STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 000	INITIAL COMMENTS A follow-up complaint and new complaint investigation was conducted from 5/3/17 through 5/6/17. Immediate Jeopardy was identified at: CFR 483.15 at tag F204 at a scope and severity (J) CFR 483.70 at tag F251 at a scope and severity (J) CFR 483.21 at tag F284 at a scope and severity (J) CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F490 at a scope and severity (J) CFR 483.75 at tag F520 at a scope and severity (J) Immediate Jeopardy began on 2/25/17 at tags F323, F 490 and F520 for Resident #13 and on 4/1/17 at tags F204, F251, F284, F490 and F520 for Resident # 9. Immediate Jeopardy was removed on 5/6/17. An extended survey was conducted.	F 000		
F 204 SS=J	483.15(c)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG (c)(7) Orientation for Transfer or Discharge A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced	F 204		6/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/29/2017

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F 204	Continued From page 1 by: Based on observations, facility staff, Home Health Care staff, physician, resident and family interviews, and facility and hospital medical record reviews, the facility failed to arrange 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 training on tracheostomy care, and access to tracheostomy supplies for 1 of 1 sampled resident (Resident #9) who was discharged home from the facility with a tracheostomy. This resulted in a lack of tracheostomy care after discharge; and, the resident was subsequently diagnosed with neck cellulitis (a common and potentially serious bacterial skin infection) requiring treatment with antibiotics. Immediate jeopardy began on 4/1/17 when Resident #9 was discharged from the facility to his home. The resident had a tracheostomy and multiple co-morbidities (chronic conditions). The resident had not been accepted by a Home Health care agency to receive assistance with his tracheostomy care upon discharge, as he had expected. The resident did not have the training nor supplies to do the tracheostomy care on his own at home. He returned to the facility on 4/6/17 and was immediately sent to the hospital Emergency Department (ED) for an evaluation and treatment of the tracheostomy. He was diagnosed with neck cellulitis and prescribed both an oral and topical antibiotic. He was released from the hospital ED and re-admitted to the facility on 4/6/17. The immediate jeopardy was removed on 5/6/17	F 204	Brian Center Health and Rehabilitation/Salisbury acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on May 3-6, 2017. Brian Center Health and Rehabilitation/Salisbury's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, the Brian Center Health and Rehabilitation/Salisbury reserves the right to refute any deficiency on that Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F204 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #9 was discharged to his home from Brian Center Health and Rehabilitation/Salisbury on 4/1/17 at the request of the resident and his family.	

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F 204	Continued From page 2 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The findings included: A review of the Resident #9 ' s medical records revealed he was hospitalized on 12/17/16 for acute on chronic respiratory failure and pneumonia. While in the hospital, the resident required intubation and a tracheostomy (also known as a trach). Resident #9 was discharged from the hospital to the facility on 2/7/17. His cumulative diagnoses included chronic obstructive pulmonary disease, respiratory failure, and diabetes. A review of Resident #9 ' s admission Minimum Data Set (MDS) assessment dated 2/14/17 revealed he had intact cognitive skills for daily decision making. He required extensive assistance for bed mobility, dressing, and toileting; limited assistance for transfers and personal hygiene; and, supervision from staff for locomotion on the unit. The resident was independent with eating. Section O of the MDS assessment indicated Resident #9 received Occupational Therapy (OT) and Physical Therapy (PT) services. It also reported he had a tracheostomy and received oxygen therapy while he was a resident. Section Q of the MDS assessment revealed the resident and his family participated in the assessment process. The MDS reported his overall goal about returning to	F 204	Resident #9 required home health services for nursing, oxygen and supplies 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 nurse prior to discharge that they were unable to provide service for this resident. This nurse has received education form the Area Staff Development Coordinator regarding discharge policy and procedure on 5/5/17. The oxygen provider delivered oxygen but was unable to provide tracheostomy supplies. No arrangements for DME was confirmed prior to discharge. Resident #9 was returned to facility by his family on 4/6/17, was assessed and determined a need for care for his trach, due to drainage and odor, was sent to ER for eval and returned to facility where he readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17, and treated for infection. Resident #9 remains a current resident. At time of discharge there was no validation of home health admitting resident, what care was necessary to maintain stable health, and consequences of not providing this care for the resident and his family/caregiver. Section Q of the MDS was completed for Resident #9 on 4/13/17 and indicated that resident expects to remain in the facility. Throughout the discharge planning process for Resident #9 the facility was without a Qualified Social Worker.	

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F 204	Continued From page 3 the community was unknown or uncertain; and, active discharge planning was not occurring for the resident to return to the community. Section Q of the MDS reported the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community at the time of the assessment. However, Section Q of the MDS also indicated the resident wanted to be asked about returning to the community on all subsequent assessments. A review of the resident ' s care plan included the following areas of focus: --[Name of Resident] has a tracheostomy related to impaired breathing mechanics" (Initiated 2/7/17; Revised on 2/7/17). The stated goal for this area of focus was for the resident to have no signs/symptoms of infection through the review date (Initiated on 2/7/17; Revised on 3/16/17). The interventions outlined to meet this goal included: --Ensure that the tracheostomy ties (the bands that go around the neck and hold the trach tube in place, also known as trach collars) are secured at all times." (Initiated 2/7/17); --Observe/document respiratory rate, depth and quality. Check and document every shift or as ordered (Initiated 2/7/17); and, --Suction as necessary (Initiated 2/7/17). ---[Name of Resident] wishes to be discharged to home when able (Initiated on 3/8/17; Revised on 3/8/17). The stated goal for this area of focus was for the resident to be able to verbalize/communicate the assistance he would need post-discharge and the services required to meet his needs before discharge (Initiated on 3/8/17; Revised on	F 204	Facility's full-time Social Service Director 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 3/30/17. Qualified Social Worker remains employed. The administrator had an active role in the discharge process/planning for Resident #9. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: All residents discharging from the facility have the potential to be affected by this alleged deficient practice. The nurse managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: The Area Staff Development Director completed re-education on 5/5/17 of current licensed nurses and members of the interdisciplinary team involved in	

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F 204	Continued From page 4 3/16/17). The interventions outlined to meet this goal included: --Establish a pre-discharge plan with the resident/family/caregivers, evaluate progress, and revise the plan as needed with the resident ' s need for assistance with his tracheostomy care and Activities of Daily Living (ADL) assistance (Initiated on 3/8/17; Revised on 3/8/17); and, --Evaluate the resident ' s motivation to return to the community (Initiated on 3/8/17). A review of the resident ' s medical record included Respiratory Therapist (RT) notes dated 2/7/17, 2/8/17, 2/14/17, 2/23/17, 3/14/17, and 3/21/17. One additional RT note was not dated. No notations were made on the RT notes to indicate the RT provided education/training for the resident on the care of his tracheostomy. A review of Resident #9 ' s therapy notes revealed a home visit was conducted on 3/27/17 by OT and PT in anticipation of his discharge from the facility. Recommendations made from the home visit included the need for a shower chair, hand held shower head, grab bar in the shower, and oxygen on an as needed (PRN) basis. The notes recommended follow up OT, PT, and Speech Therapy (ST) upon discharge. A review of the resident ' s current physician orders (as of 3/31/17) included the following: --Tracheostomy: Change tubing and equipment every night shift every Wednesday (Initiated 2/7/17); --Oxygen saturation (also known as an O2 Sat) to be checked every shift and notify the Medical Doctor (MD) if the O2 Sat is less than 88% (Initiated 2/7/17). (An O2 Sat is a relative	F 204	discharge planning to include the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician. This education includes the facility policy 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 by: a) informing the resident where he or she is going; b) involving the resident and/or the responsible party in selecting the new residence; c) providing a home visit for the resident to the new location, if possible; d) making appropriate referrals; i.e.: Home Health, DME, O2 Supplies B. Nursing staff completes the Resident Transfer form if the resident is transferring to an acute health care facility or another nursing facility. C. The Post-Discharge Care Plan is completed by the Interdisciplinary Team for all planned discharges from the facility. If a resident is discharged home, nursing	

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F 204	Continued From page 5 measure of the amount of oxygen carried in the blood. Normal blood oxygen levels are typically considered to be 95-100%); --Trach #6 Shiley long (referring to the inner diameter and length of the tracheostomy tube): Tracheostomy care to be completed every shift and as needed (Initiated 2/7/17); and, --Oxygen (O2) at 5 liters (referring to the oxygen flow rate per minute) every shift (Initiated 3/2/17). A review of the resident ' s medical record included a Respiratory Therapist (RT) note dated 3/31/17. The respiratory assessment note revealed Resident #9 was sitting up in the chair with a pleasant demeanor. Tracheostomy care was done and the RT noted there was no change in the stoma (surgical opening) site at that time. Resident #9 was noted to be scheduled for discharge to home on 4/1/17. There was no notation on the RT note to indicate the resident was trained on care of the tracheostomy. A review of the resident ' s medical record included a physician ' s note dated 3/31/17 at 12:51 PM. The physician noted Resident #9 was seen for a discharge summary. The notation read as follows, in part: "[Name of Resident] is seen today in anticipation of his discharge from the facility this weekend. He was admitted to the [Name of Facility] on 2/8/17 after being hospitalized for acute on chronic respiratory failure and pneumonia subsequently requiring intubation and tracheostomy. Since his admission he has done well with rehabilitation and with trach care. For the past several weeks he has been seen ambulating around the facility without any SOB or imbalance and has not been requiring oxygen when walking ..."	F 204	staff reviews the plan with the resident and/or the resident's legal representative prior to discharge. D. The physician provides discharge order. No licensed nurses shall work after 5/5/17 before receiving this education. This education has been added to the facility orientation program for all new hires and agency staff to be completed prior to beginning work after 5/5/17. District Care Management Director (MDS educated the facility MDS department and Social Services Director on completion of Section Q on 5/6/17. The Administrator, Director of Nursing or Nurse Manager will review residents planned for discharge three times per week for 12 weeks to ensure a safe and orderly discharge has been planned, by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visit when possible and validating the completion of appropriate referrals. District Director of Care Management will audit five MDSs weekly for 12 weeks to validate accurate completion of Section Q. Opportunities will be corrected as identified. Monitoring Process:	

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F 204	Continued From page 6 Plan: "COPD: Diminished breath sounds and is high risk for re-hospitalization but is felt stable to go home. HH (Home Health) nursing, PT/OT." A review of Resident #9 ' s medical record revealed a Nursing Note dated 4/1/17 at 7:35 PM reported, in part: " ...Patient went home." A review of the Home Health agency notes dated 4/1/17 (not timed) included the following text: "Call from [name of resident ' s Family Member #2] regarding waiting for [name of Home Health agency] to come out. Informed non-admitted due to trach. Spoke with [name of Home Health representative] who informed [name of Nurse #1] at [name of facility]. Also spoke with [name of Home Health staff member], could not accept referral as it would take 2-3 weeks to set up PDN (private duty nurse). She informed marketing manager [name of manager]. Tried to call [name of facility], but they would not provide any information and CM (Case Management) Department is closed until Monday." An email dated 4/3/17 at 4:16 PM was provided by the Home Health agency for review. The email was sent from the Home Health agency ' s Marketing Manager to both the Office Manager for Resident #9 ' s primary care physician and the facility ' s Administrator. The text of the email read: "I have copied [name of facility ' s Administrator] on this email as well to keep everyone in the loop. I spoke with the other Home Health Agencies and even though [name of Resident #9 ' s insurance company] approved Home Health hours for this client he is not appropriate for Home Care. He is high risk for a hospitalization and his best place is back in [name of facility] where he can get the	F 204	The Administrator will report the results of these audits weekly for 12 weeks during QAPI meeting and then monthly thereafter. The committee will review these results and make recommendations as required.	

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 204	Continued From page 7	F 204		

proper care he needs. The client wanted to go home and when [name of resident ' s physician at the facility] saw him last week he even stated he would end up back in the hospital. I talked with [name of representative for the oxygen supply company] and they only delivered Oxygen to the home and no Trach supplies-When you guys see this client tomorrow I would recommend sending him back to [name of the facility]. I hate it for [resident ' s name] but his best place for the care he needs is at SNF (skilled nursing facility) level. [Name of facility ' s Administrator] will have his team prepare a bed to make a smooth transition just in case."

A review of Resident #9 ' s paper medical record included documentation from a follow-up diabetic visit on 4/4/17 with an outside Internal Medicine service. Progress notes written by the Physician Assistant (PA) on 4/4/17 included the following notations, in part:
" ...Recently hospitalized for respiratory failure 12/17/16, tracheostomy performed. Discharged to SNF [name of facility]. Patient was told he could be discharged over the weekend. He was released however has had difficulty getting home health to come out with trach supplies. [Name of Family Member #2] accompanies the patient today-she states he will not go back to [name of facility] because "he doesn ' t want to." Patient has a history of noncompliance and refusing home health. He lives at home with his [name of Family Member #1]. No fever or difficulty breathing since discharge."
The PA ' s Impression/Plan from the 4/4/17 visit read:
"Do not think patient is appropriate for outpatient care. Discussed at length my concerns of not returning to a SNF for care given multiple

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F 204	Continued From page 8	F 204		

comorbidities. Both he and his [name of Family Member #2] are adamant that patient will not be returning to [name of facility]. [Name of another Home Health agency] will bring supplies out to patient. Patient is in agreement for close follow up-will return in 2 weeks for BP (blood pressure) check. Labs pending."

A review of the hospital Emergency Department (ED) records from 4/6/17 revealed Resident #9 arrived to the ED at 2:48 PM via Emergency Medical Services (EMS). The ED history included the following comments:
"Patient presents today complaining of need for tracheostomy care. He was released from the [name of facility] on Saturday and has been home for the last 5 days. He is referred back to the [name of facility] today because of inability to care for himself in the home but upon return to the Center, they sent him here because he had foul discharge from his tracheostomy site. Patient is denying any other problems. He states that he does get confused to time so he is unclear as to exact dates when his last trach collar and trach was changed."
The hospital ED records revealed upon examination, Resident #9 had erythematous (redness) and superficial skin breakdown all around the trach collar site. The resident was diagnosed with cellulitis of the neck. The ED Respiratory Notes dated 4/6/17 at 3:57 PM read, "trach was in place with trach collar-foul smell coming from trach area states last changed Saturday-collar wet with drainage-Respiratory at bedside will change out trach and replace trach collar ..." The resident was discharged from the ED to the facility on 4/6/17. His discharge medication orders included 2% Bactroban (a topical antibiotic ointment) and 875-125

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F 204	Continued From page 9	F 204		

milligrams (mg) amoxicillin-clavulanate (an oral antibiotic) to be given as one tablet by mouth every 12 hours for 10 days.

A review of the Resident #9 ' s electronic medical record dated 4/6/17 at 9:49 PM indicated the resident was re-admitted to the facility. No distress was noted and he was assessed as being alert and oriented.

A review of the resident ' s physician orders for the re-admission included the following:
--Tracheostomy: Change tubing and equipment every night shift every Wednesday (Initiated 4/7/17);
--Trach #6 Shiley long: Tracheostomy care to be completed every shift and as needed (Initiated 4/7/17);
--Check O2 Sat every shift and notify MD if O2 Sat is less than 88% (Initiated 4/7/17);
--Trach collar with 5 liters O2 per minute as needed during the day for O2 Sats less than 91% (Initiated 4/8/17); and,
--Trach collar with 5 liters O2 per minute every evening and night shift (Initiated 4/8/17).

A review of the resident ' s medical record included a Respiratory Therapist (RT) note dated 4/7/17. The respiratory assessment revealed Resident #9 ' s trach was changed on 4/6/17 at the hospital. The respiratory assessment noted the resident was readmitted on 4/6/17 after going to the ED for cellulitis around his trach. It read, in part: "No trach care was done while he was at home. He is on ABT (antibiotic) and Bactroban to trach site." The resident ' s trach site was noted as red, sore, and bleeding easily.

A review of Resident #9 ' s admission Minimum

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 204	Continued From page 10	F 204		

Data Set (MDS) assessment dated 4/13/17 revealed the resident had intact cognitive skills for daily decision making. He was independent for all of his ADLs, with the exception of requiring supervision from staff for eating. Section O of the MDS assessment reported he received tracheostomy care and oxygen therapy while he was a resident. Section Q of the MDS assessment revealed the resident participated in the assessment process and was expecting to remain in the facility. However, the MDS also revealed the resident did want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community at the time of the assessment.

An interview was conducted on 5/4/17 at 2:15 PM with the facility ' s Unit 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 2:20 PM with a Corporate Director of Nursing (Corporate DON #1). During the interview, the Corporate DON stated she recalled the facility ' s Administrator had worked with Resident #9 quite

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 11	F 204		

a bit and suggested he might be able provide additional insight into the events of 4/6/17.

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 family knew ahead of time they wanted the resident to go home. The Administrator stated he himself arranged Home Health care "well in advance" of the resident ' s discharge on 4/1/17. Upon request, the Administrator provided contact information for the Home Health representative. The Administrator stated, "Everybody knew what was happening." He reported on Friday night (3/31/17) around 6:00 PM, both he and Resident #9 met with an oxygen supply company when they brought his oxygen to take home and educated him on its use. The Administrator confirmed Resident #9 was discharged on Saturday, 4/1/17.

As the interview continued on 5/4/17 at 2:30 PM, the Administrator reported Resident #9 ' s insurance company contacted him on Monday (4/3/17) and reported the resident ' s family was concerned he wasn ' t doing well at home with the tracheostomy. The Administrator spoke with the resident ' s family member (Family Member #2) by telephone on 4/3/17, 4/4/17, and 4/5/17. He told this family member that the facility would be happy to take the resident back. However, the resident had a physician appointment scheduled that week and the family planned to take him to it. On Thursday, 4/6/17, the Administrator reported he called the family member [Family Member #2] around 12:00 PM and was basically told they were on their way to bring the resident back to the facility. When the resident arrived, the Administrator stated he could smell the trach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 12	F 204		

collar and wanted to get it evaluated. The facility called 911 and the hospital ED to tell them the resident was being sent over. The Administrator reported the resident was seen in the ED and returned to the facility around 8:00 -9:00 PM the evening of 4/6/17.

A telephone interview was conducted on 5/4/17 at 4:35 PM with the Marketing Manager for the Home Health agency who had received a referral from the Administrator for Resident #9 ' s home care. During the interview, the resident ' s discharge arrangements for 4/1/17 were discussed. As the Marketing Manager reviewed the resident ' s Home Health record, she reported the agency was given the Home Care referral on 3/28/17. The Manager explained their Home Health agency was divided into two sections: the Hourly care side (which did work with tracheostomies) and the Home Health care side (which did not work with trachs). On 3/31/17, the agency learned the resident did not have insurance coverage for the Hourly care; and the Home Health care side did not do trach care. The Home Health office contacted the Marketing Manager on 3/31/17. On 3/31/17, the Marketing Manager telephoned the facility and informed Nurse #1 their Home Health agency couldn ' t take this resident. She also reported her agency contacted two other Home Health agencies, but Resident #9 was not accepted by either of them. With the discharge still planned for 4/1/17, the Marketing Manager stated she coordinated a delivery of oxygen to the facility on Friday night (3/31/17) so the resident would have it when he went home. On Monday (4/3/17), she went to the facility for follow-up because she was concerned about an unsafe discharge if the resident actually went home over the weekend. The Marketing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 13	F 204		

Manager stated she also wanted to make sure the facility had a bed for the resident if he decided to come back. The Marketing Manager reported she talked with the Office Manager for Resident #9 ' s primary care physician on 4/3/17, then followed up with an email to both the Office Manager and the facility ' s Administrator to be sure everyone had the information.

An interview was conducted on 5/5/17 at 8:00 AM with Resident #9. During the interview, the resident recalled he and the Administrator met with someone on Friday night (3/31/17) to get his oxygen arranged for discharge. When the resident was asked what was arranged for him prior to discharge, he reported that in addition to the oxygen he had a shower chair, a shower bar, and a railing for the commode at home that his family had purchased. He stated the shower bar and railing for the commode had not yet been installed by his landlord when he arrived home on 4/1/17. Upon further inquiry, the resident stated "someone" on the phone had told him he would get 24-hour nursing care when he got home. He reported he did not know how to do his own trach care and did not receive any trach supplies to use at home when he was discharged from the facility. He reported he expected a Home Health nurse to come out to his home to take care of his tracheostomy, but no one did.

