08/2017 RM APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING				R-C 5/06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY			35 STATESVILLE BOULEVARD ALISBURY, NC 28144		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 204	Plan: "COPD: Dimin high risk for re-hospit go home. HH (Home A review of Resident revealed a Nursing N reported, in part: " A review of the Home 4/1/17 (not timed) inc "Call from [name of re #2] regarding waiting agency] to come out. to trach. Spoke with representative] who in at [name of facility]. / Home Health staff me referral as it would ta (private duty nurse). manager [name of ma of facility], but they we information and CM (Department is closed An email dated 4/3/17 by the Home Health a email was sent from to Marketing Manager to for Resident #9 's pri facility 's Administrative read: "I have copied [name on this email as well to I spoke with the other even though [name of company] approved F client he is not approp high risk for a hospita	alization but is felt stable to a Health) nursing, PT/OT." #9 's medical record ote dated 4/1/17 at 7:35 PM Patient went home." • Health agency notes dated buded the following text: esident 's Family Member for [name of Home Health Informed non-admitted due [name of Home Health nformed [name of Nurse #1] Also spoke with [name of ember], could not accept ke 2-3 weeks to set up PDN She informed marketing anager]. Tried to call [name ould not provide any Case Management)	F	204	The Administrator will report the result these audits weekly for 12 weeks du QAPI meeting and then monthly thereafter. The committee will review these results and make recommend as required.	ring w	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		345115	B. WING				/06/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY						
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COM REFERENCED TO THE APPROPRIATE		
F 204	proper care he needs home and when [nam the facility] saw him la would end up back in [name of representati company] and they or home and no Trach s this client tomorrow I him back to [name of [resident ' s name] but he needs is at SNF (s [Name of facility ' s Ac team prepare a bed to just in case." A review of Resident to included documentati visit on 4/4/17 with an service. Progress not Assistant (PA) on 4/4/ notations, in part: "Recently hospitalita 12/17/16, tracheostor to SNF [name of facilit could be discharged of released however has health to come out wi Family Member #2] at today-she states he w facility] because "he of has a history of nonco home health. He lives Family Member #1]. breathing since disch The PA ' s Impression read: "Do not think patient i	. The client wanted to go the of resident 's physician at ast week he even stated he the hospital. I talked with ve for the oxygen supply hly delivered Oxygen to the upplies-When you guys see would recommend sending the facility]. I hate it for t his best place for the care skilled nursing facility) level. dministrator] will have his to make a smooth transition #9 's paper medical record on from a follow-up diabetic to outside Internal Medicine tes written by the Physician (17 included the following zed for respiratory failure my performed. Discharged ty]. Patient was told he over the weekend. He was is had difficulty getting home th trach supplies. [Name of companies the patient vill not go back to [name of doesn 't want to." Patient ompliance and refusing s at home with his [name of No fever or difficulty arge." v/Plan from the 4/4/17 visit s appropriate for outpatient ngth my concerns of not	F	204				

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345115	B. WING			R-C 05/06/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				6	35 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		s	SALISBURY, NC 28144		
(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 E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 204	comorbidities. Both h Member #2] are adam returning to [name of Home Health agency] patient. Patient is in a up-will return in 2 wee check. Labs pending A review of the hospit (ED) records from 4/6 arrived to the ED at 2 Medical Services (EW the following commer "Patient presents toda tracheostomy care. H [name of facility] on S for the last 5 days. H [name of facility] toda for himself in the hom Center, they sent him discharge from his tra denying any other pro does get confused to exact dates when his was changed." The hospital ED recor examination, Residern (redness) and superfi around the trach collal diagnosed with celluli Respiratory Notes da "trach was in place wi coming from trach are Saturday-collar wet w bedside will change o collar" The resider ED to the facility on 4	the and his [name of Family hant that patient will not be facility]. [Name of another will bring supplies out to agreement for close follow eks for BP (blood pressure) ." al Emergency Department 6/17 revealed Resident #9 :48 PM via Emergency IS). The ED history included hts: ay complaining of need for de was released from the aturday and has been home e is referred back to the y because of inability to care e but upon return to the here because he had foul icheostomy site. Patient is oblems. He states that he time so he is unclear as to last trach collar and trach rds revealed upon it #9 had erythematous cial skin breakdown all ar site. The resident was tis of the neck. The ED ted 4/6/17 at 3:57 PM read, th trach collar-foul smell ea states last changed ith drainage-Respiratory at ut trach and replace trach at was discharged from the /6/17. His discharge luded 2% Bactroban (a	F	204			

Facility ID: 953007

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391						
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		345115	B. WING				R-C /06/2017		
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 204	milligrams (mg) amox antibiotic) to be given every 12 hours for 10 A review of the Resid record dated 4/6/17 a resident was re-admit distress was noted ar being alert and orient A review of the reside the re-admission inclu Tracheostomy: Cha every night shift every 4/7/17); Trach #6 Shiley long completed every shift 4/7/17); Check O2 Sat every Sat is less than 88% Trach collar with 5 li needed during the da (Initiated 4/8/17); and Trach collar with 5 li evening and night shi A review of the reside included a Respirator 4/7/17. The respirato Resident #9 ' s trach the hospital. The respirato to the ED for cellulitis part: "No trach care w home. He is on ABT trach site." The resid as red, sore, and blee	ticillin-clavulanate (an oral as one tablet by mouth days. ent #9's electronic medical t 9:49 PM indicated the tted to the facility. No od he was assessed as ed. ent 's physician orders for uded the following: ange tubing and equipment y Wednesday (Initiated g: Tracheostomy care to be and as needed (Initiated y shift and notify MD if O2 (Initiated 4/7/17); ters O2 per minute as y for O2 Sats less than 91% , ters O2 per minute every ft (Initiated 4/8/17). ent 's medical record y Therapist (RT) note dated ry assessment revealed was changed on 4/6/17 at piratory assessment noted Imitted on 4/6/17 after going around his trach. It read, in vas done while he was at (antibiotic) and Bactroban to ent 's trach site was noted	F	204					

HUMAN SERVICES DICAID SERVICES				M APPROVED O. 0938-0391
			(X3) DAT COM	E SURVEY IPLETED R-C
345115	B. WING			C 5/06/2017
		STREET ADDRESS, CITY, STATE, ZIP CODE		
BURY		635 STATESVILLE BOULEVARD		
-		SALISBURY, NC 28144		
JST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
nent dated 4/13/17 d intact cognitive skills for le was independent for exception of requiring reating. Section O of the ed he received oxygen therapy while he Q of the MDS e resident participated in and was expecting to wever, the MDS also want to talk to someone aving the facility and tive services in the the assessment. Atted on 5/4/17 at 2:15 PM anager and the Area dinator (SDC). Upon r and the SDC recalled into the facility on 4/6/17 4:00 PM. The nurses s not expected and the admission orders for him. DC stated the facility did that time; he appeared is trach and was sent out tion and treatment. The e hospital later on that en asked what time he ewed the medical record. tated he had returned to 4/6/17 at 9:49 PM.	F 20	4		
) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER: A. BUILDING 345115 B. WING) PROVIDER/SUPPLIER/CLIA (x2) MULTIPLE CONSTRUCTION	p. PROVIDERSUPPLERCLA (X2) MULTIPLE CONSTRUCTION (X3) DAT JDENTIFICATION NUMBER: A. BUILDING (X3) MULTIPLE CONSTRUCTION (X3) DAT 345115 B. WING (D) (D) (D) BURY STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILE BOULEVARD SALISBURY, NC 23144 (D) IBURY STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILE BOULEVARD SALISBURY, NC 23144 (C) WENT OF DEFICIENCIES pp. PROVIDER'S PLAN OF CORRECTION (C) (C) (C) IDENTIFYING INFORMATION TAG PROVIDER'S PLAN OF CORRECTION (D) (C) (C) IDENTIFYING INFORMATION TAG PROVIDER'S PLAN OF CORRECTION (C) (C) (C) IDENTIFYING INFORMATION TAG PROVIDER'S PLAN OF CORRECTION (C) (C) (C) IDENTIFYING INFORMATION TAG PROVIDER'S PLAN OF CORRECTION (C) (C) (C) (C) IDENTIFYING INFORMATION TAG (C) (C)

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 06/08/2017 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345115	B. WING		R-C 05/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
				635 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAB/SA	LISBURY		SALISBURY, NC 28144		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 204	Continued From page		F 204			
	a bit and suggested h additional insight into	e might be able provide the events of 4/6/17.				
		ducted on 5/4/17 at 2:30 PM ninistrator. During the				
	interview, the adminis	strator reported Resident #9 ' of time they wanted the				
	resident to go home.	The Administrator stated he ne Health care "well in				
	-	ent 's discharge on 4/1/17.				
		ministrator provided contact				
		me Health representative.				
		ted, "Everybody knew what				
		reported on Friday night PM, both he and Resident				
		n supply company when				
	they brought his oxyg					
		se. The Administrator				
	confirmed Resident # Saturday, 4/1/17.	9 was discharged on				
	As the interview conti the Administrator repo	nued on 5/4/17 at 2:30 PM, orted Resident #9 ' s				
		ontacted him on Monday				
		the resident 's family was				
		t doing well at home with the				
	tracheostomy. The A	dministrator spoke with the				
	· ·	mber (Family Member #2)				
		7, 4/4/17, and 4/5/17. He				
	•	er that the facility would be				
		dent back. However, the ian appointment scheduled				
		nily planned to take him to it.				
		the Administrator reported				
	-	nember [Family Member #2]				
	· ·	I was basically told they				
		pring the resident back to the				
	facility. When the res					
	Administrator stated h	ne could smell the trach				

Facility ID: 953007

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			000 100			10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		
		245445	B. WING			R-C
		345115	B. WING			5/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
BRIAN CI	R HEALTH & REHAB/S	ALISBURY		635 STATESVILLE BOULEVARD		
				SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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) COMPLETIO DATE
F 204	Continued From pag	e 12	F 20	14		
1 204			F 20	14		
		get it evaluated. The facility				
		ospital ED to tell them the				
		ent over. The Administrator				
		t was seen in the ED and y around 8:00 -9:00 PM the				
	evening of 4/6/17.	y around 0.00 -9.00 Fivi line				
	A telephone interview	v was conducted on 5/4/17 at				
		rketing Manager for the				
		who had received a referral				
		or for Resident #9 's home				
		erview, the resident 's				
	discharge arrangeme					
		arketing Manager reviewed				
		e Health record, she reported				
		n the Home Care referral on				
		er explained their Home				
	-	livided into two sections: the				
	Hourly care side (wh					
		the Home Health care side				
		with trachs). On 3/31/17, the				
	agency learned the r					
		for the Hourly care; and the				
	-	de did not do trach care.				
	The Home Health off	fice contacted the Marketing				
	Manager on 3/31/17.	On 3/31/17, the Marketing				
	Manager telephoned	the facility and informed				
		Health agency couldn ' t				
		he also reported her agency				
		Home Health agencies, but				
		accepted by either of them.				
	-	till planned for 4/1/17, the				
		stated she coordinated a				
		the facility on Friday night				
		dent would have it when he				
		iday (4/3/17), she went to the				
		because she was concerned				
		harge if the resident actually				
		weekend. The Marketing				

Facility ID: 953007

If continuation sheet Page 13 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE COMF	
		345115	B. WING				/06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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)	ЗE	(X5) COMPLETION DATE
F 204	Manager stated she a the facility had a bed to come back. The M she talked with the Of #9 's primary care ph followed up with an en Manager and the facil sure everyone had the An interview was con- with Resident #9. Du resident recalled he a with someone on Frid oxygen arranged for or resident was asked w prior to discharge, he the oxygen he had a s and a railing for the con- installed by his landlo 4/1/17. Upon further "someone" on the pho get 24-hour nursing c reported he did not kr care and did not rece at home when he was facility. He reported h nurse to come out to tracheostomy, but no A telephone interview 10:48 AM with the Re who worked with Res she worked for a cont to the facility once a v tracheostomy care for 4/1/17 discharge, the	also wanted to make sure for the resident if he decided larketing Manager reported ffice Manager for Resident hysician on 4/3/17, then mail to both the Office lity 's Administrator to be e information. ducted on 5/5/17 at 8:00 AM ring the interview, the and the Administrator met lay night (3/31/17) to get his discharge. When the that was arranged for him reported that in addition to shower chair, a shower bar, ommode at home that his . He stated the shower bar nmode had not yet been rd when he arrived home on inquiry, the resident stated one had told him he would are when he got home. He how how to do his own trach ive any trach supplies to use is discharged from the ne expected a Home Health his home to take care of his one did.	F	204			

Facility ID: 953007

If continuation sheet Page 14 of 130

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MELLTIDI	E CONSTRUCTION	(X3) TAU	IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	IPLETED	
			/			R-C	
		345115	B. WING			5/06/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODI	•		
				635 STATESVILLE BOULEVARD			
BRIAN CI	R HEALTH & REHAB/SA	ALISBURY		SALISBURY, NC 28144			
(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 204	to a small amount of trouble keeping the s skin looked a little irri when cleaned. The F the Home Health nurs this issue under his tr asked what kind of tra required, the RT state care once every shift facility, but may have care twice daily upon routine tracheostomy area behind the flang sutures are connecte place) and making su changing the trach tie the tube that is insert replacing the drain sp stated she was under and a family member care, with the Home I times a week to make	nall amount of drainage and having some e keeping the skin dry. She reported the oked a little irritated and was a little sore cleaned. The RT stated she was hoping ome Health nurse would continue to follow sue under his tracheostomy collar. When what kind of trach care the resident ed, the RT stated he received routine trach nce every shift (3 times a day) while in the , but may have been able to do the trach vice daily upon discharge. She reported e tracheostomy care involved cleaning the ehind the flange (the area where the ties or s are connected to secure the tube in and making sure there were no secretions; ing the trach ties and cannula (the body of be that is inserted into the trachea), and ing the drain sponge underneath. The RT she was under the impression the resident family member would do some of his trach with the Home Health nurse going out a few a week to make sure it was done briately. Without reviewing her notes, the					
	RT did not recall if sh care training with the she did not train a far care. The RT stated i teaching with the resi included a notation do Respiratory Notes. Th was trained, he may he for the trach care. Ho would reliably do the When asked if she ha would be going home stated, "Absolutely."	e had done tracheostomy resident, but was certain mily member on the trach f she had done trach care ident, she would have ocumenting this in her he RT stated if the resident be able to do the procedure owever, she was unsure if he care twice daily every day. ad understood this resident e with Home Health, she Upon further inquiry, the RT ction machine would usually					

Facility ID: 953007

If continuation sheet Page 15 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 204	were regarding the re suction machine, the she didn ' t think he ' o stated, "You never kn saw the resident the o to the facility on 4/6/1 been put on an antibio reported the condition significantly over the I An interview was com PM with Nurse #2. N shift nurse assigned t When asked if she ha care teaching with the reported since she wo would typically "talk h stated the resident ne demonstration for her know when he left the own trach care." A follow-up interview 1 12:52 PM with Reside (Family Member #1) v that time. During the stated he lived with Fa was discharged from resident and his famil trach care was done o home, the resident star resident acknowledge his oxygen equipmen shown how to do the When Family Membe trained to provide trac the resident and famil saying, "No." The resident	sident going home without a RT reported that although d have a big problem, she ow." The RT stated she day after he was readmitted 7. She recalled he had of for neck cellulitis and n of the skin had improved last few weeks. ducted on 5/5/17 at 12:24 urse #2 worked as a 3rd o care for Resident #9. nd done any tracheostomy e resident, Nurse #2 orked on the 3rd shift, she im through it." The nurse ever did a return 5. Nurse #2 stated, "I do e facility he was not doing his was conducted on 5/5/17 at ent #9. A family member was visiting the resident at interview, the resident at interview, the resident amily Member #1 after he the facility. When the y member were asked what during the time he was ated, "nothing." The ed he was shown how to use t, but reiterated he was not	F	204			

Facility ID: 953007

If continuation sheet Page 16 of 130

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/08/2017 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345115	B. WING		-	R- 05/	-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				635 STATESVILLE BOULEV	ARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
	Continued From page (Family Member #2). family member provid had been in contact w providers. A follow-up interview 1 1:21 PM with the facil inquiry, the Unit Mana knowledge, the reside trach care during his s Manager reported shar resident presented or drainage from his trac Manager stated she of tracheostomy and cou drainage was. She re have assessed the dr resident out to the hos the facility. A telephone interview 1:24 PM with Nurse # as the nurse who rece Home Health agency facility Resident #9 w Health due to having asked about this phor believe they did speal Administrator was goi [name of the Marketin	As the reported the second ed his transportation and was conducted on 5/5/17 at ity 's Unit Manager. Upon ager reported that to her ent did not do any of his own stay at the facility. The Unit e was at the facility when the a 4/6/17 with foul smelling theostomy. The Unit lid not assess the uld not tell what color the eported two nurses who may ainage prior to sending the spital no longer worked at was conducted on 5/5/17 at 1. Nurse #1 was identified eived a phone call from the on 3/31/17, informing the as not admitted to Home a tracheostomy. When he call, the nurse stated, "I k with methe olved. Someone called		CROSS-REFEREN D	ICED TO THE APPROPRIA		DATE
	made prior to the resi stated she knew som oxygen for the residen were also going to de When asked if the res	dent 's discharge, the nurse eone brought out portable nt 's trip home and they liver his home oxygen. sident had received any on trach care, the nurse					

Facility ID: 953007

If continuation sheet Page 17 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	ESURVEY PLETED
		345115	B. WING				/06/2017
NAME OF P	ROVIDER OR SUPPLIER		I	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 204	reported, "Anytime I w to teach him." When did the tracheostomy stated, "Not really." A follow-up interview 3:20 PM with the facil the interview, an inqui involved in the discha #9. The Administrato "between Social Work and the Activities Mari the Social Worker wh He reported the disch handled between him the Activities Manage Administrator stated H was notified on 3/31/- agency that Resident home care. He repor information out until M A telephone interview 3:45 PM with the resi- facility. This physicia s Medical Director. T when he saw the resi expected the resident services upon dischal that if he was not goin he would have wante stated, "I certainly wo again." A telephone interview 9:25 AM with the resident (Family Member #2) w	vorked with his trach I tried asked if the resident ever care himself, the nurse was conducted on 5/5/17 at ity 's Administrator. During iry was made as to who was irge process for Resident r stated the facility had been kers," so he, the MDS nurse hager, shared the duties of ile the position was vacant. harge for Resident #9 was self, nursing, and possibly r. Upon inquiry, the ne was not aware the facility 17 by the Home Health #9 was not accepted for ted he did not find this Monday, 4/3/17.	F	204			

							IO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		NSTRUCTION	· · ·	E SURVEY		
			A. BUILDII	NG			R-C		
		345115	B. WING				5/06/2017		
NAME OF PF	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		5/00/2017		
				635 STATESVILLE BOULEVARD					
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY			SALISBURY, NC 28144				
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 204	Continued From page	a 18		204					
1 204				204					
1	2	nily Member #2 reported she							
	began talking with the facility about the resident ' s discharge sometime in March. When asked								
	0	his discharge date, she							
		did. They told us they could							
	get things in place for	April 1st." The family							
		gen was delivered to the							
		it #9 would be staying on							
	• •	n for his discharge. When							
	-	ent up from the facility on							
		0 AM - 12:00 PM), he had							
	portable oxygen for th								
	Member #2 stated the	ng discharged. The family							
	-	igned a paper saying she							
		sident, and was given							
		nedications. When asked if							
	either she or the resid								
	instructions for home	, she said, "No." She							
	recalled asking the n	urse (Nurse #3) if the Home							
		nd was told they "thought so"							
		nurse would be out to the							
		Family Member #2 stated							
		v often the Home Health							
		e coming out, but expected n the nurse came to the							
		e stated her main concern							
		resident 's trach was							
		nd generally taken care of.							
		ated when she got the							
		with Family Member #1,							
		nurse to come out. The							
		lidn ' t know how the trach							
		amily Member #2 reported							
	-	two to three times on 4/1/17							
	to ask why the Home	Health care people weren ' t							
	a substant of the state	and the course for both the second							
	-	and she was told they would ting with the resident at his							

Facility ID: 953007

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED			
		345115	B. WING				R-C / 06/2017			
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•				
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144					
(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)	ЗE	(X5) COMPLETION DATE			
F 204	Health agency herself told her nobody was of stated she questioned already at home and a was coming, I would in They said they didn ' said they had told sor didn ' t do them. The made an appointment physician to see if the out to take care of the check it either." She the week a nurse from agency came to the h the trach because he home who was able to care. Family Member with the facility ' s Adr the week Resident #9 the facility would take did not want to go bad stated, "I was scared trach and it was alrea reported bringing the on that Thursday (4/6 tracheostomy) was sr standing back. It was member stated the fa ED after he arrived th to the facility later tha A telephone interview 10:32 AM with Nurse worked at the facility of a week. Nurse #3 wa who worked the 1st si	e and called the Home f. The Home Health agency coming. The family member d that because he was stated, "Had I known nobody not have taken him home." t do patients with trachs and nebody at the facility they family member stated she t with the resident ' s ey could help get someone e trach, "but they didn ' t recalled sometime during n another Home Health ouse, but she didn ' t touch didn ' t have anybody at o provide help with the trach r #2 reported she had talked ministrator each day during 0 was home. She was told him back, but the resident ck. The family member with nobody checking the dy kinda messy." She resident back to the facility /17) and stated, "It (the nelling and everybody was a mess." The family cility sent him to the hospital ere. Resident #9 returned	F	204						

Facility ID: 953007

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CENTER	MENT OF HEALTH AN			E CONSTRUCTION		FORM	0: 06/08/2017 APPROVED 0: 0938-0391
	FCORRECTION	IDENTIFICATION NUMBER:	· /			COMP	LETED
		345115	B. WING		-		-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BRIAN C	IR HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULEV SALISBURY, NC 28144	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 204	Resident #9 's family the resident on the mo- reported she had not the resident was goin morning. Nurse #3 re and family member a come out to the home sent home with the re she gave him prescrip and 3 tracheostomy k However, the family m for the Home Health a and would get the trac- them. Nurse #3 stated routine teaching with (not at discharge). Up reported she thought some of his own track facility. However, she have been, "some tim while back she left the supplies in the room f trach care, but when a done. She tried to en saying, "you ' ve gotta to. Nurse #3 describe not necessarily cognit his cognition varied fr reported she tried to ca agency did not return An interview was con- with the facility 's Adr interview, the Adminis expectations were in safe and orderly disch Administrator stated h	member came to pick up orning of 4/1/17. Nurse #3 been told ahead of time that g to be discharged that called telling the resident Home Care agency would a. When asked what was sident, the nurse reported otions for his medications its from the facility. nember said they would wait agency nurse to come out cheostomy supplies from d she had done some the resident during his stay con inquiry, the nurse the resident may have done n care during his stay at the e also reported that would age tracheostomy care or the resident to do his own she came back it was not courage the resident by a do it," but he didn ' t want ed the resident as alert but tively intact. She reported om day to day. Nurse #3 call Home Health, but the her call.	F 204				

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES					FOR	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		345115	B. WING					-C /06/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL)E		
					635 STATESVILLE BOULEVARD			
	R HEALTH & REHAB/SA	LISBURT			SALISBURY, NC 28144			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 204	Continued From page	21	F	20	14			
	Interdisciplinary Team		1	20				
		1.						
	informed of the imme provided a credible a	l, the Administrator was diate jeopardy. The facility llegation on 5/6/17 at 1:06						
	PM. The allegation o	f compliance indicated:						
	Credible Allegation fo F204: Orientation for	r F204 Transfer or Discharge						
	[Name of Facility] on required Home Health Oxygen, suction mac manage tracheostom Administrator comple Health Agency on 3/2 from the facility. Hor staff nurse prior to dis unable to provide ser information was not of management for follo received education fr Development Coordin Policy and Procedure Provider delivered Ox DME (Durable Medic confirmed prior to dis returned to facility by assessed and determ Tracheostomy, due to sent to ER for eval ar he was readmitted to 4/6/2017, and treated remains a current res there was no validation	h Services for Nursing, hine, and supplies to y care at home. The Facility ted a referral to the Home 8/2017, prior to discharge me Health Agency informed scharge that they were vice for this resident. This communicated with facility w up. This nurse has om the Areas Staff hator, regarding Discharge e on 5/5/17. The Oxygen kygen. No arrangements for al Equipment) was charge. Resident # 9 was his family on 4/6, was inied need for care for his o drainage and odor, was hd returned to facility where [Name of Facility] on I for infection. Resident # 9 ident. At time of discharge on of Home Health admitting						

Facility ID: 953007

If continuation sheet Page 22 of 130

		ND HUMAN SERVICES			PRINTED: 06/08/2 FORM APPRO OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED R-C
		345115	B. WING		05/06/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD	•
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144	
(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 COMPLET
F 204	to maintain stable here not providing this carri- family/ caregiver. Section Q of the MDS Resident # 9 on 4/13, resident expects to re- Throughout the Disch Resident #9 the Facil Social Worker. Facili Director resigned with Facility went without a from 1/26/2017 until a was retained on 3/30 remains employed. T active role in the disc Resident # 9. Criteria 2 All residents discharge potential to be affected practice. The Nurse audit of residents who facility since 4/1/17 to received sufficient pro- ensure a safe and or validated by reviewin documentation of cool services and by cond the resident or their m successful discharge by 5/5/17. Criteria 3 The Area Staff Develor re-education on 5/5/1 Nurses and members	ns, what care was necessary alth, and consequences of e, for the resident and his S was completed for /17 and indicated that	F 20	4	

Facility ID: 953007

If continuation sheet Page 23 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	00/2011
					635 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			SALISBURY, NC 28144		
(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 204	the Administrator, Dim Managers, Social Ser Program Manager, Di Resident Care Manage, Di Resident Care Manage, Nurse), Business Offi This education include regarding Transfer an follows: A. The Social Service preparation of the reside preparation of the reside -Involving the reside -Involving the reside -Involving the reside -Involving the reside -Providing a home visi location if possible; -Making appropriate r DME, O2 supplies. B. Nursing staff comp form if the resident is health care facility or C. The Post-Discharg the Interdisciplinary Tr discharges from the fa- discharged to home, fi plan with the resident representative prior to D. The Physician prov No Licensed Nurses as before receiving this e has been added to the program for all new his	ector of Nursing, Nurse vices Director, Therapy jetary Services Manager, gement Director (MDS ce Director and Physician. es the facility policy ad Discharge Procedures as as Director coordinates the ident to ensure safe and charge from the facility by: nt where he or she is going; t and/or the responsible new residence; sit for the resident to the new referrals; ie: Home Health, bletes the Resident Transfer transferring to an acute another nursing facility. ge Care Plan is completed by feam for all planned acility. If a resident is nursing staff reviews the and/or the resident ' s legal o discharge. vides a discharge order. shall work after 5/5/17 education. This education e Facility Orientation ires and agency staff to be ginning work after 5/5/17.	F	204	4		

Facility ID: 953007

If continuation sheet Page 24 of 130

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/08/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345115	B. WING					-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE	, ZIP CODE	-	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144					
(X4) ID PREFIX TAG					/E ACTION SHOULD B		(X5) COMPLETION DATE	
F 204	ensure a safe and ord planned by meeting of family and completing Care, providing a hon validating the complet District Care Manager educated the facility M Service Director on or 5/6/17. Facility alleged IJ rem The credible allegatio 5:29 PM. On 5/6/17 f PM, staff members fro Nurses), Social Servic Departments were int to describe the educa policy regarding Trans Procedures and the m fulfill during the discha MDS nurses were inter verbalize the in-servic accurate completion of assessment. Adminis Director of Nursing an interviewed. The DO able to describe the e along with their respe planned for discharge of residents who have since 4/1/17 was revier resources for a safe of	week for 12 weeks to derly discharge has been with the resident and/or g the Post Discharge Plan of ne visits when possible and tion of appropriate referrals. ment Director (MDS), MDS department and Social ompletion of Section Q, on hoval 5/6/17 n was validated on 5/6/17 at from 4:25 PM through 5:29 om the Nursing (Licensed ces, and Therapy erviewed. Staff were able tion received on the facility sfer and Discharge ole they were expected to arge planning process. The erviewed and able to cing received for the of Section Q of the MDS strative staff, including the nd Administrator, were also N and Administrator were education each received, ctive role to review residents e and ensure the appropriate and resources were available e of each resident. An audit e discharged from the facility ewed, verifying each	F	204				

Facility ID: 953007

If continuation sheet Page 25 of 130

-					FOR	D: 06/08/2017 M APPROVED D. 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED R-C		
	345115	B. WING			05/06/2017		
ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	100/2011	
			6	35 STATESVILLE BOULEVARD			
R HEALTH & REHAB/SA	LISBURY		s	SALISBURY, NC 28144			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL				ION SHOULD BE COMPLETIC THE APPROPRIATE DATE		
Continued From page	e 25	F	251				
483.70(p)(1)(2) QUA	LIFICATIONS OF SOCIAL		-			6/7/17	
(p) Social worker.							
a qualified social wor	ker on a full-time basis. A						
degree in social work human services field sociology, gerontolog rehabilitation counsel (2) One year of supe experience in a healt directly with individua	or a bachelor's degree in a including, but not limited to, y, special education, ing, and psychology; and ervised social work h care setting working ls						
Based on facility staf physician, resident ar facility and hospital m facility failed to retain Social Worker on a fur responsibility for the or planning, including ar assistance for the car tracheostomy (a surg allows a curved tube windpipe to open a re breathing), resident a on tracheostomy care tracheostomy supplie sampled resident (Re discharged home from tracheostomy and rest tracheostomy care af	nd family interviews, and nedical record reviews, the the services of a qualified ull-time basis to assume coordination of discharge rranging Home Health re of a resident ' s ical opening in the neck that to be inserted into the estricted airway and enable and/or care provider training e, and access to es. This occurred for 1 of 1 esident #9) who was m the facility with a sulted in a lack of ter discharge. The resident			residents found to have been affected the deficient practice: Resident #9 was discharged to his hor from Brian Center Health and Rehabilitation/Salisbury on 4/1/17 at th request of the resident and his family. Resident #9 required home health services for nursing, oxygen and suppl to manage tracheostomy care at home The Facility Administrator completed a referral to the home health agency on 3/28/17, prior to discharge from the facility. Home health agency informed staff prior to discharge that they were	by ne lies 9.		
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER R HEALTH & REHAB/SA SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page 483.70(p)(1)(2) QUA WORKER > 120 BEE (p) Social worker. Any facility with more a qualified social work (1) An individual with degree in social work (2) One year of supe experience in a healt directly with individua This REQUIREMENT by: Based on facility staf physician, resident and facility failed to retain Social Worker on a fur responsibility for the can tracheostomy (a surg allows a curved tube windpipe to open a re breathing), resident a on tracheostomy care tracheostomy supplie sampled resident (Re discharged home from tracheostomy and rest tracheostomy and rest tracheostomy and rest tracheostomy and rest tracheostomy care af	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345115 ROVIDER OR SUPPLIER R HEALTH & REHAB/SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 483.70(p)(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS (p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker on a full-time basis. A qualified social worker is: (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals This REQUIREMENT is not met as evidenced	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. (X2) MUL A BUILD 345115 B. WING ROVIDER OR SUPPLIER B. WING SOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREF TAC Continued From page 25 F 483.70(p)(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS F (p) Social worker. F Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: F (1) An individual with a minimum of a bachelor's degree in social worker or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individuals This REQUIREMENT is not met as evidenced by: Based on facility staff, Home Health Care staff, physician, resident and family interviews, and facility and hospital medical record reviews, the facility for the care of a resident 's tracheostomy (a surgical opening in the neck that allows a curved tube to be inserted into the windpipe to open a restricted airway and enable breathing), resident and/or care provider training on tracheostomy care, and access to tracheostomy care, and access to tracheostomy care estlet in a lack of tracheostomy care after discharge. The resident <td>S FOR MEDICARE & MEDICAID SERVICES pr DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING 345115 B. WING RVIDER OR SUPPLIER B. WING RHEALTH & REHAB/SALISBURY B SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 25 F 251 483.70(p)(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS F 251 (p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: F 251 (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individual This REQUIREMENT is not met as evidenced by: Based on facility staff, Home Health Care staff, physician, resident and family interviews, and facility and hospital medical record reviews, the facility failed to retain the services of a qualified Social Worker on a full-time basis to assume responsibility for the coordination of discharge planning, including arranging Home Health assistance for the care of a resident 's tracheostomy (a surgical opening in the neck that allows a curved tube to be inserted into the windpipe to open a restricted airway and enable breathing), resident and/or care provider tr</td> <td>S FOR MEDICARE & MEDICAID SERVICES 0° DEFINITION (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILDING 345115 STREET ADDRESS, CITY, STATE, 2/P CODE ess stratesvulle BOULEVARD satisface for the service of period construction (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC DEINTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, 2/P CODE ess stratesvulle BOULEVARD SALISBURY, NC 28144 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC DEINTIFYING INFORMATION) Continued From page 25 483.70(p(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS (p) Social worker. 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WING RVIDER OR SUPPLIER B. WING RHEALTH & REHAB/SALISBURY B SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX Continued From page 25 F 251 483.70(p)(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS F 251 (p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: F 251 (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and (2) One year of supervised social work experience in a health care setting working directly with individual This REQUIREMENT is not met as evidenced by: Based on facility staff, Home Health Care staff, physician, resident and family interviews, and facility and hospital medical record reviews, the facility failed to retain the services of a qualified Social Worker on a full-time basis to assume responsibility for the coordination of discharge planning, including arranging Home Health assistance for the care of a resident 's tracheostomy (a surgical opening in the neck that allows a curved tube to be inserted into the windpipe to open a restricted airway and enable breathing), resident and/or care provider tr	S FOR MEDICARE & MEDICAID SERVICES 0° DEFINITION (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILDING 345115 STREET ADDRESS, CITY, STATE, 2/P CODE ess stratesvulle BOULEVARD satisface for the service of period construction (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC DEINTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, 2/P CODE ess stratesvulle BOULEVARD SALISBURY, NC 28144 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC DEINTIFYING INFORMATION) Continued From page 25 483.70(p(1)(2) QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS (p) Social worker. 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Facility ID: 953007

If continuation sheet Page 26 of 130

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 1 APPROVED). 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345115	B. WING			R-C 05/06/2017		
NAME OF PI	ROVIDER OR SUPPLIER		_	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1		
	R HEALTH & REHAB/SA			63	5 STATESVILLE BOULEVARD			
	R HEALTH & REHAD/3A			S	ALISBURY, NC 28144			
(X4) ID PREFIX TAG	SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 251	Continued From page	26	F	251				
	(a common and poter	ntially serious bacterial skin d treatment with antibiotics.			This information was not communicate with facility management for follow up. This nurse has received education for			
	Resident #9 was disc his home. The resider multiple co-morbiditie resident had not been Health care agency to tracheostomy care up expected. The resider	began on 4/1/17 when harged from the facility to ent had a tracheostomy and s (chronic conditions). The n accepted by a Home o receive assistance with his bon discharge, as he had ent did not have the training tracheostomy care on his			the Area Staff Development Coordinat regarding discharge policy and proced on 5/5/17. The oxygen provider delive oxygen but was unable to provide tracheostomy supplies. No arrangeme for DME was confirmed prior to discha Resident #9 was returned to facility by family on 4/6/17, was assessed and determined need for his tracheostomy	or lure ered ents irge. r his		
	own at home. He retu and was immediately Emergency Departme and treatment of the t	urned to the facility on 4/6/17			due to drainage and odor, was sent to for evaluation and returned to facility where he was readmitted to Brian Cer Health and Rehabilitation/Salisbury on 4/6/17 and treated for infection. Resid	ER nter		
		-			#9 remains a current resident. At time discharge there was no validation of h health admitting resident, no confirma of DME, and no documented educatio related to signs and symptoms of	ome		
	when the facility provi allegation of complian out of compliance at a	rdy was removed on 5/6/17 ided an acceptable credible nce. The facility will remain a scope and severity level of th the potential for more			problems, what care was necessary to maintain stable health, and consequer of not providing this care, for the reside and his family/caregiver.	nces		
		at is not immediate ity to complete staff training ring systems put into place			Section Q of the MDS was completed Resident #9 on 4/13/17, and indicated resident expects to remain in the facili	that		
	The findings included	:			Throughout the discharge planning process for Resident #9 the facility wa without a Qualified Social Worker.	s		
	revealed he was hosp acute on chronic resp pneumonia. While in	ent #9 ' s medical records bitalized on 12/17/16 for biratory failure and the hospital, the resident and a tracheostomy (also			Facility's full time Social Service Direct resigned without notice on 1/26/17. Facility went without a Qualified Social Worker form 1/26/17 until a Qualified Social Worker was retained on 3/30/1	I		

Event ID: H58611

Facility ID: 953007

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/2017 RM APPROVED IO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED	
		345115	B. WING		R-C 05/06/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				635 STATESVILLE BOULEVARD			
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		SALISBURY, NC 28144			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 251	from the hospital to the cumulative diagnoses obstructive pulmonar and diabetes. A review of Resident Data Set (MDS) asse- revealed he had intace decision making. He assistance for bed m toileting; limited assiss personal hygiene; an locomotion on the un- independent with eat assessment indicated Occupational Therap (PT) services. It also tracheostomy and rea he was a resident. S assessment revealed participated in the as MDS reported his ow the community was u active discharge plant the resident to return Q of the MDS reported to talk to someone at the facility and return services in the comma assessment. Howey	Resident #9 was discharged the facility on 2/7/17. His is included chronic y disease, respiratory failure, #9's admission Minimum resonent dated 2/14/17 ct cognitive skills for daily required extensive obility, dressing, and stance for transfers and d, supervision from staff for it. The resident was ing. Section O of the MDS d Resident #9 received y (OT) and Physical Therapy oreported he had a ceived oxygen therapy while ection Q of the MDS I the resident and his family sessment process. The erall goal about returning to inknown or uncertain; and, uning was not occurring for to the community. Section ed the resident did not want bout the possibility of leaving ing to live and receive unity at the time of the er, Section Q of the MDS sident wanted to be asked a community on all	F 25		#9. d for those o be ce: he facility d by this nurse of residents facility esident and d orderly vided by a as dent record ion of nducting ent or their uccessful pleted by rvice eriod the Social ator, DON were ess. There		
	A review of the reside following areas of foc [Name of Resident	ent ' s care plan included the		the facility to cover Social Serv responsibilities. Measures put into place or sys changes made to ensure that the	ice temic		

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345115	B. WING		05/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CT	IR HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144	
(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 APPROPE DEFICIENCY)	BE COMPLETION
F 251	resident to have no si through the review da Revised on 3/16/17). The interventions out included: Ensure that the tract that go around the ne place, also known as all times (Initiated 2/7 Observe/document quality. Check and do ordered (Initiated 2/7/ Suction as necessa [Name of Resident] home when able (Initi 3/8/17). The stated goal for the resident to be able to assistance he would services required to re discharge (Initiated of 3/16/17). The interventions out included: Establish a pre-disc resident/family/caregi revise the plan as nea need for assistance w and Activities of Daily (Initiated on 3/8/17; R Evaluate the resider the community (Initiated A review of the resider	is area of focus was for the gns/symptoms of infection the (Initiated on 2/7/17; lined to meet this goal heostomy ties (the bands ck and hold the trach tube in trach collars) are secured at /17); respiratory rate, depth and ocument every shift or as '17); and, ry (Initiated 2/7/17). I wishes to be discharged to ated on 3/8/17; Revised on is area of focus was for the verbalize/communicate the need post-discharge and the neet his needs before in 3/8/17; Revised on lined to meet this goal harge plan with the vers, evaluate progress, and eded with the resident ' s <i>i</i> th his tracheostomy care Living (ADL) assistance tevised on 3/8/17); and, it ' s motivation to return to red on 3/8/17).	F 251	 practice will not occur: The Director of Clinical Services completed re-education of Administra and Director of Nursing on 5/5/17. The education included facility policy of providing social services and state and federal regulations governing long ter care facilities with regards to provision social services. In the absence of the Social Service Director, the Administre will ensure that appropriate and adeq Social Service Support is retained to the requirements of regulation. The District Director of Clinical Service the District Director of Operations will provide oversight of Facility Administre to ensure implementation and adhered to F251 by providing on site and remo- support to validate employment of a qualified Social Worker weekly for 12 weeks. Any opportunities will be corrected as identified. Monitoring Process: The Administrator will report the result these audits weekly for 12 weeks dur the QAPI meeting and then monthly thereafter. The committee will review these results and make recommenda as required. 	his ind ind in monocomments ind in monocomment in of example ator uate index meet index or example ator examp

Facility ID: 953007

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 06/08/2017 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				6	35 STATESVILLE BOULEVARD		
BRIANCI	'R HEALTH & REHAB/SA	LISBURY		5	SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 251	No notations were maindicate the RT providers resident on the care of a review of Resident is revealed a home visit by OT and PT in antious from the facility. Record the home visit included chair, hand held shows shower, and oxygen of basis. The notes record PT, and Speech There A review of the resider orders (as of 3/31/17)Tracheostomy: Chara every night shift every 2/7/17);Oxygen saturation (a be checked every shift Doctor (MD) if the O2 (Initiated 2/7/17). An measure of the amout blood. Normal blood considered to be 95-1Trach #6 Shiley long diameter and length of Tracheostomy care to and as needed (InitiatOxygen (O2) at 5 litter flow rate per minute) of A review of the resider included a Respirator 3/31/17. The respirat revealed Resident #9 with a pleasant demants of the and the state of the and the st	ade on the RT notes to led education/training for the of his tracheostomy. #9 ' s therapy notes was conducted on 3/27/17 cipation of his discharge ommendations made from ed the need for a shower ver head, grab bar in the on an as needed (PRN) ommended follow up OT, apy (ST) upon discharge. ent ' s current physician included the following: ange tubing and equipment v Wednesday (Initiated also known as an O2 Sat) to ft and notify the Medical Sat is less than 88% O2 Sat is a relative nt of oxygen carried in the oxygen levels are typically 00%; g (referring to the inner of the tracheostomy tube): b be completed every shift ted 2/7/17); and, ers (referring to the oxygen every shift (Initiated 3/2/17). ent ' s medical record y Therapist (RT) note dated	F	251			

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If continuation sheet Page 30 of 130

		D HUMAN SERVICES				FORM	MAPPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED
		245445	B. WING				-C
	ROVIDER OR SUPPLIER	345115	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	06/2017
	ROVIDER OR SUPPLIER				635 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		:			
(X4) ID PREFIX TAG				x	(X5) COMPLETION DATE		
F 251	Continued From page in the stoma (surgical Resident #9 was note discharge to home or notation on the RT no was trained on care of A review of the reside included a physician ' 12:51 PM. The physic seen for a discharge for read as follows, in pa "[Name of Resident] i of his discharge from He was admitted to th 2/8/17 after being hos chronic respiratory fai subsequently requirin tracheostomy. Since well with rehabilitation the past several week ambulating around th imbalance and has no when walking" Plan: "COPD: Dimin high risk for re-hospit go home. HH (Home A review of Resident revealed a Nursing N reported, in part: " A review of the Home 4/1/17 (not timed) inc "Call from [name of re #2] regarding waiting agency] to come out.	 a 30 opening) site at that time. ad to be scheduled for a/1/17. There was note to indicate the resident f the tracheostomy. ant 's medical record s note dated 3/31/17 at the notation of the facility this weekend. as seen today in anticipation the facility this weekend. as seen today in anticipation the facility this weekend. as seen today in anticipation the facility this weekend. as seen today in anticipation the facility this weekend. be [Name of Facility] on spitalized for acute on lure and pneumonia g intubation and his admission he has done in and with trach care. For its he has been seen be facility without any SOB or of been requiring oxygen ashed breath sounds and is alization but is felt stable to Health) nursing, PT/OT." #9 's medical record one dated 4/1/17 at 7:35 PM Patient went home." Health agency notes dated fuded the following text: esident 's Family Member for [name of Home Health] Informed non-admitted due 	F	251	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	representative] who in	name of Home Health nformed [name of Nurse #1] Also spoke with [name of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345115	B. WING				-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		'	635 STATESVILLE BOULEVARD		
				:	SALISBURY, NC 28144		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 251	referral as it would tal	e 31 ember], could not accept ke 2-3 weeks to set up PDN She informed marketing	F	251	1		
		anager]. Tried to call [name ould not provide any Case Management)					
	by the Home Health a email was sent from t Marketing Manager to for Resident #9 ' s pri	7 at 4:16 PM was provided agency for review. The he Home Health agency ' s b both the Office Manager mary care physician and the pr. The text of the email					
	on this email as well t I spoke with the other even though [name of company] approved H client he is not approp	of facility 's Administrator] to keep everyone in the loop. Home Health Agencies and f Resident #9 's insurance Home Health hours for this priate for Home Care. He is lization and his best place is					
	back in [name of facil proper care he needs home and when [nam the facility] saw him la would end up back in [name of representati	ity] where he can get the . The client wanted to go he of resident 's physician at ast week he even stated he the hospital. I talked with ve for the oxygen supply					
	home and no Trach s this client tomorrow I him back to [name of [resident ' s name] bu he needs is at SNF (s [Name of facility ' s Ad	hly delivered Oxygen to the upplies-When you guys see would recommend sending the facility]. I hate it for t his best place for the care skilled nursing facility) level. dministrator] will have his to make a smooth transition					
	A review of Resident	#9 's paper medical record					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
					635 STATESVILLE BOULEVARD		
BRIAN CI	R HEALTH & REHAB/SA	LISBURY			SALISBURY, NC 28144		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 251	included documentati visit on 4/4/17 with an service. Progress nor Assistant (PA) on 4/4/ notations, in part: "Recently hospitalia 12/17/16, tracheostor to SNF [name of facili could be discharged of released however has health to come out wi Family Member #2] at today-she states he w facility] because "he of has a history of nonco home health. He lives Family Member #1]. breathing since disch The PA's Impression read: "Do not think patient i care. Discussed at le returning to a SNF for comorbidities. Both h Member #2] are adan returning to [name of Home Health agency] patient. Patient is in a up-will return in 2 wee check. Labs pending A review of the hospit (ED) records from 4/6 arrived to the ED at 2 Medical Services (EM the following commer "Patient presents toda tracheostomy care. H	on from a follow-up diabetic o outside Internal Medicine tes written by the Physician (17 included the following zed for respiratory failure my performed. Discharged (ty]. Patient was told he over the weekend. He was a had difficulty getting home th trach supplies. [Name of companies the patient vill not go back to [name of doesn ' t want to." Patient ompliance and refusing s at home with his [name of No fever or difficulty arge." //Plan from the 4/4/17 visit s appropriate for outpatient mgth my concerns of not care given multiple ue and his [name of Family hant that patient will not be facility]. [Name of another will bring supplies out to agreement for close follow eks for BP (blood pressure) ."	F	25	51		

Facility ID: 953007

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345115	B. WING			R-C 05/06/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			335 STATESVILLE BOULEVARD SALISBURY, NC 28144			
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 251	[name of facility] toda for himself in the hom Center, they sent him discharge from his tra denying any other pro- does get confused to exact dates when his was changed." The hospital ED recor- examination, Residen (redness) and superfi around the trach colla diagnosed with celluli Respiratory Notes da "trach was in place wi coming from trach are Saturday-collar wet w bedside will change of collar" The resider ED to the facility on 4 medication orders ince topical antibiotic ointh milligrams (mg) amox antibiotic) to be given every 12 hours for 10 A review of the reside record dated 4/6/17 a resident was re-admit distress was noted ar being alert and orient A review of the reside the re-admission inclu Tracheostomy: Cha every night shift every 4/7/17);	e is referred back to the y because of inability to care e but upon return to the here because he had foul ucheostomy site. Patient is oblems. He states that he time so he is unclear as to last trach collar and trach rds revealed upon it #9 had erythematous cial skin breakdown all in site. The resident was tis of the neck. The ED ted 4/6/17 at 3:57 PM read, ith trach collar-foul smell ea states last changed ith drainage-Respiratory at ut trach and replace trach at was discharged from the /6/17. His discharge luded 2% Bactroban (a nent) and 875-125 icillin-clavulanate (an oral as one tablet by mouth days. nt ' s electronic medical t 9:49 PM indicated the ted to the facility. No ad he was assessed as ed.	F	251				

Facility ID: 953007

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 06/08/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CI	R HEALTH & REHAB/SA	LISBURY			5 STATESVILLE BOULEVARD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 251	4/7/17); Check O2 Sat every Sat is less than 88% (Trach collar with 5 li needed during the da (Initiated 4/8/17); and Trach collar with 5 li evening and night shi A review of the reside included a Respirator 4/7/17. The respirato Resident #9 ' s trach y the hospital. The resp the resident was read to the ED for cellulitis part: "No trach care w home. He is on ABT trach site." The residu as red, sore, and blee A review of Resident is Data Set (MDS) asse revealed the resident daily decision making all of his ADLs, with th supervision from staff MDS assessment rep tracheostomy care an was a resident. Secti assessment proce remain in the facility. revealed the resident	and as needed (Initiated r shift and notify MD if O2 (Initiated 4/7/17); ters O2 per minute as y for O2 Sats less than 91% reters O2 per minute every ft (Initiated 4/8/17). nt ' s medical record y Therapist (RT) note dated ry assessment revealed was changed on 4/6/17 at biratory assessment noted mitted on 4/6/17 after going around his trach. It read, in ras done while he was at (antibiotic) and Bactroban to ent ' s trach site was noted dig easily. #9 ' s admission Minimum ssment dated 4/13/17 had intact cognitive skills for . He was independent for ne exception of requiring for eating. Section O of the orted he received d oxygen therapy while he on Q of the MDS the resident participated in ess and was expecting to However, the MDS also did want to talk to someone f leaving the facility and eceive services in the	F 2	51			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED R-C	/EY	
345115 B. WING 05/06/201	017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CTR HEALTH & REHAB/SALISBURY 635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) MPLETION DATE	
F 251 Continued From page 35 F 251 An interview was conducted on 5/4/17 at 2:15 PM with the facility's 10nit Manager and the Area Staff Development Coordinator (SDC). Upon inquiry, the Unit Manager and the SDC recalled Resident #9 came back into the facility on 4/6/17 sometime between 2:00-4:00 PM. The nurses reported Resident #9 was not expected and the facility did not have any admission orders for him. The Unit Manager and SDC stated the facility did not admit the resident at that time; he appeared to have a problem with his trach and was sent out to the hospital for evaluation and treatment. The resident returned from the hospital later on that same date (4/6/17). When asked what time he returned, the nurses reviewed the medical record. The first note which indicated he had returned to the facility was made on 4/6/17 at 9:49 PM. An interview was conducted on 5/4/17 at 2:30 PM with the facility 's Administrator. During the interview, the administrator reported Resident #9 's sfamily have adaed of time they vanted the resident 's discharge on 4/1/17. Upon request, the Administrator provided contact information for the Home Healtin Prevendative. The Administrator stated, "Everybody knew what was happening." He reported Nesident #9 what may appening." He reported no Fiday might (/3/31/17) around 6:00 PM, both he and Resident #9 's insurance company when they brought its oxygen to take home and educated him on its use. The Administrator confirmed Resident #9 's insurance company contacted bin in on Monday		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 251	concerned he wasn ' tracheostomy. The A resident ' s family men by telephone on 4/3/1 told this family membi- happy to take the resi resident had a physic that week and the family m around 12:00 PM and were on their way to b facility. When the resident collar and wanted to g called 911 and the ho resident was being se reported the resident returned to the facility evening of 4/6/17. A telephone interview 4:35 PM with the Mar Home Health agency from the Administrato care. During the inter discharge arrangeme discussed. As the Ma the resident ' s Home the agency was given 3/28/17. The Manage Health agency was di Hourly care side (which did not work w agency learned the re- insurance coverage for	the resident ' s family was t doing well at home with the dministrator spoke with the mber (Family Member #2) 7, 4/4/17, and 4/5/17. He er that the facility would be dent back. However, the ian appointment scheduled hily planned to take him to it. the Administrator reported hember [Family Member #2] I was basically told they bring the resident back to the ident arrived, the he could smell the trach get it evaluated. The facility spital ED to tell them the ent over. The Administrator was seen in the ED and a round 8:00 -9:00 PM the two had received a referral r for Resident #9 ' s home rview, the resident ' s nts for 4/1/17 were arketing Manager reviewed Health record, she reported the Home Care referral on er explained their Home vided into two sections: the ch did work with the Home Health care side ith trachs). On 3/31/17, the	F	251			

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345115	B. WING				-0 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 251	Manager on 3/31/17. Manager telephoned Nurse #1 their Home take this resident. Sh contacted two other H Resident #9 was not a With the discharge st Marketing Manager st delivery of oxygen to (3/31/17) so the resid went home. On Mone facility for follow-up by about an unsafe disch went home over the v Manager stated she a the facility had a bed to come back. The M she talked with the O #9 ' s primary care ph followed up with an ei Manager and the faci sure everyone had th An interview was con with Resident #9. Du resident recalled he a with someone on Frid oxygen arranged for o resident was asked w prior to discharge, he the oxygen he had a and a railing for the cor installed by his landlo 4/1/17. Upon further "someone" on the pho	ce contacted the Marketing On 3/31/17, the Marketing the facility and informed Health agency couldn ' t he also reported her agency dome Health agencies, but accepted by either of them. ill planned for 4/1/17, the tated she coordinated a the facility on Friday night ent would have it when he day (4/3/17), she went to the ecause she was concerned harge if the resident actually veekend. The Marketing also wanted to make sure for the resident if he decided larketing Manager reported ffice Manager for Resident hysician on 4/3/17, then mail to both the Office lity ' s Administrator to be e information. ducted on 5/5/17 at 8:00 AM rring the interview, the and the Administrator met lay night (3/31/17) to get his	F	251			

Facility ID: 953007

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	S FOR MEDICARE &					O. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED		
			A. BUILDING		R-C			
		345115	B. WING			5/06/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/2017		
				635 STATESVILLE BOULEVARD				
BRIAN CT	TR HEALTH & REHAB/S	ALISBURY		SALISBURY, NC 28144				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 251	Continued From page	10.29	Г. О.Г.					
F 201			F 25	1				
	· ·	know how to do his own trach						
		eive any trach supplies to use ed he expected a Home						
	· ·	e out to his home to take						
		omy, but no one did.						
	A telephone interviev	w was conducted on 5/5/17 at						
		espiratory Therapist (RT)						
	who worked with Re	sident #9. The RT reported						
	she worked for a cor	ntracted company and came						
	to the facility once a	•						
	-	or the resident. Prior to his						
		e RT noted Resident #9 had						
		under the tracheostomy due						
		drainage and having some						
		skin dry. She reported the itated and was a little sore						
		RT stated she was hoping						
		rse would continue to follow						
		tracheostomy collar. When						
		rach care the resident						
	required, the RT stat	ted he received routine trach						
		t (3 times a day) while in the						
	facility, but may have	e been able to do the trach						
		n discharge. She reported						
		y care involved cleaning the						
		ge (the area where the ties or						
		ed to secure the tube in						
		ure there were no secretions;						
		es and cannula (the body of ted into the trachea), and						
		ponge underneath. The RT						
		er the impression the resident						
		r would do some of his trach						
	-	Health nurse going out a few						
	times a week to mak							
		out reviewing her notes, the						
	RT did not recall if sl	he had done tracheostomy						