A telephone interview was conducted on 5/5/17 at 10:48 AM with the Respiratory Therapist (RT) who worked with Resident #9. The RT reported she worked for a contracted company and came to the facility once a week to provide tracheostomy care for the resident. Prior to his 4/1/17 discharge, the RT noted Resident #9 had issues with his skin under the tracheostomy due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 14	F 204		

to a small amount of drainage and having some trouble keeping the skin dry. She reported the skin looked a little irritated and was a little sore when cleaned. The RT stated she was hoping the Home Health nurse would continue to follow this issue under his tracheostomy collar. When asked what kind of trach care the resident required, the RT stated he received routine trach care once every shift (3 times a day) while in the facility, but may have been able to do the trach care twice daily upon discharge. She reported routine tracheostomy care involved cleaning the area behind the flange (the area where the ties or sutures are connected to secure the tube in place) and making sure there were no secretions; changing the trach ties and cannula (the body of the tube that is inserted into the trachea), and replacing the drain sponge underneath. The RT stated she was under the impression the resident and a family member would do some of his trach care, with the Home Health nurse going out a few times a week to make sure it was done appropriately. Without reviewing her notes, the RT did not recall if she had done tracheostomy care training with the resident, but was certain she did not train a family member on the trach care. The RT stated if she had done trach care teaching with the resident, she would have included a notation documenting this in her Respiratory Notes. The RT stated if the resident was trained, he may be able to do the procedure for the trach care. However, she was unsure if he would reliably do the care twice daily every day. When asked if she had understood this resident would be going home with Home Health, she stated, "Absolutely." Upon further inquiry, the RT reported having a suction machine would usually be a standard for anyone going home with a tracheostomy. When asked what her thoughts

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 15	F 204		

were regarding the resident going home without a suction machine, the RT reported that although she didn ' t think he ' d have a big problem, she stated, "You never know." The RT stated she saw the resident the day after he was readmitted to the facility on 4/6/17. She recalled he had been put on an antibiotic for neck cellulitis and reported the condition of the skin had improved significantly over the last few weeks.

An interview was conducted on 5/5/17 at 12:24 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 16	F 204		

(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 Manager reported she was at the facility when the resident presented on 4/6/17 with foul smelling drainage from his tracheostomy. The Unit Manager stated she did not assess the tracheostomy and could not tell what color the drainage was. She reported two nurses who may have assessed the drainage prior to sending the resident out to the hospital no longer worked at the facility.

A telephone interview was conducted on 5/5/17 at 1:24 PM with Nurse #1. Nurse #1 was identified as the nurse who received a phone call from the Home Health agency on 3/31/17, informing the facility Resident #9 was not admitted to Home Health due to having a tracheostomy. When asked about this phone call, the nurse stated, "I believe they did speak with me ...the Administrator was involved. Someone called ...the supply company maybe ...and the Administrator was going to call and confirm with [name of the Marketing Manager] everything was in place." When asked what preparations were made prior to the resident ' s discharge, the nurse stated she knew someone brought out portable oxygen for the resident ' s trip home and they were also going to deliver his home oxygen. When asked if the resident had received any training or education on trach care, the nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 17	F 204		

reported, "Anytime I worked with his trach I tried to teach him." When asked if the resident ever did the tracheostomy care himself, the nurse stated, "Not really."

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 process for Resident #9. The Administrator stated the facility had been "between Social Workers," so he, the MDS nurse and the Activities Manager, shared the duties of the Social Worker while the position was vacant. He reported the discharge for Resident #9 was handled between himself, nursing, and possibly the Activities Manager. Upon inquiry, the Administrator stated he was not aware the facility was notified on 3/31/17 by the Home Health agency that Resident #9 was not accepted for home care. He reported he did not find this information out until Monday, 4/3/17.

A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident ' s physician at the facility. This physician also served as the facility ' s Medical Director. The physician recalled that when he saw the resident on 3/31/17, he expected the resident to receive Home Health services upon discharge. The physician stated that if he was not going to receive these services, he would have wanted to be informed. The MD stated, "I certainly would not want this to happen again."

A telephone interview was conducted on 5/6/17 at 9:25 AM with the resident ' s 2nd family member (Family Member #2) who provided transportation for the resident and had been in contact with his health care providers after he was discharged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 18	F 204		

from the facility. Family Member #2 reported she began talking with the facility about the resident ' s discharge sometime in March. When asked who chose 4/1/17 as his discharge date, she stated, "I guess they did. They told us they could get things in place for April 1st." The family member reported oxygen was delivered to the home where Resident #9 would be staying on 3/31/17 in preparation for his discharge. When she picked the resident up from the facility on 4/1/17 (between 10:00 AM - 12:00 PM), he had portable oxygen for the trip home. Family Member #2 stated the staff seemed a little surprised he was being discharged. The family member stated she signed a paper saying she was picking up the resident, and was given prescriptions for his medications. When asked if either she or the resident were given any instructions for home, she said, "No." She recalled asking the nurse (Nurse #3) if the Home Health was set up, and was told they "thought so" and the Home Health nurse would be out to the house later that day. Family Member #2 stated she was not sure how often the Home Health nurse was going to be coming out, but expected to find out more when the nurse came to the house on 4/1/17. She stated her main concern was making sure the resident ' s trach was cleaned, changed, and generally taken care of. Family Member #2 stated when she got the resident home to stay with Family Member #1, they couldn ' t get a nurse to come out. The resident told her he didn ' t know how the trach had to be cleaned. Family Member #2 reported she called the facility two to three times on 4/1/17 to ask why the Home Health care people weren ' t coming to the home and she was told they would be coming. After waiting with the resident at his home for hours, Family Member #2 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 19	F 204		

went to her own home and called the Home Health agency herself. The Home Health agency told her nobody was coming. The family member stated she questioned that because he was already at home and stated, "Had I known nobody was coming, I would not have taken him home." They said they didn ' t do patients with trachs and said they had told somebody at the facility they didn ' t do them. The family member stated she made an appointment with the resident ' s physician to see if they could help get someone out to take care of the trach, "but they didn ' t check it either." She recalled sometime during the week a nurse from another Home Health agency came to the house, but she didn ' t touch the trach because he didn ' t have anybody at home who was able to provide help with the trach care. Family Member #2 reported she had talked with the facility ' s Administrator each day during the week Resident #9 was home. She was told the facility would take him back, but the resident did not want to go back. The family member stated, "I was scared with nobody checking the trach and it was already kinda messy." She reported bringing the resident back to the facility on that Thursday (4/6/17) and stated, "It (the tracheostomy) was smelling and everybody was standing back. It was a mess." The family member stated the facility sent him to the hospital ED after he arrived there. Resident #9 returned to the facility later that evening.

A telephone interview was conducted 5/6/17 at 10:32 AM with Nurse #3. The nurse reported she worked at the facility on an "as needed" basis, ranging in frequency from twice a month to twice a week. Nurse #3 was identified as the nurse who worked the 1st shift on 4/1/17 when Resident #9 was discharged. The nurse recalled when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 20	F 204		

Resident #9 ' s family member came to pick up the resident on the morning of 4/1/17. Nurse #3 reported she had not been told ahead of time that the resident was going to be discharged that morning. Nurse #3 recalled telling the resident and family member a Home Care agency would come out to the home. When asked what was sent home with the resident, the nurse reported she gave him prescriptions for his medications and 3 tracheostomy kits from the facility. However, the family member said they would wait for the Home Health agency nurse to come out and would get the tracheostomy supplies from them. Nurse #3 stated she had done some routine teaching with the resident during his stay (not at discharge). Upon inquiry, the nurse reported she thought the resident may have done some of his own trach care during his stay at the facility. However, she also reported that would have been, "some time ago." The nurse stated a while back she left the tracheostomy care supplies in the room for the resident to do his own trach care, but when she came back it was not done. She tried to encourage the resident by saying, "you ' ve gotta do it," but he didn ' t want to. Nurse #3 described the resident as alert but not necessarily cognitively intact. She reported his cognition varied from day to day. Nurse #3 reported she tried to call Home Health, but the agency did not return her call.

An interview was conducted on 5/6/17 at 6:10 PM with the facility ' s Administrator. During the interview, the Administrator was asked what his expectations were in relation to the provision of a safe and orderly discharge of a resident. The Administrator stated he would expect his Director of Social Services to coordinate and plan the resident ' s discharge with input from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 21 Interdisciplinary Team. On 5/5/17 at 3:58 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 5/6/17 at 1:06 PM. The allegation of compliance indicated: Credible Allegation for F204 F204: Orientation for Transfer or Discharge Criteria 1 Resident #9 was discharged to his home from [Name of Facility] on 4/1/17. Resident #9 required Home Health Services for Nursing, Oxygen, suction machine, and supplies to manage tracheostomy care at home. The Facility Administrator completed a referral to the Home Health Agency on 3/28/2017, prior to discharge from the facility. Home Health Agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse has received education from the Areas Staff Development Coordinator, regarding Discharge Policy and Procedure on 5/5/17. The Oxygen Provider delivered Oxygen. No arrangements for DME (Durable Medical Equipment) was confirmed prior to discharge. Resident # 9 was returned to facility by his family on 4/6, was assessed and determined need for care for his Tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to [Name of Facility] on 4/6/2017, and treated for infection. Resident # 9 remains a current resident. At time of discharge there was no validation of Home Health admitting resident, no confirmation of DME, and no documented education related to signs and	F 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 22 symptoms of problems, what care was necessary to maintain stable health, and consequences of not providing this care, for the resident and his family/ caregiver. Section Q of the MDS was completed for Resident # 9 on 4/13/17 and indicated that resident expects to remain in the facility. Throughout the Discharge Planning Process for Resident #9 the Facility was without a Qualified Social Worker. Facilities Full Time Social Service Director resigned without notice on 1/26/17. Facility went without a qualified Social Worker 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. Criteria 2 All residents discharging from the facility have the potential to be affected by this alleged deficient practice. The Nurse Managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. Criteria 3 The Area Staff Development Director completed re-education on 5/5/17 of current Licensed Nurses and members of the Interdisciplinary Team involved in discharge planning to include	F 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 23	F 204		

the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician. This education includes the facility policy 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 by:
- Informing the resident where he or she is going;
-Involving the resident and/or the responsible party in selecting the new residence;
-Providing a home visit for the resident to the new location if possible;
-Making appropriate referrals; ie: Home Health, DME, O2 supplies.

B. Nursing staff completes the Resident Transfer form if the resident is transferring to an acute health care facility or another nursing facility.

C. The Post-Discharge Care Plan is completed by the Interdisciplinary Team for all planned discharges from the facility. If a resident is discharged to home, nursing staff reviews the plan with the resident and/or the resident ' s legal representative prior to discharge.

D. The Physician provides a discharge order.
No Licensed Nurses shall work after 5/5/17 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work after 5/5/17.

The Administrator, Director of Nursing or Nurse Manager will review residents planned for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 204	Continued From page 24 discharge 3 times per week for 12 weeks to ensure a safe and orderly discharge has been planned by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visits when possible and validating the completion of appropriate referrals. District Care Management Director (MDS), educated the facility MDS department and Social Service Director on completion of Section Q, on 5/6/17. Facility alleged IJ removal 5/6/17 The credible allegation was validated on 5/6/17 at 5:29 PM. On 5/6/17 from 4:25 PM through 5:29 PM, staff members from the Nursing (Licensed Nurses), Social Services, and Therapy Departments were interviewed. Staff were able to describe the education received on the facility policy regarding Transfer and Discharge Procedures and the role they were expected to fulfill during the discharge planning process. The MDS nurses were interviewed and able to verbalize the in-servicing received for the accurate completion of Section Q of the MDS assessment. Administrative staff, including the Director of Nursing and Administrator, were also interviewed. The DON and Administrator were able to describe the education each received, along with their respective role to review residents planned for discharge and ensure the appropriate plans were in place and resources were available for the safe discharge of each resident. An audit of residents who have discharged from the facility since 4/1/17 was reviewed, verifying each resident received sufficient preparation and resources for a safe discharge. The immediate jeopardy was removed on 5/6/17 at 5:29 PM.	F 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 25	F 251		
F 251 SS=J	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 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 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 training on tracheostomy care, and access to tracheostomy supplies. This occurred for 1 of 1 sampled resident (Resident #9) who was discharged home from the facility with a tracheostomy and resulted in a lack of tracheostomy care after discharge. The resident was subsequently diagnosed with neck cellulitis	F 251	F251 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #9 was discharged to his home from Brian Center Health and Rehabilitation/Salisbury on 4/1/17 at the request of the resident and his family. Resident #9 required home health services for nursing, oxygen and supplies 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 unable to provide service for the resident.	6/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 26 (a common and potentially serious bacterial skin infection) and required treatment with antibiotics. Immediate jeopardy began on 4/1/17 when Resident #9 was discharged from the facility to his home. The resident had a tracheostomy and multiple co-morbidities (chronic conditions). The resident had not been accepted by a Home Health care agency to receive assistance with his tracheostomy care upon discharge, as he had expected. The resident did not have the training nor supplies to do the tracheostomy care on his own at home. He returned to the facility on 4/6/17 and was immediately sent to the hospital Emergency Department (ED) for an evaluation and treatment of the tracheostomy. He was diagnosed with neck cellulitis (a common and potentially serious bacterial skin infection) and prescribed both an oral and topical antibiotic. He was released from the hospital ED and re-admitted to the facility on 4/6/17. The immediate jeopardy was removed on 5/6/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The findings included: A review of the Resident #9 ' s medical records revealed he was hospitalized on 12/17/16 for acute on chronic respiratory failure and pneumonia. While in the hospital, the resident required intubation and a tracheostomy (also	F 251	This information was not communicated with facility management for follow up. This nurse has received education form the Area Staff Development Coordinator regarding discharge policy and procedure on 5/5/17. The oxygen provider delivered oxygen but was unable to provide tracheostomy supplies. No arrangements for DME was confirmed prior to discharge. Resident #9 was returned to facility by his family on 4/6/17, was assessed and determined need for his tracheostomy , due to drainage and odor, was sent to ER for evaluation and returned to facility where he was readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17 and treated for infection. Resident #9 remains a current resident. At time of discharge there was no validation of home health 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 consequences of not providing this care, for the resident and his family/caregiver. Section Q of the MDS was completed for Resident #9 on 4/13/17, and indicated that resident expects to remain in the facility. Throughout the discharge planning process for Resident #9 the facility was without a Qualified Social Worker. Facility's full time Social Service Director 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 3/30/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 251	Continued From page 27 known as a trach). Resident #9 was discharged from the hospital to the facility on 2/7/17. His cumulative diagnoses included chronic obstructive pulmonary disease, respiratory failure, and diabetes. A review of Resident #9 ' s admission Minimum Data Set (MDS) assessment dated 2/14/17 revealed he had intact cognitive skills for daily decision making. He required extensive assistance for bed mobility, dressing, and toileting; limited assistance for transfers and personal hygiene; and, supervision from staff for locomotion on the unit. The resident was independent with eating. Section O of the MDS assessment indicated Resident #9 received Occupational Therapy (OT) and Physical Therapy (PT) services. It also reported he had a tracheostomy and received oxygen therapy while he was a resident. Section Q of the MDS assessment revealed the resident and his family participated in the assessment process. The MDS reported his overall goal about returning to the community was unknown or uncertain; and, active discharge planning was not occurring for the resident to return to the community. Section Q of the MDS reported the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community at the time of the assessment. However, Section Q of the MDS also indicated the resident wanted to be asked about returning to the community on all subsequent assessments. A review of the resident ' s care plan included the following areas of focus: ---[Name of Resident] has a tracheostomy related to impaired breathing mechanics (Initiated 2/7/17;	F 251	Qualified Social Worker remains employed. The Administrator had an active role in the discharge process/planning for Resident #9. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: All residents discharging form the facility have the potential to be affected by this alleged deficient practice. The nurse managers conducted an audit of residents who have discharged form the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge and support was provided by a qualified social worker. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. Administrator has no Social Service background. During the time period the facility was without a qualified Social Service Director, the Administrator, Business Office Manager, and DON were responsible for discharge process. There was no additional support form outside the facility to cover Social Service responsibilities. Measures put into place or systemic changes made to ensure that the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 28 Revised on 2/7/17). The stated goal for this area of focus was for the resident to have no signs/symptoms of infection through the review date (Initiated on 2/7/17; Revised on 3/16/17). The interventions outlined to meet this goal included: --Ensure that the tracheostomy ties (the bands that go around the neck and hold the trach tube in place, also known as trach collars) are secured at all times (Initiated 2/7/17); --Observe/document respiratory rate, depth and quality. Check and document every shift or as ordered (Initiated 2/7/17); and, --Suction as necessary (Initiated 2/7/17). ---[Name of Resident] wishes to be discharged to home when able (Initiated on 3/8/17; Revised on 3/8/17). The stated goal for this area of focus was for the resident to be able to verbalize/communicate the assistance he would need post-discharge and the services required to meet his needs before discharge (Initiated on 3/8/17; Revised on 3/16/17). The interventions outlined to meet this goal included: --Establish a pre-discharge plan with the resident/family/caregivers, evaluate progress, and revise the plan as needed with the resident ' s need for assistance with his tracheostomy care and Activities of Daily Living (ADL) assistance (Initiated on 3/8/17; Revised on 3/8/17); and, --Evaluate the resident ' s motivation to return to the community (Initiated on 3/8/17). A review of the resident ' s medical record included Respiratory Therapist (RT) notes dated 2/7/17, 2/8/17, 2/14/17, 2/23/17, 3/14/17, and 3/21/17. One additional RT note was not dated.	F 251	practice will not occur: The Director of Clinical Services completed re-education of Administrator and Director of Nursing on 5/5/17. This education included facility policy of providing social services and state 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 Service Support is retained to meet the requirements of regulation. The District Director of Clinical Services or the District Director of Operations will provide oversight of Facility Administrator to ensure implementation and adherence to F251 by providing on site and remote 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 results of these audits weekly for 12 weeks during the QAPI meeting and then monthly thereafter. The committee will review these results and make recommendations as required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 29	F 251		

No notations were made on the RT notes to indicate the RT provided education/training for the resident on the care of his tracheostomy.

A review of Resident #9 ' s therapy notes revealed a home visit was conducted on 3/27/17 by OT and PT in anticipation of his discharge from the facility. Recommendations made from the home visit included the need for a shower chair, hand held shower head, grab bar in the shower, and oxygen on an as needed (PRN) basis. The notes recommended follow up OT, PT, and Speech Therapy (ST) upon discharge.

A review of the resident ' s current physician orders (as of 3/31/17) included the following:
--Tracheostomy: Change tubing and equipment every night shift every Wednesday (Initiated 2/7/17);
--Oxygen saturation (also known as an O2 Sat) to be checked every shift and notify the Medical Doctor (MD) if the O2 Sat is less than 88% (Initiated 2/7/17). An O2 Sat is a relative measure of the amount of oxygen carried in the blood. Normal blood oxygen levels are typically considered to be 95-100%;
--Trach #6 Shiley long (referring to the inner diameter and length of the tracheostomy tube): Tracheostomy care to be completed every shift and as needed (Initiated 2/7/17); and,
--Oxygen (O2) at 5 liters (referring to the oxygen flow rate per minute) every shift (Initiated 3/2/17).

A review of the resident ' s medical record included a Respiratory Therapist (RT) note dated 3/31/17. The respiratory assessment note revealed Resident #9 was sitting up in the chair with a pleasant demeanor. Tracheostomy care was done and the RT noted there was no change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 30	F 251		

in the stoma (surgical opening) site at that time. Resident #9 was noted to be scheduled for discharge to home on 4/1/17. There was no notation on the RT note to indicate the resident was trained on care of the tracheostomy.

A review of the resident ' s medical record included a physician ' s note dated 3/31/17 at 12:51 PM. The physician noted Resident #9 was seen for a discharge summary. The notation read as follows, in part:
"[Name of Resident] is seen today in anticipation of his discharge from the facility this weekend. He was admitted to the [Name of Facility] on 2/8/17 after being hospitalized for acute on chronic respiratory failure and pneumonia subsequently requiring intubation and tracheostomy. Since his admission he has done well with rehabilitation and with trach care. For the past several weeks he has been seen ambulating around the facility without any SOB or imbalance and has not been requiring oxygen when walking ..."
Plan: "COPD: Diminished breath sounds and is high risk for re-hospitalization but is felt stable to go home. HH (Home Health) nursing, PT/OT."

A review of Resident #9 ' s medical record revealed a Nursing Note dated 4/1/17 at 7:35 PM reported, in part: " ...Patient went home."

A review of the Home Health agency notes dated 4/1/17 (not timed) included the following text:
"Call from [name of resident ' s Family Member #2] regarding waiting for [name of Home Health agency] to come out. Informed non-admitted due to trach. Spoke with [name of Home Health representative] who informed [name of Nurse #1] at [name of facility]. Also spoke with [name of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 31	F 251		

Home Health staff member], could not accept referral as it would take 2-3 weeks to set up PDN (private duty nurse). She informed marketing manager [name of manager]. Tried to call [name of facility], but they would not provide any information and CM (Case Management) Department is closed until Monday."

An email dated 4/3/17 at 4:16 PM was provided by the Home Health agency for review. The email was sent from the Home Health agency ' s Marketing Manager to both the Office Manager for Resident #9 ' s primary care physician and the facility ' s Administrator. The text of the email read:
"I have copied [name of facility ' s Administrator] on this email as well to keep everyone in the loop. I spoke with the other Home Health Agencies and even though [name of Resident #9 ' s insurance company] approved Home Health hours for this client he is not appropriate for Home Care. He is high risk for a hospitalization and his best place is back in [name of facility] where he can get the proper care he needs. The client wanted to go home and when [name of resident ' s physician at the facility] saw him last week he even stated he would end up back in the hospital. I talked with [name of representative for the oxygen supply company] and they only delivered Oxygen to the home and no Trach supplies-When you guys see this client tomorrow I would recommend sending him back to [name of the facility]. I hate it for [resident ' s name] but his best place for the care he needs is at SNF (skilled nursing facility) level. [Name of facility ' s Administrator] will have his team prepare a bed to make a smooth transition just in case."