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CI	R HEALTH & REHAB/SA	LISBURY			335 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 251	care. The RT stated if teaching with the resid- included a notation do Respiratory Notes. The was trained, he may be for the trach care. How would reliably do the When asked if she haw would be going home stated, "Absolutely." reported having a suc- be a standard for any tracheostomy. When were regarding the re- suction machine, the she didn ' t think he ' of stated, "You never kn saw the resident the of to the facility on 4/6/1 been put on an antibior reported the condition significantly over the I An interview was com- PM with Nurse #2. N shift nurse assigned to When asked if she had care teaching with the reported since she wo would typically "talk h stated the resident need demonstration for her know when he left the own trach care." A follow-up interview to 12:52 PM with Resider	nily member on the trach f she had done trach care dent, she would have ocumenting this in her ne RT stated if the resident or able to do the procedure owever, she was unsure if he care twice daily every day. ad understood this resident with Home Health, she Upon further inquiry, the RT ction machine would usually one going home with a asked what her thoughts esident going home without a RT reported that although d have a big problem, she ow." The RT stated she day after he was readmitted 7. She recalled he had otic for neck cellulitis and n of the skin had improved last few weeks. ducted on 5/5/17 at 12:24 urse #2 worked as a 3rd o care for Resident #9. ad done any tracheostomy e resident, Nurse #2 orked on the 3rd shift, she im through it." The nurse	F	251			

Facility ID: 953007

If continuation sheet Page 40 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345115	B. WING				-0 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 251	stated he lived with F was discharged from resident and his famil trach care was done of home, the resident sta- resident acknowledge his oxygen equipmen shown how to do the When Family Membe trained to provide tract the resident and famil saying, "No." The resise second family member #2). family Member #2). family Member #2). family Member #2). family member provid had been in contact w providers. A follow-up interview 1:21 PM with the facil inquiry, the Unit Mana- knowledge, the reside trach care during his Manager reported sho resident presented or drainage from his tract Manager stated she of tracheostomy and cool drainage was. A telephone interview 1:24 PM with Nurse # as the nurse who reco Home Health agency facility Resident #9 w Health due to having	interview, the resident amily Member #1 after he the facility. When the y member were asked what during the time he was ated, "nothing." The ed he was shown how to use t, but reiterated he was not trach care for himself. r #1 was asked if she was ch care for the resident, both by member responded by sident consented to have a er interviewed by telephone He reported the second led his transportation and with his health care was conducted on 5/5/17 at ity 's Unit Manager. Upon ager reported that to her ent did not do any of his own stay at the facility. The Unit e was at the facility when the n 4/6/17 with foul smelling cheostomy. The Unit did not assess the uld not tell what color the r was conducted on 5/5/17 at 1. Nurse #1 was identified eived a phone call from the on 3/31/17, informing the as not admitted to Home a tracheostomy. When he call, the nurse stated, "I	F	251			

Facility ID: 953007

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FOF	ED: 06/08/2017 RM APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	345115	B. WING			R-C 5/06/2017
NAME OF PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP COD		
			635 STATESVILLE BOULEVARD		
BRIAN CTR HEALTH & REHAB/SA	LISBURY		SALISBURY, NC 28144		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
 the supply company Administrator was go [name of the Marketin in place." When asked made prior to the resist stated she knew som oxygen for the reside were also going to de When asked if the resist training or education reported, "Anytime I with to teach him." When did the tracheostomy stated, "Not really." An interview was con- with the facility 's So inquiry, the SW states 3/30/17 and first recase returned to the facility interview, the SW dist discharge process. Sist SW was to contact the provide them with infor- resident. From there Home Health agency their home (usually the the facility). The SW recommended PT, Of discharge, which allof agency to do their ow determine any service reported the residents was kept separate fro When asked what the included, the SW reported the SW reported the SW reported was kept separate fro When asked what the included, the SW reported the SW reported the SW reported the SW reported the SW reported the SW reported the SW reported the	volved. Someone called y maybeand the ing to call and confirm with ng Manager] everything was ed what preparations were ident 's discharge, the nurse eone brought out portable nt 's trip home and they eliver his home oxygen. sident had received any on trach care, the nurse worked with his trach I tried asked if the resident ever care himself, the nurse ducted on 5/5/17 at 2:54 PM cial Worker (SW). Upon d she started her position on lled Resident #9 when he y on 4/6/17. During the cussed the facility 's She reported her role as the e Home Health agency and ormation needed on the , a date would be set for the to meet with the resident at he day after discharge from reported the facility typically T, and ST for residents upon wed the Home Health care yn assessments on each and es needed. The SW s' discharge paper work orted both a Post-Discharge Interdisciplinary Discharge	F 25			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345115	B. WING				-C 06/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>·</u>		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD GALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 251	 3:20 PM with the facili the interview, an inquinvolved in the dischation of the Administrator "between Social Work and the Activities Marithe Social Worker where the Social Worker where the Social Worker where the dischation of the Activities Manage Administrator stated here and the discharge of the Activities Manager. A review the discharge A telephone interview 3:45 PM with the resinated interview the there are and the tight of the saw the resinated the resident services upon dischating that if here are not goin here would have wante stated, "I certainly wo again." A follow-up interview 3:55 PM with the Administrator and the Activities and the Activities and the Activities and the administrator and the Activities and the administrator and the Activities and the Activities and the administrator and the Activities and the administrator and the Activities and the Activitie	from the facility. was conducted on 5/5/17 at lity's Administrator. During iry was made as to who was arge process for Resident r stated the facility had been kers," so he, the MDS nurse hager, shared the duties of ile the position was vacant. harge for Resident #9 was uself, nursing, and possibly r. Upon inquiry, the ne was not aware the facility 17 by the Home Health #9 was not accepted for ted he did not find this Aonday, 4/3/17. When harge planning paper work t #9, the Administrator w but would ask the A request was made to paper work for Resident #9.	F	251				

Facility ID: 953007

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345115	B. WING			R-C
		545115	B. WING			5/06/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CT	R HEALTH & REHAB/S	ALISBURY		635 STATESVILLE BOULEVARD		
				SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 251	Continued From pag	e 43	F 25	1		
1 201			F 20			
	discharge on 4/1/17.	npleted for Resident #9 ' s When asked, the				
	•	he had a degree in Health				
		He reported between				
		0/17, no one who worked at				
	the facility had a deg					
		w was conducted on 5/6/17 at				
		ident 's 2nd family member				
		who provided transportation				
		had been in contact with his				
	-	s after he was discharged nily Member #2 reported she				
		e facility about the resident '				
		e in March. When asked				
		his discharge date, she				
		did. They told us they could				
		r April 1st." The family				
		ygen was delivered to the				
		nt #9 would be staying on				
		n for his discharge. When				
		ent up from the facility on				
		00 AM - 12:00 PM), he had				
		he trip home. Family e staff seemed a little				
		ing discharged. The family				
		signed a paper saying she				
		esident, and was given				
		medications. When asked if				
	either she or the resi					
		e, she said, "No." She				
	-	urse (Nurse #3) if the Home				
	-	nd was told they "thought so"				
		n nurse would be out to the				
	-	Family Member #2 stated				
		w often the Home Health				
		e coming out, but expected				
	LO IINO OUL MOLE Whe	n the nurse came to the	1			1

Facility ID: 953007

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	MPLETED
			A. BOILDING	<u> </u>	R-C	
		345115	B. WING			
		340113		STREET ADDRESS, CITY, STATE, ZIP CO		5/06/2017
NAME OF P	ROVIDER OR SUPPLIER				DE	
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		635 STATESVILLE BOULEVARD		
				SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 251	Continued From page 44		F 25	51		
		resident 's trach was				
		nd generally taken care of.				
	-	tated when she got the				
		y with Family Member #1,				
		nurse to come out. The				
		lidn ' t know how the trach				
		amily Member #2 reported				
		two to three times on 4/1/17				
		e Health care people weren ' t				
		and she was told they would				
	-	iting with the resident at his				
		ily Member #2 stated she				
		e and called the Home				
		If. The Home Health agency				
		coming. The family member				
	-	d that because he was				
	-	stated, "Had I known nobody				
		not have taken him home."				
	0.	t do patients with trachs and				
		mebody at the facility they				
	didn ' t do them. The	family member stated she				
	made an appointmer	-				
		ey could help get someone				
	out to take care of the	e trach, "but they didn ' t				
	check it either." She	recalled sometime during				
		m another Home Health				
		nouse, but she didn ' t touch				
		e didn ' t have anybody at				
		to provide help with the trach				
		er #2 reported she had talked				
	-	ministrator each day during				
		9 was home. She was told				
	-	e him back, but the resident				
	-	ck. The family member				
		with nobody checking the				
		ady kinda messy." She				
		resident back to the facility				
		6/17) and stated, "It (the melling and everybody was				

Facility ID: 953007

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	· · /	LETED	
			A. DOILDIN		R-C		
		345115	B. WING			06/2017	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		00/2017	
				635 STATESVILLE BOULEVARD			
BRIAN CT	R HEALTH & REHAB/S/	ALISBURY		SALISBURY, NC 28144			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE	
F 251	Continued From pag	e 45	F 2	51			
		s a mess." The family					
	member stated the facility sent him to the hospital						
		here. Resident #9 returned					
	to the facility later that						
	-	-					
		v was conducted 5/6/17 at					
		#3. The nurse reported she					
		on an "as needed" basis,					
		from twice a month to twice					
		as identified as the nurse shift on 4/1/17 when Resident					
		The nurse recalled when					
	-	y member came to pick up					
		norning of 4/1/17. Nurse #3					
		been told ahead of time that					
	•	ng to be discharged that					
		stated, "I did not have a					
	discharge packet bed	cause we did not have a					
		time." Nurse #3 reported					
	-	er happened to be working					
	-	ig so she got a discharge					
		im. Upon inquiry, the nurse					
		ge packet contained the Plan					
		arge Planning form. Nurse e resident and family member					
		would come out to the					
	.	what was sent home with the					
		eported she gave him					
	prescriptions for his r						
		m the facility. However, the					
		she would wait for the Home					
		to come out and would get					
		oplies from them. Nurse #3					
	stated she had done	some routine teaching with					
		-					
		is stay (not at discharge).					
	Upon inquiry, the nur	is stay (not at discharge). se reported she thought the					
	Upon inquiry, the nur resident may have de	is stay (not at discharge).					

Facility ID: 953007

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CENTERS FOR MEDICARE & MEDICAID SERVI	CES				APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION N	LIER/CLIA (X2) M		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
3451	15 B. WIN	IG			-C 06/2017
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
			635 STATESVILLE BOULEVARD		
BRIAN CTR HEALTH & REHAB/SALISBURY			SALISBURY, NC 28144		
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFO	BY FULL PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 251 Continued From page 46 time ago." The nurse stated a while back the tracheostomy care supplies in the ro- the resident to do his own trach care, bu she came back it was not done. She tri encourage the resident by saying, "you do it," but he didn 't want to. Nurse #3 the resident as alert but not necessarily cognitively intact. She reported his cog varied from day to day. When asked, N thought a family member may have call facility either later on 4/1/17 or on 4/2/17 the Home Health agency didn 't come thouse. The nurse told the family she w the Home Health agency. Nurse #3 rep tried to call Home Health, but the agence return her call. An interview was conducted on 5/6/17 a AM with the Administrator. During the in the Administrator reported the facility 's Social Worker did not give notice when resigned on 1/26/17. No Social Worker employed by the facility until the new SV on 3/30/17. When asked who fulfilled th responsibilities from 1/26/17 to 3/29/17 Administrator reported the MDS nurse a Activities Manager completed the reside assessments; the Activities Manager co the discharge planning paperwork; and, Administrator contacted the Home Heal with referrals if a resident needed to hav care provided. The Administrator report remainder of the SW duties were shared nursing staff, the MDS nurse, the Activit Manager, and himself. Upon inquiry, th Administrator reported the facility 's cer 3/31/17 was 136 residents; and, on 4/1/ day Resident #9 was discharged), the fa census was 135 residents.	ck she left pom for ut when ed to ' ve gotta described nition urse #3 ed the 7 saying o the ould call ported she by did not at 11:50 nterview, former he was W started he SW the and ent mpleted the th agency ve home ted the d by ies e nsus on 17 (the	F 25			

Facility ID: 953007

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	MAPPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE			
		345115	B. WING				-C 1 06/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	D BE COMPLETION			
F 251	with the facility 's Act Activities Manager re Degree in Human Se Bachelor 's degree. reported she helped w facility was without a included calling famili talking with difficult re issues, assisting with making outside appoi When asked about th on 4/1/17, the Activitie not recall the Adminis was going to go home discharge forms were	ducted on 5/6/17 at 1:12 PM ivities Manager. The ported she had an Associate rvices; she did not have a The Activities Manager with extra duties while the Social Worker, which es about a room change, sidents to help resolve discharge paperwork, and ntments for residents. e discharge of Resident #9 es Manager reported she did trator telling her the resident e. She reported the two e not on the resident ' s chart	F	251					
	Activities Manager re- scheduled to work that forms, filled them out, nursing station for the how the Interdisciplina form could be comple reported the different the form. A follow-up interview 3:28 PM with the Adminis s census consistently residents from 1/26/1 period of time when the qualified Social Work An interview was con with the facility 's Administer to how he would ensure to how he would ensure	7 through 3/29/17 (the he facility did not employ a							

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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) COMPLETION DATE
F 251	social services until a Worker could be hired interview conducted of Administrator was asl were in relation to hav Social Worker. The A would expect the serv Worker to be provided interruption. On 5/5/17 at 3:58 PM informed of the imme provided a credible al PM. The allegation of Credible Allegation fo Facility respectfully su of compliance for F25 Criteria 1 Resident #9 was disc Brian Center Salisbur required Home Health Oxygen, suction mach manage tracheostom Administrator comple Health Agency on 3/2 from the facility. Hor staff nurse prior to dis unable to provide serv information was not c management for follo received education for Development Coordin Policy and Procedure	rim corporate support for full-time, permanent Social d. During a follow-up on 5/6/17 at 6:10 PM, the ked what his expectations ving a full-time qualified administrator indicated he vices of a full-time Social d at the facility without , the Administrator was diate jeopardy. The facility legation on 5/6/17 at 1:00 f compliance indicated: r F251 ubmits the below allegation i1 Qualified Social Worker. harged to his home from y on 4/1/17. Resident #9 n Services for Nursing, hine, and supplies to y care at home. The Facility ted a referral to the Home (8/2017, prior to discharge me Health Agency informed acharge that they were vice for this resident; This ommunicated with facility w up. This nurse has om the Areas Staff nator; regarding Discharge on 5/5/17 The Oxygen sygen. No arrangements for	F	251			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			335 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 251	returned to facility by assessed and determ Tracheostomy due to sent to ER for eval an he was readmitted to 4/6/2017, and treated remains a current res there was no validation resident, no confirmated documented education symptoms of problem to maintain stable heat not providing this care family/ caregiver. Section Q of the MDS Resident # 9 on 4/13/ resident expects to re Throughout the Disch Resident #9 the Facili Social Worker. Facili Director resigned with Facility went without a from 1/26/2017 until a was retained on 3/30/ remains employed. T active role in the discl Resident # 9. Criteria 2 All residents discharg potential to be affected practice. The Nurse I audit of residents who facility since 4/1/17 to received sufficient pre-	charge. Resident # 9 was his family on 4/6, was ined need for care for his drainage and odor, was d returned to facility where Brian Center Salisbury on for infection. Resident # 9 ident. At time of discharge on of Home Health admitting tion of DME, and no on related to signs and us, what care was necessary alth, and consequences of e, for the resident and his	F	251			

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345115	B. WING				-C 06/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144			
(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 251	was validated by revie documentation of coor services and by cond the resident or their re- successful discharge. by 5/5/17. Administrator has no During the time period qualified Social Servie Administrator and Bus DON were responsible There was no addition facility to cover Socia Criteria 3 The Director of Clinica re-education of Admir Nursing on 5/5/2017. facility policy of provis and state and federal term care facilities wit social services. In the Service Director, the a that appropriate and a support is retained to regulation. Facility alleged IJ rem The credible allegatio 5:29 PM. On 5/6/17 f PM, interviews were of of Nursing and the Ao Administrator were at each received and ver retain a qualified Soci	alified social worker. This ewing the resident record for ordination of home care ucting phone interviews with esponsible party to validate . This audit was completed Social Service background. d the facility was without a ce Director. The siness Office Manager and le for discharge process. nal support from outside the I Service responsibilities. al Services completed histrator and Director of This education included sion of social work services regulations governing long th regards to provision of the absence of the Social Administrator will ensure adequate Social Service meet the requirements of hoval 5/6/17 on was validated on 5/6/17 at from 4:25 PM through 5:29 conducted with the Director dministrator. The DON and ble to describe the education erbalize the requirement to ial Worker on a full-time sidents who have discharged	F	251				

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED O. 0938-0391	
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		345115	B. WING _				२-C 5/06/2017	
NAME OF PF	OVIDER OR SUPPLIER	•	·	STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY						
				SALIS	SBURY, NC 28144			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 251	1 Continued From page 51		F 2	251				
	verifying each resider		1 2	-51				
		es, and support for a safe						
	discharge. Interviews							
	facility had employed	's current SW verified the						
		liate jeopardy was removed						
	on 5/6/17 at 5:29 PM	-						
F 284 SS=J	483.21(c)(1)(2)(iv) AN POST-DISCHARGE	NTICIPATE DISCHARGE: PLAN	F 2	284			6/7/17	
	(c)(1) Discharge Plan	ining Process						
	The facility must deve	elop and implement an						
	÷ .	anning process that focuses						
		harge goals, the preparation ive partners and effectively						
		st-discharge care, and the						
	reduction of factors le							
		cility's discharge planning sistent with the discharge						
	•	.15(b) as applicable and-						
	(i) Ensure that the dis	scharge needs of each						
	resident are identified	and result in the						
	development of a disc	charge plan for each						
	resident.							
	(ii) Include regular re-	evaluation of residents to						
		require modification of the						
		discharge plan must be to reflect these changes.						
	(iii) Involve the interdi	isciplinary team, as defined						
		n the ongoing process of						
	developing the discha	arge plan.						
	(iv) Consider caregive	er/support person availability						
	and the resident's or	caregiver's/support nd capability to perform						
	noroon(a) conceitu on	a conchility to norferm	1	1			1	

Facility ID: 953007

If continuation sheet Page 52 of 130

	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345115	B. WING				-C 06/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
BRIAN C	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144			
(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 284	required care, as part discharge needs. (v) Involve the resider representative in the of discharge plan and in resident representative (vi) Address the resid treatment preferences (vii) Document that a about their interest in regarding returning to (A) If the resident indi to the community, the referrals to local conta appropriate entities m (B) Facilities must up comprehensive care p appropriate, in respor from referrals to local appropriate entities. (C) If discharge to the to not be feasible, the made the determination (viii) For residents wh SNF or who are disch LTCH, assist resident representatives in sel provider by using data limited to SNF, HHA, patient assessment d	of the identification of the and resident development of the form the resident and re of the final plan. ent's goals of care and s. resident has been asked receiving information the community. cates an interest in returning facility must document any act agencies or other ade for this purpose. date a resident's blan and discharge plan, as use to information received contact agencies or other e community is determined facility must document who on and why. o are transferred to another larged to a HHA, IRF, or s and their resident ecting a post-acute care a that includes, but is not IRF, or LTCH standardized	F	284				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				6:	35 STATESVILLE BOULEVARD		
BRIAN CT	IR HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE			
F 284	the data is available. the post-acute care si assessment data, dat data on resource use the resident's goals o preferences. (ix) Document, compl on the resident's need record, the evaluation needs and discharge evaluation must be di resident's representat information must be in discharge plan to faci to avoid unnecessary discharge or transfer. (c)(2) Discharge Sum When the facility antion must have a discharge but is not limited to, th (iv) A post-discharge developed with the pa and, with the resident representative(s), whi adjust to his or her ne post-discharge plan o the individual plans to that have been made care and any post-dis non-medical services This REQUIREMENT by: Based on facility staf physician, resident an facility and hospital m	The facility must ensure that tandardized patient ta on quality measures, and is relevant and applicable to f care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident ncorporated into the litate its implementation and d delays in the resident's mary cipates discharge, a resident ge summary that includes, he following: plan of care that is articipation of the resident t's consent, the resident t's consent, the resident to aw living environment. The of care must indicate where o reside, any arrangements for the resident's follow up scharge medical and	F	284	F 284 Corrective action accomplished for thor residents found to have been affected		

Facility ID: 953007

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08 FORM APPRC OMB NO. 0938-	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING		R-C 05/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				635 STATESVILLE BOULEVARD		
	R HEALTH & REHAB/SA	LISBURT		SALISBURY, NC 28144		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLE	
F 284	Continued From page	e 54	F 284	1		
1 201	planning process to i	dentify and address the 1 of 1 sampled resident	1 20	the deficient practice:		
	-	as discharged home with a		Resident #9 was discharged	to his home	
	tracheostomy (a surg	ical opening in the neck that		from Brian Center Health and	I	
		to be inserted into the		Rehabilitation/Salisbury on 4/		
		estricted airway and enable		Resident #9 required home h		
		#9 was discharged without sistance, resident and/or		services for nursing, oxygen, machine, and supplies to mar		
		on tracheostomy care, or		tracheostomy care at home.	•	
		my supplies, which resulted		Administrator completed a ref		
		omy care after discharge.		home health agency on 3/28/		
	-	scharge from the facility, the		discharge from the facility. H		
		ed with neck cellulitis (a		agency informed staff nurse p		
	-	ally serious bacterial skin		discharge that they were una		
	intection) requiring to	eatment with antibiotics.		provide service for this reside information was not communi		
	Immediate ieopardy t	began on 4/1/17 when		facility management for follow		
		charged from the facility to		nurse received education for		
	his home. The reside	ent had a tracheostomy and		Staff Development Coordinate	or regarding	
	-	es (chronic conditions). The		discharge policy and procedu		
		n accepted by a Home		The oxygen provider delivere		
		o receive assistance with his		No arrangements for DME wa		
		oon discharge, as he had ent did not have the training		prior to discharge. Resident a returned to facility by his fami		
		e tracheostomy care on his		was assessed and determine	-	
		urned to the facility on 4/6/17		his care for his tracheostomy		
	and was immediately	-		drainage and odor, was sent		
	Emergency Departm	ent (ED) for an evaluation		eval and returned to facility w		
		tracheostomy. He was		readmitted to Brian Center He		
	-	cellulitis (a common and		Rehabilitation/Salisbury on 4/		
		cterial skin infection) and		treated for infection. Resident		
		ral and topical antibiotic. eased from the hospital ED		a current resident. At time of there was no validation of hore	•	
	and re-admitted to th	•		admitting resident, no confirm DME, and no documented ed	nation of	
	The immediate jeopa	rdy was removed on 5/6/17		related to signs and symptom		
		ided an acceptable credible		problems, what care was nec		
		nce. The facility will remain		maintain stable health, and co	-	
	out of compliance at	a scope and severity level of		for not providing this care, for	the resident	

Facility ID: 953007

If continuation sheet Page 55 of 130

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 M APPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345115	B. WING				R-C / 06/2017	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
				63	35 STATESVILLE BOULEVARD			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 284	Continued From page	55		284				
. 201		th the potential for more		204	and his family/caregiver.			
	jeopardy) for the facil	ity to complete staff training ring systems put into place			Section Q of the MDS was completed Resident #9 on 4/13/17 and indicated resident expects to remain at the faci	l that		
	revealed he was hosp acute on chronic resp pneumonia. While in required intubation ar known as a trach). R from the hospital to th cumulative diagnoses	ent #9 ' s medical records bitalized on 12/17/16 for biratory failure and the hospital, the resident a tracheostomy (also esident #9 was discharged he facility on 2/7/17. His			Throughout the discharge planning process for Resident #9 the facility we without a Qualified Social Worker. Facility's full time Social Service Direct resigned without notice on 1/26/17. Facility went without a qualified Social Worker from 1/26/17 until a Qualified Social Worker was retained on 3/30/1 Qualified Social Worker remains employed. The Administrator had an active role in the discharge process/planning for Resident #9.	9 the facility was ial Worker. Il Service Director on 1/26/17. qualified Social htil a Qualified ined on 3/30/17. r remains strator had an arge		
	Data Set (MDS) asserve aled he had intact decision making. He assistance for bed mot toileting; limited assist personal hygiene; and locomotion on the uni independent with eati assessment indicated Occupational Therapy (PT) services. It also tracheostomy and rec he was a resident. S assessment revealed participated in the ass MDS reported his over the community was u active discharge plan	obility, dressing, and tance for transfers and d, supervision from staff for it. The resident was ing. Section O of the MDS d Resident #9 received y (OT) and Physical Therapy reported he had a ceived oxygen therapy while			Corrective action accomplished for the residents having the potential to be affected by the deficient practice: All residents discharging from the face have the potential to be affected by the alleged deficient practice. The nurse managers conducted an audit of resident who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orde discharge. This was validated by reviewing the resident record for documentation of coordination of hom care services and by conducting photo interviews with the resident or their responsible party to validate successs discharge. This audit was completed 5/5/17.	ility his dents rly ne ne ful		

Facility ID: 953007

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345115	B. WING		R-C 05/06/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CTR HEALTH & REHAB/S	ALISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144	
PREFIX (EACH DEFICIEN			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
to talk to someone a the facility and return services in the comma assessment. Howe also indicated the re- about returning to the subsequent MDS as A review of the resider to impaired breathin Revised on 2/7/17). The stated goal for resident to have no through the review of Revised on 3/16/17 The interventions on included: Ensure that the trat that go around the re- place, also known a all times (Initiated 2/ Observe/documen quality. Check and ordered (Initiated 2/ Suction as necess [Name of Resider home when able (In 3/8/17). The stated goal for resident to be able to assistance he would services required to discharge (Initiated 3/16/17).	the resident did not want about the possibility of leaving ming to live and receive munity at the time of the ver, Section Q of the MDS usident wanted to be asked the community on all assessments. Hent 's care plan included the cus: ti] has a tracheostomy related g mechanics (Initiated 2/7/17; his area of focus was for the signs/symptoms of infection tate (Initiated on 2/7/17; trace of the bands the costomy ties (the bands the costomy ties (the bands the collars) are secured at 7/17); t respiratory rate, depth and document every shift or as	F 24	 Facility nurses and IDT will be e on Discharge Process and Post Discharge Plan of Care policies Education initiated on 5/5/17 by Development Coordinator. Rem staff will be educated prior to ref duty. Beginning 5/6/17 all new l and IDT will receive this educati The Area Staff Development Co completed re-education of all lic nurses and members of the Interdisciplinary Team involved i discharge planning on 5/5/17. T education included the Administ Director of Nursing, Nurse Mana Social Services Director, Therap Program Manager, Dietary Serv Manager, Resident Care Manag Director (MDS Nurse), Business Director and Physician. This education includes the facil regarding Transfer and Discharg Procedures as follows: Post Discharge Plan of Care: 1. Upon admission the IDT mer consultation with the resident ar resident's legal representative (i practicable), develops the reside discharge. 2. The Social Service Director of designee, the IDT members, an resident and/or the resident's legal 	Area Staff haining turning to hire nurses on. ordinator ensed in This rator, agers, by rices gement s Office lity policy ge mbers, in hd/or the f ent's date of