A review of Resident #9 ' s paper medical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 32	F 251		

included documentation from a follow-up diabetic visit on 4/4/17 with an outside Internal Medicine service. Progress notes written by the Physician Assistant (PA) on 4/4/17 included the following notations, in part:
" ...Recently hospitalized for respiratory failure 12/17/16, tracheostomy performed. Discharged to SNF [name of facility]. Patient was told he could be discharged over the weekend. He was released however has had difficulty getting home health to come out with trach supplies. [Name of Family Member #2] accompanies the patient today-she states he will not go back to [name of facility] because "he doesn ' t want to." Patient has a history of noncompliance and refusing home health. He lives at home with his [name of Family Member #1]. No fever or difficulty breathing since discharge."
The PA ' s Impression/Plan from the 4/4/17 visit read:
"Do not think patient is appropriate for outpatient care. Discussed at length my concerns of not returning to a SNF for care given multiple comorbidities. Both he and his [name of Family Member #2] are adamant that patient will not be returning to [name of facility]. [Name of another Home Health agency] will bring supplies out to patient. Patient is in agreement for close follow up-will return in 2 weeks for BP (blood pressure) check. Labs pending."

A review of the hospital Emergency Department (ED) records from 4/6/17 revealed Resident #9 arrived to the ED at 2:48 PM via Emergency Medical Services (EMS). The ED history included the following comments:
"Patient presents today complaining of need for tracheostomy care. He was released from the [name of facility] on Saturday and has been home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 33	F 251		

for the last 5 days. He is referred back to the [name of facility] today because of inability to care for himself in the home but upon return to the Center, they sent him here because he had foul discharge from his tracheostomy site. Patient is denying any other problems. He states that he does get confused to time so he is unclear as to exact dates when his last trach collar and trach was changed."
The hospital ED records revealed upon examination, Resident #9 had erythematous (redness) and superficial skin breakdown all around the trach collar site. The resident was diagnosed with cellulitis of the neck. The ED Respiratory Notes dated 4/6/17 at 3:57 PM read, "trach was in place with trach collar-foul smell coming from trach area states last changed Saturday-collar wet with drainage-Respiratory at bedside will change out trach and replace trach collar ..." The resident was discharged from the ED to the facility on 4/6/17. His discharge medication orders included 2% Bactroban (a topical antibiotic ointment) and 875-125 milligrams (mg) amoxicillin-clavulanate (an oral antibiotic) to be given as one tablet by mouth every 12 hours for 10 days.

A review of the resident ' s electronic medical record dated 4/6/17 at 9:49 PM indicated the resident was re-admitted to the facility. No distress was noted and he was assessed as being alert and oriented.

A review of the resident ' s physician orders for the re-admission included the following:
--Tracheostomy: Change tubing and equipment every night shift every Wednesday (Initiated 4/7/17);
--Trach #6 Shiley long: Tracheostomy care to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 34	F 251		

completed every shift and as needed (Initiated 4/7/17);
--Check O2 Sat every shift and notify MD if O2 Sat is less than 88% (Initiated 4/7/17);
--Trach collar with 5 liters O2 per minute as needed during the day for O2 Sats less than 91% (Initiated 4/8/17); and,
--Trach collar with 5 liters O2 per minute every evening and night shift (Initiated 4/8/17).

A review of the resident ' s medical record included a Respiratory Therapist (RT) note dated 4/7/17. The respiratory assessment revealed Resident #9 ' s trach was changed on 4/6/17 at the hospital. The respiratory assessment noted the resident was readmitted on 4/6/17 after going to the ED for cellulitis around his trach. It read, in part: "No trach care was done while he was at home. He is on ABT (antibiotic) and Bactroban to trach site." The resident ' s trach site was noted as red, sore, and bleeding easily.

A review of Resident #9 ' s admission Minimum Data Set (MDS) assessment dated 4/13/17 revealed the resident had intact cognitive skills for daily decision making. He was independent for all of his ADLs, with the exception of requiring supervision from staff for eating. Section O of the MDS assessment reported he received tracheostomy care and oxygen therapy while he was a resident. Section Q of the MDS assessment revealed the resident participated in the assessment process and was expecting to remain in the facility. However, the MDS also revealed the resident did want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community at the time of the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 Unit 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 family knew ahead of time they wanted the resident to go home. The Administrator stated he himself arranged Home Health care "well in advance" of the resident ' s discharge on 4/1/17. Upon request, the Administrator provided contact information for the Home Health representative. The Administrator stated, "Everybody knew what was happening." He reported on Friday night (3/31/17) around 6:00 PM, both he and Resident #9 met with an oxygen supply company when they brought his oxygen to take home and educated him on its use. The Administrator confirmed Resident #9 was discharged on Saturday, 4/1/17.

As the interview continued on 5/4/17 at 2:30 PM, the Administrator reported Resident #9 ' s insurance company contacted him on Monday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 36	F 251		

(4/3/17) and reported the resident ' s family was concerned he wasn ' t doing well at home with the tracheostomy. The Administrator spoke with the resident ' s family member (Family Member #2) by telephone on 4/3/17, 4/4/17, and 4/5/17. He told this family member that the facility would be happy to take the resident back. However, the resident had a physician appointment scheduled that week and the family planned to take him to it. On Thursday, 4/6/17, the Administrator reported he called the family member [Family Member #2] around 12:00 PM and was basically told they were on their way to bring the resident back to the facility. When the resident arrived, the Administrator stated he could smell the trach collar and wanted to get it evaluated. The facility called 911 and the hospital ED to tell them the resident was being sent over. The Administrator reported the resident was seen in the ED and returned to the facility around 8:00 -9:00 PM the evening of 4/6/17.

A telephone interview was conducted on 5/4/17 at 4:35 PM with the Marketing Manager for the Home Health agency who had received a referral from the Administrator for Resident #9 ' s home care. During the interview, the resident ' s discharge arrangements for 4/1/17 were discussed. As the Marketing Manager reviewed the resident ' s Home Health record, she reported the agency was given the Home Care referral on 3/28/17. The Manager explained their Home Health agency was divided into two sections: the Hourly care side (which did work with tracheostomies) and the Home Health care side (which did not work with trachs). On 3/31/17, the agency learned the resident did not have insurance coverage for the Hourly care; and the Home Health care side did not do trach care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 37	F 251		

The Home Health office contacted the Marketing Manager on 3/31/17. On 3/31/17, the Marketing Manager telephoned the facility and informed Nurse #1 their Home Health agency couldn ' t take this resident. She also reported her agency contacted two other Home Health agencies, but Resident #9 was not accepted by either of them. With the discharge still planned for 4/1/17, the Marketing Manager stated she coordinated a delivery of oxygen to the facility on Friday night (3/31/17) so the resident would have it when he went home. On Monday (4/3/17), she went to the facility for follow-up because she was concerned about an unsafe discharge if the resident actually went home over the weekend. The Marketing Manager stated she also wanted to make sure the facility had a bed for the resident if he decided to come back. The Marketing Manager reported she talked with the Office Manager for Resident #9 ' s primary care physician on 4/3/17, then followed up with an email to both the Office Manager and the facility ' s Administrator to be sure everyone had the information.

An interview was conducted on 5/5/17 at 8:00 AM with Resident #9. During the interview, the resident recalled he and the Administrator met with someone on Friday night (3/31/17) to get his oxygen arranged for discharge. When the resident was asked what was arranged for him prior to discharge, he reported that in addition to the oxygen he had a shower chair, a shower bar, and a railing for the commode at home that his family had purchased. He stated the shower bar and railing for the commode had not yet been installed by his landlord when he arrived home on 4/1/17. Upon further inquiry, the resident stated "someone" on the phone had told him he would get 24-hour nursing care when he got home. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 38	F 251		

reported he did not know how to do his own trach care and did not receive any trach supplies to use at home. He reported he expected a Home Health nurse to come out to his home to take care of his tracheostomy, but no one did.

A telephone interview was conducted on 5/5/17 at 10:48 AM with the Respiratory Therapist (RT) who worked with Resident #9. The RT reported she worked for a contracted company and came to the facility once a week to provide tracheostomy care for the resident. Prior to his 4/1/17 discharge, the RT noted Resident #9 had issues with his skin under the tracheostomy due to a small amount of drainage and having some trouble keeping the skin dry. She reported the skin looked a little irritated and was a little sore when cleaned. The RT stated she was hoping the Home Health nurse would continue to follow this issue under his tracheostomy collar. When asked what kind of trach care the resident required, the RT stated he received routine trach care once every shift (3 times a day) while in the facility, but may have been able to do the trach care twice daily upon discharge. She reported routine tracheostomy care involved cleaning the area behind the flange (the area where the ties or sutures are connected to secure the tube in place) and making sure there were no secretions; changing the trach ties and cannula (the body of the tube that is inserted into the trachea), and replacing the drain sponge underneath. The RT stated she was under the impression the resident and a family member would do some of his trach care, with the Home Health nurse going out a few times a week to make sure it was done appropriately. Without reviewing her notes, the RT did not recall if she had done tracheostomy care training with the resident, but was certain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 39	F 251		

she did not train a family member on the trach care. The RT stated if she had done trach care teaching with the resident, she would have included a notation documenting this in her Respiratory Notes. The RT stated if the resident was trained, he may be able to do the procedure for the trach care. However, she was unsure if he would reliably do the care twice daily every day. When asked if she had understood this resident would be going home with Home Health, she stated, "Absolutely." Upon further inquiry, the RT reported having a suction machine would usually be a standard for anyone going home with a tracheostomy. When asked what her thoughts were regarding the resident going home without a suction machine, the RT reported that although she didn ' t think he ' d have a big problem, she stated, "You never know." The RT stated she saw the resident the day after he was readmitted to the facility on 4/6/17. She recalled he had been put on an antibiotic for neck cellulitis and reported the condition of the skin had improved significantly over the last few weeks.

An interview was conducted on 5/5/17 at 12:24 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 40	F 251		

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 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 Manager reported she was at the facility when the resident presented on 4/6/17 with foul smelling drainage from his tracheostomy. The Unit Manager stated she did not assess the tracheostomy and could not tell what color the drainage was.

A telephone interview was conducted on 5/5/17 at 1:24 PM with Nurse #1. Nurse #1 was identified as the nurse who received a phone call from the Home Health agency on 3/31/17, informing the facility Resident #9 was not admitted to Home Health due to having a tracheostomy. When asked about this phone call, the nurse stated, "I believe they did speak with me ...the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 41	F 251		

Administrator was involved. Someone called ...the supply company maybe ...and the Administrator was going to call and confirm with [name of the Marketing Manager] everything was in place." When asked what preparations were made prior to the resident ' s discharge, the nurse stated she knew someone brought out portable oxygen for the resident ' s trip home and they were also going to deliver his home oxygen. When asked if the resident had received any training or education on trach care, the nurse reported, "Anytime I worked with his trach I tried to teach him." When asked if the resident ever did the tracheostomy care himself, the nurse stated, "Not really."

An interview was conducted on 5/5/17 at 2:54 PM with the facility ' s Social Worker (SW). Upon inquiry, the SW stated she started her position on 3/30/17 and first recalled Resident #9 when he returned to the facility on 4/6/17. During the interview, the SW discussed the facility ' s discharge process. She reported her role as the SW was to contact the Home 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 paperwork was kept separate from his/her medical record. When asked what the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 42	F 251		

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 process for Resident #9. The Administrator stated the facility had been "between Social Workers," so he, the MDS nurse and the Activities Manager, shared the duties of the Social Worker while the position was vacant. He reported the discharge for Resident #9 was handled between himself, nursing, and possibly the Activities Manager. Upon inquiry, the Administrator stated he was not aware the facility was notified on 3/31/17 by the Home Health agency that Resident #9 was not accepted for home care. He reported he did not find this information out until Monday, 4/3/17. When asked where the discharge planning paper work was kept for Resident #9, the Administrator stated he did not know but would ask the Activities Manager. A request was made to review the discharge paper work for Resident #9.

A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident ' s physician at the facility. This physician also served as the facility ' s Medical Director. The physician recalled that when he saw the resident on 3/31/17, he expected the resident to receive Home Health services upon discharge. The physician stated that if he was not going to receive these services, he would have wanted to be informed. The MD stated, "I certainly would not want this to happen again."

A follow-up interview was conducted on 5/5/17 at 3:55 PM with the Administrator. During the interview, the Administrator reported no discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 43	F 251		

papers had been completed for Resident #9 ' s discharge on 4/1/17. When asked, the Administrator stated he had a degree in Health Care Management. He reported between mid-January and 3/30/17, no one who worked at the facility had a degree in Social Work.

A telephone interview was conducted on 5/6/17 at 9:25 AM with the resident ' s 2nd family member (Family Member #2) who provided transportation for the resident and had been in contact with his health care providers after he was discharged from the facility. Family Member #2 reported she began talking with the facility about the resident ' s discharge sometime in March. When asked who chose 4/1/17 as his discharge date, she stated, "I guess they did. They told us they could get things in place for April 1st." The family member reported oxygen was delivered to the home where Resident #9 would be staying on 3/31/17 in preparation for his discharge. When she picked the resident up from the facility on 4/1/17 (between 10:00 AM - 12:00 PM), he had portable oxygen for the trip home. Family Member #2 stated the staff seemed a little surprised he was being discharged. The family member stated she signed a paper saying she was picking up the resident, and was given prescriptions for his medications. When asked if either she or the resident were given any instructions for home, she said, "No." She recalled asking the nurse (Nurse #3) if the Home Health was set up, and was told they "thought so" and the Home Health nurse would be out to the house later that day. Family Member #2 stated she was not sure how often the Home Health nurse was going to be coming out, but expected to find out more when the nurse came to the house on 4/1/17. She stated her main concern

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 44	F 251		

was making sure the resident ' s trach was cleaned, changed, and generally taken care of. Family Member #2 stated when she got the resident home to stay with Family Member #1, they couldn ' t get a nurse to come out. The resident told her he didn ' t know how the trach had to be cleaned. Family Member #2 reported she called the facility two to three times on 4/1/17 to ask why the Home Health care people weren ' t coming to the home and she was told they would be coming. After waiting with the resident at his home for hours, Family Member #2 stated she went to her own home and called the Home Health agency herself. The Home Health agency told her nobody was coming. The family member stated she questioned that because he was already at home and stated, "Had I known nobody was coming, I would not have taken him home." They said they didn ' t do patients with trachs and said they had told somebody at the facility they didn ' t do them. The family member stated she made an appointment with the resident ' s physician to see if they could help get someone out to take care of the trach, "but they didn ' t check it either." She recalled sometime during the week a nurse from another Home Health agency came to the house, but she didn ' t touch the trach because he didn ' t have anybody at home who was able to provide help with the trach care. Family Member #2 reported she had talked with the facility ' s Administrator each day during the week Resident #9 was home. She was told the facility would take him back, but the resident did not want to go back. The family member stated, "I was scared with nobody checking the trach and it was already kinda messy." She reported bringing the resident back to the facility on that Thursday (4/6/17) and stated, "It (the tracheostomy) was smelling and everybody was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 251	Continued From page 45	F 251		

standing back. It was a mess." The family member stated the facility sent him to the hospital ED after he arrived there. Resident #9 returned to the facility later that evening.

A telephone interview was conducted 5/6/17 at 10:32 AM with Nurse #3. The nurse reported she worked at the facility on an "as needed" basis, ranging in frequency from twice a month to twice a week. Nurse #3 was identified as the nurse who worked the 1st shift on 4/1/17 when Resident #9 was discharged. The nurse recalled when Resident #9 ' s family member came to pick up the resident on the morning of 4/1/17. Nurse #3 reported she had not been told ahead of time that the resident was going to be discharged that morning. The nurse stated, "I did not have a discharge packet because we did not have a Social Worker at that time." Nurse #3 reported the Activities Manager happened to be working that Saturday morning so she got a discharge packet together for him. Upon inquiry, the nurse reported the discharge packet contained the Plan of Care and a Discharge Planning form. Nurse #3 recalled telling the resident and family member a Home Care agency would come out to the home. When asked what was sent home with the resident, the nurse reported she gave him prescriptions for his medications and 3 tracheostomy kits from the facility. However, the family member said she would wait for the Home Health agency nurse to come out and would get the tracheostomy supplies from them. Nurse #3 stated she had done some routine teaching with the resident during his stay (not at discharge). Upon inquiry, the nurse reported she thought the resident may have done some of his own trach care in during his stay at the facility. However, she also reported that would have been, "some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 251	Continued From page 46	F 251		

time ago." The nurse stated a while back she left the tracheostomy care supplies in the room for the resident to do his own trach care, but when she came back it was not done. She tried to encourage the resident by saying, "you ' ve gotta do it," but he didn ' t want to. Nurse #3 described the resident as alert but not necessarily cognitively intact. She reported his cognition varied from day to day. When asked, Nurse #3 thought a family member may have called the facility either later on 4/1/17 or on 4/2/17 saying the Home Health agency didn ' t come to the house. The nurse told the family she would call the Home Health agency. Nurse #3 reported she tried to call Home Health, but the agency did not return her call.

An interview was conducted on 5/6/17 at 11:50 AM with the Administrator. During the interview, the Administrator reported the facility ' s former Social Worker did not give notice when he resigned on 1/26/17. No Social Worker was employed by the facility until the new SW started on 3/30/17. When asked who fulfilled the SW responsibilities from 1/26/17 to 3/29/17 the Administrator reported the MDS nurse and Activities Manager completed the resident assessments; the Activities Manager completed the discharge planning paperwork; and, the Administrator contacted the Home Health agency with referrals if a resident needed to have home care provided. The Administrator reported the remainder of the SW duties were shared by nursing staff, the MDS nurse, the Activities Manager, and himself. Upon inquiry, the Administrator reported the facility ' s census on 3/31/17 was 136 residents; and, on 4/1/17 (the day Resident #9 was discharged), the facility ' s census was 135 residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 251	Continued From page 47	F 251		

An interview was conducted on 5/6/17 at 1:12 PM with the facility ' s Activities Manager. The Activities Manager reported she had an Associate Degree in Human Services; she did not have a Bachelor ' s degree. The Activities Manager reported she helped with extra duties while the facility was without a Social Worker, which included calling families about a room change, talking with difficult residents to help resolve issues, assisting with discharge paperwork, and making outside appointments for residents. When asked about the discharge of Resident #9 on 4/1/17, the Activities Manager reported she did not recall the Administrator telling her the resident was going to go home. She reported the two discharge forms were not on the resident ' s chart when the nurse was ready to discharge him. The Activities Manager reported she happened to be scheduled to work that weekend, so she got the forms, filled them out, and brought them to the nursing station for the nurse. Upon inquiry as to how the Interdisciplinary Discharge Summary form could be completed, the Activities Manager reported the different disciplines did not complete the form.

A follow-up interview was conducted on 5/6/17 at 3:28 PM with the Administrator. During the interview, the Administrator confirmed the facility ' s census consistently remained above 120 residents from 1/26/17 through 3/29/17 (the period of time when the facility did not employ a qualified Social Worker).

An interview was conducted on 5/6/17 at 5:09 PM with the facility ' s Administrator. Upon inquiry as to how he would ensure Social Work support was retained for the facility, the Administrator reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 251	Continued From page 48	F 251		

he would request interim corporate support for social services until a full-time, permanent Social Worker could be hired. During a follow-up interview conducted on 5/6/17 at 6:10 PM, the Administrator was asked what his expectations were in relation to having a full-time qualified Social Worker. The Administrator indicated he would expect the services of a full-time Social Worker to be provided at the facility without interruption.

On 5/5/17 at 3:58 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 5/6/17 at 1:00 PM. The allegation of compliance indicated:

Credible Allegation for F251
Facility respectfully submits the below allegation of compliance for F251 Qualified Social Worker.

Criteria 1

Resident #9 was discharged to his home from Brian Center 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 Facility Administrator completed a referral to the Home Health Agency on 3/28/2017, prior to discharge from the facility. Home Health Agency informed staff nurse prior to discharge that they were unable to provide service for this resident; This information was not communicated with facility management for follow up. This nurse has received education from the Areas Staff Development Coordinator; regarding Discharge Policy and Procedure on 5/5/17 The Oxygen Provider delivered Oxygen. No arrangements for DME (Durable Medical Equipment) were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 251	Continued From page 49	F 251		

confirmed prior to discharge. Resident # 9 was returned to facility by his family on 4/6, was assessed and determined need for care for his Tracheostomy due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to Brian Center Salisbury on 4/6/2017, and treated for infection. Resident # 9 remains a current resident. At time of discharge there was no validation of Home Health 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 consequences of not providing this care, for the resident and his family/ caregiver.

Section Q of the MDS was completed for Resident # 9 on 4/13/17, and indicated that resident expects to remain in the facility.

Throughout the Discharge Planning Process for Resident #9 the Facility was without a Qualified Social Worker. Facilities Full Time Social Service Director resigned without notice on 1/26/17. Facility went without a qualified Social Worker 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.

Criteria 2
All residents discharging from the facility have the potential to be affected by this alleged deficient practice. The Nurse Managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge and support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 251	Continued From page 50	F 251		

was provided by a qualified social worker. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17.