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 06/08/201 RM APPROVE NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		ATE SURVEY	
		345115	B. WING			R-C)5/06/2017	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				63	35 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		S	ALISBURY, NC 28144		
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 284	Continued From page	e 57	F2	284			
	revise the plan as new need for assistance w and Activities of Daily (Initiated on 3/8/17; F Evaluate the resident the community (Initiat A review of the resident included Respiratory 2/7/17, 2/8/17, 2/14/1 3/21/17. One addition No notations were may provided education/tr care of his tracheostor A review of Resident revealed a home visit by OT and PT in antion from the facility. Rec the home visit included chair, hand held show shower, and oxygen of basis. The notes rec PT, and Speech There A review of the resided orders (as of 3/31/17) Tracheostomy: Cha	ivers, evaluate progress, and eded with the resident 's vith his tracheostomy care / Living (ADL) assistance Revised on 3/8/17); and, nt 's motivation to return to ted on 3/8/17). ent 's medical record Therapist (RT) notes dated 7, 2/23/17, 3/14/17, and nal RT note was not dated. ade to indicate the RT aining for the resident on the omy.			 representative determine the individual needs, resources, and services requires upon discharge through the IDT cares meeting and process. 3. Social Service Dept. arranges for post-discharge services. 4. Contact those service agencies with can support resident's needs, resour and services upon discharge (e.g., he health, durable medical equipment, therapy services, meals, transportatienter.). 5. Initiate the discharge paperwork with all IDT members to ensure that the resident, the resident's legal representative or receiving provider obtains correct and detailed, confider and protected health information upon discharge. Measures put into place or systemic changes made to ensure that the depractice will not occur: The Administrator, Director of Nursin Nurse Manager will review residents planned for discharge three times per week for 12 weeks to ensure a safe orderly discharge has been planned. 	ired plan who ces, ome on, with ntial on ficient	
	be checked every shi Doctor (MD) if the O2 (Initiated 2/7/17). An measure of the amou blood. Normal blood	nt of oxygen carried in the oxygen levels are typically			meeting with the resident and/or fam and completing the Post Discharge I of Care, providing a home visit when possible and validating the completion appropriate referrals.	Plan	
	considered to be 95-7	100%;			Opportunities will be corrected as		

Facility ID: 953007

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 /I APPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		345115	B. WING _				-C 06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY			35 STATESVILLE BOULEVARD			
				S	ALISBURY, NC 28144			
(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) COMPLETION DATE	
F 284	Continued From page	<u>- 58</u>	F	284				
	Trach #6 Shiley long	g (referring to the inner of the tracheostomy tube):		-0-	identified.			
	Tracheostomy care to and as needed (Initia	b be completed every shift ted 2/7/17); and,			Monitoring Process:			
	flow rate per minute)	ers (referring to the oxygen every shift (Initiated 3/2/17).	these audits wee		The Administrator will report the result these audits weekly for 12 weeks duri the QAPI meeting and then monthly			
	note dated 3/31/17. The note revealed Reside	ent ' s medical record al Respiratory Therapist (RT) The respiratory assessment ent #9 was sitting up in the demeanor. Tracheostomy			thereafter. The committee will review these results and make recommendat as required.	ions		
	change in the stoma that time. Resident #							
		rge to home on 4/1/17. n on the RT note to indicate ned on care of his						
	12:51 PM. The physic seen for a discharge	' s note dated 3/31/17 at cian noted Resident #9 was summary. The notation						
	of his discharge from He was admitted to the	is seen today in anticipation the facility this weekend. ne [Name of Facility] on						
	chronic respiratory fa subsequently requirin	•						
	well with rehabilitation the past several weel ambulating around th	n and with trach care. For ks he has been seen le facility without any SOB or						
	when walking" Plan: "COPD: Dimin	ot been requiring oxygen hished breath sounds and is alization but is felt stable to						

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG.				
		345115	B. WING				R-C / 06/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 284	go home. HH (Home A review of Resident revealed a Nursing N reported, in part: " A review of the Home 4/1/17 (not timed) inc "Call from [name of re #2] regarding waiting agency] to come out. to trach. Spoke with representative] who in at [name of facility]. / Home Health staff me referral as it would tal (private duty nurse). manager [name of ma of facility], but they we information and CM (Department is closed An email dated 4/3/17 by the Home Health a email was sent from t Marketing Manager to for Resident #9 's pri facility 's Administrato read: "I have copied [name on this email as well to I spoke with the other even though [name o company] approved H client he is not approp high risk for a hospital	Health) nursing, PT/OT." #9 ' s medical record ote dated 4/1/17 at 7:35 PM Patient went home." Health agency notes dated luded the following text: esident ' s Family Member for [name of Home Health Informed non-admitted due [name of Home Health nformed [name of Nurse #1] Also spoke with [name of ember], could not accept ke 2-3 weeks to set up PDN She informed marketing anager]. Tried to call [name buld not provide any Case Management) until Monday." At 4:16 PM was provided agency for review. The he Home Health agency ' s b both the Office Manager mary care physician and the for. The text of the email of facility ' s Administrator] to keep everyone in the loop. Home Health Agencies and f Resident #9 ' s insurance Home Health hours for this priate for Home Care. He is lization and his best place is	F	284				
	proper care he needs	ity] where he can get the . The client wanted to go ne of resident ' s physician at						

Facility ID: 953007

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DEPARTMENT OF HEAL CENTERS FOR MEDICA						FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
			A. BUILD	NG _			-C	
		345115	B. WING				-C 06/2017	
NAME OF PROVIDER OR SUPPLI	R			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CTR HEALTH & REH	AB/SA	LISBURY		6	635 STATESVILLE BOULEVARD			
BRIAN OTR TEACHT & REI				S	SALISBURY, NC 28144			
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
 would end up b [name of repress company] and t home and no Tr this client tomon him back to [na [resident 's name he needs is at S [Name of facility] team prepare a just in case." A review of Ress included docum visit on 4/4/17 v service. Progree Assistant (PA) of notations, in pa "Recently ho 12/17/16, trache to SNF [name of could be dischar released howev health to come Family Member today-she state facility] because has a history of home health. H Family Member breathing since The PA's Impriread: "Do not think pa care. Discusse returning to a S comorbidities. 	him la ack in hentati hey or ach si row I me of he] bu SNF (so bed to bed to ident : entati vith an so 4/4) ft: spitalizeostor f facili rged of er has out wi #2] ac s he w e "he c nonco le live: #1]. disch ession tident i f or bed to bed to be bed to be bed to be to to be to be to be to be to be to be to be to be to to be to to to be to to to to to to to to to to to to to	ast week he even stated he the hospital. I talked with ve for the oxygen supply hly delivered Oxygen to the upplies-When you guys see would recommend sending the facility]. I hate it for t his best place for the care killed nursing facility) level. dministrator] will have his o make a smooth transition #9 ' s paper medical record on from a follow-up diabetic to utside Internal Medicine tes written by the Physician '17 included the following zed for respiratory failure my performed. Discharged ty]. Patient was told he over the weekend. He was a had difficulty getting home th trach supplies. [Name of companies the patient <i>v</i> ill not go back to [name of loesn ' t want to." Patient ompliance and refusing s at home with his [name of No fever or difficulty	F	284				

Facility ID: 953007

If continuation sheet Page 61 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345115	B. WING		_		-C 06/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA			35 STATESVILLE BOULE	VARD		
BRIANOT	R HEALIN & REHADIOA		:	SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 284	Continued From page	9 61	F 284				
	v -	facility]. [Name of another] will bring supplies out to					
		agreement for close follow					
		eks for BP (blood pressure)					
		al Emergency Department					
	. ,	6/17 revealed Resident #9 :48 PM via Emergency					
		1S). The ED history included					
	the following commen						
	"Patient presents toda	ay complaining of need for					
	•	e was released from the					
		aturday and has been home					
	-	e is referred back to the					
		y because of inability to care le but upon return to the					
		here because he had foul					
		acheostomy site. Patient is					
		blems. He states that he					
		time so he is unclear as to					
	exact dates when his was changed."	last trach collar and trach					
	The hospital ED recor	rds revealed upon					
		nt #9 had erythematous					
		cial skin breakdown all					
	around the trach colla	ar site. The resident was					
	•	tis of the neck. The ED					
		ted 4/6/17 at 3:57 PM read,					
		ith trach collar-foul smell					
	-	ea states last changed					
	•	vith drainage-Respiratory at					
		out trach and replace trach nt was discharged from the					
	ED to the facility on 4						
	-	luded 2% Bactroban (a					
	topical antibiotic ointr	•					
	-	icillin-clavulanate (an oral					
	antibiotic) to be given	as one tablet by mouth					

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>			(X3) DATE		
		345115	B. WING _				R-C 106/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			335 STATESVILLE BOULEVARD SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 284	record dated 4/6/17 a resident was re-admit distress was noted ar being alert and orient A review of the reside the re-admission inclu Tracheostomy: Cha every night shift every 4/7/17); Trach #6 Shiley long completed every shift 4/7/17); Check O2 Sat every Sat is less than 88% Trach collar with 5 li needed during the da (Initiated 4/8/17); and Trach collar with 5 li evening and night shi A review of the reside included a Respirator 4/7/17. The respirator Resident #9 ' s trach the hospital. The resid the resident was read to the ED for cellulitis part: "No trach care w home. He is on ABT trach site." The resid as red, sore, and blee A review of Resident	days. ent ' s electronic medical t 9:49 PM indicated the the to the facility. No hd he was assessed as ed. ent ' s physician orders for uded the following: ange tubing and equipment y Wednesday (Initiated g: Tracheostomy care to be and as needed (Initiated y shift and notify MD if O2 (Initiated 4/7/17); iters O2 per minute as y for O2 Sats less than 91% , ters O2 per minute every ft (Initiated 4/8/17). ent ' s medical record y Therapist (RT) note dated my assessment revealed was changed on 4/6/17 at piratory assessment noted imitted on 4/6/17 after going around his trach. It read, in vas done while he was at (antibiotic) and Bactroban to ent ' s trach site was noted eding easily. #9 ' s admission Minimum	F	284				
	. ,	ssment dated 4/13/17 had intact cognitive skills for						

Facility ID: 953007

If continuation sheet Page 63 of 130

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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) COMPLETION DATE
F 284	all of his ADLs, with the supervision from staff MDS assessment rep tracheostomy care and was a resident. Section assessment revealed the assessment proce- remain in the facility. revealed the resident about the possibility of returning to live and re- community at the time An interview was con- with the facility 's Unit Staff Development Co- inquiry, the Unit Mana- Resident #9 came ba- sometime between 2: reported Resident #9 facility did not have and The Unit Manager and not admit the resident to have a problem with to the hospital for eva- resident returned from same date (4/6/17). A returned, the nurses re The first note which in the facility was made An interview was con- with the facility 's Adri interview, the adminis s family knew ahead of resident to go home. himself arranged Hom	. He was independent for ne exception of requiring for eating. Section O of the orted he received ad oxygen therapy while he on Q of the MDS the resident participated in the resident participated in the ses and was expecting to However, the MDS also did want to talk to someone of leaving the facility and eccive services in the	F	284			

Facility ID: 953007

If continuation sheet Page 64 of 130

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING				-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA			63	35 STATESVILLE BOULEVARD		
BRIANOT				S	ALISBURY, NC 28144		
(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)	ЗE	(X5) COMPLETION DATE
F 284	information for the He The Administrator stat was happening." He (3/31/17) around 6:00 #9 met with an oxyge they brought his oxyge educated him on its u confirmed Resident # Saturday, 4/1/17. As the interview contr the Administrator reprinsurance company of (4/3/17) and reported concerned he wasn ' tracheostomy. The A resident ' s family me by telephone on 4/3/1 told this family memb happy to take the ress resident had a physic that week and the far On Thursday, 4/6/17, he called the family n around 12:00 PM and were on their way to facility. When the ress resident was being se reported the resident returned to the facility evening of 4/6/17. A telephone interview 4:35 PM with a Marke	Iministrator provided contact ome Health representative. Inted, "Everybody knew what reported on Friday night D PM, both he and Resident en supply company when gen to take home and use. The Administrator 99 was discharged on inued on 5/4/17 at 2:30 PM, orted Resident #9 's contacted him on Monday I the resident 's family was t doing well at home with the administrator spoke with the ember (Family Member #2) 17, 4/4/17, and 4/5/17. He ere that the facility would be ident back. However, the cian appointment scheduled mily planned to take him to it. the Administrator reported nember [Family Member #2] d was basically told they bring the resident back to the sident arrived, the he could smell the trach get it evaluated. The facility ospital ED to tell them the ent over. The Administrator was seen in the ED and ty around 8:00 -9:00 PM the	F	284			
		ad received a referral from					

Facility ID: 953007

If continuation sheet Page 65 of 130

IDENTIFICATION NUMBER: 345115 LISBURY TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 65	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE 35 STATESVILLE BOULEVARD SALISBURY, NC 28144 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	TION LD BE	2-C 2-C 206/2017
LISBURY ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	35 STATESVILLE BOULEVARD SALISBURY, NC 28144 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	ION LD BE	(06/2017 (X5)
ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	35 STATESVILLE BOULEVARD SALISBURY, NC 28144 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	
ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	CALISBURY, NC 28144 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	
Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE	
65		DEFICIENCY)		DATE
Resident #9 's home care. he resident 's discharge 17 were discussed. As the eviewed the resident 's she reported the agency Care referral on 3/28/17. ed their Home Health to two sections: the Hourly vork with tracheostomies) care side (which did not 3/31/17, the agency id not have insurance dy care; and the Home ot do trach care. The bottacted the Marketing On 3/31/17, the Marketing the facility and informed Health agency couldn 't e also reported her agency lome Health agencies, but accepted by either of them. Il planned for 4/1/17, the tated she coordinated a the facility on Friday night ent would have it when he day (4/3/17), she went to the ecause she was concerned harge if the resident actually veekend. The Marketing Iso wanted to make sure for the resident if he decided arketing Manager reported fice Manager for Resident ysician on 4/3/17, then nail to both the Office ity 's Administrator to be e information.	F 284			
	17 were discussed. As the viewed the resident 's she reported the agency Care referral on 3/28/17. ed their Home Health to two sections: the Hourly vork with tracheostomies) care side (which did not 3/31/17, the agency id not have insurance ly care; and the Home of do trach care. The ontacted the Marketing On 3/31/17, the Marketing he facility and informed Health agency couldn 't e also reported her agency ome Health agencies, but accepted by either of them. Il planned for 4/1/17, the ated she coordinated a he facility on Friday night ent would have it when he lay (4/3/17), she went to the ecause she was concerned arge if the resident actually reekend. The Marketing Iso wanted to make sure for the resident if he decided arketing Manager reported fice Manager for Resident ysician on 4/3/17, then nail to both the Office ity 's Administrator to be	17 were discussed. As the viewed the resident 's she reported the agency Care referral on 3/28/17. ed their Home Health to two sections: the Hourly vork with tracheostomies) care side (which did not 3/31/17, the agency id not have insurance ly care; and the Home ot do trach care. The ontacted the Marketing On 3/31/17, the Marketing he facility and informed Health agency couldn 't e also reported her agency ome Health agencies, but accepted by either of them. Il planned for 4/1/17, the ated she coordinated a he facility on Friday night ent would have it when he lay (4/3/17), she went to the ecause she was concerned arge if the resident actually reekend. The Marketing lso wanted to make sure for the resident if he decided arketing Manager reported fice Manager for Resident ysician on 4/3/17, then nail to both the Office ity 's Administrator to be a information.	17 were discussed. As the viewed the resident 's she reported the agency Care referral on 3/28/17. 3d their Home Health to two sections: the Hourly ork with tracheostomies) care side (which did not 3/31/17, the agency id not have insurance ly care; and the Home ot do trach care. The intacted the Marketing On 3/31/17, the Marketing he facility and informed Health agency couldn 't e also reported her agency ome Health agencies, but incepted by either of them. I planned for 4/1/17, the ated she coordinated a he facility on Friday night ent would have it when he lay (4/3/17), she went to the cause she was concerned arge if the resident actually eekend. The Marketing Iso wanted to make sure for the resident if he decided arketing Manager reported fice Manager for Resident ysician on 4/3/17, then nail to both the Office ity 's Administrator to be a information.	17 were discussed. As the viewed the resident's she reported the agency 2are referral on 3/28/17. ad their Home Health to two sections: the Hourly ork with tracheostomies) care side (which did not 3/31/17, the agency id not have insurance ly care; and the Home of do trach care. The intacted the Marketing On 3/31/17, the Marketing the facility and informed Health agency couldn't e also reported her agency ome Health agencies, but accepted by either of them. Il planned for 4/1/17, the ated she coordinated a he facility on Friday night ent would have it when he hay (4/3/17), she went to the scause she was concerned arge if the resident actually eekend. The Marketing Iso wanted to make sure for the resident if he decided arketing Manager reported fice Manager for Resident ysician on 4/3/17, then nail to both the Office ity's Administrator to be a information.

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 06/08/2017 ORM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) D	DATE SURVEY OMPLETED
		345115	B. WING				R-C 05/06/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				63	35 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAB/SA	LISBURY		S/	ALISBURY, NC 28144		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 284	with Resident #9. Du resident recalled he a with someone on Frid oxygen arranged for o resident was asked w prior to discharge, he the oxygen he had a and a railing for the con- installed by his landlo 4/1/17. Upon further "someone" on the pho- get 24-hour nursing c reported he did not kr care and did not rece at home. He reported Health nurse to come care of his tracheosto A telephone interview 10:48 AM with the Re who worked with Res she worked for a cont to the facility once a v tracheostomy care for 4/1/17 discharge, the issues with his skin un to a small amount of o trouble keeping the sl skin looked a little irrit when cleaned. The F the Home Health nurs this issue under his tr asked what kind of tra- required, the RT state care once every shift facility, but may have	ring the interview, the and the Administrator met lay night (3/31/17) to get his discharge. When the /hat was arranged for him reported that in addition to shower chair, a shower bar, ommode at home that his 1. He stated the shower bar mode had not yet been ord when he arrived home on inquiry, the resident stated one had told him he would are when he got home. He now how to do his own trach ive any trach supplies to use d he expected a Home e out to his home to take omy, but no one did. was conducted on 5/5/17 at espiratory Therapist (RT) ident #9. The RT reported tracted company and came week to provide r the resident. Prior to his RT noted Resident #9 had nder the tracheostomy due drainage and having some kin dry. She reported the tated and was a little sore RT stated she was hoping se would continue to follow racheostomy collar. When	F 2	284			

Facility ID: 953007

If continuation sheet Page 67 of 130

DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEI					FORM): 06/08/2017 APPROVED 0. 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345115	B. WING				-C 06/2017
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CTR HEALTH & REHAB/SALISI	DIDV		63	35 STATESVILLE BOULEVARD		
BRIAN CIR HEALIN & REHAB/SALISI	BURI		S	ALISBURY, NC 28144		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
would reliably do the care When asked if she had un would be going home with stated, "Absolutely." Upon reported having a suction be a standard for anyone tracheostomy. When ask	re involved cleaning the he area where the ties or o secure the tube in there were no secretions; nd cannula (the body of nto the trachea), and ge underneath. The RT e impression the resident uld do some of his trach lith nurse going out a few tre it was done eviewing her notes, the ad done tracheostomy ident, but was certain member on the trach e had done trach care it, she would have menting this in her RT stated if the resident able to do the procedure ever, she was unsure if he e twice daily every day. Inderstood this resident th Home Health, she on further inquiry, the RT n machine would usually e going home with a ked what her thoughts ent going home without a reported that although ave a big problem, she " The RT stated she after he was readmitted She recalled he had for neck cellulitis and the skin had improved few weeks.	F	284	DEFICIENCY)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SUPPLY COMPLETED NAME OF PROVIDER OR SUPPLIER 345115 B WING R-C 05/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 (X4) ID RECAT DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X0) DIE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X0) DIE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 284 Continued From page 68 PM with Nurse #2. Nurse #2 worked as a 3rd shift nurse assigned to care for Resident #9. When asked if she had done any tracheostomy care teaching with the resident, Nurse #2 reported since she worked on the 3rd shift, she would typically "talk him through it." The nurse stated the resident #0 as not doing his own trach care." F 284 A follow-up interview was conducted on 5/5/17 at 12:52 PM with Resident #0. A family member (Family Member #1) was visiting the resident stated he lived with Family Member #1 after he was discharged from the facility. When the resident and his family member were asked what trach care was done during the time he was home, the resident stated, "nothing." The			ID HUMAN SERVICES MEDICAID SERVICES					INTED: 06/08/2017 FORM APPROVED IB NO. 0938-0391
MING 05/06/2017 NAME OF PROVIDER OF SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CTR HEALTH & REHAB/SALISBURY STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CTR HEALTH & REHAB/SALISBURY STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL ID TAG Continued From page 68 F 284 PM with Nurse #2. Nurse #2 F 284 When asked if she had done any tracheostomy F 284 VMent masked if she had done any tracheostomy F 284 A follow-up interview was conducted on 5/5/17 at 12:52 PM with Resident #9. Kithe Resident #9. When asked the lealthy he main member F 284 A follow-up interview was conducted on 5/5/17 at 12:52 PM with R	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /) DATE SURVEY COMPLETED
BRIAN CR HEALTH & REHAB/SALISBURY 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 Image: Construct of the proceeding o			345115	B. WING				
BRIAN CTR HEALTH & REHAB/SALISBURY SALISBURY, NC 28144 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 284 Continued From page 68 PM with Nurse #2. Nurse #2 worked as a 3rd shift nurse assigned to care for Resident #9. When asked if she had done any tracheostomy care teaching with the resident, Nurse #2 reported since she worked on the 3rd shift, she would typically "talk him through it." The nurse stated the resident never did a return demonstration for her. Nurse #2 stated, "I do know when he left the facility he was not doing his own trach care." F 284 A follow-up interview was conducted on 5/5/17 at 12:52 PM with Resident #9. A family member (Family Member #1) was visiting the resident at that time. During the interview, the resident stated he lived with Family Member #1 after he was discharged from the facility. When the resident and his family member were asked what trach care was done during the time he was home, the resident stated, "nothing." The	NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
SALISBURY, NC 28144 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ODER'S FULAN OF CORRECTION (EACH ODER'S FULAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 284 Continued From page 68 PM with Nurse #2. Nurse #2 worked as a 3rd shift nurse assigned to care for Resident #9. When asked if she had done any tracheostomy care teaching with the resident, Nurse #2 reported since she worked on the 3rd shift, she would typically "talk him through it." The nurse stated the resident never did a return demonstration for her. Nurse #2 stated, "I do know when he left the facility he was not doing his own trach care." F 284 A follow-up interview was conducted on 5/5/17 at 12:52 PM with Resident #9. A family member (Family Member #1) was visiting the resident at that time. During the interview, the resident stated he lived with Family Member #1 after he was discharged from the facility. When the resident and his family member were asked what trach care was done during the time he was home, the resident stated, "nothing." The	BRIAN CT	R HEALTH & REHAB/SA				635 STATESVILLE BOULEVARD		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMPLETION DATE F 284 Continued From page 68 PM with Nurse 42. Nurse #2 worked as a 3rd shift nurse assigned to care for Resident #9. When asked if she had done any tracheostomy care teaching with the resident, Nurse #2 reported since she worked on the 3rd shift, she would typically "talk him through it." The nurse stated the resident never did a return demonstration for her. Nurse #2 stated, "1 do know when he left the facility he was not doing his own trach care." F 284 A follow-up interview was conducted on 5/5/17 at 12:52 PM with Resident #1 was visiting the resident at that time. During the interview, the resident stated he lived with Family Member #1 after he was discharged from the facility. When the resident and his family member were asked what trach care was done during the time he was home, the resident stated, "nothing." The	BRIANOT					SALISBURY, NC 28144		
PM with Nurse #2. Nurse #2 worked as a 3rd shift nurse assigned to care for Resident #9. When asked if she had done any tracheostomy care teaching with the resident, Nurse #2 reported since she worked on the 3rd shift, she would typically "talk him through it." The nurse stated the resident never did a return demonstration for her. Nurse #2 stated, "I do know when he left the facility he was not doing his own trach care." A follow-up interview was conducted on 5/5/17 at 12:52 PM with Resident #9. A family member (Family Member #1) was visiting the resident at that time. During the interview, the resident stated he lived with Family Member #1 after he was discharged from the facility. When the resident and his family member were asked what trach care was done during the time he was home, the resident stated, "nothing." The	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOULD BE	COMPLETION
resident acknowledged he was shown how to use his oxygen equipment, but reiterated he was not shown how to do the trach care for himself. When Family Member #1 was asked if she was trained to provide trach care for the resident, both the resident and family member responded by saying, "No." The resident consented to have a second family member interviewed by telephone (Family Member #2). He reported the second family member provided his transportation and had been in contact with his health care providers. A follow-up interview was conducted on 5/5/17 at 1:21 PM with the facility 's Unit Manager. Upon inquiry, the Unit Manager reported that to her knowledge, the resident did not do any of his own trach care during his stay at the facility. The Unit	F 284	PM with Nurse #2. N shift nurse assigned t When asked if she ha care teaching with the reported since she we would typically "talk h stated the resident ne demonstration for her know when he left the own trach care." A follow-up interview 12:52 PM with Reside (Family Member #1) of that time. During the stated he lived with F was discharged from resident and his famil trach care was done home, the resident st resident acknowledge his oxygen equipmen shown how to do the When Family Member trained to provide trac the resident and fami saying, "No." The res second family member (Family Member #2). family member provid had been in contact w providers. A follow-up interview 1:21 PM with the facili inquiry, the Unit Mana knowledge, the reside	lurse #2 worked as a 3rd to care for Resident #9. ad done any tracheostomy e resident, Nurse #2 orked on the 3rd shift, she him through it." The nurse ever did a return r. Nurse #2 stated, "I do e facility he was not doing his was conducted on 5/5/17 at ent #9. A family member was visiting the resident at interview, the resident amily Member #1 after he the facility. When the ly member were asked what during the time he was ated, "nothing." The ed he was shown how to use it, but reiterated he was not trach care for himself. er #1 was asked if she was ch care for the resident, both ly member responded by sident consented to have a er interviewed by telephone He reported the second ded his transportation and with his health care	F	284			

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345115	B. WING				-C /06/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			5 STATESVILLE BOULEVARD		
				SA	LISBURY, NC 28144		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 284	resident presented or drainage from his trac Manager stated she of tracheostomy and co drainage was. She re have assessed the di resident out to the ho the facility. A telephone interview 1:24 PM with Nurse # as the nurse who rec Home Health agency facility Resident #9 w Health due to having asked about this phot believe they did spea Administrator was inv the supply company Administrator was go [name of the Marketir in place." When aske made prior to the resi stated she knew som oxygen for the reside were also going to de When asked if the res training or education reported, "Anytime I w to teach him." When did the tracheostomy stated, "Not really." An interview was con with the facility ' s So inquiry, the SW state 3/30/17. During the i	h 4/6/17 with foul smelling cheostomy. The Unit did not assess the uld not tell what color the eported two nurses who may rainage prior to sending the spital no longer worked at v was conducted on 5/5/17 at t1. Nurse #1 was identified eived a phone call from the on 3/31/17, informing the as not admitted to Home a tracheostomy. When ne call, the nurse stated, "I k with methe volved. Someone called	F	284			

Facility ID: 953007

If continuation sheet Page 70 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DAT COM NAME OF PROVIDER OR SUPPLIER 345115 B. WING 05 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 SALISBURY, NC 28144	O. 0938-0391 E SURVEY IPLETED R-C 5/06/2017
345115 B. WING OE NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CTR HEALTH & REHAB/SALISBURY 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 SALISBURY, NC 28144	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CTR HEALTH & REHAB/SALISBURY 635 STATESVILLE BOULEVARD SALISBURY, NC 28144 SALISBURY, NC 28144	
BRIAN CTR HEALTH & REHAB/SALISBURY SALISBURY, NC 28144	
SALISBURY, NC 28144	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284 Continued From page 70 F 284 Health agency and provide them with information needed on the resident. From there, a date would be set for the Home Health agency to meet with the resident at their home (usually the day after discharge from the facility). The SW reported the facility typically recommended PT, OT, and ST for residents upon discharge, which allowed the Home Health care agency to do their own assessments on each and determine any services needed. The SW reported the residents ' discharge paper work included, the SW reported both a Post-Discharge Plan of Care and an Interdisciplinary Discharge Summary needed to be completed prior to a resident ' s discharge from the facility. A follow-up interview was conducted on 5/5/17 at 3:20 PM with the facility ' s Administrator. During the interview, an inquiry was made as to who was involved in the discharge for Resident #9 was handled between himself, nursing, and possibly the Activities Manager. Upon inquiry, the Administrator stated he was not accepted for home care. He exported do an 3311/1 by the Home Health agency that Resident #9 was not accepted for home care. He reported the discharge paper work was kept tor Resident #9. A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident #9. A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident #9. A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident #9. A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident #9. A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident #9.	