Administrator has no Social Service background. During the time period the facility was without a qualified Social Service Director. The Administrator and Business Office Manager and DON were responsible for discharge process. There was no additional support from outside the facility to cover Social Service responsibilities.

Criteria 3
The Director of Clinical Services completed re-education of Administrator and Director of Nursing on 5/5/2017. This education included facility policy of provision of social work services and state 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 Service support is retained to meet the requirements of regulation.

Facility alleged IJ removal 5/6/17
The credible allegation was validated on 5/6/17 at 5:29 PM. On 5/6/17 from 4:25 PM through 5:29 PM, interviews were conducted with the Director of Nursing and the Administrator. The DON and Administrator were able to describe the education each received and verbalize the requirement to retain a qualified Social Worker on a full-time basis. An audit of residents who have discharged from the facility since 4/1/17 was reviewed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 251	Continued From page 51 verifying each resident received sufficient preparation, resources, and support for a safe discharge. Interviews and review of the credentials for facility ' s current SW verified the facility had employed a qualified SW since 03/30/17. The immediate jeopardy was removed on 5/6/17 at 5:29 PM.	F 251		
F 284 SS=J	483.21(c)(1)(2)(iv) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN (c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform	F 284		6/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 284	Continued From page 52	F 284		

required care, as part of the identification of discharge needs.

(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(vi) Address the resident's goals of care and treatment preferences.

(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent

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F 284	Continued From page 53 the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. (c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. 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 implement an effective discharge	F 284	F 284 Corrective action accomplished for those residents found to have been affected by	

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 284	Continued From page 54 planning process to identify and address the discharge needs for 1 of 1 sampled resident (Resident #9) who was discharged home with a 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 #9 was discharged without Home Health care assistance, resident and/or care provider training on tracheostomy care, or access to tracheostomy supplies, which resulted in a lack of tracheostomy care after discharge. Five days after his discharge from the facility, the resident was diagnosed with neck cellulitis (a common and potentially serious bacterial skin infection) requiring treatment with antibiotics. Immediate jeopardy began on 4/1/17 when Resident #9 was discharged from the facility to his home. The resident had a tracheostomy and multiple co-morbidities (chronic conditions). The resident had not been accepted by a Home Health care agency to receive assistance with his tracheostomy care upon discharge, as he had expected. The resident did not have the training nor supplies to do the tracheostomy care on his own at home. He returned to the facility on 4/6/17 and was immediately sent to the hospital Emergency Department (ED) for an evaluation and treatment of the tracheostomy. He was diagnosed with neck cellulitis (a common and potentially serious bacterial skin infection) and prescribed both an oral and topical antibiotic. The resident was released from the hospital ED and re-admitted to the facility on 4/6/17. The immediate jeopardy was removed on 5/6/17 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of	F 284	the deficient practice: Resident #9 was discharged to his home 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 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 nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse received education form the Area Staff Development Coordinator regarding discharge policy and procedure on 5/5/17. The oxygen provider delivered oxygen. No arrangements for DME was confirmed prior to discharge. Resident #9 was returned to facility by his family on 4/6/17, was assessed and determined need for his care for his tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17, and treated for infection. Resident #9 remains a current resident. At time of discharge there was no validation of home health 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 consequences for not providing this care, for the resident	

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F 284	Continued From page 55 D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The findings included: A review of the Resident #9 ' s medical records revealed he was hospitalized on 12/17/16 for acute on chronic respiratory failure and pneumonia. While in the hospital, the resident required intubation and a tracheostomy (also known as a trach). Resident #9 was discharged from the hospital to the facility on 2/7/17. His cumulative diagnoses included chronic obstructive pulmonary disease, respiratory failure, and diabetes. A review of Resident #9 ' s admission Minimum Data Set (MDS) assessment dated 2/14/17 revealed he had intact cognitive skills for daily decision making. He required extensive assistance for bed mobility, dressing, and toileting; limited assistance for transfers and personal hygiene; and, supervision from staff for locomotion on the unit. The resident was independent with eating. Section O of the MDS assessment indicated Resident #9 received Occupational Therapy (OT) and Physical Therapy (PT) services. It also reported he had a tracheostomy and received oxygen therapy while he was a resident. Section Q of the MDS assessment revealed the resident and his family participated in the assessment process. The MDS reported his overall goal about returning to the community was unknown or uncertain; and, active discharge planning was not occurring for the resident to return to the community. Section	F 284	and his family/caregiver. Section Q of the MDS was completed for Resident #9 on 4/13/17 and indicated that resident expects to remain at the facility. Throughout the discharge planning process for Resident #9 the facility was without a Qualified Social Worker. Facility's full time Social Service Director 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 3/30/17. Qualified Social Worker remains employed. The Administrator had an active role in the discharge process/planning for Resident #9. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: All residents discharging from the facility have the potential to be affected by this alleged deficient practice. The nurse managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 284	Continued From page 56 Q of the MDS reported the resident did not want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community at the time of the assessment. However, Section Q of the MDS also indicated the resident wanted to be asked about returning to the community on all subsequent MDS assessments. A review of the resident ' s care plan included the following areas of focus: ---[Name of Resident] has a tracheostomy related to impaired breathing mechanics (Initiated 2/7/17; Revised on 2/7/17). The stated goal for this area of focus was for the resident to have no signs/symptoms of infection through the review date (Initiated on 2/7/17; Revised on 3/16/17). The interventions outlined to meet this goal included: --Ensure that the tracheostomy ties (the bands that go around the neck and hold the trach tube in place, also known as trach collars) are secured at all times (Initiated 2/7/17); --Observe/document respiratory rate, depth and quality. Check and document every shift or as ordered (Initiated 2/7/17); and, --Suction as necessary (Initiated 2/7/17). ---[Name of Resident] wishes to be discharged to home when able (Initiated on 3/8/17; Revised on 3/8/17). The stated goal for this area of focus was for the resident to be able to verbalize/communicate the assistance he would need post-discharge and the services required to meet his needs before discharge (Initiated on 3/8/17; Revised on 3/16/17). The interventions outlined to meet this goal included:	F 284	Facility nurses and IDT will be educated on Discharge Process and Post Discharge Plan of Care policies. Education initiated on 5/5/17 by Area Staff Development Coordinator. Remaining staff will be educated prior to returning to duty. Beginning 5/6/17 all new hire nurses and IDT will receive this education. The Area Staff Development Coordinator completed re-education of all licensed nurses and members of the Interdisciplinary Team involved in discharge planning on 5/5/17. This education included the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician. This education includes the facility policy regarding Transfer and Discharge Procedures as follows: Post Discharge Plan of Care: 1. Upon admission the IDT members, in consultation with the resident and/or the resident's legal representative (if practicable), develops the resident's discharge plan and anticipated date of discharge. 2. The Social Service Director or designee, the IDT members, and the resident and/or the resident's legal	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 57 --Establish a pre-discharge plan with the resident/family/caregivers, evaluate progress, and revise the plan as needed with the resident ' s need for assistance with his tracheostomy care and Activities of Daily Living (ADL) assistance (Initiated on 3/8/17; Revised on 3/8/17); and, --Evaluate the resident ' s motivation to return to the community (Initiated on 3/8/17). A review of the resident ' s medical record included Respiratory Therapist (RT) notes dated 2/7/17, 2/8/17, 2/14/17, 2/23/17, 3/14/17, and 3/21/17. One additional RT note was not dated. No notations were made to indicate the RT provided education/training for the resident on the care of his tracheostomy. A review of Resident #9 ' s therapy notes revealed a home visit was conducted on 3/27/17 by OT and PT in anticipation of his discharge from the facility. Recommendations made from the home visit included the need for a shower chair, hand held shower head, grab bar in the shower, and oxygen on an as needed (PRN) basis. The notes recommended follow up OT, PT, and Speech Therapy (ST) upon discharge. A review of the resident ' s current physician orders (as of 3/31/17) included the following: --Tracheostomy: Change tubing and equipment every night shift every Wednesday (Initiated 2/7/17); --Oxygen saturation (also known as an O2 Sat) to be checked every shift and notify the Medical Doctor (MD) if the O2 Sat is less than 88% (Initiated 2/7/17). An O2 Sat is a relative measure of the amount of oxygen carried in the blood. Normal blood oxygen levels are typically considered to be 95-100%;	F 284	representative determine the individual needs, resources, and services required upon discharge through the IDT care plan meeting and process. 3. Social Service Dept. arranges for post-discharge services. 4. Contact those service agencies who can support resident's needs, resources, and services upon discharge (e.g., home health, durable medical equipment, therapy services, meals, transportation, etc.). 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, confidential and protected health information upon discharge. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: The Administrator, Director of Nursing or Nurse Manager will review residents planned for discharge three times per week for 12 weeks to ensure a safe and orderly discharge has been planned, by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visit when possible and validating the completion of appropriate referrals. Opportunities will be corrected as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 58 --Trach #6 Shiley long (referring to the inner diameter and length of the tracheostomy tube): Tracheostomy care to be completed every shift and as needed (Initiated 2/7/17); and, --Oxygen (O2) at 5 liters (referring to the oxygen flow rate per minute) every shift (Initiated 3/2/17). A review of the resident ' s medical record included an additional Respiratory Therapist (RT) note dated 3/31/17. The respiratory assessment note revealed Resident #9 was sitting up in the chair with a pleasant demeanor. Tracheostomy care was done and the RT noted there was no change in the stoma (surgical opening) site at that time. Resident #9 was noted to be scheduled for discharge to home on 4/1/17. There was no notation on the RT note to indicate the resident was trained on care of his tracheostomy. A review of the resident ' s medical record included a physician ' s note dated 3/31/17 at 12:51 PM. The physician noted Resident #9 was seen for a discharge summary. The notation read as follows, in part: "[Name of Resident] is seen today in anticipation of his discharge from the facility this weekend. He was admitted to the [Name of Facility] on 2/8/17 after being hospitalized for acute on chronic respiratory failure and pneumonia subsequently requiring intubation and tracheostomy. Since his admission he has done well with rehabilitation and with trach care. For the past several weeks he has been seen ambulating around the facility without any SOB or imbalance and has not been requiring oxygen when walking ..." Plan: "COPD: Diminished breath sounds and is high risk for re-hospitalization but is felt stable to	F 284	identified. Monitoring Process: The Administrator will report the results of these audits weekly for 12 weeks during the QAPI meeting and then monthly thereafter. The committee will review these results and make recommendations as required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 59 go home. HH (Home Health) nursing, PT/OT." A review of Resident #9 ' s medical record revealed a Nursing Note dated 4/1/17 at 7:35 PM reported, in part: " ...Patient went home." A review of the Home Health agency notes dated 4/1/17 (not timed) included the following text: "Call from [name of resident ' s Family Member #2] regarding waiting for [name of Home Health agency] to come out. Informed non-admitted due to trach. Spoke with [name of Home Health representative] who informed [name of Nurse #1] at [name of facility]. Also spoke with [name of Home Health staff member], could not accept referral as it would take 2-3 weeks to set up PDN (private duty nurse). She informed marketing manager [name of manager]. Tried to call [name of facility], but they would not provide any information and CM (Case Management) Department is closed until Monday." An email dated 4/3/17 at 4:16 PM was provided by the Home Health agency for review. The email was sent from the Home Health agency ' s Marketing Manager to both the Office Manager for Resident #9 ' s primary care physician and the facility ' s Administrator. The text of the email read: "I have copied [name of facility ' s Administrator] on this email as well to keep everyone in the loop. I spoke with the other Home Health Agencies and even though [name of Resident #9 ' s insurance company] approved Home Health hours for this client he is not appropriate for Home Care. He is high risk for a hospitalization and his best place is back in [name of facility] where he can get the proper care he needs. The client wanted to go home and when [name of resident ' s physician at	F 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 60	F 284		

the facility] saw him last week he even stated he would end up back in the hospital. I talked with [name of representative for the oxygen supply company] and they only delivered Oxygen to the home and no Trach supplies-When you guys see this client tomorrow I would recommend sending him back to [name of the facility]. I hate it for [resident ' s name] but his best place for the care he needs is at SNF (skilled nursing facility) level. [Name of facility ' s Administrator] will have his team prepare a bed to make a smooth transition just in case."

A review of Resident #9 ' s paper medical record included documentation from a follow-up diabetic visit on 4/4/17 with an outside Internal Medicine service. Progress notes written by the Physician Assistant (PA) on 4/4/17 included the following notations, in part:
" ...Recently hospitalized for respiratory failure 12/17/16, tracheostomy performed. Discharged to SNF [name of facility]. Patient was told he could be discharged over the weekend. He was released however has had difficulty getting home health to come out with trach supplies. [Name of Family Member #2] accompanies the patient today-she states he will not go back to [name of facility] because "he doesn ' t want to." Patient has a history of noncompliance and refusing home health. He lives at home with his [name of Family Member #1]. No fever or difficulty breathing since discharge."
The PA ' s Impression/Plan from the 4/4/17 visit read:
"Do not think patient is appropriate for outpatient care. Discussed at length my concerns of not returning to a SNF for care given multiple comorbidities. Both he and his [name of Family Member #2] are adamant that patient will not be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 61	F 284		

returning to [name of facility]. [Name of another Home Health agency] will bring supplies out to patient. Patient is in agreement for close follow up-will return in 2 weeks for BP (blood pressure) check. Labs pending."

A review of the hospital Emergency Department (ED) records from 4/6/17 revealed Resident #9 arrived to the ED at 2:48 PM via Emergency Medical Services (EMS). The ED history included the following comments:
"Patient presents today complaining of need for tracheostomy care. He was released from the [name of facility] on Saturday and has been home for the last 5 days. He is referred back to the [name of facility] today because of inability to care for himself in the home but upon return to the Center, they sent him here because he had foul discharge from his tracheostomy site. Patient is denying any other problems. He states that he does get confused to time so he is unclear as to exact dates when his last trach collar and trach was changed."
The hospital ED records revealed upon examination, Resident #9 had erythematous (redness) and superficial skin breakdown all around the trach collar site. The resident was diagnosed with cellulitis of the neck. The ED Respiratory Notes dated 4/6/17 at 3:57 PM read, "trach was in place with trach collar-foul smell coming from trach area states last changed Saturday-collar wet with drainage-Respiratory at bedside will change out trach and replace trach collar ..." The resident was discharged from the ED to the facility on 4/6/17. His discharge medication orders included 2% Bactroban (a topical antibiotic ointment) and 875-125 milligrams (mg) amoxicillin-clavulanate (an oral antibiotic) to be given as one tablet by mouth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 62	F 284		

every 12 hours for 10 days.

A review of the resident ' s electronic medical record dated 4/6/17 at 9:49 PM indicated the resident was re-admitted to the facility. No distress was noted and he was assessed as being alert and oriented.

A review of the resident ' s physician orders for the re-admission included the following:
--Tracheostomy: Change tubing and equipment every night shift every Wednesday (Initiated 4/7/17);
--Trach #6 Shiley long: Tracheostomy care to be completed every shift and as needed (Initiated 4/7/17);
--Check O2 Sat every shift and notify MD if O2 Sat is less than 88% (Initiated 4/7/17);
--Trach collar with 5 liters O2 per minute as needed during the day for O2 Sats less than 91% (Initiated 4/8/17); and,
--Trach collar with 5 liters O2 per minute every evening and night shift (Initiated 4/8/17).

A review of the resident ' s medical record included a Respiratory Therapist (RT) note dated 4/7/17. The respiratory assessment revealed Resident #9 ' s trach was changed on 4/6/17 at the hospital. The respiratory assessment noted the resident was readmitted on 4/6/17 after going to the ED for cellulitis around his trach. It read, in part: "No trach care was done while he was at home. He is on ABT (antibiotic) and Bactroban to trach site." The resident ' s trach site was noted as red, sore, and bleeding easily.

A review of Resident #9 ' s admission Minimum Data Set (MDS) assessment dated 4/13/17 revealed the resident had intact cognitive skills for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 63	F 284		

daily decision making. He was independent for all of his ADLs, with the exception of requiring supervision from staff for eating. Section O of the MDS assessment reported he received tracheostomy care and oxygen therapy while he was a resident. Section Q of the MDS assessment revealed the resident participated in the assessment process and was expecting to remain in the facility. However, the MDS also revealed the resident did want to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community at the time of the assessment.

An interview was conducted on 5/4/17 at 2:15 PM with the facility ' s Unit 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 family knew ahead of time they wanted the resident to go home. The Administrator stated he himself arranged Home Health care "well in advance" of the resident ' s discharge on 4/1/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 64	F 284		

Upon request, the Administrator provided contact information for the Home Health representative. The Administrator stated, "Everybody knew what was happening." He reported on Friday night (3/31/17) around 6:00 PM, both he and Resident #9 met with an oxygen supply company when they brought his oxygen to take home and educated him on its use. The Administrator confirmed Resident #9 was discharged on Saturday, 4/1/17.

As the interview continued on 5/4/17 at 2:30 PM, the Administrator reported Resident #9 ' s insurance company contacted him on Monday (4/3/17) and reported the resident ' s family was concerned he wasn ' t doing well at home with the tracheostomy. The Administrator spoke with the resident ' s family member (Family Member #2) by telephone on 4/3/17, 4/4/17, and 4/5/17. He told this family member that the facility would be happy to take the resident back. However, the resident had a physician appointment scheduled that week and the family planned to take him to it. On Thursday, 4/6/17, the Administrator reported he called the family member [Family Member #2] around 12:00 PM and was basically told they were on their way to bring the resident back to the facility. When the resident arrived, the Administrator stated he could smell the trach collar and wanted to get it evaluated. The facility called 911 and the hospital ED to tell them the resident was being sent over. The Administrator reported the resident was seen in the ED and returned to the facility around 8:00 -9:00 PM the evening of 4/6/17.

A telephone interview was conducted on 5/4/17 at 4:35 PM with a Marketing Manager for the Home Health agency who had received a referral from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 65	F 284		

the Administrator for Resident #9 ' s home care. During the interview, the resident ' s discharge arrangements for 4/1/17 were discussed. As the Marketing Manager reviewed the resident ' s Home Health record, she reported the agency was given the Home Care referral on 3/28/17. The Manager explained their Home Health agency was divided into two sections: the Hourly care side (which did work with tracheostomies) and the Home Health care side (which did not work with trachs). On 3/31/17, the agency learned the resident did not have insurance coverage for the Hourly care; and the Home Health care side did not do trach care. The Home Health office contacted the Marketing Manager on 3/31/17. On 3/31/17, the Marketing Manager telephoned the facility and informed Nurse #1 their Home Health agency couldn ' t take this resident. She also reported her agency contacted two other Home Health agencies, but Resident #9 was not accepted by either of them. With the discharge still planned for 4/1/17, the Marketing Manager stated she coordinated a delivery of oxygen to the facility on Friday night (3/31/17) so the resident would have it when he went home. On Monday (4/3/17), she went to the facility for follow-up because she was concerned about an unsafe discharge if the resident actually went home over the weekend. The Marketing Manager stated she also wanted to make sure the facility had a bed for the resident if he decided to come back. The Marketing Manager reported she talked with the Office Manager for Resident #9 ' s primary care physician on 4/3/17, then followed up with an email to both the Office Manager and the facility ' s Administrator to be sure everyone had the information.

An interview was conducted on 5/5/17 at 8:00 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 66	F 284		

with Resident #9. During the interview, the resident recalled he and the Administrator met with someone on Friday night (3/31/17) to get his oxygen arranged for discharge. When the resident was asked what was arranged for him prior to discharge, he reported that in addition to the oxygen he had a shower chair, a shower bar, and a railing for the commode at home that his family had purchased. He stated the shower bar and railing for the commode had not yet been installed by his landlord when he arrived home on 4/1/17. Upon further inquiry, the resident stated "someone" on the phone had told him he would get 24-hour nursing care when he got home. He reported he did not know how to do his own trach care and did not receive any trach supplies to use at home. He reported he expected a Home Health nurse to come out to his home to take care of his tracheostomy, but no one did.

A telephone interview was conducted on 5/5/17 at 10:48 AM with the Respiratory Therapist (RT) who worked with Resident #9. The RT reported she worked for a contracted company and came to the facility once a week to provide tracheostomy care for the resident. Prior to his 4/1/17 discharge, the RT noted Resident #9 had issues with his skin under the tracheostomy due to a small amount of drainage and having some trouble keeping the skin dry. She reported the skin looked a little irritated and was a little sore when cleaned. The RT stated she was hoping the Home Health nurse would continue to follow this issue under his tracheostomy collar. When asked what kind of trach care the resident required, the RT stated he received routine trach care once every shift (3 times a day) while in the facility, but may have been able to do the trach care twice daily upon discharge. She reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 67	F 284		

routine tracheostomy care involved cleaning the area behind the flange (the area where the ties or sutures are connected to secure the tube in place) and making sure there were no secretions; changing the trach ties and cannula (the body of the tube that is inserted into the trachea), and replacing the drain sponge underneath. The RT stated she was under the impression the resident and a family member would do some of his trach care, with the Home Health nurse going out a few times a week to make sure it was done appropriately. Without reviewing her notes, the RT did not recall if she had done tracheostomy care training with the resident, but was certain she did not train a family member on the trach care. The RT stated if she had done trach care teaching with the resident, she would have included a notation documenting this in her Respiratory Notes. The RT stated if the resident was trained, he may be able to do the procedure for the trach care. However, she was unsure if he would reliably do the care twice daily every day. When asked if she had understood this resident would be going home with Home Health, she stated, "Absolutely." Upon further inquiry, the RT reported having a suction machine would usually be a standard for anyone going home with a tracheostomy. When asked what her thoughts were regarding the resident going home without a suction machine, the RT reported that although she didn ' t think he ' d have a big problem, she stated, "You never know." The RT stated she saw the resident the day after he was readmitted to the facility on 4/6/17. She recalled he had been put on an antibiotic for neck cellulitis and reported the condition of the skin had improved significantly over the last few weeks.

An interview was conducted on 5/5/17 at 12:24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 68	F 284		

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 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 Manager reported she was at the facility when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 284	Continued From page 69	F 284		

resident presented on 4/6/17 with foul smelling drainage from his tracheostomy. The Unit Manager stated she did not assess the tracheostomy and could not tell what color the drainage was. She reported two nurses who may have assessed the drainage prior to sending the resident out to the hospital no longer worked at the facility.

A telephone interview was conducted on 5/5/17 at 1:24 PM with Nurse #1. Nurse #1 was identified as the nurse who received a phone call from the Home Health agency on 3/31/17, informing the facility Resident #9 was not admitted to Home Health due to having a tracheostomy. When asked about this phone call, the nurse stated, "I believe they did speak with me ...the Administrator was involved. Someone called ...the supply company maybe ...and the Administrator was going to call and confirm with [name of the Marketing Manager] everything was in place." When asked what preparations were made prior to the resident ' s discharge, the nurse stated she knew someone brought out portable oxygen for the resident ' s trip home and they were also going to deliver his home oxygen. When asked if the resident had received any training or education on trach care, the nurse reported, "Anytime I worked with his trach I tried to teach him." When asked if the resident ever did the tracheostomy care himself, the nurse stated, "Not really."

An interview was conducted on 5/5/17 at 2:54 PM with the facility ' s Social Worker (SW). Upon inquiry, the SW stated she started her position on 3/30/17. During the interview, the SW discussed the facility ' s discharge process. She reported her role as the SW was to contact the Home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 paperwork was kept separate from his/her medical record. When asked what the 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 process for Resident #9. He reported the discharge for Resident #9 was handled between himself, nursing, and possibly the Activities Manager. Upon inquiry, the Administrator stated he was not aware the facility was notified on 3/31/17 by the Home Health agency that Resident #9 was not accepted for home care. He reported he did not find this information out until Monday, 4/3/17. When asked where the discharge planning paper work was kept for Resident #9, the Administrator stated he did not know but would ask the Activities Manager. A request was made to review the discharge paper work for Resident #9.

A telephone interview was conducted on 5/5/17 at 3:45 PM with the resident ' s physician at the facility. This physician also served as the facility '

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 284	Continued From page 71	F 284		

s Medical Director. The physician recalled that when he saw the resident on 3/31/17, he expected the resident to receive Home Health services upon discharge. The physician stated that if he was not going to receive these services, he would have wanted to be informed. The MD stated, "I certainly would not want this to happen again."

A follow-up interview was conducted on 5/5/17 at 3:55 PM with the Administrator. During the interview, the Administrator reported no discharge papers had been completed for Resident #9 ' s discharge on 4/1/17.

A telephone interview was conducted on 5/6/17 at 9:25 AM with the resident ' s 2nd family member (Family Member #2) who provided transportation for the resident and had been in contact with his health care providers after he was discharged from the facility. Family Member #2 reported she began talking with the facility about the resident ' s discharge sometime in March. When asked who chose 4/1/17 as his discharge date, she stated, "I guess they did. They told us they could get things in place for April 1st." The family member reported oxygen was delivered to the home where Resident #9 would be staying on 3/31/17 in preparation for his discharge. When she picked the resident up from the facility on 4/1/17 (between 10:00 AM - 12:00 PM), he had portable oxygen for the trip home. Family Member #2 stated the staff seemed a little surprised he was being discharged. The family member stated she signed a paper saying she was picking up the resident, and was given prescriptions for his medications. When asked if either she or the resident were given any instructions for home, she said, "No." She

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 284	Continued From page 72	F 284		

recalled asking the nurse (Nurse #3) if the Home Health was set up, and was told they "thought so" and the Home Health nurse would be out to the house later that day. Family Member #2 stated she was not sure how often the Home Health nurse was going to be coming out, but expected to find out more when the nurse came to the house on 4/1/17. She stated her main concern was making sure the resident ' s trach was cleaned, changed, and generally taken care of. Family Member #2 stated when she got the resident home to stay with Family Member #1, they couldn ' t get a nurse to come out. The resident told her he didn ' t know how the trach had to be cleaned. Family Member #2 reported she called the facility two to three times on 4/1/17 to ask why the Home Health care people weren ' t coming to the home and she was told they would be coming. After waiting with the resident at his home for hours, Family Member #2 stated she went to her own home and called the Home Health agency herself. The Home Health agency told her nobody was coming. The family member stated she questioned that because he was already at home and stated, "Had I known nobody was coming, I would not have taken him home." They said they didn ' t do patients with trachs and said they had told somebody at the facility they didn ' t do them. The family member stated she made an appointment with the resident ' s physician to see if they could help get someone out to take care of the trach, "but they didn ' t check it either." She recalled sometime during the week a nurse from another Home Health agency came to the house, but she didn ' t touch the trach because he didn ' t have anybody at home who was able to provide help with the trach care. Family Member #2 reported she had talked with the facility ' s Administrator each day during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 284	Continued From page 73	F 284		

the week Resident #9 was home. She was told the facility would take him back, but the resident did not want to go back. The family member stated, "I was scared with nobody checking the trach and it was already kinda messy." She reported bringing the resident back to the facility on that Thursday (4/6/17) and stated, "It (the tracheostomy) was smelling and everybody was standing back. It was a mess." The family member stated the facility sent him to the hospital ED after he arrived there. Resident #9 returned to the facility later that evening.

A telephone interview was conducted 5/6/17 at 10:32 AM with Nurse #3. The nurse reported she worked at the facility on an "as needed" basis, ranging in frequency from twice a month to twice a week. Nurse #3 was identified as the nurse who worked the 1st shift on 4/1/17 when Resident #9 was discharged. The nurse recalled when Resident #9 ' s family member came to pick up the resident on the morning of 4/1/17. Nurse #3 reported she had not been told ahead of time that the resident was going to be discharged that morning. The nurse stated, "I did not have a discharge packet because we did not have a Social Worker at that time." Nurse #3 reported the Activities Manager happened to be working that Saturday morning so she got a discharge packet together for him. Upon inquiry, the nurse reported the discharge packet contained the Plan of Care and a Discharge Planning form. Nurse #3 recalled telling the resident and family member a Home Care agency would come out to the home. When asked what was sent home with the resident, the nurse reported she gave him prescriptions for his medications and 3 tracheostomy kits from the facility. However, the family member said she would wait for the Home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 284	Continued From page 74	F 284		

Health agency nurse to come out and would get the tracheostomy supplies from them. Nurse #3 stated she had done some routine teaching with the resident during his stay (not at discharge). Upon inquiry, the nurse reported she thought the resident may have done some of his own trach care during his stay at the facility. However, she also reported that would have been, "some time ago." The nurse stated a while back she left the tracheostomy care supplies in the room for the resident to do his own trach care, but when she came back it was not done. She tried to encourage the resident by saying, "you ' ve gotta do it," but he didn ' t want to. Nurse #3 described the resident as alert but not necessarily cognitively intact. She reported his cognition varied from day to day. When asked, Nurse #3 thought a family member may have called the facility either later on 4/1/17 or on 4/2/17 saying the Home Health agency didn ' t come to the house. The nurse told the family she would call the Home Health agency. Nurse #3 reported she tried to call Home Health, but the agency did not return her call.

An interview was conducted on 5/6/17 at 11:50 AM with the Administrator. During the interview, the Administrator reported the facility ' s former Social Worker did not give notice when he resigned on 1/26/17. No Social Worker was employed by the facility until the new SW started on 3/30/17. When asked who fulfilled the SW responsibilities from 1/26/17 to 3/29/17, the Administrator reported the MDS nurse and Activities Manager completed the resident assessments; the Activities Manager completed the discharge planning paperwork; and, the Administrator contacted the Home Health agency with referrals if a resident needed to have home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 284	Continued From page 75	F 284		

care provided. The Administrator reported the remainder of the SW duties were shared by nursing staff, the MDS nurse, the Activities Manager, and himself.

An interview was conducted on 5/6/17 at 1:12 PM with the facility ' s Activities Manager. The Activities Manager reported she had an Associate Degree in Human Services; she did not have a Bachelor ' s degree. The Activities Manager reported she helped with extra duties while the facility was without a Social Worker, which included calling families about a room change, talking with difficult residents to help resolve issues, assisting with discharge paperwork, and making outside appointments for residents. When asked about the discharge of Resident #9 on 4/1/17, the Activities Manager reported she did not recall the Administrator telling her the resident was going to go home. She reported the two discharge forms were not on the resident ' s chart when the nurse was ready to discharge him. The Activities Manager reported she happened to be scheduled to work that weekend, so she got the forms, filled them out, and brought them to the nursing station for the nurse. Upon inquiry as to how the Interdisciplinary Discharge Summary form was completed, the Activities Manager reported the different disciplines did not complete the form.

An interview was conducted on 5/6/17 at 5:09 PM with the facility ' s Administrator. Upon inquiry, the Administrator reported discharge planning needed to start immediately upon admission for a resident with a goal to return to the community. During a follow-up interview conducted on 5/6/17 at 6:10 PM, the Administrator was asked what his expectations were in relation to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 284	Continued From page 76	F 284		

Post-Discharge Plan of Care and Interdisciplinary Discharge Summary. The Administrator reported he expected the Social Worker to coordinate the completion of these discharge plans.

On 5/5/17 at 3:58 PM, the Administrator was informed of the immediate jeopardy. The facility provided a credible allegation on 5/6/17 at 1:38 PM. The allegation of compliance indicated:

Credible Allegation for F284
Criteria 1
Resident #9 was discharged to his home from [Name of Facility] on 4/1/17. Resident #9 required Home Health Services for Nursing, Oxygen, suction machine, and supplies to manage tracheostomy care at home. The Facility Administrator completed a referral to the Home Health Agency on 3/28/2017, prior to discharge from the facility. Home Health Agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse has received education from the Areas Staff Development Coordinator, regarding Discharge Policy and Procedure on 5/5/17. The Oxygen Provider delivered Oxygen. No arrangements for DME (Durable Medical Equipment) was confirmed prior to discharge. Resident # 9 was returned to facility by his family on 4/6, was assessed and determined need for care for his Tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to [Name of Facility] on 4/6/2017, and treated for infection. Resident # 9 remains a current resident. At time of discharge there was no validation of Home Health admitting resident, no confirmation of DME, and no

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 284	Continued From page 77	F 284		

documented education related to signs and symptoms of problems, what care was necessary to maintain stable health, and consequences of not providing this care, for the resident and his family/ caregiver.

Section Q of the MDS was completed for Resident # 9 on 4/13/17 and indicated that resident expects to remain in the facility.

Throughout the Discharge Planning Process for Resident #9 the Facility was without a Qualified Social Worker. Facilities Full Time Social Service Director resigned without notice on 1/26/17. Facility went without a qualified Social Worker 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.

Criteria 2
All residents discharging from the facility have the potential to be affected by this alleged deficient practice. The Nurse Managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17.

Criteria 3
Facility Nurses and IDT will be educated on Discharge Process and Post Discharge Plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 284	Continued From page 78	F 284		

Care Policies. Education initiated on 5/5/16 by the Area Staff Development Coordinator. Remaining staff will be educated prior to returning to duty. Beginning 5/6//2017 all new hire Nurses and IDT will receive this education.

The Area Staff Development Director completed re-education of all Licensed Nurses and members of the Interdisciplinary Team involved in discharge planning, on 5/5/17, Education included the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician.

This education includes the facility policy regarding Transfer and Discharge Procedures as follows:
Post Discharge Plan of Care:
1. Upon admission the IDT members, in consultation with the resident and/or the resident ' s legal representative (if practicable), develops the resident ' s discharge plan and anticipated date of discharge.

2. The Social Service Director or designee, the IDT members, and the resident and/or the resident ' s legal representative determine the individual needs, resources, and services required upon discharge through the IDT care plan meeting and process.

3. Social Service Department arranges for post-discharge services

4. Contact those service agencies who can support resident ' s needs, resources, and services upon discharge (e.g., home health,

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 284	Continued From page 79 durable medical equipment, therapy services, meals, transportation, etc.). 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, confidential and protected health information upon discharge. The Social Services Director will contact all residents who discharge home within 1 week of discharge, 2 weeks of discharge and at 30 days post discharge to ensure that they have all care necessary services to safely remain in their home environment. Facility alleged IJ removal 5/6/17 The credible allegation was validated on 5/6/17 at 5:38 PM. On 5/6/17 from 4:25 PM through 5:38 PM, staff members from the Nursing (Licensed Nurses), Social Services, and Therapy Departments were interviewed. Staff were able to describe the education received on the facility policy regarding Transfer and Discharge Procedures, including the development of a resident ' s post-discharge plan of care and the role each staff member was expected to fulfill during the discharge planning process. The MDS nurses were interviewed and able to verbalize the in-servicing received for the accurate completion of Section Q of the MDS assessment. Administrative staff, including the Director of Nursing and Administrator, were also interviewed. The DON and Administrator were able to describe the education each received, along with their respective role in the discharge planning process. An audit of residents who have discharged from the facility since 4/1/17 was reviewed, verifying each resident received sufficient preparation and	F 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 284	Continued From page 80 resources upon discharge. The immediate jeopardy was removed on 5/6/17 at 5:38 PM.	F 284		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff interview the facility failed to prevent 1 of 4 cognitively impaired residents, who were assessed as a high elopement risk, (Resident #13) from exiting a locked unit and failed to identify that there were windows in the building	F 323	F 323 Corrective action accomplished for those residents found to have been affected by the deficient practice:	6/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 81 that could be opened sufficiently to allow a resident to elope through them. Resident #13 exited a resident room window then walked 43 feet and across an access road for the neighboring apartment complex; this access road ran next to the facility. Facility staff were notified that Resident #13 had eloped by a neighbor who had seen Resident #13 exit the window. When Resident #13 was located by staff he was at the base of a hill on the other side of the access road. Resident #13 sustained a skin tear during the incident. Immediate Jeopardy began 2/25/17 when Resident #13 exited the facility unattended by facility staff and was found outside, after a concerned neighbor reported seeing someone exit the building through a window. The Immediate Jeopardy was lifted at 6:00 PM on 5/6/17 when the facility ' s acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement new procedures monitoring windows for potential exit hazards, and for ensuring residents with elopement risk and exit seeking behaviors have appropriate and timely interventions care planned and implemented. The findings included: Resident #13 was admitted 1/27/17 to the facility ' s locked unit. He had diagnoses including Alzheimer ' s disease, Parkinson ' s, cerebral vascular disease, dementia with behaviors and mood disorder.	F 323	Resident #13 was admitted to Brian Center Health and Rehabilitation/Salisbury on 1/27/17, to room 306 in the secure unit. Resident #13 was assessed as being at risk for elopement on 1/27/17. At approx. 1:00pm on 2/25/17, Resident #13 was found outside of the facility after a facility staff was alerted by a facility neighbor. Resident #13 was found 43 feet from window, across the driveway outside the facility between facility and neighboring apartment buildings. Resident #13 was returned to the facility by the Manager on Duty and housekeeping staff. Resident #13 was assisted back into the facility and secure unit. Nurse #7 immediately completed a head to toe assessment of Resident #13 with minor injury of a skin tear noted, unknown where/how injury occurred, due to not witnessed. An updated Elopement Assessment was completed for Resident #13 on 2/25/17. The care plan was reviewed and updated by the DON on 3/6/17 to include "Window stopper and room change." Nurse #7 initiated increased supervision for Resident #13 on 2/25/17 to include every 15 minute checks to monitor location. These checks were completed by the nursing assistants and documented on the flow record by the 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 on 2/25/17 where the window exited to a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 82 The Admission Minimum Data Set (MDS) Assessment dated 2/3/17 revealed Resident #13 was cognitively impaired, had physical and verbal behavior toward others (1 - 3 days during the 7 day look back period), and had wandering behavior (4-6 days during the 7 day look back period). Resident #13 required limited assistance for transfers, extensive assistance for walking and used a wheelchair and walker according to the MDS. Review of the Elopement Risk Assessment dated 1/27/17 revealed Resident #13 was at high risk for elopement. Review of the Physician ' s Orders from 1/27/17 through 2/25/17 revealed no orders for a Wanderguard (an electronic bracelet typically worn on a resident ' s wrist or ankle, which would cause an exit door to alarm or lock when the resident got within a programmed distance of the door.) On 1/28/17 the 6:01 PM Nursing Note revealed "alert male, oriented to self, very determined to ambulate without assistance, agitated that he is here and unable to go home, has tried to call his number numerous times with no answer noted." On 1/31/17 the SBAR (Situation, Background, Assessment, Recommendation) Note revealed "resident had been coming up to nurses station multiple times since beginning of shift wanting to go home. Started to become more agitated at 11:45 PM with prn (as needed) Ativan (an anti-anxiety medication 0.5 mg (milligrams). Resident continued to come to nurses (sic) station and agitation continued. No effect noted from Ativan one hour later. Began to wander in and out of other rooms and verbally abusive to	F 323	courtyard enclosed on three sides by the building and on the fourth by a six foot fence with a key pad gate. The window for room 319 was checked by the nurse on 2/25/17 and it did not open more than six inches. Nurse #7 notified Resident #13 responsible party on 2/25/17 at 1:20pm and physician on 2/25/17 at 1:30pm regarding Resident #13 exiting the facility, physical assessment following the event and plan for increased monitoring. No new physician's orders were received. An incident report was completed by Nurse #7 on 2/25/17. Nurse #7 notified the DON and Administrator of the event on 2/25/17 at approx. 1:00pm. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: It was determined on 2/27/17 during an IDT ADHOC QAPI meeting that the resident had been able to open the window past the existing window stopper screw and was able to exit through the open window. Maintenance was called on 2/25/17 at approx. 1:00pm to facility and arrived within a half hour and immediately secured resident's window, and conducted an audit of all windows in secure unit to ensure that they were secure. Several other windows were found not secured when checked by the nurse. The maintenance assistant put in new window stopper screws and then verified that they opened no more than six	

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 83 staff." The Care Plan initiated 2/17/17 revealed a plan of care for Resident #13 in regards to his elopement risk related to dementia. Interventions at that time included: assess for fall risk, observe for fatigue and weight loss, offer emotional and psychological support, orient resident to environment and reorient/validate and redirect resident as needed. On 2/25/17 at 12:42 PM the SBAR Note revealed "resident is frequently confused, at times combative with care." "Resident was at nursing desk, then went up hallway toward his room, when housekeeping came and notified staff that resident was crossing the road at side of facility, staff out to assist resident back in facility, staff (sic) became combative, picking up sticks etc. and hitting them, sitting on buttocks, when staff assisted him to standing resident pulled hand away causing a skin tear to left hand." On 2/25/17 a 3:30 PM Nursing Note revealed "due to recent happenings, resident will be moved to room 319 where if resident is able to get out it will be within perimeter of facility. Family notified." Review of the Quarter Hour Monitoring Tool revealed every 15 minute observations for Resident #13 were initiated at 12:30 PM on 2/25/17 when he was observed "sitting on the ground." At 12:45 PM the documentation indicated he was inside the facility at the desk. Review of an Incident/Accident Report for the elopement incident involving Resident #13 indicated the incident occurred on 2/25/17 at 12:45 PM. The Description of the Incident	F 323	inches. On 2/27/17 Maintenance Director and Administrator rechecked all windows in the secure unit to ensure they were secure. Post event on 2/25/17 at approx. 1:00pm the nurse on duty conducted a head count of all residents on the secure unit and ensured all residents were present and accounted for. A review identifying residents that have exit seeking behaviors was conducted for the entire facility on 5/6/17 to ensure that they have an elopement risk assessment and care plan to address their behaviors and providing supervision to make sure they are safe. This review was completed by the District Director of Care Management. Any discrepancies were corrected on 5/6/17. On 5/4/17 the Maintenance Director re-checked all windows on the secure unit and documented on window check log. On 5/6/17 the Maintenance Director, Rehab Director, Administrator and District Housekeeping secured all windows on the 100 and 200 halls to ensure that they could not open past six inches. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: Nursing staff working on 5/4/17 were	