Facility ID: 953007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345115	B. WING _				-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				63	35 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
TAG F 284	Continued From page s Medical Director. T when he saw the resident services upon dischar that if he was not goin he would have wanter stated, "I certainly wo again." A follow-up interview 3:55 PM with the Adminis papers had been com discharge on 4/1/17. A telephone interview 9:25 AM with the reside (Family Member #2) v for the resident and h health care providers from the facility. Fam began talking with the s discharge sometime who chose 4/1/17 as stated, "I guess they of get things in place for member reported oxy home where Residen 3/31/17 in preparation she picked the reside 4/1/17 (between 10:00 portable oxygen for th Member #2 stated the surprised he was bein	e 71 he physician recalled that dent on 3/31/17, he to receive Home Health rge. The physician stated ing to receive these services, d to be informed. The MD uld not want this to happen was conducted on 5/5/17 at inistrator. During the strator reported no discharge upleted for Resident #9 's was conducted on 5/6/17 at dent 's 2nd family member vho provided transportation ad been in contact with his after he was discharged ily Member #2 reported she e facility about the resident ' e in March. When asked his discharge date, she did. They told us they could April 1st." The family gen was delivered to the t #9 would be staying on n for his discharge. When nt up from the facility on 0 AM - 12:00 PM), he had he trip home. Family	F 2	84			
	was picking up the re- prescriptions for his meither she or the resident instructions for home,	nedications. When asked if lent were given any					

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IALEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	 }	· · ·	PLETED
						२- С
		345115	B. WING		05	5/06/2017
NAME OF PR	OVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
				635 STATESVILLE BOULEVARD		
	R HEALTH & REHAB/SA			SALISBURY, NC 28144		
(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)	I SHOULD BE	(X5) COMPLETIO DATE
F 284	Continued From page	- 72	F 28	4		
		urse (Nurse #3) if the Home	120			
	•	nd was told they "thought so"				
		nurse would be out to the				
		Family Member #2 stated				
	-	v often the Home Health				
	nurse was going to be	e coming out, but expected				
	to find out more when	n the nurse came to the				
		e stated her main concern				
		resident 's trach was				
		nd generally taken care of.				
		ated when she got the				
	-	/ with Family Member #1, ourse to come out. The				
		idn ' t know how the trach				
		amily Member #2 reported				
		two to three times on 4/1/17				
		Health care people weren ' t				
	-	and she was told they would				
		ting with the resident at his				
	home for hours, Fam	ily Member #2 stated she				
	went to her own home	e and called the Home				
		f. The Home Health agency				
	-	coming. The family member				
	-	d that because he was				
	•	stated, "Had I known nobody				
		not have taken him home." t do patients with trachs and				
	• •	mebody at the facility they				
		family member stated she				
	made an appointmen					
		ey could help get someone				
		e trach, "but they didn ' t				
		recalled sometime during				
		n another Home Health				
		nouse, but she didn ' t touch				
	the trach because he	didn ' t have anybody at				
	home who was able t	o provide help with the trach r #2 reported she had talked				

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345115	B. WING				R-C /06/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				635	5 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAB/SA	LISBURY		SA	LISBURY, NC 28144		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 284	the facility would take did not want to go bas stated, "I was scared trach and it was alrea reported bringing the on that Thursday (4/6 tracheostomy) was si standing back. It was member stated the fa ED after he arrived th to the facility later that A telephone interview 10:32 AM with Nurse worked at the facility ranging in frequency a week. Nurse #3 was who worked the 1st s #9 was discharged. Resident #9 ' s family the resident on the m reported she had not the resident was goin morning. The nurse si discharge packet bed Social Worker at that the Activities Manage that Saturday morning packet together for hi reported the discharg of Care and a Discha #3 recalled telling the a Home Care agency home. When asked w	e was home. She was told him back, but the resident ck. The family member with nobody checking the dy kinda messy." She resident back to the facility 6/17) and stated, "It (the melling and everybody was a mess." The family cility sent him to the hospital tere. Resident #9 returned t evening. was conducted 5/6/17 at #3. The nurse reported she on an "as needed" basis, from twice a month to twice as identified as the nurse hift on 4/1/17 when Resident The nurse recalled when member came to pick up orning of 4/1/17. Nurse #3 been told ahead of time that g to be discharged that stated, "I did not have a time." Nurse #3 reported r happened to be working g so she got a discharge m. Upon inquiry, the nurse resident and family member would come out to the what was sent home with the ported she gave him	F	284			
F 284	the week Resident #S the facility would take did not want to go ba stated, "I was scared trach and it was alrea reported bringing the on that Thursday (4/6 tracheostomy) was si standing back. It was member stated the fa ED after he arrived th to the facility later that A telephone interview 10:32 AM with Nurse worked at the facility ranging in frequency a week. Nurse #3 wa who worked the 1st s #9 was discharged. Resident #9 ' s family the resident on the m reported she had not the resident was goin morning. The nurse discharge packet bed Social Worker at that the Activities Manage that Saturday morning packet together for hi reported the discharg of Care and a Discha #3 recalled telling the a Home Care agency home. When asked w resident, the nurse re prescriptions for his m	e was home. She was told him back, but the resident ck. The family member with nobody checking the dy kinda messy." She resident back to the facility 6/17) and stated, "It (the melling and everybody was a mess." The family cility sent him to the hospital tere. Resident #9 returned t evening. was conducted 5/6/17 at #3. The nurse reported she on an "as needed" basis, from twice a month to twice as identified as the nurse hift on 4/1/17 when Resident The nurse recalled when member came to pick up orning of 4/1/17. Nurse #3 been told ahead of time that g to be discharged that stated, "I did not have a time." Nurse #3 reported or happened to be working g so she got a discharge m. Upon inquiry, the nurse the packet contained the Plan rge Planning form. Nurse resident and family member would come out to the what was sent home with the ported she gave him nedications and 3	F	284			

Facility ID: 953007

If continuation sheet Page 74 of 130

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345115	B. WING				-0 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 284	the tracheostomy sup stated she had done as the resident during his Upon inquiry, the nurs resident may have do care during his stay a also reported that wor ago." The nurse state tracheostomy care sur resident to do his own came back it was not encourage the residen do it," but he didn 't w the resident as alert b cognitively intact. She varied from day to day thought a family mem facility either later on the Home Health age house. The nurse tol- the Home Health age tried to call Home Heal the age tried to call Home Heal return her call. An interview was com AM with the Administra- the Administrator reported Activities Manager co assessments; the Act the discharge plannin Administrator contact	to come out and would get plies from them. Nurse #3 some routine teaching with a stay (not at discharge). Se reported she thought the ne some of his own trach t the facility. However, she uld have been, "some time ed a while back she left the pplies in the room for the n trach care, but when she done. She tried to nt by saying, "you' ve gotta want to. Nurse #3 described but not necessarily e reported his cognition y. When asked, Nurse #3 ber may have called the 4/1/17 or on 4/2/17 saying ncy didn ' t come to the d the family she would call ncy. Nurse #3 reported she alth, but the agency did not ducted on 5/6/17 at 11:50 rator. During the interview, orted the facility ' s former give notice when he No Social Worker was ity until the new SW started ked who fulfilled the SW //26/17 to 3/29/17, the d the MDS nurse and	F	284			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345115	B. WING			R-C 05/06/2017		
NAME OF P	ROVIDER OR SUPPLIER	I	I	ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/SA			63	5 STATESVILLE BOULEVARD			
				S	ALISBURY, NC 28144			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 284	remainder of the SW nursing staff, the MD Manager, and himsel An interview was con with the facility ' s Act Activities Manager re Degree in Human Se Bachelor ' s degree. reported she helped of facility was without a included calling familit talking with difficult re issues, assisting with making outside appoi When asked about th on 4/1/17, the Activitie not recall the Adminis was going to go hom discharge forms were when the nurse was n Activities Manager re scheduled to work that forms, filled them out nursing station for the how the Interdisciplin form was completed, reported the different the form. An interview was con with the facility ' s Adu the Administrator report	Administrator reported the duties were shared by S nurse, the Activities f. ducted on 5/6/17 at 1:12 PM divities Manager. The ported she had an Associate rvices; she did not have a The Activities Manager with extra duties while the	F	284				
	resident with a goal to During a follow-up int	o return to the community. erview conducted on 5/6/17 nistrator was asked what his						

Facility ID: 953007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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)	ЗE	(X5) COMPLETION DATE
F 284	Discharge Summary. he expected the Social completion of these d On 5/5/17 at 3:58 PM informed of the immer provided a credible al PM. The allegation of Credible Allegation for Criteria 1 Resident #9 was disc [Name of Facility] on - Home Health Service suction machine, and tracheostomy care at Administrator complet Health Agency on 3/2 from the facility. Hor staff nurse prior to disu unable to provide servin information was not c management for follow received education fro Development Coordin Policy and Procedure Provider delivered Ox DME (Durable Medica confirmed prior to disu returned to facility by assessed and determ Tracheostomy, due to sent to ER for eval an he was readmitted to 4/6/2017, and treated remains a current res	of Care and Interdisciplinary The Administrator reported al Worker to coordinate the ischarge plans. , the Administrator was diate jeopardy. The facility legation on 5/6/17 at 1:38 f compliance indicated: r F284 harged to his home from 4/1/17. Resident #9 required s for Nursing, Oxygen, supplies to manage home. The Facility ted a referral to the Home 8/2017, prior to discharge me Health Agency informed scharge that they were vice for this resident. This ommunicated with facility w up. This nurse has om the Areas Staff hator, regarding Discharge on 5/5/17. The Oxygen tygen. No arrangements for al Equipment) was charge. Resident # 9 was his family on 4/6, was ined need for care for his o drainage and odor, was d returned to facility where [Name of Facility] on for infection. Resident # 9 ident. At time of discharge on of Home Health admitting	F	284			

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 284	documented educatio symptoms of problem to maintain stable hea not providing this care family/ caregiver. Section Q of the MDS Resident # 9 on 4/13/ resident expects to re Throughout the Disch Resident #9 the Facili Social Worker. Facili Director resigned with Facility went without a from 1/26/2017 until a was retained on 3/30/ remains employed. T active role in the discl Resident # 9. Criteria 2 All residents discharg potential to be affecte practice. The Nurse I audit of residents who facility since 4/1/17 to received sufficient pre ensure a safe and ord validated by reviewing documentation of coo services and by cond the resident or their re successful discharge. by 5/5/17. Criteria 3 Facility Nurses and IE	on related to signs and us, what care was necessary alth, and consequences of e, for the resident and his S was completed for 17 and indicated that	F	284			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 284	Care Policies. Educat Area Staff Developme staff will be educated Beginning 5/6//2017 a will receive this educat The Area Staff Develor re-education of all Lic members of the Interd discharge planning, o the Administrator, Dir Managers, Social Ser Program Manager, Di Resident Care Manage Nurse), Business Offi This education include regarding Transfer an follows: Post Discharge Plan of 1. Upon admission the consultation with the re s legal representative the resident 's dischar date of discharge. 2. The Social Service IDT members, and the resident 's legal repre- individual needs, reso required upon dischar plan meeting and pro- 3. Social Service Dep post-discharge servic 4. Contact those service	tion initiated on 5/5/16 by the ent Coordinator. Remaining prior to returning to duty. all new hire Nurses and IDT ation. opment Director completed ensed Nurses and disciplinary Team involved in n 5/5/17, Education included ector of Nursing, Nurse vices Director, Therapy ietary Services Manager, gement Director (MDS ce Director and Physician. es the facility policy d Discharge Procedures as of Care: e IDT members, in resident and/or the resident ' of if practicable), develops arge plan and anticipated Director or designee, the e resident and/or the esentative determine the purces, and services rge through the IDT care cess. hartment arranges for es lice agencies who can	F	28			

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 284	durable medical equip meals, transportation 5. Initiate the discharge members to ensure th 's legal representativ obtains correct and de protected health infor The Social Services II residents who dischar discharge, 2 weeks of post discharge to ensi- necessary services to environment. Facility alleged IJ rem The credible allegatio 5:38 PM. On 5/6/17 f PM, staff members fro Nurses), Social Servic Departments were int to describe the educa policy regarding Trans Procedures, including resident 's post-disch role each staff member during the discharge nurses were interview in-servicing received of Section Q of the M Administrative staff, in Nursing and Administ The DON and Administ the education each re- respective role in the An audit of residents the facility since 4/1/1	oment, therapy services, , etc.). ge paperwork with all IDT nat the resident, the resident e or receiving provider etailed, confidential and mation upon discharge. Director will contact all rge home within 1 week of f discharge and at 30 days ure that they have all care o safely remain in their home hoval 5/6/17 n was validated on 5/6/17 at from 4:25 PM through 5:38 om the Nursing (Licensed ces, and Therapy rerviewed. Staff were able tion received on the facility sfer and Discharge the development of a harge plan of care and the er was expected to fulfill planning process. The MDS /ed and able to verbalize the for the accurate completion	F	284			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345115	B. WING				06/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			85 STATESVILLE BOULEVARD ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 284 F 323 SS=J	jeopardy was remove	arge. The immediate d on 5/6/17 at 5:38 PM. (3) FREE OF ACCIDENT		284 323			6/7/17
	(d) Accidents.The facility must ensu(1) The resident envir from accident hazards	onment remains as free					
		eives adequate supervision es to prevent accidents.					
	appropriate alternativ bed rail. If a bed or si must ensure correct in	ails, including but not limited					
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.					
		and benefits of bed rails with nt representative and obtain or to installation.					
	This REQUIREMENT by: Based on observation interview the facility fa cognitively impaired m assessed as a high ef #13) from exiting a log	sident's size and weight. is not met as evidenced n record review and staff ailed to prevent 1 of 4			F 323 Corrective action accomplished for tho residents found to have been affected the deficient practice:		

Facility ID: 953007

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		MEDICAID SERVICES			OMB N	M APPROVE 0. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	COM	E SURVEY IPLETED
		345115	B. WING			R-C 5/06/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
				635 STATESVILLE BOULEVARD		
BRIAN CI	R HEALTH & REHAB/SA	ALISBURY		SALISBURY, NC 28144		
(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)	I SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 81	F 3	23		
F 323	that could be opened resident to elope thro exited a resident roor feet and across an ac neighboring apartmen ran next to the facility that Resident #13 ha had seen Resident # Resident #13 was loo base of a hill on the or Resident #13 sustain incident. Immediate Jeopardy Resident #13 exited to facility staff and was concerned neighbor exit the building throu The Immediate Jeopa 5/6/17 when the facilit allegation of complian will remain out of com severity of D (no actum more than minimal ha jeopardy) to allow the fully implement new p windows for potential ensuring residents will seeking behaviors ha interventions care pla The findings included Resident #13 was ad	I sufficiently to allow a bugh them. Resident #13 m window then walked 43 ccess road for the int complex; this access road /. Facility staff were notified d eloped by a neighbor who 13 exit the window. When cated by staff he was at the other side of the access road. The facility unattended by found outside, after a reported seeing someone ugh a window. ardy was lifted at 6:00 PM on ity ' s acceptable credible nce was verified. The facility inpliance at a scope and ual harm with potential for arm that is not immediate e facility time to monitor and procedures monitoring l exit hazards, and for ith elopement risk and exit ave appropriate and timely anned and implemented. t: mitted 1/27/17 to the facility '	F 3	 Resident #13 was admitted to Center Health and Rehabilitation 1/27/17, to room 306 in the unit. Resident #13 was assesses being at risk for elopement or approx. 1:00pm on 2/25/17, I was found outside of the facil facility staff was alerted by a fineighbor. Resident #13 was feet from window, across the outside the facility between far neighboring apartment buildir Resident #13 was returned to by the Manager on Duty and housekeeping staff. Residen assisted back into the facility unit. Nurse #7 immediately complet to toe assessment of Resider minor injury of a skin tear not where/how injury occurred, du witnessed. An updated Elope Assessment was completed fi #13 on 2/25/17. The care plat reviewed and updated by the 3/6/17 to include "Window stot room change." Nurse #7 initia increased supervision for Resider to monitor location. These ch completed by the nursing assidocumented on the flow record charge nurse for 72 hours foll 	tion/Salisbury e secure seed as a 1/27/17. At Resident #13 ity after a facility found 43 driveway icility and ags. the facility t #13 was and secure eted a head at #13 with ed, unknown ue to not ement or Resident n was DON on opper and ated sident #13 on inute checks recks were istants and rd by the owing the	
	s locked unit. He had Alzheimer 's disease	d diagnoses including e, Parkinson ' s, cerebral mentia with behaviors and		Resident #13 was moved to r 2/25/17 where the window ex	sident this time. oom 319 on	

Facility ID: 953007

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,	<u> </u>	· · ·	OMPLETED
						R-C
		345115	B. WING			05/06/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 323	Continued From page	e 82	F 32	23		
	The Admission Minim			courtyard enclosed on three	sides by the	
		3/17 revealed Resident #13		building and on the fourth by	-	
	• • •	ired, had physical and verbal		fence with a key pad gate.	he window	
		rs (1 - 3 days during the 7		for room 319 was checked b	•	
	• • •), and had wandering uring the 7 day look back		on 2/25/17 and it did not ope six inches.	en more than	
		3 required limited assistance		Six Inches.		
		/e assistance for walking		Nurse #7 notified Resident #	13	
	•	ir and walker according to		responsible party on 2/25/17	at 1:20pm	
	the MDS.			and physician on 2/25/17 at		
	Daview of the Elemen			regarding Resident #13 exiti		
		nent Risk Assessment dated sident #13 was at high risk		physical assessment followir and plan for increased monit	-	
	for elopement.	sident #15 was at high hisk		new physician's orders were	•	
	•	ian ' s Orders from 1/27/17		incident report was complete		
	through 2/25/17 revea			#7 on 2/25/17. Nurse #7 not		
	÷ .	ctronic bracelet typically		and Administrator of the eve	nt on 2/25/17	
		wrist or ankle, which would alarm or lock when the		at approx. 1:00pm.		
		programmed distance of the		Corrective action accomplish	ed for those	
	door.)			residents having the potentia		
	,			affected by the deficient prac		
		PM Nursing Note revealed				
		to self, very determined to		It was determined on 2/27/1	-	
		istance, agitated that he is o home, has tried to call his		IDT ADHOC QAPI meeting t resident had been able to op		
		nes with no answer noted."		window past the existing win		
				screw and was able to exit the		
		R (Situation, Background,		open window. Maintenance	was called on	
		mendation) Note revealed		2/25/17 at approx. 1:00pm to	-	
		oming up to nurses station beginning of shift wanting to		arrived within a half hour and secured resident's window, a		
		become more agitated at		conducted an audit of all win		
	11:45 PM with prn (as			secure unit to ensure that the		
	anti-anxiety medication	on 0.5 mg (milligrams).		secure. Several other windo	ws were	
		o come to nurses (sic)		found not secured when che	-	
	-	continued. No effect noted		nurse. The maintenance as		
		later. Began to wander in as and verbally abusive to		new window stopper screws verified that they opened no		

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C
		345115	B. WING		05/06/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		335 STATESVILLE BOULEVARD SALISBURY, NC 28144	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323	Continued From page	83	F 323		
	staff."			inches.	
	care for Resident #13 risk related to dement time included: assess	ed 2/17/17 revealed a plan of in regards to his elopement tia. Interventions at that s for fall risk, observe for ss, offer emotional and		On 2/27/17 Maintenance Director a Administrator rechecked all window the secure unit to ensure they were secure.	/s in
	psychological support environment and reor resident as needed.	t, orient resident to ient/validate and redirect		Post event on 2/25/17 at approx. 1: the nurse on duty conducted a hear of all residents on the secure unit a ensured all residents were present	d count nd
	"resident is frequently combative with care." desk, then went up ha when housekeeping of resident was crossing staff out to assist resid (sic) became combati and hitting them, sittir assisted him to stand away causing a skin to	"Resident was at nursing allway toward his room, came and notified staff that the road at side of facility, dent back in facility, staff ve, picking up sticks etc. ng on buttocks, when staff ing resident pulled hand ear to left hand."		A review identifying residents that h exit seeking behaviors was conduct the entire facility on 5/6/17 to ensure they have an elopement risk assess and care plan to address their beha and providing supervision to make they are safe. This review was com by the District Director of Care Management. Any discrepancies w corrected on 5/6/17.	ted for e that sment aviors sure npleted
	"due to recent happer to room 319 where if will be within perimete notified." Review of the Quarter revealed every 15 min Resident #13 were in 2/25/17 when he was ground." At 12:45 PM	r Hour Monitoring Tool nute observations for itiated at 12:30 PM on observed "sitting on the		On 5/4/17 the Maintenance Director re-checked all windows on the secu- and documented on window check On 5/6/17 the Maintenance Director Rehab Director, Administrator and Housekeeping secured all windows 100 and 200 halls to ensure that the could not open past six inches.	ure unit log. r, District s on the
	Review of an Incident elopement incident in	/Accident Report for the volving Resident #13 occurred on 2/25/17 at		Measures put into place or systemi changes made to ensure that the d practice will not occur: Nursing staff working on 5/4/17 wer	eficient

Facility ID: 953007

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/08/2017 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DA COM	TE SURVEY MPLETED
		345115	B. WING				R-C 5/06/2017
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				6	35 STATESVILLE BOULEVARD		
BRIAN CT	RIAN CTR HEALTH & REHAB/SALISBURY			s	SALISBURY, NC 28144		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page	e 84	F	323			
	revealed: "crawled o side road attempting became combative w him back inside facilit obtained skin tear. A tear was on the top o The treatments listed motion and skin treat indicated the Respon 1:20 PM and that the 1:30 PM. According to www.wu temperature on 2/25/ was located in, was a Fahrenheit (F) and a mean of 61 degrees I An Elopement Risk A for Resident #13 on 2	ut of window of 306 crossed to leave (without) assistance then staff attempted to assist ty jerked hand away and a diagram indicated the skin f Resident #13 ' s left hand. were body check, range of ment. The report also sible Party was notified at physician was notified at underground.com the 17, in the area the facility a high of 77 degrees low of 45 degrees F with a		523	 educated by the Area Staff Developm Coordinator that were currently in the facility and completed phone education those not presently in facility. No state members who have not received the education will work on the unit until the complete the education. All new hire also receive this education. Education includes the facility policy the elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with exit see behavior and intervention strategies. Education was conducted by District Director of Clinical Services with the Maintenance staff on 5/6/17 regarding expectations for monitoring the window and immediately addressing any ider issues with the window stoppers not effective. 	e on for ff ney s will for nd king g pws ntified	
	dated 2/25/17 revealed toward room then war road at building side, back inside building," climb tree, sat down, standing position resi causing skin tear to le Recommendations au following was written maintenance fixed wi room change, freque Review of the facility Improvement Project	nd New Interventions the "head count census, ndows - window stopper, nt checks."			 Windows in resident rooms will be checked three times week by the Maintenance Director, Maintenance Assistant, or Manager on Duty to vali stoppers are in place and are working properly. Any opportunities will be corrected as identified. The Director of Nursing will review residents at risk for elopement weekl 12 weeks to ensure interventions are place. Residents exhibiting new behaviors of wandering or exit seekir be reviewed to ensure the elopement assessment is accurate and interven have been implemented. Any 	g ⊨in ng will t	

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SUR COMPLETE		
		345115	B. WING			R-C 05/06/2017		
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 35 STATESVILLE BOULEVARD	<u> </u>		
BRIANO				S	ALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 323	hall: Root Cause ide able to open his wind slide window and exit Investigation was cor (Interdisciplinary Tear resident was able to p screws securing the w Projected Outcome w windows will be secu- can open past 6 inche plan included the follo listed as being compl placed on checks ever moved to room with a courtyard (courtyard windows secured to r Review of the Quarte 2/26/17 resident ' s w documented every 15 Resident #13 was no 8:15 PM and again at were documented in the resident ' s locatio and through the night On 2/26/17 a care pla following new interve room change." Review of the Quarte 2/27/17 revealed ther the resident ' s where 2/2717 until 2:00 PM Further review of the Improvement Plan for revealed the following being completed 2/27	ntification - "resident was low and then was able to a through opening. mpleted by the IDT m), it was believed that the push the window past the window for safety." Under vas the following: "all red to ensure no residents es." Action items for the boxing actions that were eted 2/25/17: resident a window that faced a was enclosed on 4 sides), not open past 6 inches. rr Hour Monitoring Tool for thereabouts were 5 minutes. In addition ted to be exit seeking at t 8:30 PM. No interventions the medical record however on was in bed from 9:00 PM t. an update revealed the ntions "window stopper, ar Hour Monitoring Tool for the was no documentation of the was no documentation of the abouts from 6:00 AM on	F	323	opportunities will be corrected as identified. Monitoring Process: The Administrator will report on windor monitoring and Director of Nursing will report on elopement assessment monitoring weekly for 12 weeks during QAPI meeting then monthly thereafter The committee will review these result and make recommendations as requir	the .s		

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	hall and a Quality Ass Improvement (QAPI) review the plan with the the elopement process started 2/25/17 but the available was for 2/27 Maintenance would be window checks and the check windows on weet Review of an in service 2/27/17 revealed that an in service on Elope listed were those that when Resident #13 eff Assistant Director of N listed as the instructor The previous staff meet the time of the incider interviewed 5/5/17 at stated she may have elopement on 2/27/17 remember doing it so whether the in service seeking behaviors an she was off work 2/25 did not find out about returned to work on 2 that if she did an in-se until 2/27/17. Review of the Quarter 2/28/17 revealed ther the resident 's where 2/28/17 until 7:30 AM 1:00 PM on 2/28/15 the	surance Performance meeting was held 2/27/17 to he team. Re-education on as was indicated as having e only sign-in sheet 7/17. The Plan also revealed e completing monthly nat the Administrator would eekly rounds. the Administrator would eekly rounds. the Attendance Form dated 22 staff members received ement. None of the staff had worked on 300 hall loped. The previous Nursing (ADON #1) was r.	F	323			

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		SURVEY PLETED -C
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			335 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	3/1/17 revealed there the resident 's where 3/1/17 until 2:00 PM of Review of the Quarte 3/2/17 revealed Resid documented every 15 documentation conclu and there were no fur Monitoring Tools for th On 3/3/17 the Physici order for "Wandergua elopement risk, check every shift." Review of the Care P the plan of care for el with the following inte upper extremity for el placement and function Further review of the update to the elopem 3/21/17 with the inter- replaced." An Elopement Risk A for Resident #13 on 3 assessed as having a On 3/22/17 the Physic order for "change Wa elopement risk." Review of the Progress from 3/3/17 through 5	was no documentation of abouts from 6:00 AM on on 3/1/17. r hour monitoring tool for dent #13 ' s location was 5 minutes. The uded at 2:15 PM on 3/2/17 ther Quarter Hour his resident. an ' s Orders revealed an trd to upper extremity for c placement and function lan revealed that on 3/3/17 opement risk was updated rvention: Wanderguard to opement risk, check on q (every) shift." Care Plan revealed another ent risk plan of care on vention "Wanderguard ssessment was completed 4/22/17 and he was again a high elopement risk. cian ' s Orders revealed an nderguard every 90 days for ss notes and Incident Log 4/17 revealed no concerns or incidents t ' s Wanderguard.	F	323			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA				IO. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	` <i>'</i>		· · ·	IE SURVEY MPLETED		
			A. BUILDIN	G				
		345115	B. WING			R-C		
		545115				5/06/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE			
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		635 STATESVILLE BOULEVARD				
				SALISBURY, NC 28144				
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 323	Continued From page	<u>- 88</u>	F 3	22				
1 020			Г J.	23				
		. He was sitting in his						
		e window and adjusting the						
	0	s on the heating unit under sked how he was he said						
		o home." When asked how						
	• •	t the facility he indicated he						
	. .	only been there one day.						
	-	he resident was noted to						
		bugh the sliding window						
		window from opening more						
	· · ·	he window looked out onto						
	an enclosed courtyar							
	an enclosed courtyar	u.						
	Telephone interview	with Housekeeping Aide #1						
		11:40 AM revealed that she						
		cility anymore but recalled						
		nt that occurred on 2/25/17.						
		ad gone outside through the						
		dry room to place dirty						
		bin for pick up. The door she						
		left side of the building (when						
		nce). She added that						
	-	n the apartments, which						
	were located on the b	back side of the building,						
	came by and told her	that one of the residents						
	came out a window.	HA #1 indicated she did not						
	•	on for the informant and						
		identify her. HA #1 said						
		could see Resident #13						
		I on the other side of the						
		an next to the left side of the						
	-	e apartments. She added						
		on the hill and a fence at the						
	-	then went over to where the						
		ed him to go back into the						
	-	Resident #13 told her he did						
	-	The Housekeeping Aide						
		e talkie with her at the time of						

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 MAPPROVED D: 0938-0391	
STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345115	B. WING			R-C 05/06/2017		
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				6	35 STATESVILLE BOULEVARD			
BRIANCI	R HEALTH & REHAB/SA	LISBURY		s	ALISBURY, NC 28144			
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	housekeeping staff ha she could only reach device. HA #1 said th help but they were un #13 to go back inside help. The Manager of Assistant came out to the facility. She said walk back into the face him into a wheelchair asked who it was that she could not recall. it took about 20 - 30 r able to get the reside Telephone Interview v 3:45 PM, revealed that elopement incident th She said that day was worked on the locked knew it was a locked windows opened." Si was a lot of windows with residents who ne behaviors like exit set she found out a residu unit when a housekee "you let someone get indicated her respons ' s when she was told said that the Manager Assistant (Medication resident. Nurse #7 sa to determine how a re stated that while she	p. She stated that only the ad these walkie talkies so other housekeepers with the at 3 housekeepers came to hable to convince Resident so one of them left to get on Duty and a Nursing o assist the resident back in Resident #13 would not cility but they eventually got and took him inside. When t brought the wheelchair out HA #1 said she thought that ninutes before they were nt back inside the facility. with Nurse #7 on 5/4/17, at at she recalled the lat occurred on 2/25/17. s the first time she had unit (300 hall) and added "I unit, no one told me the he further said she thought it to monitor on a locked unit eeded supervision for eking. Nurse #7 said that ent was missing from the eping person came and said off the unit." Nurse #7 se was "no I didn ' t" and that someone was outside. She r on Duty and the Nursing Aide #2) went out to get the aid that she proceeded to try esident got off the unit. She	F	323				
	he showed her the wi	ndow that was wide open in stated that she then tried all						

Facility ID: 953007

If continuation sheet Page 90 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN C	IR HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	the other resident roo found about 20 that o she called the Director was told to call the Mi #2 and ADON #1 wer facility at the time of t the Maintenance Assi 30 minutes after she Director and that she where the windows ca that the MA said he w she went behind him checked herself as w brought back to the u assessment and also had a window that did addition this room's w that enclosed on 3 sid the 4th side by a 6 for gate. On 5/4/17 at 2:00 PM (MA) was interviewed Maintenance Director go the facility and ma windows on 300 hall a elopements. He said window in Room # 30 it, the window opened difficulty. He stated the Room #306 by insertive Window track to stop He also said that he p in the other windows Observation of the window	m windows on the unit and pened. The Nurse said that or of Nursing (DON #2) and of Nursing (ADON #1) and aintenance Director (DON re no longer employed at the he investigation). She said istant (MA) showed up about called the Maintenance gave him a list of the rooms bould open. Nurse #7 added vould fix them and she said when he was done and ell. When Resident #13 was nit she did a physical moved him to a room that d not open (Room 319). In vindow faced a courtyard des by the building and on ot fence and keypad locked I the Maintenance Assistant I. The MA said that the realled him and told him to ke adjustments to the as needed to prevent Nurse #7 showed him the 16 and when he tried to open d all the way without that he fixed the window in ng a screw in the sliding the window from opening. but window stopper screws on the unit well.	F	323			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CI	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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) COMPLETION DATE
F 323	windows had one stat right side of the window window panel on the open the window the functioning, would slite of the fixed window pa following windows rev Room #306 (on 300 h room with the window through) - There was drilled strait down ver at approximately 6 ind the sliding window pa track edges and appe window could slide ow new looking screws d track right up beside t screws prevented the The window faced a s Room #319 (on 300 h room Resident #13 w immediately following one old looking screw window track at appro- from the sliding windo track edges and appe window could not slid there was a shiny new screwed horizontally t track 4-6 inches away window panel. This w which was enclosed of and on the 4th side by pad locked gate. Room #329 (on 300 h Resident #13 ' s room	tionary window panel on the ow and there was a sliding left side of the window. To sliding window panel, when de towards the right, in front anel. Observations of the yealed: nall/the locked unit and the y that Resident #13 eloped one old looking screw tically into the window track ches away from the right of anel; it was lower than the eared as if the sliding yer top. There were 3 shiny, Irilled down into the window the sliding window. These window from opening at all. side access road.	F	323			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 323	down vertically into the approximately 6 inchese window. This screw we edges and appeared could slide over top. looking screws that we through the sliding window panel inches away from the panel. The M Dir atter and was able to open The windows for Root their neighboring room from the outside of the Mechanisms for secu- outside were not evid On 5/4/17 at 2:15 PM Dir, he stated he had windows in the past p them on 2/27/17 after monthly since then. He had always been chee- electronic log for the of checks on the window system. He indicated for window checks he 2/25/17 elopement, if also indicated that, ew incident on 2/25/17, the windows to either not more than 6 inches for window checks prior to were provided during During interview on 5.	e window track es away from the sliding was lower than the track as if the sliding window There were two shiny, new ere screwed horizontally ndow track, one at es away from the right of the and one at approximately 4 right of the sliding window empted to open the window it approximately 2 inches. m # 319, 329 and #306 and n windows were observed e facility as well. ring the windows from the ent at this time. during interview with the M checked the 300 hall eriodically but had checked the elopement incident and de noted that the exit doors cked daily, and he had an door checks, but said vs were not in that electronic that he would provide logs had done, before the he could locate any. He ven before the elopement ne expectation was for the open at all or to open no or ventilation. No logs for to the 2/25/27 elopement	F	323			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345115	B. WING		_		-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
				35 STATESVILLE BOULE	VARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	was on 100 hall on 2/ Aide told her that a re- the building. She said Housekeeping Aide it asked the HA if some she said yes so the M and told the Nursing A #2) that she needed h was outside. The MR outside she saw Resi hill across the access a tree limb and told the in and he started swin stated she did not ren wheelchair outside an while but eventually the the wheelchair and to Resident #13 was bac contacted the Mainter Administrator and the #2) but said they were reached them. She ac conducted a head cou residents were accou On 5/4/17 at 5:00 PM (MA) was re-interview not recall Nurse #7 gi that could be opened. window in Room #306 to open before insertin The MA added that he the windows did not op through the sliding win would not open more He then checked eacd	2/25/17, she said that she 25/17 when a Housekeeping sident got out to the side of d she did not recall which was. The MRD said she one was the resident and IRD then went to 300 hall Assistant (Medication Aide help getting a resident that RD stated that when she got dent #13 at the start of treed road. She said he grabbed hem he was not going back highing sticks. The MRD member who brought a hid added that it took quite a hey talked him to getting in ok him inside. Once ck in the building she hance Director, the Director of Nursing (DON e already aware when she dded that she also unt to ensure all the	F 323				
	He then checked each screws were inserted	h window after the stopper					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345115	B. WING		_		-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULE SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	room windows on 300 map revealed there w 300 hall. On 5/5/17 at 10:10 All was observed with the the Regional Nurse C Assistant removed all added after the 2/25/1 There was a small 1/4 vertically into the slidii dull appearance comp that were removed. acknowledged the on only one that had bee This screw was not re place. The sliding wir prevented intrusion the outside the facility wh Maintenance Assistan latch was manually di then was able to movial the way to the right fixed window panel, w window fully open the foot wide by 4 foot hig exit through. The win 3 feet from the ground	topper in all the resident o hall. Review of a facility were 35 resident rooms on M the window to Room #306 e Maintenance Assistant and onsultant. The Maintenance the screws that had been 17 elopement incident. inch hex head screw driven ng window track that had a bared to the shiny screws The Maintenance Assistant e dull sheen screw was the en present prior to 2/25/17. emoved and remained in hodow panel had a latch that prough the window from	F 32		DEFICIENCY)		
	open. A similar demonstration window in Room #310 #306 was secured. T more difficulty when the removed, two hands of	ked to ensure it did not on was conducted with the D after the window in Room his window opened with he new screws were were required and it had to orth some, but it did open all					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345115	B. WING				-C /06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 323	the way. Similar to R previously existing he driven vertically in the screw was not remove and did not prevent the it. The removed scree the demonstration and to ensure it did not op On 5/5/17 at 12:40 Pl worked at the facility) telephone. She state member at the facility out about the elopem on the Monday, 2/27/ have done some in-se nursing staff on 2/17/ but she could not reca Elopement incident pr included elopement ri behaviors and interved did investigate the ind show her where Resi ADON #1 also said th determine how long F the unit before he was On 5/5/17 at 4:13 PM re-interviewed by tele could not recall how r the unit that day. She Housekeeping Aide (I residents was outside help and she stayed B residents. She stated	oom #306 this window had a ex head screw that was e sliding window track. This ed during the demonstration he window from sliding over ws were replaced following d the window was checked ben. MADON #1 (who no longer was interviewed by d that she had been a staff on 2/25/17 but did not find ent until she came into work 17. She stated that she may ervice education with the 17 in regards to elopement all if the content was just on oblicy and procedure or if it sk factors, exit seeking entions. She said that she cident and asked staff to dent #13 was located. hat she was unable to Resident #13 was gone from s located outside. a Nurse #7 was phone. She stated she nany NA ' s were working on e said that when the HA) told her one of their e the other staff went out to behind by herself with the d that Resident #13 had	F	323			

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	S FOR MEDICARE &					0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMF	PLETED
			A. BOILDING		R	-C
		345115	B. WING			06/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/2017
				635 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/S/	ALISBURY		SALISBURY, NC 28144		
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC		(X5) COMPLETIO
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	DATE
F 323	Continued From pag	e 96	F 32	23		
		then he wheeled down the				
	hall towards his roon					
		cation regarding elopement or				
	exit seeking since th					
		Assignment sheet for 2/25/17				
	-	sistant #2 and #3 (NA #2, NA				
		ed NA 's for the hall on				
		ent #13 eloped. NA #2 and				
		lable for interview during the				
		t be contacted when an m by telephone was made.				
	allempt to reach the	in by telephone was made.				
	On 5/5/17 at 5:30 PM	A Nursing Assistant #1 was				
		She stated she was not one				
	· · · ·	working during the shift that				
		l but she was familiar with				
	him. She stated that	t it was unusual for Resident				
		the window and that she was				
		ng to do so prior to the				
		She stated that his exit				
	behaviors had focus					
		ng home. She said that once				
	•	he was going he was pretty				
		nes he gathered his clothes and said someone was				
	coming to pick him u					
	• .	o work for Resident #13 as				
		kit seeking. NA #1 said she				
		I shift (2:00 PM - 10:00 PM)				
	•	I to go home she would say				
	-	tch TV and wait for your ride.				
		ching television for a while				
		eventually get tired and say				
	-	ed. NA#1 also said prior to				
		idea any of the windows on				
	the unit could open.	She added that she had				
		l just assumed they were				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345115	B. WING				-C 06/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CT	R HEALTH & REHAB/SA	LISBURY							
(X4) ID PREFIX TAG	(EACH DEFICIENC				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 323	Continued From page	97	F	323					
	asked if the facility ha the 100 and 200 half of inches, given that the known high elopemer They indicated they w sure. On 5/6/17 at 1:30 PM #13 was found was o Records Director (MF the resident back insi from the window of R the access road, whe #13 was found when with a rolling distance Maintenance Director was 43 feet. On 5/6/17 at 1:45 PM was observed. The w sliders that opened by up in front of the top s than opening by slidir the windows on 300 h screw noted on the sl left hand side, approx bottom window. The not impeded by the p somewhat difficult to hands and rocking ba to be opened approxi The windows were ap the window sill was an ground.	orate Vice President were id ensured the windows on did not open more than 6 re were residents with nt risk on those units as well. yould need to verify to be the location where Resident bserved with the Medical RD) who had helped bring de on 2/25/17. The distance oom #306 to the spot across re the MRD said Resident he eloped, was measured							

						O. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BOILDING			R-C
		345115	B. WING			5/06/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				635 STATESVILLE BOULEVARD		
BRIAN CI	R HEALTH & REHAB/S/	ALISBURY		SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From pag	e 98	F 32	23		
		indicated she had tried to				
		lows on 100/200 halls and				
		n it with some difficulty that age of the windows. She				
		ere already working to				
	•	ad 200 hall windows with				
	window stoppers.					
		A Medication Aide #2 (Med				
		ewed and said she recalled ent on 2/25/17. Med Aide #2				
	-	e resident at and after				
		He had been roaming around				
	-	m and seemed like his				
		d that he talked about his				
		lo that on a normal basis.				
		ed Resident #13 would come e next flight was and that he				
		led to get on the next flight.				
		s baseline but that he was				
	not talking about actu	ually leaving that morning,				
		ane. She stated that when				
		eding to take a flight she				
		y saying there were no flights I they would get him on that				
		hat she found this effective				
		#2 stated that the last time				
		3, prior to him eloping, was				
	around noon when s	-				
		le #2 stated he was either in				
		n, she could not remember. Diserved at this time with the				
		boom. He did not have a				
		wrist/upper extremity but the				
	Med Aide located it c					
	During this interview	on 5/6/17 at 1:57 PM with				
	-	UT JUTT AL 1.37 FIVEWILLE				
	Med Aide #2 she sta	ted that she was at the nurse				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345115	B. WING				-C 06/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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) COMPLETION DATE
F 323	the residents went ou she then went outside (Medical Records Dir Nursing Assistants on the Dining Room at the outside she said she the side street in the f he had sticks and "wa us." He said he was was across the fence top of the bushy, tree bottom. She stated th 20 minutes, to get Re finally got the residen 12:45 PM. On 5/6/17 at 4:00 PM Services # 1 reported and 200 hall windows The 5/4/17 the Admin Immediate Jeopardy a Administrator provide allegation of complian Resident #13 was ad Salisbury on 1/27/17, Unit. Resident #13 was for elopement on 1/27 pm on 2/25/17, Resid of the facility after a fa facility neighbor. Resi window, across the di between facility and m buildings. Was return Manager on Duty and	t a window. She said that e with the Manager on Duty ector). She thought the unit in the hall may have been in he time. When they got saw Resident #13 across bushes trying to climb a tree; as trying to swing them at going to get his plane that . There was a fence at the d hill, and he was near the hat it took a while, possibly sident #13 inside but they t back in the facility around the Director of Clinical that the securing of the 100 shad been completed. istrator was notified of at 5:35 PM. The d the following credible nee on 5/6/17 at 2:00 PM. mitted to Brian Center to room 306 in the Secure as assessed as being at risk 7/17. At approximately 1:00 ent #13 was found outside acility staff was alerted by a dent was found 43 feet from riveway outside facility neighboring apartment ed to the facility by the	F	323			

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	MENT OF HEALTH AN S FOR MEDICARE & I		FORM APPROVED OMB NO. 0938-0391						
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		LE CONSTRUCTION	(X3) DATE			
						R	-C		
		345115	B. WING			05/	06/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CI	R HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
F 323	Nurse #7 immediately to Toe Assessment of injury of a skin tear no injury occurred, due to updated Elopement A for Resident #13 on 2 reviewed and updated include "Window stop Nurse #7 initiated inco Resident #13 on 2/25 minute checks to mor checks were complete and documented on t Charge Nurse for 72 I No evidence that resid during this time. Resident #13 was more where the window exi on 3 sides by the built foot fence with key par room 319 was checked and it did not open more Nurse #7 notified Res Party on 2/25/17 at 1: 2/25/17 at 1:30 pm, re exiting the facility, phy the event and plan foo new Physician ' s Ord Incident report was co 2/25/17. Nurse #7 not Administrator of the e approximately 1:00 pm It was determined on ADHOC QAPI meetin	 2/25/17 completed a Head Resident #13 with minor bed, unknown where/how bed by the DON #2 on 3/6 to ber and room change." reased supervision for 7/17 to include every 15 bed by the Nursing Assistants bed on room 319 on 2/25/17 ted to a courtyard enclosed ding and on the 4th by a 6 ad gate. The window for bed by the nurse on 2/25/17 bed by the nurse on 2/25/17 bed on the atth by a 6 ad gate. The window for bed by the nurse on 2/25/17 bed on the 4th by a 6 ad gate. The window for bed by the nurse on 2/25/17 bed by th	F	320					

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP		
		345115	B. WING				06/2017	
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>		
BRIAN CI	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144			
(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 323	through the open wind called on 2/25/17 at a facility and arrived with immediately secured conducted an audit of to ensure that they we windows were found b by the nurse, the main new window stopper at they opened no more On 2/27/2017 Maintel Administrator recheck secure unit to ensure Post event on 2/25/17 the nurse on duty cor residents on the secur residents on the secur residents were present On 5/4/17 The Mainte all windows on 300 U secure. Staff were re-educated the Area Staff Develo shall work until re-edu 2/27/17 there was edu staff who worked that #1. Nursing staff wor by the Area Staff Dev were currently in the fe education for those no staff members who has education will work or the education. Educated Procedure when there suspected elopement	dow. Maintenance was approximately 1:00 pm to thin a half hour and resident ' s window, and f all windows in secure unit ere secure, several other not secured when checked intenance assistant put in screws and then verified that than 6 inches. nance Director and ked all windows in the they were secure. 7 at approximately 1:00 pm inducted a head count of all ire unit and ensured all int and accounted for. enance Director re-checked nit, and found them all to be ed on Elopement Process by pment Coordinator, no staff ucated on process On ucation done with Nursing today, conducted by ADON king 5/4/17 were educated elopment Coordinator that facility and completed phone of presently in facility. No ave not received the in the unit until they complete ation includes Policy e is an Elopement or	F	323				

Facility ID: 953007

If continuation sheet Page 102 of 130

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		345115	B. WING				06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 323	exit seeking behavior All new hires will also Education was condu Clinical Services with and Maintenance Dire expectations for moni immediately addressi the window stoppers A review identifying re seeking behaviors wa facility on 5/6/17 to e elopement risk asses address their behavior to make sure they are completed by the Dist Management. Any di on 5/6/2017. To the knowledge of R Resident #13 has had exiting the facility with 2/25/17, nor was then Resident #13 exiting the mindow. All windows on the se Maintenance staff on checked by the Maint Administrator on 2/27 randomly check the w during facility rounds, be corrected immedia the Administrator met Root Cause Analysis	and intervention strategies. receive this education. inceed by District Director of the Maintenance Assistant ector on 5/6/17 regarding itoring the windows and ing any identified issues with not being effective. esidents that have exit as conducted for the entire insure that they have an isment and care plan to ors and providing supervision e safe. This review was trict Director of Care screpancies were corrected Facility Staff and Leadership, d no other instances of nout supervision since e any prior incident of the facility through a ecure unit were checked by 2/25/17 and were double enance Director and 717. The Administrator will vindows on the secure unit Opportunities identified will ately. On Monday 2/27/17 with the IDT team to review for this event, it was esident had been able to t the existing window	F	323			

Facility ID: 953007

If continuation sheet Page 103 of 130

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	_	(X3) DATE COMP	SURVEY LETED
		345115	B. WING				-C 06/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	, STATE, ZIP CODE	-	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		635 STATESVILLE BOU SALISBURY, NC 281			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page		F 32	23			
	was put into motion o On 5/4/17 the Mainter all windows on the Se	nance Director re-checked ecure Unit and documented					
	Director, Administrato Housekeeping secure	nance Director, Rehab					
	A validation of the cre	dible allegation was at 6:00 PM by the following:					
	facility on 300 hall positive sign in sheet						
	with multiple licensed staff to verify their uno						
	interview with the Mai Maintenance Director of the education they						
	issues immediately, re elopement risk reside elopement risk care p	ws and fixing any identified eview of care plans for high nts to verify they had an lan in place, review of the s information and photos					
	binder to ensure all re high risk for elopemen binder, 100 percent a	esidents assessed as being nt were included in the udit of all windows on 300					
	resident rooms on 30	dows were secured (all 35 0 hall) and an audit of 0 and 200 hall to verify the 1 more than 6 inches.					
F 490	483.70 EFFECTIVE		F 49	00			6/7/17

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345115	B. WING		R-C 05/06/2017
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
				635 STATESVILLE BOULEVARD	
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		SALISBURY, NC 28144	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 490 SS=J	483.70 Administration	ESIDENT WELL-BEING	F 490		
	enables it to use its re efficiently to attain or practicable physical, it well-being of each res This REQUIREMENT by: Based on observatio Health Care staff, phy interviews, and facility record reviews, the ac provide oversight to p impaired residents, w elopement risk, (Resi locked unit and failed in place to identify that building that could be a resident to elope th provide oversight and Social Worker on a fu effective discharge pl for the safe discharge (Residents #9) dischar Immediate jeopardy the Resident #13 was ab through a resident roo to open. The facility of systems in place to e facility did not open. to his home without h and addressed to ens	esources effectively and maintain the highest mental, and psychosocial sident. is not met as evidenced ns, facility staff, Home ysician, family and resident y and hospital medical dministration: 1) failed to prevent 1 of 4 cognitively ho were assessed as a high dent #13) from exiting a to have monitoring systems at there were windows in the opened sufficiently to allow rough them; and, 2) failed to I leadership to retain a all-time basis, implement an anning process, and provide e of one sampled resident arged to his home. Degan on 2/25/17 for Resident #9 on 4/1/17. Ie to exit a locked unit om window that he was able did not have monitoring nsure the windows in the Resident #9 was discharged is needs being identified sure a safe discharge from		F 490 Corrective action accomplished for the residents found to have been affected the deficient practice (A): Resident #9 was discharged to his he from Brian Center Health and Rehabilitation/Salisbury on 4/1/17. Resident #9 required home health services for nursing, oxygen, suction machine, and supplies to manage tracheostomy care at home. The Fac Administrator completed a referral to home health agency on 3/28/17, prio discharge from the facility. Home he agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated w facility management for follow up. The nurse received education form the Ar Staff Development Coordinator regar discharge policy and procedure on 500 The oxygen provider delivered oxygen No arrangements for DME was confi	d by cility the r to alth s vith nis rea rding /5/17. en.
	the facility. The resid multiple co-morbiditie	ent had a tracheostomy and s (chronic conditions). The a accepted by a Home		No arrangements for DME was confil prior to discharge. Resident #9 was returned to facility by his family on 4/	rmed

Facility ID: 953007

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/08/201 [°] RM APPROVEI IO. 0938-039 [°]
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345115	B. WING				R-C 5/06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	0,00,2011
				63	35 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		S	ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From page	a 105		490			
1 100				490	was assessed and determined need	for	
		o receive assistance with his oon discharge, as he had			was assessed and determined need his care for his tracheostomy, due to	01	
		ent did not have the training			drainage and odor, was sent to ER for	r	
		e tracheostomy care on his			eval and returned to facility where he		
		urned to the facility on 4/6/17			readmitted to Brian Center Health an		
	and was immediately	•			Rehabilitation/Salisbury on 4/6/17, ar		
	Emergency Departm	ent (ED) for an evaluation			treated for infection. Resident #9 ren	nains	
	and treatment of the	tracheostomy. He was			a current resident. At time of dischar	ge	
		cellulitis and prescribed both			there was no validation of home hear		
	-	ntibiotic. He was released			admitting resident, no confirmation of		
	-	and re-admitted to the			DME, and no documented education		
	facility on 4/6/17.				related to signs and symptoms of		
	Immediate Jeanardy	for both Docident #12 and			problems, what care was necessary t		
		for both Resident #13 and ed at 6:00 PM on 5/6/17			maintain stable health, and conseque for not providing this care, for the res		
		cceptable credible allegation			and his family/caregiver.	uent	
		23 and F490 were verified.					
	-	n out of compliance at a			Section Q of the MDS was completed	l for	
	-	evel D (no actual harm with			Resident #9 on 4/13/17 and indicated		
		an minimal harm that is not			resident expects to remain at the faci	lity.	
	immediate jeopardy)	for the facility to complete					
	-	nsure monitoring systems			Throughout the discharge planning		
	put into place are effe	ective.			process for Resident #9 the facility w	as	
		1.			without a Qualified Social Worker.	-4	
	The findings included	1:			Facility's full time Social Service Direct	ctor	
	This citation is areas	referenced to:			resigned without notice on 1/26/17.		
	This citation is cross-				Facility went without a qualified Socia Worker from 1/26/17 until a Qualified		
	F323 - Based on obs	ervation, record review and			Social Worker was retained on 3/30/		
		cility failed to prevent 1 of 4			Qualified Social Worker remains		
	cognitively impaired i				employed. The Administrator had an		
		elopement risk, (Resident			active role in the discharge		
		cked unit and failed to			process/planning for Resident #9.		
		re windows in the building			-		
		sufficiently to allow a			The nurse managers conducted an a		
		ough them. Resident #13			of residents who have discharged for		
		m window then walked 43			the facility since 4/1/17 to validate ea		
	feet and across the a				resident received sufficient preparation	n	
	neighboring apartme	nt complex; this access road			and orientation to ensure a safe and		