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 84 revealed: "crawled out of window of 306 crossed side road attempting to leave (without) assistance became combative when staff attempted to assist him back inside facility jerked hand away and obtained skin tear. A diagram indicated the skin tear was on the top of Resident #13 ' s left hand. The treatments listed were body check, range of motion and skin treatment. The report also indicated the Responsible Party was notified at 1:20 PM and that the physician was notified at 1:30 PM. According to www.wunderground.com the temperature on 2/25/17, in the area the facility was located in, was a high of 77 degrees Fahrenheit (F) and a low of 45 degrees F with a mean of 61 degrees F. An Elopement Risk Assessment was completed for Resident #13 on 2/25/17, after the incident, and he was again assessed as having a high elopement risk. An Incident/Accident Investigation Follow up form dated 2/25/17 revealed "was at desk, rolled toward room then was observed crossing side road at building side, staff out to assist resident back inside building," "resident after attempting to climb tree, sat down, while being assisted back to standing position resident jerked hand away causing skin tear to left hand." Under Recommendations and New Interventions the following was written "head count census, maintenance fixed windows - window stopper, room change, frequent checks." Review of the facility ' s Performance Improvement Project Plan for Elopement, initiated 2/25/17, revealed the following, specific to 300	F 323	educated by the Area Staff Development Coordinator that were currently in the facility and completed phone education for those not presently in facility. No staff members who have not received the education will work on the unit until they complete the education. All new hires will also receive this education. Education includes the facility policy for elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with exit seeking 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 windows and immediately addressing any identified issues with the window stoppers not being effective. Windows in resident rooms will be checked three times week by the Maintenance Director, Maintenance Assistant, or Manager on Duty to validate 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 weekly for 12 weeks to ensure interventions are in place. Residents exhibiting new behaviors of wandering or exit seeking will be reviewed to ensure the elopement assessment is accurate and interventions have been implemented. Any	

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F 323	Continued From page 85 hall: Root Cause identification - "resident was able to open his window and then was able to slide window and exit through opening. Investigation was completed by the IDT (Interdisciplinary Team), it was believed that the resident was able to push the window past the screws securing the window for safety." Under Projected Outcome was the following: "all windows will be secured to ensure no residents can open past 6 inches." Action items for the plan included the following actions that were listed as being completed 2/25/17: resident placed on checks every 15 minutes, resident moved to room with a window that faced a courtyard (courtyard was enclosed on 4 sides), windows secured to not open past 6 inches. Review of the Quarter Hour Monitoring Tool for 2/26/17 resident ' s whereabouts were documented every 15 minutes. In addition Resident #13 was noted to be exit seeking at 8:15 PM and again at 8:30 PM. No interventions were documented in the medical record however the resident ' s location was in bed from 9:00 PM and through the night. On 2/26/17 a care plan update revealed the following new interventions "window stopper, room change." Review of the Quarter Hour Monitoring Tool for 2/27/17 revealed there was no documentation of the resident ' s whereabouts from 6:00 AM on 2/2717 until 2:00 PM on 2/27/17. Further review of the Facility ' s Performance Improvement Plan for Elopement, on 300 hall, revealed the following actions were listed as being completed 2/27/17: Maintenance Director and Administrator rechecked all windows on 300	F 323	opportunities will be corrected as identified. Monitoring Process: The Administrator will report on window monitoring and Director of Nursing will report on elopement assessment monitoring weekly for 12 weeks during the QAPI meeting then monthly thereafter. The committee will review these results and make recommendations as required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 86	F 323		

hall and a Quality Assurance Performance Improvement (QAPI) meeting was held 2/27/17 to review the plan with the team. Re-education on the elopement process was indicated as having started 2/25/17 but the only sign-in sheet available was for 2/27/17. The Plan also revealed Maintenance would be completing monthly window checks and that the Administrator would check windows on weekly rounds.

Review of an in service Attendance Form dated 2/27/17 revealed that 22 staff members received an in service on Elopement. None of the staff listed were those that had worked on 300 hall when Resident #13 eloped. The previous Assistant Director of Nursing (ADON #1) was listed as the instructor.

The previous staff member who was the ADON at the time of the incident (ADON #1) was interviewed 5/5/17 at 12:40 PM via telephone and stated she may have done an in-service on elopement on 2/27/17 but she could not really remember doing it so could not elaborate on whether the in service content included exit seeking behaviors and interventions. She added she was off work 2/25/17 and 2/26/17 and said did not find out about the elopement until she returned to work on 2/27/17. She further indicated that if she did an in-service it wouldn't have been until 2/27/17.

Review of the Quarter Hour Monitoring Tool for 2/28/17 revealed there was no documentation of the resident ' s whereabouts from 6:00 AM on 2/28/17 until 7:30 AM on 2/28 and again from 1:00 PM on 2/28/15 through 2:00 PM on 2/28/17.

Review of the Quarter Hour Monitoring Tool for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 87	F 323		

3/1/17 revealed there was no documentation of the resident ' s whereabouts from 6:00 AM on 3/1/17 until 2:00 PM on 3/1/17.

Review of the Quarter hour monitoring tool for 3/2/17 revealed Resident #13 ' s location was documented every 15 minutes. The documentation concluded at 2:15 PM on 3/2/17 and there were no further Quarter Hour Monitoring Tools for this resident.

On 3/3/17 the Physician ' s Orders revealed an order for "Wanderguard to upper extremity for elopement risk, check placement and function every shift."

Review of the Care Plan revealed that on 3/3/17 the plan of care for elopement risk was updated with the following intervention: Wanderguard to upper extremity for elopement risk, check placement and function q (every) shift."
Further review of the Care Plan revealed another update to the elopement risk plan of care on 3/21/17 with the intervention "Wanderguard replaced."

An Elopement Risk Assessment was completed for Resident #13 on 3/22/17 and he was again assessed as having a high elopement risk.

On 3/22/17 the Physician ' s Orders revealed an order for "change Wanderguard every 90 days for elopement risk."
Review of the Progress notes and Incident Log from 3/3/17 through 5/4/17 revealed no information regarding concerns or incidents related to the resident ' s Wanderguard.

On 5/3/16 at 5:30 PM Resident #13 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 88	F 323		

observed in his room. He was sitting in his wheelchair beside the window and adjusting the heating control knobs on the heating unit under the window. When asked how he was he said "not good I want to go home." When asked how long he had stayed at the facility he indicated he had just arrived and only been there one day. The window beside the resident was noted to have two screws through the sliding window track, to prevent the window from opening more than a few inches. The window looked out onto an enclosed courtyard.

Telephone interview with Housekeeping Aide #1 (HA #1) on 5/4/17 at 11:40 AM revealed that she did not work at the facility anymore but recalled the elopement incident that occurred on 2/25/17. She stated that she had gone outside through the back door of the laundry room to place dirty linens in the outside bin for pick up. The door she went out was on the left side of the building (when facing the front entrance). She added that someone who lived in the apartments, which were located on the 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 get contact information for the informant and would not be able to identify her. HA #1 said when she looked she could see Resident #13 trying to go up the hill on the other side of the access road, which ran next to the left side of the facility and back to the apartments. She added that there were trees on the hill and a fence at the top. HA #1 said she then went over to where the resident was and asked him to go back into the building with her but Resident #13 told her he did not want to go back. The Housekeeping Aide said she had a walkie talkie with her at the time of the incident and was able to use it to reach other

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 89	F 323		

housekeepers for help. She stated that only the housekeeping staff had these walkie talkies so she could only reach other housekeepers with the device. HA #1 said that 3 housekeepers came to help but they were unable to convince Resident #13 to go back inside so one of them left to get help. The Manager on Duty and a Nursing Assistant came out to assist the resident back in the facility. She said Resident #13 would not walk back into the facility but they eventually got him into a wheelchair and took him inside. When asked who it was that brought the wheelchair out she could not recall. HA #1 said she thought that it took about 20 - 30 minutes before they were able to get the resident back inside the facility.

Telephone Interview with Nurse #7 on 5/4/17, at 3:45 PM, revealed that she recalled the elopement incident that occurred on 2/25/17. She said that day was the first time she had worked on the locked unit (300 hall) and added "I knew it was a locked unit, no one told me the windows opened." She further said she thought it was a lot of windows to monitor on a locked unit with residents who needed supervision for behaviors like exit seeking. Nurse #7 said that she found out a resident was missing from the unit when a housekeeping person came and said "you let someone get off the unit." Nurse #7 indicated her response was "no I didn ' t" and that ' s when she was told someone was outside. She said that the Manager on Duty and the Nursing Assistant (Medication Aide #2) went out to get the resident. Nurse #7 said that she proceeded to try to determine how a resident got off the unit. She stated that while she was looking another resident said "I ' ll show you how he got out" and he showed her the window that was wide open in room 306. Nurse #7 stated that she then tried all

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 90	F 323		

the other resident room windows on the unit and found about 20 that opened. The Nurse said that she called the Director of Nursing (DON #2) and the Assistant Director of Nursing (ADON #1) and was told to call the Maintenance Director (DON #2 and ADON #1 were no longer employed at the facility at the time of the investigation). She said the Maintenance Assistant (MA) showed up about 30 minutes after she called the Maintenance Director and that she gave him a list of the rooms where the windows could open. Nurse #7 added that the MA said he would fix them and she said she went behind him when he was done and checked herself as well. When Resident #13 was brought back to the unit she did a physical assessment and also moved him to a room that had a window that did not open (Room 319). In addition this room's window faced a courtyard that enclosed on 3 sides by the building and on the 4th side by a 6 foot fence and keypad locked gate.

On 5/4/17 at 2:00 PM the Maintenance Assistant (MA) was interviewed. The MA said that the Maintenance Director called him and told him to go the facility and make adjustments to the windows on 300 hall as needed to prevent elopements. He said Nurse #7 showed him the window in Room # 306 and when he tried to open it, the window opened all the way without difficulty. He stated that he fixed the window in Room #306 by inserting a screw in the sliding window track to stop the window from opening. He also said that he put window stopper screws in the other windows on the unit well.

Observation of the windows on 300 hall with the MA and the Maintenance Director (M Dir) at 2:10 PM on 5/4/17 revealed the resident room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 91	F 323		

windows had one stationary window panel on the right side of the window and there was a sliding window panel on the left side of the window. To open the window the sliding window panel, when functioning, would slide towards the right, in front of the fixed window panel. Observations of the following windows revealed:
Room #306 (on 300 hall/the locked unit and the room with the window that Resident #13 eloped through) - There was one old looking screw drilled strait down vertically into the window track at approximately 6 inches away from the right of the sliding window panel; it was lower than the track edges and appeared as if the sliding window could slide over top. There were 3 shiny, new looking screws drilled down into the window track right up beside the sliding window. These screws prevented the window from opening at all. The window faced a side access road.

Room #319 (on 300 hall/the locked unit and the room Resident #13 was transferred to immediately following the elopement) - There was one old looking screw drilled strait down into the window track at approximately 6 inches away from the sliding window, it was higher than the track edges and appeared as if the sliding window could not slide over top. In addition, there was a shiny new looking screw that was screwed horizontally through the sliding window track 4-6 inches away from the right of the sliding window panel. This window faced a courtyard which was enclosed on 3 sides by the building and on the 4th side by a 6 foot fence with a key pad locked gate.

Room #329 (on 300 hall/the locked unit and Resident #13 ' s room at the time of the survey) - There was one old looking screw drilled strait

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 92	F 323		

down vertically into the window track approximately 6 inches away from the sliding window. This screw was lower than the track edges and appeared as if the sliding window could slide over top. There were two shiny, new looking screws that were screwed horizontally through the sliding window track, one at approximately 2 inches away from the right of the sliding window panel and one at approximately 4 inches away from the right of the sliding window panel. The M Dir attempted to open the window and was able to open it approximately 2 inches.

The windows for Room # 319, 329 and #306 and their neighboring room windows were observed from the outside of the facility as well. Mechanisms for securing the windows from the outside were not evident at this time.

On 5/4/17 at 2:15 PM during interview with the M Dir, he stated he had checked the 300 hall windows in the past periodically but had checked them on 2/27/17 after the elopement incident and monthly since then. He noted that the exit doors had always been checked daily, and he had an electronic log for the door checks, but said checks on the windows were not in that electronic system. He indicated that he would provide logs for window checks he had done, before the 2/25/17 elopement, if he could locate any. He also indicated that, even before the elopement incident on 2/25/17, the expectation was for the windows to either not open at all or to open no more than 6 inches for ventilation. No logs for window checks prior to the 2/25/27 elopement were provided during the survey.

During interview on 5/4/17 at 4:45 PM with the Medical Records Director (MRD), who had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 93	F 323		

the Duty Manager on 2/25/17, she said that she was on 100 hall on 2/25/17 when a Housekeeping Aide told her that a resident got out to the side of the building. She said she did not recall which Housekeeping Aide it was. The MRD said she asked the HA if someone was the resident and she said yes so the MRD then went to 300 hall and told the Nursing Assistant (Medication Aide #2) that she needed help getting a resident that was outside. The MRD stated that when she got outside she saw Resident #13 at the start of treed hill across the access road. She said he grabbed a tree limb and told them he was not going back in and he started swinging sticks. The MRD stated she did not remember who brought a wheelchair outside and added that it took quite a while but eventually they talked him to getting in the wheelchair and took him inside. Once Resident #13 was back in the building she contacted the Maintenance Director, the Administrator and the Director of Nursing (DON #2) but said they were already aware when she reached them. She added that she also conducted a head count to ensure all the residents were accounted for.

On 5/4/17 at 5:00 PM the Maintenance Assistant (MA) was re-interviewed. He stated that he did not recall Nurse #7 giving him a list of windows that could be opened. He also said that the window in Room #306 was the only one he tried to open before inserting a window stopper screw. The MA added that he was asked to make sure the windows did not open so he inserted screws through the sliding window tracks, so the windows would not open more than 6 inches for ventilation. He then checked each window after the stopper screws were inserted to ensure they did not open beyond the window stopper. The MA indicated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 94	F 323		

put a screw window stopper in all the resident room windows on 300 hall. Review of a facility map revealed there were 35 resident rooms on 300 hall.

On 5/5/17 at 10:10 AM the window to Room #306 was observed with the Maintenance Assistant and the Regional Nurse Consultant. The Maintenance Assistant removed all the screws that had been added after the 2/25/17 elopement incident. There was a small ¼ inch hex head screw driven vertically into the sliding window track that had a dull appearance compared to the shiny screws that were removed. The Maintenance Assistant acknowledged the one dull sheen screw was the only one that had been present prior to 2/25/17. This screw was not removed and remained in place. The sliding window panel had a latch that prevented intrusion through the window from outside the facility when engaged. The Maintenance Assistance demonstrated how the latch was manually disengaged, by hand, and then was able to move the sliding window panel all the way to the right, completely in front of the fixed window panel, with minimal effort. With the window fully open there was approximately a 3 foot wide by 4 foot high opening for someone to exit through. The window sill was approximately 3 feet from the ground. The removed screws were replaced after the demonstration and then the window was checked to ensure it did not open.

A similar demonstration was conducted with the window in Room #310 after the window in Room #306 was secured. This window opened with more difficulty when the new screws were removed, two hands were required and it had to be rocked back and forth some, but it did open all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 95	F 323		

the way. Similar to Room #306 this window had a previously existing hex head screw that was driven vertically in the sliding window track. This screw was not removed during the demonstration and did not prevent the window from sliding over it. The removed screws were replaced following the demonstration and the window was checked to ensure it did not open.

On 5/5/17 at 12:40 PM ADON #1 (who no longer worked at the facility) was interviewed by telephone. She stated that she had been a staff member at the facility on 2/25/17 but did not find out about the elopement until she came into work on the Monday, 2/27/17. She stated that she may have done some in-service education with the nursing staff on 2/17/17 in regards to elopement but she could not recall if the content was just on Elopement incident policy and procedure or if it included elopement risk factors, exit seeking behaviors and interventions. She said that she did investigate the incident and asked staff to show her where Resident #13 was located. ADON #1 also said that she was unable to determine how long Resident #13 was gone from the unit before he was located outside.

On 5/5/17 at 4:13 PM a Nurse #7 was re-interviewed by telephone. She stated she could not recall how many NA ' s were working on the unit that day. She said that when the Housekeeping Aide (HA) told her one of their residents was outside the other staff went out to help and she stayed behind by herself with the residents. She stated that Resident #13 had been calm that day and that she saw him approximately 10 minutes before the HA said a resident was outside. Nurse #7 said Resident #13 had been up at the nurse ' s station talking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 96	F 323		

about his friend and then he wheeled down the hall towards his room. She did not recall receiving any reeducation regarding elopement or exit seeking since the incident occurred.

Review of the Staff Assignment sheet for 2/25/17 revealed Nursing Assistant #2 and #3 (NA #2, NA #3) were the assigned NA ' s for the hall on 2/25/17 when Resident #13 eloped. NA #2 and NA #3 were not available for interview during the survey and could not be contacted when an attempt to reach them by telephone was made.

On 5/5/17 at 5:30 PM Nursing Assistant #1 was interviewed (NA #1). She stated she was not one of the staff members working during the shift that Resident #13 eloped but she was familiar with him. She stated that it was unusual for Resident #13 to try to get out the window and that she was not aware of him trying to do so prior to the elopement incident. She stated that his exit behaviors had focused on exit doors and verbalizations of going home. She said that once he made up his mind he was going he was pretty determined; sometimes he gathered his clothes up in his wheelchair and said someone was coming to pick him up. NA#1 stated that distraction seemed to work for Resident #13 as an intervention for exit seeking. NA #1 said she normally worked 2nd shift (2:00 PM - 10:00 PM) and when he wanted to go home she would say to him ' let ' s go watch TV and wait for your ride. ' She said after watching television for a while Resident #13 would eventually get tired and say he wanted to go to bed. NA#1 also said prior to 2/25/17, she had no idea any of the windows on the unit could open. She added that she had never tried them and just assumed they were locked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 97	F 323		

On 5/6/17 at 1:20 PM the Regional Nurse Consultant and Corporate Vice President were asked if the facility had ensured the windows on the 100 and 200 hall did not open more than 6 inches, given that there were residents with known high elopement risk on those units as well. They indicated they would need to verify to be sure.

On 5/6/17 at 1:30 PM the location where Resident #13 was found was observed with the Medical Records Director (MRD) who had helped bring the resident back inside on 2/25/17. The distance from the window of Room #306 to the spot across the access road, where the MRD said Resident #13 was found when he eloped, was measured with a rolling distance calculator by the Maintenance Director. The measured distance was 43 feet.

On 5/6/17 at 1:45 PM the window in Room #109 was observed. The windows on this hall were sliders that opened by sliding the bottom window up in front of the top stationary window, rather than opening by sliding the window to the side like the windows on 300 hall. There was a small screw noted on the sliding window track, on the left hand side, approximately 6 inches above the bottom window. The window did open and was not impeded by the presence of the screw. It was somewhat difficult to open in that it required two hands and rocking back and forth, but it was able to be opened approximately to a 2 foot height. The windows were approximately 3 feet wide and the window sill was approximately 3 feet from the ground.

On 5/6/17 at 1:50 PM the District Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 98	F 323		

Clinical Services #2 indicated she had tried to open one of the windows on 100/200 halls and she was able to open it with some difficulty that she attributed to the age of the windows. She also said that they were already working to secure all the 100 and 200 hall windows with window stoppers.

On 5/6/17 at 1:57 PM Medication Aide #2 (Med Aide #2) was interviewed and said she recalled the elopement incident on 2/25/17. Med Aide #2 said that she saw the resident at and after breakfast that day. He had been roaming around as was normal for him and seemed like his normal self. She said that he talked about his plane but he would do that on a normal basis. The Med Aide revealed Resident #13 would come up and ask when the next flight was and that he had a pass and needed to get on the next flight. She said that was his baseline but that he was not talking about actually leaving that morning, just about his own plane. She stated that when he did talk about needing to take a flight she would redirect him by saying there were no flights until the morning and they would get him on that one. She indicated that she found this effective with him. Med Aide #2 stated that the last time she saw Resident #13, prior to him eloping, was around noon when she gave him some medication. Med Aide #2 stated he was either in the hall or in his room, she could not remember. Resident #13 was observed at this time with the Med Aide #2 in his room. He did not have a Wanderguard on his wrist/upper extremity but the Med Aide located it on his left ankle.

During this interview on 5/6/17 at 1:57 PM with Med Aide #2 she stated that she was at the nurse ' s station when a Housekeeping Aide said one of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 99	F 323		

the residents went out a window. She said that she then went outside with the Manager on Duty (Medical Records Director). She thought the unit Nursing Assistants on the hall may have been in the Dining Room at the time. When they got outside she said she saw Resident #13 across the side street in the bushes trying to climb a tree; he had sticks and "was trying to swing them at us." He said he was going to get his plane that was across the fence. There was a fence at the top of the bushy, treed hill, and he was near the bottom. She stated that it took a while, possibly 20 minutes, to get Resident #13 inside but they finally got the resident back in the facility around 12:45 PM.

On 5/6/17 at 4:00 PM the Director of Clinical Services # 1 reported that the securing of the 100 and 200 hall windows had been completed.

The 5/4/17 the Administrator was notified of Immediate Jeopardy at 5:35 PM. The Administrator provided the following credible allegation of compliance on 5/6/17 at 2:00 PM.

Resident #13 was admitted to Brian Center Salisbury on 1/27/17, to room 306 in the Secure Unit. Resident #13 was assessed as being at risk for elopement on 1/27/17. At approximately 1:00 pm on 2/25/17, Resident #13 was found outside of the facility after a facility staff was alerted by a facility neighbor. Resident was found 43 feet from window, across the driveway outside facility between facility and neighboring apartment buildings. Was returned to the facility by the Manager on Duty and housekeeping staff. Resident #13 was assisted back into the facility and secure unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 100	F 323		

Nurse #7 immediately 2/25/17 completed a Head to Toe Assessment of Resident #13 with minor injury of a skin tear noted, unknown where/how injury occurred, due to not witnessed. An updated Elopement Assessment was completed for Resident #13 on 2/25/17. The care plan was reviewed and updated by the DON #2 on 3/6 to include "Window stopper and room change." Nurse #7 initiated increased supervision for Resident #13 on 2/25/17 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented on the flow record by the 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 on 2/25/17 where the window exited to a courtyard enclosed on 3 sides by the building and on the 4th by a 6 foot fence with key pad gate. The window for room 319 was checked by the nurse on 2/25/17 and it did not open more than 6 inches.

Nurse #7 notified Resident #13 ' s Responsible Party on 2/25/17 at 1:20 pm and Physician on 2/25/17 at 1:30 pm, regarding Resident #13 exiting the facility, physical assessment following the event and plan for increased monitoring. No new Physician ' s Orders were received. An Incident report was completed by Nurse #7 on 2/25/17. Nurse #7 notified the DON #2 and Administrator of the event on 2/25/17 at approximately 1:00 pm.

It was determined on 2/27/17 during an IDT ADHOC QAPI meeting, that the resident had been able to open the window past the existing window stopper screw and was able to exit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 101	F 323		

through the open window. Maintenance was called on 2/25/17 at approximately 1:00 pm to facility and arrived within a half hour and immediately secured resident ' s window, and conducted an audit of all windows in secure unit to ensure that they were secure, several other windows were found not secured when checked by the nurse, the maintenance assistant put in new window stopper screws and then verified that they opened no more than 6 inches.

On 2/27/2017 Maintenance Director and Administrator rechecked all windows in the secure unit to ensure they were secure.

Post event on 2/25/17 at approximately 1:00 pm the nurse on duty conducted a head count of all residents on the secure unit and ensured all residents were present and accounted for.

On 5/4/17 The Maintenance Director re-checked all windows on 300 Unit, and found them all to be secure.

Staff were re-educated on Elopement Process by the Area Staff Development Coordinator, no staff shall work until re-educated on process On 2/27/17 there was education done with Nursing staff who worked that day, conducted by ADON #1. Nursing staff working 5/4/17 were educated by the Area Staff Development Coordinator that were currently in the facility and completed phone education for those not presently in facility. No staff members who have not received the education will work on the unit until they complete the education. Education includes Policy Procedure when there is an Elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 323	Continued From page 102	F 323		

exit seeking behavior and intervention strategies. All new hires will also receive this education. Education was conducted by District Director of Clinical Services with the Maintenance Assistant and Maintenance Director on 5/6/17 regarding expectations for monitoring the windows and immediately addressing any identified issues with the window stoppers not being effective.

A review identifying residents that have exit seeking behaviors was conducted for the entire facility on 5/6/17 to ensure that they have an elopement risk assessment and care plan to address their behaviors and providing supervision to make sure they are safe. This review was completed by the District Director of Care Management. Any discrepancies were corrected on 5/6/2017.

To the knowledge of Facility Staff and Leadership, Resident #13 has had no other instances of exiting the facility without supervision since 2/25/17, nor was there any prior incident of Resident #13 exiting the facility through a window.

All windows on the secure unit were checked by Maintenance staff on 2/25/17 and were double checked by the Maintenance Director and Administrator on 2/27/17. The Administrator will randomly check the windows on the secure unit during facility rounds, Opportunities identified will be corrected immediately. On Monday 2/27/17 the Administrator met with the IDT team to review Root Cause Analysis for this event, it was determined that the resident had been able to open the window past the existing window stopper screw and exit facility through the window.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 323	Continued From page 103 On 5/5/17, IDT Team reviewed Action Plan that was put into motion on 2/25/17. On 5/4/17 the Maintenance Director re-checked all windows on the Secure Unit and documented on Window Check Log. On 5/6/17 the Maintenance Director, Rehab Director, Administrator, and District Housekeeping secured all windows on the 100 and 200 halls to ensure that they could not open past 6 inches. A validation of the credible allegation was completed on 5/6/17 at 6:00 PM by the following: Review of the window audits completed by the facility on 300 hall post 2/25/17, review of the in-service sign in sheets for 5/6/17 and the materials regarding the topics covered, interviews with multiple licensed and non-licensed nursing staff to verify their understanding of the information covered in the 5/6/17 in-service, interview with the Maintenance Assistant and Maintenance Director to verify their understanding of the education they received regarding monitoring the windows and fixing any identified issues immediately, review of care plans for high elopement risk residents to verify they had an elopement risk care plan in place, review of the wandering resident ' s information and photos binder to ensure all residents assessed as being high risk for elopement were included in the binder, 100 percent audit of all windows on 300 hall to ensure the windows were secured (all 35 resident rooms on 300 hall) and an audit of selected rooms on 100 and 200 hall to verify the windows did not open more than 6 inches.	F 323		
F 490	483.70 EFFECTIVE	F 490		6/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 490 SS=J	Continued From page 104 ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff, Home Health Care staff, physician, family and resident interviews, and facility and hospital medical record reviews, the administration: 1) failed to provide oversight to prevent 1 of 4 cognitively impaired residents, who were assessed as a high elopement risk, (Resident #13) from exiting a locked unit and failed to have monitoring systems in place to identify that there were windows in the building that could be opened sufficiently to allow a resident to elope through them; and, 2) failed to provide oversight and leadership to retain a Social Worker on a full-time basis, implement an effective discharge planning process, and provide for the safe discharge of one sampled resident (Residents #9) discharged to his home. Immediate jeopardy began on 2/25/17 for Resident #13 and for Resident #9 on 4/1/17. Resident #13 was able to exit a locked unit through a resident room window that he was able to open. The facility did not have monitoring systems in place to ensure the windows in the facility did not open. Resident #9 was discharged to his home without his needs being identified and addressed to ensure a safe discharge from the facility. The resident had a tracheostomy and multiple co-morbidities (chronic conditions). The resident had not been accepted by a Home	F 490	F 490 Corrective action accomplished for those residents found to have been affected by the deficient practice (A): Resident #9 was discharged to his home 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 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 nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse received education form the Area Staff Development Coordinator regarding discharge policy and procedure on 5/5/17. The oxygen provider delivered oxygen. No arrangements for DME was confirmed prior to discharge. Resident #9 was returned to facility by his family on 4/6/17,	

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F 490	Continued From page 105 Health care agency to receive assistance with his tracheostomy care upon discharge, as he had expected. The resident did not have the training nor supplies to do the tracheostomy care on his own at home. He returned to the facility on 4/6/17 and was immediately sent to the hospital Emergency Department (ED) for an evaluation and treatment of the tracheostomy. He was diagnosed with neck cellulitis and prescribed both an oral and topical antibiotic. He was released from the hospital ED and re-admitted to the facility on 4/6/17. Immediate Jeopardy for both Resident #13 and Resident #9 were lifted at 6:00 PM on 5/6/17 when the facility ' s acceptable credible allegation of compliance for F323 and F490 were verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The findings included: This citation is cross-referenced to: F323 - Based on observation, record review and staff interview the facility failed to prevent 1 of 4 cognitively impaired residents, who were assessed as a high elopement risk, (Resident #13) from exiting a locked unit and failed to identify that there were windows in the building that could be opened sufficiently to allow a resident to elope through them. Resident #13 exited a resident room window then walked 43 feet and across the access road for the neighboring apartment complex; this access road	F 490	was assessed and determined need for his care for his tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17, and treated for infection. Resident #9 remains a current resident. At time of discharge there was no validation of home health 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 consequences for not providing this care, for the resident and his family/caregiver. Section Q of the MDS was completed for Resident #9 on 4/13/17 and indicated that resident expects to remain at the facility. Throughout the discharge planning process for Resident #9 the facility was without a Qualified Social Worker. Facility's full time Social Service Director 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 3/30/17. Qualified Social Worker remains employed. The Administrator had an active role in the discharge process/planning for Resident #9. The nurse managers conducted an audit of residents who have discharged form the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and	

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F 490	Continued From page 106 ran next to the facility. Facility staff were notified that Resident #13 had eloped by a neighbor who had seen Resident #13 exit the window. When Resident #13 was located by staff he was at the base of a treed hill on the other side of the access road. Resident #13 sustained a skin tear during the incident. F204 - Based on observations, facility staff, Home Health Care staff, physician, resident and family interviews, and facility and hospital medical record reviews, the facility failed to arrange Home Health assistance for the care of a resident ' s tracheostomy, resident and/or care provider training on tracheostomy care, and access to tracheostomy supplies for 1 of 1 sampled resident (Resident #9) who was discharged home from the facility with a tracheostomy. This resulted in a lack of tracheostomy care after discharge; and, the resident was subsequently diagnosed with neck cellulitis requiring treatment with antibiotics. F251-- 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, resident and/or care provider training on tracheostomy care, and access to tracheostomy supplies. This occurred for 1 of 1 sampled resident (Resident #9) who was discharged home from the facility with a tracheostomy and resulted in a lack of tracheostomy care after discharge. The resident was subsequently diagnosed with neck cellulitis	F 490	orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. The results of this meeting and QA plan were shared with the Facility Medical Director on 5/5/17 and he was in agreement. The Area Staff Development Coordinator completed re-education of all licensed nurses and members of the Interdisciplinary Team involved in discharge planning on 5/5/17. This education included the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician. This education includes the facility policy regarding Transfer and Discharge Procedures as follows: Post Discharge Plan of Care: 1. Upon admission the IDT members, in consultation with the resident and/or the resident's legal representative (if practicable), develops the resident's discharge plan and anticipated date of discharge.	

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F 490	Continued From page 107 and required treatment with antibiotics. F284-- Based on facility staff, Home Health Care staff, physician, resident and family interviews, and facility and hospital medical record reviews, the facility failed to implement an effective discharge planning process to identify and address the discharge needs for 1 of 1 sampled resident (Resident #9) who was discharged home with a tracheostomy. Resident #9 was discharged without Home Health care assistance, resident and/or care provider training on tracheostomy care, or access to tracheostomy supplies, which resulted in a lack of tracheostomy care after discharge. Five days after his discharge from the facility, the resident was diagnosed with neck cellulitis requiring treatment with antibiotics. Interview with the Administrator on 5/6/17 at 6:04 PM revealed that the facility did not have a system in place for monitoring the windows because it wasn ' t a known issue. He stated that as far as he knew there had never been a previous elopement incident via the windows and he had not been aware that any of the windows could be opened far enough to allow for elopement. He also said it was his expectation that the windows would not open enough to allow for elopement. During the interview conducted with the facility ' s Administrator on 5/6/17 at 6:04 PM, the Administrator indicated he should have requested interim social services be provided until the facility could hire a qualified Social Worker on a full-time basis. He reported when the position was vacant, "A lot of things fell through the cracks," including components of discharge planning.	F 490	2. The Social Service Director or designee, the IDT members, and the resident and/or the resident's legal representative determine the individual needs, resources, and services required upon discharge through the IDT care plan meeting and process. 3. Social Service Dept. arranges for post-discharge services. 4. Contact those service agencies who can support resident's needs, resources, and services upon discharge (e.g., home health, durable medical equipment, therapy services, meals, transportation, etc.). 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, confidential and protected health information upon discharge. The Social Services Director will contact all residents who discharge home within one week of discharge, two weeks of discharge and at 30 days post discharge to ensure they have all care services necessary to safely remain in their home environment. The Administrator, Director of Nursing or Nursing Manager will review residents planned for discharge three times per week for 12 weeks to ensure a safe and	

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F 490	Continued From page 108 On 5/6/17 at 10:10 AM, District Director of Clinical Services #1 and District Director of Clinical Services #2 were informed of the immediate jeopardy for Resident #13 and Resident #9. The facility provided an acceptable credible allegation of compliance on 5/6/17 at 5:10 PM. The credible allegation indicated: Resident #9 was discharged to his home from [Name of Facility] on 4/1/17. Resident #9 required Home Health Services for Nursing, Oxygen, suction machine, and supplies to manage tracheostomy care at home. The Facility Administrator completed a referral to the Home Health Agency on 3/28/2017, prior to discharge from the facility. Home Health Agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse has received education from the Areas Staff Development Coordinator, regarding Discharge Policy and Procedure on 5/5/17 The Oxygen Provider delivered Oxygen. No arrangements for DME (Durable Medical Equipment) was confirmed prior to discharge. Resident #9 was returned to facility by his family on 4/6, was assessed and determined need for care for his Tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to [Name of Facility] on 4/6/2017, and treated for infection. Resident #9 remains a current resident. At time of discharge there was no validation of Home Health admitting resident, no confirmation of DME, and no documented education related to signs and symptoms of problems, what care was necessary	F 490	orderly discharge has been planned by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visit when possible and validating the completion of appropriate referrals. The Director of Clinical of Services completed re-education of Administrator and Director of Nursing on 5/5/17. This education included facility policy of provision of social work services and state 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 Service support is retained to meet the requirements of regulation. Support will be provided from sister facilities and/or through contract agency support. On 5/4/17, the Administrator, DON, and ADON were retrained on the Quality Assurance & Performance Improvement Program by the Area Staff Development Coordinator. The Quality Assurance Committee consists of: -Administrator -Director of Nursing -Dietary Manager -Rehabilitation Manager -Maintenance or Environmental Representative -Activities Director -Social Services Director -Human Resource Designee	

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F 490	Continued From page 109 to maintain stable health, and consequences of not providing this care, for the resident and his family/ caregiver. Throughout the Discharge Planning Process for Resident #9, the Facility was without a Qualified Social Worker. Facilities Full Time Social Service Director resigned without notice on 1/26/17. Facility went without a qualified Social Worker 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. The Nurse Managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. The results of this meeting and QA Plan were shared with the Facility Medical Director on 5/5/17 and he was in agreement. The Area Staff Development Director completed re-education of all Licensed Nurses and members of the Interdisciplinary Team involved in discharge planning, on 5/5/17, Education included the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS	F 490	-Business Office Director -Resident Care Management Director -Medical Director -Infection Preventionist Corrective action accomplished for those residents found to have been affected by the deficient practice (B): Resident #13 was admitted to Brian Center Health and Rehabilitation/Salisbury on 1/27/17, to room 306 in the secure unit. Resident #13 was assessed as being at risk for elopement on 1/27/17. At approx. 1:00pm on 2/25/17, Resident #13 was found outside of the facility after a facility staff was alerted by a facility neighbor. Resident #13 was found 43 feet from window, across the driveway outside the facility between facility and neighboring apartment buildings. Resident #13 was returned to the facility by the Manager on Duty and housekeeping staff. Resident #13 was assisted back into the facility and secure unit. Nurse #1 immediately completed a head to toe assessment of Resident #13 with minor injury of a skin tear noted, unknown where/how injury occurred, due to not witnessed. An updated Elopement Assessment was completed for Resident #13 on 2/25/17. The care plan was reviewed and updated by the DON on 3/6/17 to include "Window stopper and room change." Nurse #1 initiated increased supervision for Resident #1 on 2/25/17 to include every 15 minute checks	

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F 490	Continued From page 110 Nurse), Business Office Director and Physician. This education includes the facility policy regarding Transfer and Discharge Procedures as follows: Post Discharge Plan of Care: 1. Upon admission the IDT members, in consultation with the resident and/or the Resident ' s legal representative (if practicable), develops the resident ' s discharge plan and anticipated date of discharge. 2. The Social Service Director or designee, the IDT members, and the resident and/or the Resident ' s legal representative determine the individual needs, resources, and services required upon discharge through the IDT care plan meeting and process. 3. Social Service Department arranges for post-discharge services 4. Contact those service agencies who can support resident ' s needs, resources, and services upon discharge (e.g., home health, durable medical equipment, therapy services, meals, transportation, etc.). 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, confidential and protected health information upon discharge. The Social Services Director will contact all residents who discharge home within 1 week of discharge, 2 weeks of discharge and at 30 days post discharge to ensure that they have all care necessary services to safely remain in their home environment. The Administrator, Director of Nursing or Nurse Manager will review residents planned for	F 490	to monitor location. These checks were completed by the nursing assistants and documented on the flow record by the 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 on 2/25/17 where the window exited to a courtyard enclosed on three sides by the building and on the fourth by a six foot fence with a key pad gate. The window for room 319 was checked by the nurse on 2/25/17 and it did not open more than six inches. Nurse #1 notified Resident #13 responsible party on 2/25/17 at 1:20pm and physician on 2/25/17 at 1:30pm regarding Resident #13 exiting the facility, physical assessment following the event and plan for increased monitoring. No new physician's orders were received. An incident report was completed by Nurse #1 on 2/25/17. Nurse #1 notified the DON and Administrator of the event on 2/25/17 at approx. 1:00pm. Maintenance was called on 2/25/17 at approx. 1:00pm to facility and arrived within a half hour and immediately secured resident's window, and conducted an audit of all windows in secure unit to ensure that they were secure, several other windows were found not secured when checked by the nurse, the maintenance assistant put in new window stopper screws and then verified that they opened no more than six inches.	

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F 490	Continued From page 111 discharge 3 times per week for 12 weeks to ensure a safe and orderly discharge has been planned by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visits when possible and validating the completion of appropriate referrals. The Director of Clinical Services completed re-education of Administrator and Director of Nursing on 5/5/2017. This education included facility policy of provision of social work services and state 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 Service support is retained to meet the requirements of regulation. Support will be provided from sister facilities and /or through contract agency support. On 5/4/17, the Administrator, DON and ADON were retrained on the Quality Assurance & Performance Improvement Program by the Area Staff Development Coordinator. The Quality Assurance committee consists of: · Administrator · Director of Nursing · Dietary Manager · Rehabilitation Manager · Maintenance or Environmental Representative · Activities Director · Social Services Director · Human Resource Designee · Business Office Director · Resident Care Management Director · Medical Director · Infection Preventionist	F 490	Staff were re-educated on 5/4/17 on elopement process by the Area Staff Development Coordinator, no staff shall work until re-educated on process. On 2/27/17 there was education done with nursing staff who worked that day, conducted by the ADON. Nursing staff working 5/4/17 were educated by the Area Staff Development Coordinator that were currently in the facility and completed phone education for those not presently in facility. No staff members who have not received the education will work on the unit until they complete the education. Education includes policy and procedure when there is an elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with exit seeking behavior and intervention strategies. All new hires will also receive this education. Corrective action accomplished for those residents having the potential to be affected by the deficient practice: Administrator, DON and ADON were educated on the QAPI process by the District Director of Clinical Services on 5/4/17. Administrator and IDT to complete monthly QAPI meetings with review of action plans and new areas of concern for performance improvement, with evidence of root cause analysis and action plans to address potential and actual concerns. District Director of Clinical Services will review monthly QAPI minutes x four months, and attend	

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F 490	Continued From page 112 Resident #13 was admitted to [Name of Facility] on 1/27/17, to room 306 in the Secure Unit. Resident #13 was assessed as being at risk for elopement on 1/27/17. At approximately 1:00 pm on 2/25/17, Resident #13 was found outside of the facility after a facility staff was alerted by a facility neighbor. Resident was found 43 feet from window, across the driveway outside facility between facility and neighboring apartment buildings. Was returned to the facility by the Manager on Duty and housekeeping staff. Resident #13 was assisted back into the facility and secure unit. Nurse #7 immediately 2/25/17 completed a Head to Toe Assessment of Resident #13 with minor injury of a skin tear noted, unknown where/how injury occurred, due to not witnessed. An updated Elopement Assessment was completed for Resident #13 on 2/25/17. The care plan was reviewed and updated by the DON on 3/6 to include "Window stopper and room change." Nurse #7 initiated increased supervision for Resident #1 on 2/25/17 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented on the flow record by the 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 on 2/25/17 where the window exited to a courtyard enclosed on 3 sides by the building and on the 4th by a 6 foot fence with key pad gate. The window for room 319 was checked by the nurse on 2/25/17 and it did not open more than 6 inches. Nurse #7 notified Resident #13 ' s Responsible	F 490	meetings as able. On 5/4/17, the Area Staff Development Coordinator conducted re-education for the Administrator on the facility's policy and procedures for assembling a QAPI committee, collecting data and analyzing trends, and development and implementation of a plan to improve with ongoing monitoring to sustain compliance. 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 quality improvement plans related to identified areas of opportunity. The committee has met monthly in the past to monitor ongoing compliance with F323, Supervision to Prevent Accidents and Elopement, but will begin meeting weekly on 5/4/17 to increase monitoring of F323 Supervision to Prevent Accidents with a focus on the review of Window Checks being conducted to correct and maintain the elopement management process and to evaluate systems for effectiveness of the facility's overall compliance with F323 Supervision to Prevent Accidents and Elopements. The District Director of Clinical Services re-educated the IDT on 5/6/17 on Federal Regulation of F520 and QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI) program. The QAPI	

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F 490	Continued From page 113 Party on 2/25/17 at 1:20 pm and Physician on 2/25/17 at 1:30 pm, regarding Resident #13 exiting the facility, physical assessment following the event and plan for increased monitoring. No new Physician ' s Orders were received. An Incident report was completed by Nurse #7 on 2/25/17. Nurse #7 notified the DON and Administrator of the event on 2/25/17 at approximately 1:00 pm. Maintenance was called on 2/25/17 at approximately 1:00 pm to facility and arrived within a half hour and immediately secured resident ' s window, and conducted an audit of all windows in secure unit to ensure that they were secure, several other windows were found not secured when checked by the nurse, the maintenance assistant put in new window stopper screws and then verified that they opened no more than 6 inches. Staff were re-educated 5/4/2017 on Elopement Process by the Area Staff Development Coordinator, no staff shall work until re-educated on process. On 2/27/17 there was education done with nursing staff who worked that day, conducted by the ADON. Nursing staff working 5/4/17 were educated by the Area Staff Development Coordinator that were currently in the facility and completed phone education for those not presently in facility. No staff members who have not received the education will work on the unit until they complete the education. Education includes Policy Procedure when there is an Elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with exit seeking behavior and intervention strategies. All new hires will also receive this education.	F 490	committee consists of the Administrator, Director of Nursing, Medical Director and at least three other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: The District Director of Clinical Services of the District Director of Operations will monitor QAPI meetings monthly for three months to assure compliance Federal Regulation F 520 to sustain and maintain compliance with Federal Regulation F 323 - Resident Safety to include ongoing monitoring and revisions to the plan as necessary, and to maintain compliance with F 204, 251 and 284 as they relate to Social Service provisions and adequate discharge planning and coordination of a safe and orderly discharge for all residents leaving facility. District Director of Clinical Services or the District Director of Operations will provide oversight of the Facility Administration to ensure implementation of the credible allegation, by providing on site and remote support to the facility weekly for 12 weeks to ensure implementation of all credible allegations.	