Facility ID: 953007

If continuation sheet Page 106 of 130

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/2017 RM APPROVED IO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED	
		345115	B. WING		R-C 05/06/2017		
NAME OF P	ROVIDER OR SUPPLIER	I	- -	STREET ADDRESS, CITY, STATE, ZIP CODE			
				635 STATESVILLE BOULEVARD			
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		SALISBURY, NC 28144			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	that Resident #13 had had seen Resident #7 Resident #13 was loo base of a treed hill or road. Resident #13 st the incident. F204 - Based on obse Health Care staff, phy interviews, and facility record reviews, the fa Health assistance for tracheostomy, resident training on tracheostor tracheostomy supplie resident (Resident #9 from the facility with a resulted in a lack of tr discharge; and, the re diagnosed with neck with antibiotics. F251 Based on facili staff, physician, resid and facility failed to re qualified Social Work assume responsibility discharge planning, ir Health assistance for tracheostomy, resident training on tracheostor tracheostomy supplie sampled resident (Re discharged home from tracheostomy and resident (Re	r. Facility staff were notified d eloped by a neighbor who 13 exit the window. When sated by staff he was at the n the other side of the access sustained a skin tear during ervations, facility staff, Home ysician, resident and family y and hospital medical acility failed to arrange Home the care of a resident 's nt and/or care provider omy care, and access to is for 1 of 1 sampled by who was discharged home a tracheostomy. This racheostomy care after esident was subsequently cellulitis requiring treatment lity staff, Home Health Care ent and family interviews, tal medical record reviews, tain the services of a er on a full-time basis to v for the coordination of ncluding arranging Home the care of a resident 's nt and/or care provider omy care, and access to s. This occurred for 1 of 1 esident #9) who was m the facility with a sulted in a lack of	F 4	 orderly discharge. This was vareviewing the resident record for documentation of coordination care services and by conducting interviews with the resident or the responsible party to validate surdischarge. This audit was com 5/5/17. The results of this meeting and were shared with the Facility M Director on 5/5/17 and he was agreement. The Area Staff Development Corcompleted re-education of all lignurses and members of the Interdisciplinary Team involved discharge planning on 5/5/17. education included the Administ Director of Nursing, Nurse Mana Social Services Director, Thera Program Manager, Dietary Ser Manager, Resident Care Mana Director (MDS Nurse), Business Director and Physician. This education includes the face regarding Transfer and Dischart Procedures as follows: Post Discharge Plan of Care: Upon admission the IDT me consultation with the resident a resident's legal representative or practicable), develops the resident 	or of home ig phone their inccessful pleted by QA plan edical in oordinator censed in This strator, lagers, ipy vices gement is Office so Office so Office sility policy rge		
		ter discharge. The resident agnosed with neck cellulitis		discharge plan and anticipated discharge.	date of		

Facility ID: 953007

	-	D HUMAN SERVICES				FORM	1 APPROVED
						OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
			A. BUILDI	NG _			-c
		345115	B. WING				-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			635 STATESVILLE BOULEVARD				
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF			(X5)
PREFIX	(PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		IAG		DEFICIENCY)		
F 490	Continued From page	e 107	F4	490			
	and required treatment	nt with antibiotics.					
	•				2. The Social Service Director or		
	F284 Based on facil	ity staff, Home Health Care			designee, the IDT members, and the		
		ent and family interviews,			resident and/or the resident's legal		
	•	al medical record reviews,			representative determine the individual		
	the facility failed to im				needs, resources, and services require		
	discharge planning pr	e needs for 1 of 1 sampled			upon discharge through the IDT care p meeting and process.	lan	
	•) who was discharged home			meeting and process.		
	with a tracheostomy.				3. Social Service Dept. arranges for		
	-	ome Health care assistance,			post-discharge services.		
	resident and/or care p						
		r access to tracheostomy			4. Contact those service agencies who		
		ed in a lack of tracheostomy			can support resident's needs, resource		
	care after discharge.	-			and services upon discharge (e.g., hon	ne	
		cility, the resident was cellulitis requiring treatment			health, durable medical equipment, therapy services, meals, transportation		
	with antibiotics.				etc.).	,	
	with antibiotics.						
	Interview with the Adr	ninistrator on 5/6/17 at 6:04			5. Initiate the discharge paperwork wit	h	
	PM revealed that the	facility did not have a			all IDT members to ensure that the		
	• •	onitoring the windows			resident, the resident's legal		
		known issue. He stated that			representative or receiving provider		
	as far as he knew the				obtains correct and detailed, confidenti	al	
		ncident via the windows and re that any of the windows			and protected health information upon		
	could be opened far e				discharge.		
		aid it was his expectation			The Social Services Director will conta	ct	
	-	Id not open enough to allow			all residents who discharge home withi		
	for elopement.				one week of discharge, two weeks of		
					discharge and at 30 days post discharge	ge	
	-	conducted with the facility 's			to ensure they have all care services		
	Administrator on 5/6/	•			necessary to safely remain in their hon	ne	
		d he should have requested			environment.		
		s be provided until the facility Social Worker on a full-time			The Administrator, Director of Nursing	or	
		hen the position was vacant,			Nursing Manager will review residents		
	-	ough the cracks," including			planned for discharge three times per		
	components of discha				week for 12 weeks to ensure a safe an	d	

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMF	E SURVEY PLETED
		345115	B. WING			05/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA			63	5 STATESVILLE BOULEVARD		
BRIANOT	R HEALTH & REHABIOF			S	ALISBURY, NC 28144		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	e 108	F4	190			
	On 5/6/17 at 10:10 Al Services #1 and Distr Services #2 were info jeopardy for Resident The facility provided a allegation of compliar The credible allegation Resident #9 was disco [Name of Facility] on required Home Health Oxygen, suction mac manage tracheostom Administrator comple Health Agency on 3/2 from the facility. Hor staff nurse prior to dis unable to provide ser information was not co management for follo received education fre Development Coordir Policy and Procedure Provider delivered Ox DME (Durable Medica confirmed prior to dis returned to facility by assessed and determ	M, District Director of Clinical rict Director of Clinical prined of the immediate t #13 and Resident #9. an acceptable credible noce on 5/6/17 at 5:10 PM. on indicated: tharged to his home from 4/1/17. Resident #9 h Services for Nursing, hine, and supplies to y care at home. The Facility ted a referral to the Home 28/2017, prior to discharge me Health Agency informed acharge that they were vice for this resident. This communicated with facility w up. This nurse has om the Areas Staff hator, regarding Discharge e on 5/5/17 The Oxygen kygen. No arrangements for		490	orderly discharge has been planned by meeting with the resident and/or family and completing the Post Discharge Pla of Care, providing a home visit when possible and validating the completion appropriate referrals. The Director of Clinical of Services completed re-education of Administrate and Director of Nursing on 5/5/17. Thi education included facility policy of provision of social work services and s and federal regulations governing long term care facilities with regards to provision of social services. In the absence of the Social Service Director the Administrator will ensure that appropriate and adequate Social Servi support is retained to meet the requirements of regulation. Support w be provided from sister facilities and/or through contract agency support. On 5/4/17, the Administrator, DON, an ADON were retrained on the Quality Assurance & Performance Improveme Program by the Area Staff Development Coordinator. The Quality Assurance Committee consists of: -Administrator	of of state i ice ill r d nt	
	he was readmitted to 4/6/2017, and treated remains a current res there was no validation resident, no confirmation	l for infection. Resident #9 ident. At time of discharge on of Home Health admitting			-Director of Nursing -Dietary Manager -Rehabilitation Manager -Maintenance or Environmental Representative -Activities Director -Social Services Director		
		is, what care was necessary			-Human Resource Designee		

Facility ID: 953007

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	(X3) DATE S	. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPL	
					R-	С
		345115	B. WING		05/0	6/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 490	Continued From page	e 109	F 49	o		
	not providing this can family/ caregiver. Throughout the Disch Resident #9, the Faci Social Worker. Facili Director resigned with Facility went without a from 1/26/2017 until a was retained on 3/30 remains employed. The active role in the disc Resident #9. The Nurse Managers residents who have do since 4/1/17 to valida sufficient preparation safe and orderly disc by reviewing the resid documentation of coo services and by cond the resident or their resident	alth, and consequences of e, for the resident and his harge Planning Process for ility was without a Qualified ities Full Time Social Service hout notice on 1/26/17. a qualified Social Worker a Qualified Social Worker /17. Qualified Social Worker /17. Qualified Social Worker The administrator had an tharge process/planning for conducted an audit of lischarged from the facility the each resident received and orientation to ensure a harge. This was validated dent record for ordination of home care lucting phone interviews with esponsible party to validate . This audit was completed		 Business Office Director Resident Care Management D Medical Director Infection Preventionist Corrective action accomplished residents found to have been at the deficient practice (B): Resident #13 was admitted to Center Health and Rehabilitation 1/27/17, to room 306 in the unit. Resident #13 was assesses being at risk for elopement on approx. 1:00pm on 2/25/17, R was found outside of the facilitit facility staff was alerted by a faneighbor. Resident #13 was returned to feet from window, across the doutside the facility between fact neighboring apartment building Resident #13 was returned to four by the Manager on Duty and housekeeping staff. Resident assisted back into the facility and the start of the facility and the start of the facility and housekeeping staff. Resident #13 was start of the facility and housekeeping staff. Resident assisted back into the facility and housekeeping staff. 	d for those affected by Brian on/Salisbury secure sed as 1/27/17. At esident #13 y after a cility ound 43 riveway sullity and gs. the facility #13 was	
	shared with the Facili and he was in agreer The Area Staff Develor re-education of all Lic members of the Inter- discharge planning, of the Administrator, Dir	opment Director completed censed Nurses and disciplinary Team involved in on 5/5/17, Education included rector of Nursing, Nurse rvices Director, Therapy		Nurse #1 immediately complet to toe assessment of Resident minor injury of a skin tear note where/how injury occurred, due witnessed. An updated Eloper Assessment was completed fo #13 on 2/25/17. The care plan reviewed and updated by the D 3/6/17 to include "Window stop room change." Nurse #1 initia increased supervision for Resi	#13 with d, unknown e to not ment r Resident was DON on oper and ted	

Facility ID: 953007

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CENTER STATEMENT AND PLAN O	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BOULEVAPD			PRINTED: 06/08/2 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED R-C 05/06/2017	
BRIAN C	IR HEALTH & REHAB/SA	LISBURY			TATESVILLE BOULEVARD SBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 490	Nurse), Business Offi This education includ regarding Transfer an follows: Post Discharge Plan 1. Upon admission th consultation with the 's legal representative the resident 's dischard date of discharge. 2. The Social Service IDT members, and th Resident 's legal reprindividual needs, reso required upon dischar plan meeting and pro 3. Social Service Dep post-discharge service 4. Contact those service support resident 's ne services upon dischard durable medical equip meals, transportation 5. Initiate the discharg members to ensure th Resident 's legal repri- provider obtains corre- and protected health The Social Services I residents who dischard discharge, 2 weeks o post discharge to ensi- necessary services to environment.	ce Director and Physician. es the facility policy ad Discharge Procedures as of Care: e IDT members, in resident and/or the Resident e (if practicable), develops arge plan and anticipated e Director or designee, the e resident and/or the resentative determine the burces, and services rge through the IDT care cess. bartment arranges for es ice agencies who can eeds, resources, and rge (e.g., home health, bment, therapy services, , etc.). ge paperwork with all IDT hat the resident, the resentative or receiving ect and detailed, confidential information upon discharge.	F 4	to ccc dc ch in cc R 2/ cc bu fe fo or si: N re ar e ph ar e ph ar e th w se cc se fo or si: w th w se cc th th th th th th th th th th th th th	e monitor location. These checks wer completed by the nursing assistants ar ocumented on the flow record by the harge nurse for 72 hours following the cident. No evidence that resident ontinued to exit seek during this time. esident #13 was moved to room 319 (25/17 where the window exited to a purtyard enclosed on three sides by the uilding and on the fourth by a six foot ence with a key pad gate. The window or room 319 was checked by the nurse in 2/25/17 and it did not open more that x inches. urse #1 notified Resident #13 esponsible party on 2/25/17 at 1:20pm and physician on 2/25/17 at 1:30pm egarding Resident #13 exiting the faci- hysical assessment following the eve- ind plan for increased monitoring. No ew physician's orders were received. cident report was completed by Nurs 1 on 2/25/17. Nurse #1 notified the D and Administrator of the event on 2/25/ t approx. 1:00pm. laintenance was called on 2/25/17 at prox. 1:00pm to facility and arrived ithin a half hour and immediately ecured resident's window, and onducted an audit of all windows in ecure unit to ensure that they were ecure, several other windows were foo to secured when checked by the nurs in a window stopper screws and then verific at they opened no more than six inch	nd e on ne v e an n lity, nt An e ON /17 /17	

Facility ID: 953007

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/20 ² MAPPROVE O. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING				R-C 5/06/2017
NAME OF PF	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA			63	5 STATESVILLE BOULEVARD		
DRANCT	R HEALTH & REHAD/SP			SA	ALISBURY, NC 28144		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From page	- 111	Í –	490			
1 430				490			
		r week for 12 weeks to derly discharge has been			Staff were re-educated on 5/4/17 on		
		with the resident and/or			elopement process by the Area Staff		
		g the Post Discharge Plan of			Development Coordinator, no staff sh	nall	
		ne visits when possible and			work until re-educated on process. C		
	validating the comple	tion of appropriate referrals.			2/27/17 there was education done wi	th	
					nursing staff who worked that day,		
		al Services completed			conducted by the ADON. Nursing sta		
		nistrator and Director of			working 5/4/17 were educated by the		
		This education included sion of social work services			Staff Development Coordinator that v currently in the facility and completed		
		regulations governing long			phone education for those not preser		
		th regards to provision of			facility. No staff members who have	-	
		ne absence of the Social			received the education will work on th	ne	
		Administrator will ensure			unit until they complete the education		
		adequate Social Service			Education includes policy and procee		
		meet the requirements of			when there is an elopement or suspe		
	•	vill be provided from sister			elopement, signs/symptoms of elope		
	lacinities and /or throu	igh contract agency support.			risk, and supervision of residents with seeking behavior and intervention	rexit	
	On 5/4/17 the Admin	istrator, DON and ADON			strategies. All new hires will also rec	eive	
		Quality Assurance &			this education.		
		ement Program by the Area					
	Staff Development C				Corrective action accomplished for th	ose	
	The Quality Assurance	e committee consists of:			residents having the potential to be		
	· Administrato				affected by the deficient practice:		
	· Director of N	0					
	 Dietary Man Rehabilitation 				Administrator, DON and ADON were educated on the QAPI process by the		
		e or Environmental			District Director of Clinical Services of		
	Representative				5/4/17. Administrator and IDT to		
	· Activities Di	rector			complete monthly QAPI meetings wit	h	
		ces Director			review of action plans and new areas		
		ource Designee			concern for performance improvement	nt,	
		fice Director			with evidence of root cause analysis	and	
		are Management Director			action plans to address potential and		
	Medical Dire Infection Pre				actual concerns. District Director of Clinical Services will review monthly		

Event ID: H58611

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		SURVEY LETED
		345115	B. WING				-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	R HEALTH & REHAB/SA			63	5 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAD/SP			S	ALISBURY, NC 28144		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 490	Continued From page	112	F 4	00			
1 430	Resident #13 was ad	mitted to [Name of Facility] 306 in the Secure Unit.	ГЧ	.90	meetings as able.		
	elopement on 1/27/17 on 2/25/17, Resident the facility after a faci facility neighbor. Res window, across the d between facility and r buildings. Was return Manager on Duty and Resident #13 was as and secure unit. Nurse #7 immediately to Toe Assessment of injury of a skin tear n injury occurred, due t updated Elopement A for Resident #13 on 2 reviewed and update include "Window stop Nurse #7 initiated inc Resident #1 on 2/25/ minute checks to more checks were complet and documented on t Charge Nurse for 72 No evidence that resid during this time. Resident #13 was more where the window ex on 3 sides by the buil foot fence with key pa	sisted back into the facility y 2/25/17 completed a Head f Resident #13 with minor oted, unknown where/how			On 5/4/17, the Area Staff Development Coordinator conducted re-education fo the Administrator on the facility's policy and procedures for assembling a QAPI committee, collecting data and analyzin trends, and development and implementation of a plan to improve wi ongoing monitoring to sustain complian The facility utilizes the Plan, Do, Study Act method for Quality Assurance and Performance Improvement Program including scheduling, identification of Quality Issues, trends or patterns, submission of data, and initiation of qua- improvement plans related to identified areas of opportunity. The committee h met monthly in the past to monitor ongoing compliance with F323, Supervision to Prevent Accidents and Elopement, but will begin meeting wee on 5/4/17 to increase monitoring of F32 Supervision to Prevent Accidents with a focus on the review of Window Checks being conducted to correct and maintai the elopement management process a to evaluate systems for effectiveness of the facility's overall compliance with F3 Supervision to Prevent Accidents and Elopements. The District Director of Clinical Service re-educated the IDT on 5/6/17 on Feder Regulation of F520 and QAPI Committe Policy regarding the expectations	r ng th nce. , ality as kly 23 a fin nd f 23 s seral	
	and it did not open m Nurse #7 notified Res	sident #13 ' s Responsible			regarding maintaining an ongoing Qual Assurance and Performance Improvement (QAPI) program. The QA	-	

Event ID: H58611

Facility ID: 953007

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
		345115	B. WING			R-C 5/06/2017	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/2017	
				635 STATESVILLE BOULEVARD			
BRIAN CT	R HEALTH & REHAB/S	ALISBURY		SALISBURY, NC 28144			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	Continued From pag	10 112	F 49				
1 - 50			F 48				
		1:20 pm and Physician on		committee consists of the Adm	•		
	• •	regarding Resident #13		Director of Nursing, Medical Di at least three other members a			
		nysical assessment following or increased monitoring. No		at least monthly (Medical Direc			
		ders were received. An		quarterly). Education also incl			
		completed by Nurse #7 on		processes and procedures of			
	2/25/17.			implementing, reviewing and re	evisina		
	2,20,111			substantial regulatory complian			
	Nurse #7 notified the	e DON and Administrator of		provide the highest level of car			
		at approximately 1:00 pm.		residents. Newly hired IDT er			
	Maintenance was ca			be educated upon hire.			
	approximately 1:00	om to facility and arrived					
		d immediately secured		Measures put into place or sys	temic		
	resident 's window,	and conducted an audit of all		changes made to ensure that t			
	windows in secure u	nit to ensure that they were		practice will not occur:			
	secure, several othe	r windows were found not					
	secured when check	ked by the nurse, the		The District Director of Clinical	Services of		
	maintenance assista	ant put in new window stopper		the District Director of Operation	ons will		
		ified that they opened no		monitor QAPI meetings month	-		
	more than 6 inches.			months to assure compliance I			
				Regulation F 520 to sustain an			
		ed 5/4/2017 on Elopement		compliance with Federal Regu			
	•	Staff Development		- Resident Safety to include or			
		f shall work until re-educated		monitoring and revisions to the			
	-	7/17 there was education		necessary, and to maintain con	•		
	•	aff who worked that day,		with F 204, 251 and 284 as the			
	-	OON. Nursing staff working		Social Service provisions and a			
	5/4/17 were educate	inator that were currently in		discharge planning and coordin safe and orderly discharge for			
		pleted phone education for		residents leaving facility.	an		
		n facility. No staff members					
		ed the education will work on		District Director of Clinical Service	vices or the		
		mplete the education.		District Director of Operations			
		Policy Procedure when there		oversight of the Facility Admini			
		suspected elopement,		ensure implementation of the o			
	signs/symptoms of e			allegation, by providing on site			
		ents with exit seeking		support to the facility weekly for			
		ention strategies. All new hires		to ensure implementation of al			
	will also receive this			allegations.			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		345115	B. WING				R-C 5/ 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				63	35 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From page	e 114	F4	490			
	District Director of Op oversight of the admi implementation of the providing on site visit 4 weeks, and then a X 6 months to ensure credible allegations. The credible allegations. The credible allegation 6:26 PM by the follow Review of the window facility on 300 hall po Maintenance Assistant to verify their underst received regarding m fixing any identified is percent audit of all wi locked unit to ensure (all 35 resident rooms selected rooms on 10 windows did not oper On 5/6/17 at 6:04 PM	nistration to ensure e credible allegation, by s to the facility every week x minimum of bimonthly visits e implementation of all on was validated on 5/6/17 at ving: v audits completed by the st 2/25/17, interview with the nt and Maintenance Director anding of the education they onitoring the windows and sues immediately, 100 indows on 300 hall/the the windows were secured s on 300 hall) and an audit of 00 and 200 hall to verify the n more than 6 inches.			Opportunities will be corrected as identified. Monitoring Process: The Administrator will report the resu these audits weekly for 12 weeks dur the QAPI meeting and then monthly thereafter. The committee will review these results and make recommenda as required.	ing v	
	describe the education received in regards to qualified Social Work implementation of an process, and provision resident. He was als review residents plan ensure the appropriat resources were availa of each resident. Dur Administrator revealed	e Administrator was able to on and in-servicing he had of the requirement to retain a er on a full-time basis, effective discharge planning on for the safe discharge of a o educated on his role to ned for discharge and te plans were in place and able for the safe discharge ring this interview the ed that they had not been ws because he was not					

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/08/20 RM APPROVE O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED R-C	
		345115	B. WING			5/06/2017
	ROVIDER OR SUPPLIER	LISBURY	635	EET ADDRESS, CITY, STATE, ZIP COD STATESVILLE BOULEVARD LISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 490 F 520 SS=J	secure and could not thought a future citati Administration areas because, due to rece now had an effective nursing leadership in noted that the facility stabilization plan that staffing over time. He some new positions s addition he said that in in place for the Mana effectively in their day quality assurance act analysis. He stated th corporate support for not been as evident in Corporate Oversight would continue for a in that there would also support and oversight needed. 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	ncident of elopement and because the elieved the windows were open. He added that he on in the area of would be prevented nt staff changes, the facility management team and place. The Administrator had developed a included plans to increase e said they had already hired such as Unit Managers. In new systems were being put gement Team to work more r to day clinical meetings and ivities such as root cause hat there was significant the facility now, which had n the past. In regards to the Administrator said that it minimum of six months but be ongoing corporate t beyond that time frame as (i)(ii)(h)(i) QAA ERS/MEET ant and assurance.	F 490			6/7/17

Event ID: H58611

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE	
		345115	B. WING _				-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		63	35 STATESVILLE BOULEVARD		
BRIANOT				S	ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	9 116	F	520			
	staff, at least one of w	a board member or other					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evaluation	n respect to which quality					
		ement appropriate plans of ified quality deficiencies;					
	Secretary may not rec records of such comn such disclosure is rela	mation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this					
	(i) Sanctions. Good fa committee to identify deficiencies will not be sanctions. This REQUIREMENT by:	and correct quality					
	Based on observation Health Care staff and facility and hospital m facility's Quality Asses (QAA) Committee fail procedures and moni- the committee put into	ns, facility staff, Home physician interviews, and redical record reviews, the ssment and Assurance ed to maintain implemented tor these interventions that p place in March of 2017. red deficiency related to			F 520 Corrective action accomplished for thos residents found to have been affected I the deficient practice (A): Resident #9 was discharged to his hom from Brian Center Health and	ру	

Facility ID: 953007

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345115	B. WING				R-C / 06/2017
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				63	35 STATESVILLE BOULEVARD		
BRIAN C1	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	accidents (F323), wh November of 2016 or again in March of 201 investigation. F323 w the current complaint conjunction with a fol recited deficiency rela was originally cited in complaint investigation recited on the current conducted in conjunce The continued failure federal surveys of reconstruction facility 's inability to se Assurance Program. Immediate Jeopardy Resident #13 and for Resident #13 was ab through a resident root to open. The facility of systems in place to e facility did not open. to his home without h and addressed to ensithe facility. The residen the facility. The reside multiple co-morbiditier resident had not beer Health care agency to tracheostomy care up expected. The reside nor supplies to do the own at home. He ret and was immediately Emergency Department and treatment of the f diagnosed with neck an oral and topical ar	ich was originally cited in a recertification survey and 17 on a complaint vas subsequently recited on investigation conducted in low-up survey. A second ated to Administration (F490) a March of 2017 on a on. F490 was subsequently a complaint investigation tion with a follow-up survey. of the facility during two cord show a pattern of the sustain an effective Quality began on 2/25/17 for Resident #9 on 4/1/17. be to exit a locked unit om window that he was able did not have monitoring nsure the windows in the Resident #9 was discharged us needs being identified sure a safe discharge from lent had a tracheostomy and ts (chronic conditions). The n accepted by a Home o receive assistance with his con discharge, as he had ent did not have the training a tracheostomy care on his urned to the facility on 4/6/17 sent to the hospital ent (ED) for an evaluation tracheostomy. He was cellulitis and prescribed both attibiotic. He was released	F	520	Rehabilitation/Salisbury on 4/1/17. Resident #9 required home health services for nursing, oxygen, suction machine, and supplies to manage tracheostomy care at home. The Fac Administrator completed a referral to home health agency on 3/28/17, prior discharge from the facility. Home hea agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated w facility management for follow up. Th nurse received education form the Are Staff Development Coordinator regard discharge policy and procedure on 5// The oxygen provider delivered oxyger No arrangements for DME was confir prior to discharge. Resident #9 was returned to facility by his family on 4/6 was assessed and determined need f his care for his tracheostomy, due to drainage and odor, was sent to ER fo eval and returned to facility where he readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17, an treated for infection. Resident #9 rem a current resident. At time of discharg there was no validation of home healt admitting resident, no confirmation of DME, and no documented education related to signs and symptoms of problems, what care was necessary to maintain stable health, and conseque for not providing this care, for the resi and his family/caregiver.	the to alth this ea ding 5/17. n. med 5/17, or r was d dains ge h conces dent for	
	complaint investigation recited on the current conducted in conjunce The continued failure federal surveys of reconstruction facility 's inability to se Assurance Program. Immediate Jeopardy Resident #13 and for Resident #13 was all through a resident root to open. The facility of systems in place to e facility did not open. to his home without h and addressed to ensist the facility. The reside multiple co-morbidities resident had not been Health care agency to tracheostomy care up expected. The reside nor supplies to do the own at home. He ret and was immediately Emergency Departme and treatment of the f diagnosed with neck an oral and topical ar	on. F490 was subsequently to complaint investigation tion with a follow-up survey. of the facility during two cord show a pattern of the sustain an effective Quality began on 2/25/17 for Resident #9 on 4/1/17. ble to exit a locked unit om window that he was able did not have monitoring nsure the windows in the Resident #9 was discharged bis needs being identified sure a safe discharge from lent had a tracheostomy and the (chronic conditions). The n accepted by a Home or receive assistance with his bon discharge, as he had ent did not have the training tracheostomy care on his urned to the facility on 4/6/17 sent to the hospital ent (ED) for an evaluation tracheostomy. He was cellulitis and prescribed both			agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated w facility management for follow up. Th nurse received education form the Are Staff Development Coordinator regard discharge policy and procedure on 5/5 The oxygen provider delivered oxyget No arrangements for DME was confir prior to discharge. Resident #9 was returned to facility by his family on 4/6 was assessed and determined need f his care for his tracheostomy, due to drainage and odor, was sent to ER fo eval and returned to facility where he readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17, an treated for infection. Resident #9 rem a current resident. At time of discharg there was no validation of home healt admitting resident, no confirmation of DME, and no documented education related to signs and symptoms of problems, what care was necessary to maintain stable health, and conseque for not providing this care, for the resi and his family/caregiver.	th is ea Jing 5/17. n. med 5/17, or r was J d lains Je h o nces dent for	

Facility ID: 953007

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/08/2017 APPROVED). 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345115	B. WING			R- 05/	-C 06/2017
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				63	35 STATESVILLE BOULEVARD		
BRIANCI	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 520	Continued From page	2 118	F f	520			
	facility on 4/6/17.	-			resident expects to remain at the facilit	v	
						у.	
					Throughout the discharge planning		
	The Immediate Jeopa	ardy for both Resident #13			process for Resident #9 the facility was	6	
	and Resident #9 were	e lifted at 6:26 PM on 5/6/17			without a Qualified Social Worker.		
		cceptable credible allegation			Facility's full time Social Service Direct	or	
		23 and F490 were verified.			resigned without notice on 1/26/17.		
		n out of compliance at a			Facility went without a qualified Social		
		vel D (no actual harm with			Worker from 1/26/17 until a Qualified		
	•	n minimal harm that is not			Social Worker was retained on 3/30/17 Qualified Social Worker remains	•	
		for the facility to complete nsure monitoring systems			employed. The Administrator had an		
	put into place are effe				active role in the discharge		
					process/planning for Resident #9.		
	The findings included	:					
					The nurse managers conducted an auc		
	This citation is cross r	referenced to:			of residents who have discharged form		
					the facility since 4/1/17 to validate each		
	· ·	Prevent Accidents - Based			resident received sufficient preparation		
		review and staff interview			and orientation to ensure a safe and		
		event 1 of 4 cognitively ho were assessed as a high			orderly discharge. This was validated l reviewing the resident record for	Jy	
	•	dent #13) from exiting a			documentation of coordination of home		
		to identify that there were			care services and by conducting phone		
		ng that could be opened			interviews with the resident or their		
		resident to elope through			responsible party to validate successfu	I	
	them. Resident #13 e				discharge. This audit was completed b		
	window then walked 4				5/5/17.		
	access road for the ne						
	· · ·	road ran next to the facility.			The results of this meeting and QA plan	า	
		ified that Resident #13 had			were shared with the Facility Medical		
		who had seen Resident #13			Director on 5/5/17 and he was in		
		en Resident #13 was located			agreement.		
	-	base of a hill on the other ad. Resident #13 sustained			The Area Staff Development Coordinat	or	
	a skin tear during the				completed re-education of all licensed	01	
					nurses and members of the		
	F490: Administration	- Based on observations,			Interdisciplinary Team involved in		
		ealth Care staff, physician,			discharge planning on 5/5/17. This		

Event ID: H58611

Facility ID: 953007

If continuation sheet Page 119 of 130

DEPARTMENT OF HEALTH A				PRINTED: 06/08/2017 FORM APPROVED
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	345115	B. WING		R-C 05/06/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		e	35 STATESVILLE BOULEVARD	
BRIAN CTR HEALTH & REHAB/S	SALISBURY	5	SALISBURY, NC 28144	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY 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 APPF DEFICIENCY)	ULD BE COMPLETION
 hospital medical rec administration: 1) fa prevent 1 of 4 cogn were assessed as a (Resident #13) from failed to have monit identify that there w that could be opener resident to elope the provide oversight an Social Worker on a effective discharge for the safe discharge (Residents #9) disc During a recertificat 11/18/16, the facility provide adequate si unobserved resider minor injury for 2 of (Resident #130 and investigate a reside identify and implem prevent future similar residents (Resident behavioral health un During a complaint 3/11/17, the facility supervise one of on known sexually inap prevent sexual abus (Resident #8) and a (Resident #1) and fi interventions to previse one of one 	interviews, and facility and cord reviews, the iiled to provide oversight to itively impaired residents, who a high elopement risk, a exiting a locked unit and oring systems in place to ere windows in the building ed sufficiently to allow a rough them; and, 2) failed to nd leadership to retain a full-time basis, implement an planning process, and provide ge of one sampled resident harged to his home. ion and complaint survey of was cited for F323 failure to upervision to prevent an it to resident altercation with 2 sampled residents #205), failed to thoroughly int to resident incident and to ent intervention strategies to ar incidents for 2 of 2 #130 and #205) and on 1 of 1	F 520		ers, es ment Office / policy bers, in /or the t's te of the il ridual quired are plan for s who purces, , home t,

Facility ID: 953007

If continuation sheet Page 120 of 130

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) D.	NO. 0938-03 ATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CC	COMPLETED		
	345115		B. WING		R-C 05/06/2017			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		05/06/2017		
			635 STATESVILLE BOULEVARD					
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		SALISBURY, NC 28144				
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 520	Continued From page	e 120	F 52	0				
		i i f		5. Initiate the discharge pap				
	• ·	ivestigation survey of		all IDT members to ensure the	hat the			
		as cited for F490 for failure adership to protect one of		resident, the resident's legal representative or receiving p	rovider			
		ents (Resident # 1) from		obtains correct and detailed,				
		sident (Resident # 8) with		and protected health informa				
	known sexually inapp	propriate behaviors.		discharge.				
	An interview was con	ducted with the		The Social Services Director	will contact			
	Administrator on 5/6/	17 at 6:04 PM. During the		all residents who discharge h	nome within			
		nat the quality assurance		one week of discharge, two				
		dentifying any facility issues		discharge and at 30 days po	-			
		tings, falls meetings, and the neetings. Any identified		to ensure they have all care necessary to safely remain in				
		brought to the Quality		environment.				
		prmance Improvement						
		ensure they are resolved.		The Administrator, Director of	of Nursing or			
		knowledged there had not		Nursing Manager will review				
		nitor the windows because		planned for discharge three t				
	-	im believed the windows		week for 12 weeks to ensure				
	Social Worker in place	o indicated that not having a		orderly discharge has been p meeting with the resident and	-			
	-	litated effective discharge		and completing the Post Disc				
		at the facility had developed		of Care, providing a home vis				
	a Stabilization Plan w	vith the support of their		possible and validating the c	ompletion of			
		that through Corporate		appropriate referrals.				
		y Assurance monitoring the						
	Supervision to Preve	improve in the areas of		The Director of Clinical of Se completed re-education of A				
		vent further repeat citations		and Director of Nursing on 5				
	in these areas.			education included facility po				
		M, District Director of Clinical		provision of social work servi	ices and state			
		rict Director of Clinical		and federal regulations gove				
		ormed of the immediate		term care facilities with regar				
	jeopardy.			provision of social services.				
	The facility provided :	an acceptable credible		absence of the Social Servic the Administrator will ensure				
		nce on $5/6/17$ at 3:22 PM.		appropriate and adequate So				
	The credible allegation			support is retained to meet the				

Facility ID: 953007

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		ND HUMAN SERVICES MEDICAID SERVICES					RM APPROVE 10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED		
		345115	B. WING				R-C 5/06/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/SALISBURY			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				35 STATESVILLE BOULEVARD ALISBURY, NC 28144			
						<u></u>	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 520	Continued From page	e 121	F	520			
	1.0				requirements of regulation. Suppor	t will	
	Resident #9 was disc	charged to his home from			be provided from sister facilities and		
	[Name of Facility] on	•			through contract agency support.		
	-	h Services for Nursing,					
	Oxygen, suction mac			On 5/4/17, the Administrator, DON,			
	manage tracheostom			ADON were retrained on the Quality			
	-	eted a referral to the Home 28/2017, prior to discharge			Assurance & Performance Improver Program by the Area Staff Developr		
	from the facility. Ho			Coordinator. The Quality Assurance			
	-	scharge that they were			Committee consists of:	0	
	-	vice for this resident. This					
		communicated with facility			-Administrator		
	management for follo	w up. This nurse has			-Director of Nursing		
	received education fr				-Dietary Manager		
	-	nator, regarding Discharge			-Rehabilitation Manager		
	•	e on 5/5/17 The Oxygen			-Maintenance or Environmental		
	DME (Durable Medic	xygen. No arrangements for			Representative -Activities Director		
		charge. Resident # 9 was			-Social Services Director		
		his family on 4/6, was			-Human Resource Designee		
		nined need for care for his			-Business Office Director		
		o drainage and odor, was			-Resident Care Management Direct	or	
		nd returned to facility where			-Medical Director		
		[Name of Facility] on I for infection. Resident # 9			-Infection Preventionist		
		sident. At time of discharge			Corrective action accomplished for	those	
	there was no validation	on of Home Health admitting			residents found to have been affect	ed by	
	resident, no confirma				the deficient practice (B):		
		on related to signs and					
		ns, what care was necessary			Resident #13 was admitted to Brian		
		alth, and consequences of			Center Health and Rehabilitation/Sa on 1/27/17, to room 306 in the secu		
	family/ caregiver.	e, for the resident and his			unit. Resident #13 was assessed a		
	amily caregiver.				being at risk for elopement on 1/27/		
	Throughout the Disch	narge Planning Process for			approx. 1:00pm on 2/25/17, Reside		
	-	ility was without a Qualified			was found outside of the facility after		
	Social Worker. Facil	ities Full Time Social Service			facility staff was alerted by a facility		
		hout notice on 1/26/17.			neighbor. Resident #13 was found		
	Facility went without	a qualified Social Worker			feet from window, across the drivew	/av	

Facility ID: 953007

If continuation sheet Page 122 of 130

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/08/2017 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURV COMPLETE	
	345115		B. WING				R-C 5/06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0,00,2011
				6	35 STATESVILLE BOULEVARD		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY		S	ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	 Continued From page 122 from 1/26/2017 until a Qualified Social Worker was retained on 3/30/17. Qualified Social Worker remains employed. The administrator had an active role in the discharge process/planning for Resident # 9. 		F	520	outside the facility between facility an neighboring apartment buildings. Resident #13 was returned to the faci by the Manager on Duty and housekeeping staff. Resident #13 wa assisted back into the facility and sec	lity Is	
	residents who have d since 4/1/17 to valida sufficient preparation safe and orderly discl by reviewing the resid documentation of coo services and by cond the resident or their re successful discharge. by 5/5/17. The results of this me shared with the Facili	The Nurse Managers conducted an audit of esidents who have discharged from the facility ince 4/1/17 to validate each resident received ufficient preparation and orientation to ensure a afe and orderly discharge. This was validated y reviewing the resident record for ocumentation of coordination of home care ervices and by conducting phone interviews with he resident or their responsible party to validate uccessful discharge. This audit was completed y 5/5/17.			unit. Nurse #1 immediately completed a he to toe assessment of Resident #13 w minor injury of a skin tear noted, unkr where/how injury occurred, due to nor witnessed. An updated Elopement Assessment was completed for Resid #13 on 2/25/17. The care plan was reviewed and updated by the DON or 3/6/17 to include "Window stopper an room change." Nurse #1 initiated increased supervision for Resident #1 2/25/17 to include every 15 minute ch to monitor location. These checks we completed by the nursing assistants a documented on the flow record by the	ead th iown c lent d on ecks ere ind	
	re-education of all Lic members of the Inter- discharge planning, of the Administrator, Dir Managers, Social Ser Program Manager, D Resident Care Manag Nurse), Business Offi This education includ regarding Transfer an follows: Post Discharge Plan 1.Up on admission th consultation with the	censed Nurses and disciplinary Team involved in on 5/5/17, Education included ector of Nursing, Nurse rvices Director, Therapy ietary Services Manager, gement Director (MDS ice Director and Physician. les the facility policy nd Discharge Procedures as of Care:			charge nurse for 72 hours following the incident. No evidence that resident continued to exit seek during this time. Resident #13 was moved to room 319 2/25/17 where the window exited to a courtyard enclosed on three sides by building and on the fourth by a six foo fence with a key pad gate. The windo for room 319 was checked by the nur on 2/25/17 and it did not open more the six inches. Nurse #1 notified Resident #13 responsible party on 2/25/17 at 1:20p and physician on 2/25/17 at 1:30pm	e 9 on the t se nan	

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CLINILI		MEDICAID SERVICES				IO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
	CONTRECTION	DENTIFICATION NOMBER.	A. BUILDING	i				
	345115		B. WING			R-C		
	NAME OF PROVIDER OR SUPPLIER		B. WING			5/06/2017		
NAME OF FROVIDER OR SUFFLIER			STREET ADDRESS, CITY, STATE, ZIP C	JODE				
BRIAN CT	R HEALTH & REHAB/SA	ALISBURY		635 STATESVILLE BOULEVARD SALISBURY, NC 28144				
					000000000			
(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 ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
F 520	Continued From page	e 123	F 52	0				
	-	arge plan and anticipated		regarding Resident #13 ex	iting the facility.			
	date of discharge.	- 3- han and a moleared		physical assessment follow	•			
	U U	e Director or designee, the		and plan for increased mor	-			
	IDT members, and th			new physician's orders wer				
		resentative determine the		incident report was comple	•			
	individual needs, reso			#1 on 2/25/17. Nurse #1 n				
		rge through the IDT care		and Administrator of the ev	rent on 2/25/17			
	plan meeting and pro	icess.		at approx. 1:00pm.				
	3. Social Service Dep	partment arranges for		Maintenance was called or	n 2/25/17 at			
	post-discharge servic	-		approx. 1:00pm to facility a	and arrived			
				within a half hour and imme	ediately			
		vice agencies who can		secured resident's window				
		eeds, resources, and		conducted an audit of all w				
		rge (e.g., home health, pment, therapy services,		secure unit to ensure that t	-			
	meals, transportation			secure, several other windo not secured when checked				
		ge paperwork with all IDT		the maintenance assistant	•			
	members to ensure the			window stopper screws and	•			
	Resident 's legal rep	resentative or receiving		that they opened no more t				
	•	ect and detailed, confidential						
	and protected health	information upon discharge.		Staff were re-educated on				
	The Coolel Comistor !			elopement process by the				
		Director will contact all rge home within 1 week of		Development Coordinator, work until re-educated on p				
		f discharge and at 30 days		2/27/17 there was educated				
		sure that they have all care		nursing staff who worked th				
	-	o safely remain in their home		conducted by the ADON.	•			
	environment.	-		working 5/4/17 were educa	ated by the Area			
		rector of Nursing or Nurse		Staff Development Coordin				
	Manager will review r			currently in the facility and				
		r week for 12 weeks to		phone education for those				
		derly discharge has been with the resident and/or		facility. No staff members received the education will				
		g the Post Discharge Plan of		unit until they complete the				
		me visits when possible and		Education includes policy a				
		tion of appropriate referrals.		when there is an elopemer				
		al Services completed		elopement, signs/symptom	is of elopement			
	re-education of Admir	nistrator and Director of		risk, and supervision of res	idents with exit			

Facility ID: 953007

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/08/2017 APPROVED D. 0938-0391	
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345115	B. WING				-C	
		545115	D: 11110			05/	06/2017	
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CTR HEALTH & REHAB/SALISBURY				35 STATESVILLE BOULEVARD ALISBURY, NC 28144				
(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) COMPLETION DATE	
F 520	facility policy of provis and state and federal term care facilities wit social services. In th Service Director, the A that appropriate and a support is retained to regulation. Support w facilities and /or throw On 5/4/17, the Admini were retrained on the Performance Improve Staff Development Co The Quality Assuranc Administrato Director of N Dietary Mana Rehabilitatio Maintenance Representative Activities Dir Social Servic Human Reso Business Off Resident Ca Medical Dire Infection Pre Resident # 13 was ad on 1/27/17, to room 3 Resident #13 was ass elopement on 1/27/17	This education included sion of social work services regulations governing long h regards to provision of e absence of the Social Administrator will ensure adequate Social Service meet the requirements of vill be provided from sister gh contract agency support. istrator, DON and ADON Quality Assurance & ment Program by the Area bordinator. e committee consists of: r lursing ager n Manager e or Environmental ector ces Director purce Designee fice Director re Management Director ctor eventionist mitted to [Name of Facility]	F	520	DEFICIENCY) seeking behavior and intervention strategies. All new hires will also recei- this education. Corrective action accomplished for tho- residents found to have been affected the deficient practice: On 5/4/17 the Administrator, Director of Nursing and IDT, including the Administrator, DON, ADON, District Director of Clinical Services, Area Staf Development Coordinator and Maintenance Director conducted a root cause analysis regarding facility processes for elopement prevention wir regards to Window Safety/Security. Based on the results of this root cause analysis a QA plan was developed to include re-education of all current facili staff regarding the elopement policy, a systematic approach of more frequent window checks on the secure unit. Thi will include weekly audits by the Maintenance Director for Assistant, additionally the Administrator will condu- random weekly audits on his facility rounds. The Director of Nursing will implement increases supervision for ar resident with an elopement or attempt elope immediately to establish safety a continue until the investigation has bee completed and required interventions have been implemented. Incident repo-	se by f f th th ty nd s uct to nd en		
	facility neighbor. Resi	dent was found 43 feet from iveway outside facility eighboring apartment			morning Stand Up meeting led by the Administrator. The IDT will determine acceptable interventions and ensure th care plan is revised.	e		

Facility ID: 953007

HUMAN SERVICES			PRINTED: 06/08/2017 FORM APPROVED OMB NO. 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		(X3) DATE SURVEY COMPLETED
345115			R-C 05/06/2017
		STREET ADDRESS, CITY, STATE, ZIP COI	DE
07UDV		635 STATESVILLE BOULEVARD	
SBURY		SALISBURY, NC 28144	
EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
25 ousekeeping staff. ted back into the facility 2/25/17 completed a Head desident #13 with minor ed, unknown where/how not witnessed. An sessment was completed 5/17. The care plan was by the DON on 3/6 to er and room change." ased supervision for 7 to include every 15 or location. These by the Nursing Assistants e flow record by the nurs following the incident. ent continued to exit seek ed to room 319 on ow exited to a courtyard the building and on the th key pad gate. The as checked by the nurse t open more than 6 ent #13 ' s Responsible 0 pm and Physician on arding Resident #13 ical assessment following horeased monitoring. No 's were received. An inpleted by Nurse #7 on ed the DON and ent on 2/25/17 at	F	Administrator, DON and ADO educated on the QAPI proce District Director of Clinical Se 5/4/17. Administrator and ID complete monthly QAPI meet review of action plans and ne concern for performance imp with evidence of root cause a action plans to address poter actual concerns. District Dire Clinical Services will review of minutes x four months, and a meetings as able. On 5/4/17, the Area Staff De Coordinator conducted re-ed the Administrator on the facil and procedures for assembli committee, collecting data ar trends, and development and implementation of a plan to in ongoing monitoring to sustain The facility utilizes the Plan, Act method for Quality Assur Performance Improvement P including scheduling, identified Quality Issues, trends or patt submission of data, and initia improvement plans related to areas of opportunity. The co met monthly in the past to me ongoing compliance with F32 Supervision to Prevent Accid Elopement, but will begin me on 5/4/17 to increase monito Supervision to Prevent Accid focus on the review of Windo	ss by the ervices on T to trings with ew areas of provement, analysis and ntial and ector of monthly QAPI attend velopment lucation for ity's policy ng a QAPI nd analyzing d mprove with n compliance. Do, Study, ance and Program cation of quality o identified ommittee has onitor 23, lents and eeting weekly ring of F323 lents with a ow Checks
	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345115 SBURY SBURY SMENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION) 25 ousekeeping staff. ted back into the facility /25/17 completed a Head esident #13 with minor ed, unknown where/how not witnessed. An essment was completed 5/17. The care plan was by the DON on 3/6 to er and room change." ased supervision for 7 to include every 15 or location. These by the Nursing Assistants flow record by the urs following the incident. nt continued to exit seek ed to room 319 on ow exited to a courtyard the building and on the th key pad gate. The as checked by the nurse t open more than 6 ent #13 ' s Responsible 0 pm and Physician on arding Resident #13 cal assessment following horeased monitoring. No s were received. An upleted by Nurse #7 on ed the DON and nt on 2/25/17 at	EDICAID SERVICES 1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345115 B. WING SBURY ID SBURY ID SEMING ID SEVENT	EDICAID SERVICES 1) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345115 B. WING 345115 STREET ADDRESS, CITY, STATE, ZIP COLESS ESBURY SBURY STREET ADDRESS, CITY, STATE, ZIP COLESS ESBURY SEBURY STREET ADDRESS, CITY, STATE, ZIP COLESS ESBURY SEGURY STREET ADDRESS, CITY, STATE, ZIP COLESS ESBURY 25 F 520 SEGURY Administrator, DON and ADDC educated on the GAULTANDY 25 F 520 25 F 520 25 F 520 26 STREET ADDRESS, CITY, STATE, ZIP COLESS ESURTS

Facility ID: 953007

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/08/201 MAPPROVE O. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345115	B. WING				२-C 5/ 06/2017
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				63	5 STATESVILLE BOULEVARD		
	R HEALTH & REHAB/SA	ALISBURT		SA	ALISBURY, NC 28144		
(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 SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 520	Continued From page	e 126	F 5	20			
					the elopement management process	and	
	Maintenance was cal	led on 2/25/17 at			to evaluate systems for effectiveness		
		m to facility and arrived			the facility's overall compliance with		
		immediately secured			Supervision to Prevent Accidents an		
	resident 's window, a	and conducted an audit of all			Elopements.		
		nit to ensure that they were					
		windows were found not			The District Director of Clinical Servi		
	secured when checke			re-educated the IDT on 5/6/17 on Fe			
		nt put in new window stopper			Regulation of F520 and QAPI Comm	littee	
	more than 6 inches.	fied that they opened no			Policy regarding the expectations regarding maintaining an ongoing Qu	olity	
	more than o mores.				Assurance and Performance	Janty	
	Staff were re-educate	ed 5/4/2017 on Elopement			Improvement (QAPI) program. The	QAPI	
	Process by the Area	•			committee consists of the Administra		
	2	shall work until re-educated			Director of Nursing, Medical Director		
	on process. On 2/27/	17 there was education			at least three other members and me	eets	
		iff who worked that day,			at least monthly (Medical Director at		
		ON. Nursing staff working			quarterly). Education also included t	he	
	5/4/17 were educated				processes and procedures of		
	-	nator that were currently in			implementing, reviewing and revising		
	•	eted phone education for			substantial regulatory compliance ar	Id	
		n facility. No staff members the education will work on			provide the highest level of care to	oo will	
	the unit until they con				residents. Newly hired IDT employe be educated upon hire.	CS WIII	
		olicy Procedure when there					
	is an Elopement or su	-			Opportunities will be corrected as		
	signs/symptoms of el	• •			identified.		
	supervision of resider						
		ntion strategies. All new hires			Measures put into place or systemic		
	will also receive this e	education.			changes made to ensure that the de	ficient	
	On $5/4/17$ the Admini	strator, Director of Nursing			practice will not occur:		
		plinary Team including the			The District Director of Clinical Servi	ces or	
		ADON, District Director of			the District Director of Operations wi		
		a Staff Development			monitor QAPI meetings monthly for t		
	Coordinator and Mai	-			months to assure compliance with F		
		se analysis regarding facility			Regulation F 520 to sustain and mai		
		nent prevention with regards			compliance with Federal Regulation		
		curity. Based on the results			323- Resident Safety to include ongo		

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STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE). 0938-039 SURVEY 'LETED	
	345115					R-C 05/06/2017	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CTR HEALTH & REHAB/SALISBURY			635 STATESVILLE BOULEVARD SALISBURY, NC 28144				
(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 SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 520	of this root cause and developed to include facility staff regarding systematic approach Checks on the Secure Weekly Audits by the Assistant, additionally conduct random week rounds. The Director increased supervision elopement or attempt establish safety and of investigation has beek interventions have bee Reports will be review Team daily during the led by the Administratite team will determine a ensure the care plan Administrator, DON at the QAPI Process by Clinical Services on 5 IDT to complete montareview of action plans for Performance Impri root cause analysis a potential and actual of Clinical Services will Minutes X 4 months, able. On 5/4/17, the Area S Coordinator conducted Administrator on the f procedures for asser- collecting data and an development and impri	Alysis a QA plan was re-education of all current the Elopement policy, and of more frequent Window e Unit. This will include Maintenance Director or y the Administrator will kly audits on his facility of Nursing will implement in for any resident with an to elope immediately to continue until the in completed and required een implemented .Incident wed by the Interdisciplinary e morning Stand Up meeting tor. The Interdisciplinary coceptable interventions and is revised. And ADON were educated on the District Director of 5/4/2017. Administrator and thly QAPI meetings with a and new areas of concern rovement, with evidence of ind action plans to address concerns. District Director of review monthly QAPI and attend meetings as	F 52	monitoring and revisions to the p necessary, and to maintain comp with F 204, 251, and 284 as they Social Service provisions and ad discharge planning and coordina safe and orderly discharge for all residents leaving facility. Monitoring Process: The Administrator will report the these audits weekly for 12 weeks the QAPI meeting and then moni- thereafter. The committee will re- these results and make recomme as required.	pliance relate to equate tion of a results of s during thly eview		

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		345115	B. WING				-C /06/2017	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			335 STATESVILLE BOULEVARD SALISBURY, NC 28144			
			10		PROVIDER'S PLAN OF CORRECTION		()(5)	
(X4) ID PREFIX TAG			ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 520	Study, Act method for Performance Improve scheduling, identificat or patterns, submission quality improvement p areas of opportunity. monthly in the past to compliance with F323 Accidents and Eloper weekly on 5/4/17 to in F323 Supervision to p focus on the review of conducted to correct a management process for effectiveness of th compliance with F323 Accidents and Eloper The Regional Director reeducated the IDT of Regulation F 520 and Committee Policy reg regarding maintaining Assurance and Perfor (QAPI) program. The of the Executive Director Services, Medical Director members and meets Director at least quart included the processe implementing, review action plans for areas been identified to attar regulatory compliance level of care to reside employees will be edu Regional Director of C	lity utilizes the Plan, Do, r Quality Assurance and ement Program including tion of Quality issues, trends on of data, and initiation of olans related to identified The committee has met o monitor ongoing 3 Supervision to prevent ment but will begin meeting horease monitoring with orevent Accidents with a f Window Checks being and maintain the elopement at to evaluate systems is facility ' s overall 3 Supervision to prevent ments. r of Clinical Services n 5/6/17 on Federal I Consulates QAPI arding the expectations g an ongoing Quality rmance Improvement QAPI Committee consists ctor, Director of Clinical ector and at least 3 other at least monthly (Medical terly). Education also es and procedures of ing and revising ongoing s of deficiency that have in and maintain substantial e and provide the highest	F	520				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 06/08/2017 / APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SUF	
		345115	B. WING			-		-C 06/2017
NAME OF PF	NAME OF PROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
BRIAN CT	R HEALTH & REHAB/SA	LISBURY			35 STATESVILLE BOULEV	ARD		
		ATEMENT OF DEFICIENCIES	ID		-	PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		COMPLETION DATE
F 520	compliance with Fede sustain and maintain Regulation F 323-Res ongoing monitoring an necessary, and to ma F204, 251, and F284 Service provisions an planning and coordina discharge for all resid The credible allegatio 6:26 PM by the follow Staff members from the including the Administ Rehabilitation Manage Resident Care Manage Maintenance Director these interviews they in-service training reg The Administrator was the facility 's Quality for both F323 and the F490. The Administ	m of quarterly to assure eral Regulation F 520 to compliance with Federal sident Safety to include nd revisions to the plan as intain compliance with as they relate to Social d adequate Discharge ation of a safe and orderly ents leaving facility. n was validated on 5/6/17 at ing: ne Management Team trator, Director of Nursing, er, Social Services Director, gement Director and were interviewed. During indicated that they received arding Quality Assurance. s interviewed and confirmed Assurance monitoring plans corporate oversight for trator verbalized his need to identify issues or ucility, and the role of QAPI	F	520		EFICIENCY)		

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