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 490	Continued From page 114 District Director of Clinical Services and /or the District Director of Operations will provide oversight of the administration to ensure implementation of the credible allegation, by providing on site visits to the facility every week x 4 weeks, and then a minimum of bimonthly visits X 6 months to ensure implementation of all credible allegations. The credible allegation was validated on 5/6/17 at 6:26 PM by the following: Review of the window audits completed by the facility on 300 hall post 2/25/17, interview with the Maintenance Assistant and Maintenance Director to verify their understanding of the education they received regarding monitoring the windows and fixing any identified issues immediately, 100 percent audit of all windows on 300 hall/the locked unit to ensure the windows were secured (all 35 resident rooms on 300 hall) and an audit of selected rooms on 100 and 200 hall to verify the windows did not open more than 6 inches. On 5/6/17 at 6:04 PM, the facility ' s Administrator was interviewed. The Administrator was able to describe the education and in-servicing he had received in regards to the requirement to retain a qualified Social Worker on a full-time basis, implementation of an effective discharge planning process, and provision for the safe discharge of a resident. He was also educated on his role to review residents planned for discharge and ensure the appropriate plans were in place and resources were available for the safe discharge of each resident. During this interview the Administrator revealed that they had not been monitoring the windows because he was not	F 490	Opportunities will be corrected as identified. Monitoring Process: The Administrator will report the results of these audits weekly for 12 weeks during the QAPI meeting and then monthly thereafter. The committee will review these results and make recommendations as required.	

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F 490	Continued From page 115 aware of a previous incident of elopement through the windows and because the Management Team believed the windows were secure and could not open. He added that he thought a future citation in the area of Administration areas would be prevented because, due to recent staff changes, the facility now had an effective management team and nursing leadership in place. The Administrator noted that the facility had developed a stabilization plan that included plans to increase staffing over time. He said they had already hired some new positions such as Unit Managers. In addition he said that new systems were being put in place for the Management Team to work more effectively in their day to day clinical meetings and quality assurance activities such as root cause analysis. He stated that there was significant corporate support for the facility now, which had not been as evident in the past. In regards to Corporate Oversight the Administrator said that it would continue for a minimum of six months but that there would also be ongoing corporate support and oversight beyond that time frame as needed.	F 490		
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		6/7/17

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F 520	Continued From page 116 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, facility staff, Home Health Care staff and physician interviews, and facility and hospital medical record reviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in March of 2017. This was for one recited deficiency related to	F 520	F 520 Corrective action accomplished for those residents found to have been affected by the deficient practice (A): Resident #9 was discharged to his home from Brian Center Health and	

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F 520	Continued From page 117 accidents (F323), which was originally cited in November of 2016 on a recertification survey and again in March of 2017 on a complaint investigation. F323 was subsequently recited on the current complaint investigation conducted in conjunction with a follow-up survey. A second recited deficiency related to Administration (F490) was originally cited in March of 2017 on a complaint investigation. F490 was subsequently recited on the current complaint investigation conducted in conjunction with a follow-up survey. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. Immediate Jeopardy began on 2/25/17 for Resident #13 and for Resident #9 on 4/1/17. Resident # 13 was able to exit a locked unit through a resident room window that he was able to open. The facility did not have monitoring systems in place to ensure the windows in the facility did not open. Resident #9 was discharged to his home without his needs being identified and addressed to ensure a safe discharge from the facility. The resident had a tracheostomy and multiple co-morbidities (chronic conditions). The resident had not been accepted by a Home Health care agency to receive assistance with his tracheostomy care upon discharge, as he had expected. The resident did not have the training nor supplies to do the tracheostomy care on his own at home. He returned to the facility on 4/6/17 and was immediately sent to the hospital Emergency Department (ED) for an evaluation and treatment of the tracheostomy. He was diagnosed with neck cellulitis and prescribed both an oral and topical antibiotic. He was released from the hospital ED and re-admitted to the	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 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 nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse received education form the Area Staff Development Coordinator regarding discharge policy and procedure on 5/5/17. The oxygen provider delivered oxygen. No arrangements for DME was confirmed prior to discharge. Resident #9 was returned to facility by his family on 4/6/17, was assessed and determined need for his care for his tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to Brian Center Health and Rehabilitation/Salisbury on 4/6/17, and treated for infection. Resident #9 remains a current resident. At time of discharge there was no validation of home health 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 consequences for not providing this care, for the resident and his family/caregiver. Section Q of the MDS was completed for Resident #9 on 4/13/17 and indicated that	

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F 520	Continued From page 118 facility on 4/6/17. The Immediate Jeopardy for both Resident #13 and Resident #9 were lifted at 6:26 PM on 5/6/17 when the facility ' s acceptable credible allegation of compliance for F323 and F490 were verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put into place are effective. The findings included: This citation is cross referenced to: F323: Supervision to Prevent Accidents - Based on observation record review and staff interview the facility failed to prevent 1 of 4 cognitively impaired residents, who were assessed as a high elopement risk, (Resident #13) from exiting a locked unit and failed to identify that there were windows in the building that could be opened sufficiently to allow a resident to elope through them. Resident #13 exited a resident room window then walked 43 feet and across an access road for the neighboring apartment complex; this access road ran next to the facility. Facility staff were notified that Resident #13 had eloped by a neighbor who had seen Resident #13 exit the window. When Resident #13 was located by staff he was at the base of a hill on the other side of the access road. Resident #13 sustained a skin tear during the incident. F490: Administration - Based on observations, facility staff, Home Health Care staff, physician,	F 520	resident expects to remain at the facility. Throughout the discharge planning process for Resident #9 the facility was without a Qualified Social Worker. Facility's full time Social Service Director 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 3/30/17. Qualified Social Worker remains employed. The Administrator had an active role in the discharge process/planning for Resident #9. The nurse managers conducted an audit of residents who have discharged form the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. The results of this meeting and QA plan were shared with the Facility Medical Director on 5/5/17 and he was in agreement. The Area Staff Development Coordinator completed re-education of all licensed nurses and members of the Interdisciplinary Team involved in discharge planning on 5/5/17. This	

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F 520	Continued From page 119 family and resident interviews, and facility and hospital medical record reviews, the administration: 1) failed to provide oversight to prevent 1 of 4 cognitively impaired residents, who were assessed as a high elopement risk, (Resident #13) from exiting a locked unit and failed to have monitoring systems in place to identify that there were windows in the building that could be opened sufficiently to allow a resident to elope through them; and, 2) failed to provide oversight and leadership to retain a Social Worker on a full-time basis, implement an effective discharge planning process, and provide for the safe discharge of one sampled resident (Residents #9) discharged to his home. During a recertification and complaint survey of 11/18/16, the facility was cited for F323 failure to provide adequate supervision to prevent an unobserved resident to resident altercation with minor injury for 2 of 2 sampled residents (Resident #130 and #205), failed to thoroughly investigate a resident to resident incident and to identify and implement intervention strategies to prevent future similar incidents for 2 of 2 residents (Resident #130 and #205) and on 1 of 1 behavioral health units (300 Hall). During a complaint investigation survey of 3/11/17, the facility was cited for F323 failure to supervise one of one sampled residents with known sexually inappropriate behaviors to prevent sexual abuse between this resident (Resident #8) and a cognitively impaired resident (Resident #1) and failed to implement effective interventions to prevent further inappropriate sexual behaviors for one of one sampled residents with known sexually inappropriate behaviors (Resident # 8).	F 520	education included the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician. This education includes the facility policy regarding Transfer and Discharge Procedures as follows: Post Discharge Plan of Care: 1. Upon admission the IDT members, in consultation with the resident and/or the resident's legal representative (if practicable), develops the resident's discharge plan and anticipated date of discharge. 2. The Social Service Director or designee, the IDT members, and the resident and/or the resident's legal representative determine the individual needs, resources, and services required upon discharge through the IDT care plan meeting and process. 3. Social Service Dept. arranges for post-discharge services. 4. Contact those service agencies who can support resident's needs, resources, and services upon discharge (e.g., home health, durable medical equipment, therapy services, meals, transportation, etc.).	

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F 520	Continued From page 120 During a complaint investigation survey of 3/11/17, the facility was cited for F490 for failure to provide effective leadership to protect one of three sampled residents (Resident # 1) from sexual abuse by a resident (Resident # 8) with known sexually inappropriate behaviors. An interview was conducted with the Administrator on 5/6/17 at 6:04 PM. During the interview he stated that the quality assurance process began with identifying any facility issues via daily clinical meetings, falls meetings, and the interdisciplinary team meetings. Any identified issues needed to be brought to the Quality Assurance and Performance Improvement (QAPI) committee to ensure they are resolved. The Administrator acknowledged there had not been a system to monitor the windows because the Management Team believed the windows were secure. He also indicated that not having a Social Worker in place and that this was a requirement and facilitated effective discharge planning. He said that the facility had developed a Stabilization Plan with the support of their Corporate Team and that through Corporate Oversight and Quality Assurance monitoring the facility would be able improve in the areas of Supervision to Prevent Accidents and Administration to prevent further repeat citations in these areas. On 5/6/17 at 10:10 AM, District Director of Clinical Services #1 and District Director of Clinical Services #2 were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 5/6/17 at 3:22 PM. The credible allegation indicated:	F 520	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, confidential and protected health information upon discharge. The Social Services Director will contact all residents who discharge home within one week of discharge, two weeks of discharge and at 30 days post discharge to ensure they have all care services necessary to safely remain in their home environment. The Administrator, Director of Nursing or Nursing Manager will review residents planned for discharge three times per week for 12 weeks to ensure a safe and orderly discharge has been planned by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visit when possible and validating the completion of appropriate referrals. The Director of Clinical of Services completed re-education of Administrator and Director of Nursing on 5/5/17. This education included facility policy of provision of social work services and state 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 Service support is retained to meet the	

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F 520	Continued From page 121 Resident #9 was discharged to his home from [Name of Facility] on 4/1/17. Resident #9 required Home Health Services for Nursing, Oxygen, suction machine, and supplies to manage tracheostomy care at home. The Facility Administrator completed a referral to the Home Health Agency on 3/28/2017, prior to discharge from the facility. Home Health Agency informed staff nurse prior to discharge that they were unable to provide service for this resident. This information was not communicated with facility management for follow up. This nurse has received education from the Areas Staff Development Coordinator, regarding Discharge Policy and Procedure on 5/5/17 The Oxygen Provider delivered Oxygen. No arrangements for DME (Durable Medical Equipment) was confirmed prior to discharge. Resident # 9 was returned to facility by his family on 4/6, was assessed and determined need for care for his Tracheostomy, due to drainage and odor, was sent to ER for eval and returned to facility where he was readmitted to [Name of Facility] on 4/6/2017, and treated for infection. Resident # 9 remains a current resident. At time of discharge there was no validation of Home Health 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 consequences of not providing this care, for the resident and his family/ caregiver. Throughout the Discharge Planning Process for Resident #9, the Facility was without a Qualified Social Worker. Facilities Full Time Social Service Director resigned without notice on 1/26/17. Facility went without a qualified Social Worker	F 520	requirements of regulation. Support will be provided from sister facilities and/or through contract agency support. On 5/4/17, the Administrator, DON, and ADON were retrained on the Quality Assurance & Performance Improvement Program by the Area Staff Development Coordinator. The Quality Assurance Committee consists of: -Administrator -Director of Nursing -Dietary Manager -Rehabilitation Manager -Maintenance or Environmental Representative -Activities Director -Social Services Director -Human Resource Designee -Business Office Director -Resident Care Management Director -Medical Director -Infection Preventionist Corrective action accomplished for those residents found to have been affected by the deficient practice (B): Resident #13 was admitted to Brian Center Health and Rehabilitation/Salisbury on 1/27/17, to room 306 in the secure unit. Resident #13 was assessed as being at risk for elopement on 1/27/17. At approx. 1:00pm on 2/25/17, Resident #13 was found outside of the facility after a facility staff was alerted by a facility neighbor. Resident #13 was found 43 feet from window, across the driveway	

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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. The Nurse Managers conducted an audit of residents who have discharged from the facility since 4/1/17 to validate each resident received sufficient preparation and orientation to ensure a safe and orderly discharge. This was validated by reviewing the resident record for documentation of coordination of home care services and by conducting phone interviews with the resident or their responsible party to validate successful discharge. This audit was completed by 5/5/17. The results of this meeting and QA Plan were shared with the Facility Medical Director on 5/5/17 and he was in agreement. The Area Staff Development Director completed re-education of all Licensed Nurses and members of the Interdisciplinary Team involved in discharge planning, on 5/5/17, Education included the Administrator, Director of Nursing, Nurse Managers, Social Services Director, Therapy Program Manager, Dietary Services Manager, Resident Care Management Director (MDS Nurse), Business Office Director and Physician. This education includes the facility policy regarding Transfer and Discharge Procedures as follows: Post Discharge Plan of Care: 1.Up on admission the IDT members, in consultation with the resident and/or the Resident ' s legal representative (if practicable), develops	F 520	outside the facility between facility and neighboring apartment buildings. Resident #13 was returned to the facility by the Manager on Duty and housekeeping staff. Resident #13 was assisted back into the facility and secure unit. Nurse #1 immediately completed a head to toe assessment of Resident #13 with minor injury of a skin tear noted, unknown where/how injury occurred, due to not witnessed. An updated Elopement Assessment was completed for Resident #13 on 2/25/17. The care plan was reviewed and updated by the DON on 3/6/17 to include "Window stopper and room change." Nurse #1 initiated increased supervision for Resident #1 on 2/25/17 to include every 15 minute checks to monitor location. These checks were completed by the nursing assistants and documented on the flow record by the 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 on 2/25/17 where the window exited to a courtyard enclosed on three sides by the building and on the fourth by a six foot fence with a key pad gate. The window for room 319 was checked by the nurse on 2/25/17 and it did not open more than six inches. Nurse #1 notified Resident #13 responsible party on 2/25/17 at 1:20pm and physician on 2/25/17 at 1:30pm	

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F 520	Continued From page 123 the resident ' s discharge plan and anticipated date of discharge. 2.. The Social Service Director or designee, the IDT members, and the resident and/or the Resident ' s legal representative determine the individual needs, resources, and services required upon discharge through the IDT care plan meeting and process. 3. Social Service Department arranges for post-discharge services 4. Contact those service agencies who can support resident ' s needs, resources, and services upon discharge (e.g., home health, durable medical equipment, therapy services, meals, transportation, etc.). 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, confidential and protected health information upon discharge. The Social Services Director will contact all residents who discharge home within 1 week of discharge, 2 weeks of discharge and at 30 days post discharge to ensure that they have all care necessary services to safely remain in their home environment. The Administrator, Director of Nursing or Nurse Manager will review residents planned for discharge 3 times per week for 12 weeks to ensure a safe and orderly discharge has been planned by meeting with the resident and/or family and completing the Post Discharge Plan of Care, providing a home visits when possible and validating the completion of appropriate referrals. The Director of Clinical Services completed re-education of Administrator and Director of	F 520	regarding Resident #13 exiting the facility, physical assessment following the event and plan for increased monitoring. No new physician's orders were received. An incident report was completed by Nurse #1 on 2/25/17. Nurse #1 notified the DON and Administrator of the event on 2/25/17 at approx. 1:00pm. Maintenance was called on 2/25/17 at approx. 1:00pm to facility and arrived within a half hour and immediately secured resident's window, and conducted an audit of all windows in secure unit to ensure that they were secure, several other windows were found not secured when checked by the nurse, the maintenance assistant put in new window stopper screws and then verified that they opened no more than six inches. Staff were re-educated on 5/4/17 on elopement process by the Area Staff Development Coordinator, no staff shall work until re-educated on process. On 2/27/17 there was education done with nursing staff who worked that day, conducted by the ADON. Nursing staff working 5/4/17 were educated by the Area Staff Development Coordinator that were currently in the facility and completed phone education for those not presently in facility. No staff members who have not received the education will work on the unit until they complete the education. Education includes policy and procedure when there is an elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with exit	

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	345115	A. BUILDING _____ B. WING _____	R-C 05/06/2017

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F 520	Continued From page 124 Nursing on 5/5/2017. This education included facility policy of provision of social work services and state 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 Service support is retained to meet the requirements of regulation. Support will be provided from sister facilities and /or through contract agency support. On 5/4/17, the Administrator, DON and ADON were retrained on the Quality Assurance & Performance Improvement Program by the Area Staff Development Coordinator. The Quality Assurance committee consists of: · Administrator · Director of Nursing · Dietary Manager · Rehabilitation Manager · Maintenance or Environmental Representative · Activities Director · Social Services Director · Human Resource Designee · Business Office Director · Resident Care Management Director · Medical Director · Infection Preventionist Resident # 13 was admitted to [Name of Facility] on 1/27/17, to room 306 in the Secure Unit. Resident #13 was assessed as being at risk for elopement on 1/27/17. At approximately 1:00 pm on 2/25/17, Resident # 13 was found outside of the facility after a facility staff was alerted by a facility neighbor. Resident was found 43 feet from window, across the driveway outside facility between facility and neighboring apartment buildings. Was returned to the facility by the	F 520	seeking behavior and intervention strategies. All new hires will also receive this education. Corrective action accomplished for those residents found to have been affected by 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 Staff Development Coordinator and Maintenance Director conducted a root cause analysis regarding facility processes for elopement prevention with 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 facility staff regarding the elopement policy, and systematic approach of more frequent window checks on the secure unit. This will include weekly audits by the Maintenance Director for Assistant, additionally the Administrator will conduct random weekly audits on his facility rounds. The Director of Nursing will implement increases supervision for any resident with an elopement or attempt to elope immediately to establish safety and continue until the investigation has been completed and required interventions have been implemented. Incident reports will be reviewed by the IDT during the morning Stand Up meeting led by the Administrator. The IDT will determine acceptable interventions and ensure the care plan is revised.	

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F 520	Continued From page 125 Manager on Duty and housekeeping staff. Resident #13 was assisted back into the facility and secure unit. Nurse #7 immediately 2/25/17 completed a Head to Toe Assessment of Resident #13 with minor injury of a skin tear noted, unknown where/how injury occurred, due to not witnessed. An updated Elopement Assessment was completed for Resident #13 on 2/25/17. The care plan was reviewed and updated by the DON on 3/6 to include "Window stopper and room change." Nurse #7 initiated increased supervision for Resident #13 on 2/25/17 to include every 15 minute checks to monitor location. These checks were completed by the Nursing Assistants and documented on the flow record by the 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 on 2/25/17 where the window exited to a courtyard enclosed on 3 sides by the building and on the 4th by a 6 foot fence with key pad gate. The window for room 319 was checked by the nurse on 2/25/17 and it did not open more than 6 inches. Nurse #7 notified Resident #13 ' s Responsible Party on 2/25/17 at 1:20 pm and Physician on 2/25/17 at 1:30 pm, regarding Resident #13 exiting the facility, physical assessment following the event and plan for increased monitoring. No new Physician ' s Orders were received. An Incident report was completed by Nurse #7 on 2/25/17. Nurse #7 notified the DON and Administrator of the event on 2/25/17 at approximately 1:00 pm.	F 520	Administrator, DON and ADON were educated on the QAPI process by the District Director of Clinical Services on 5/4/17. Administrator and IDT to complete monthly QAPI meetings with review of action plans and new areas of concern for performance improvement, with evidence of root cause analysis and action plans to address potential and actual concerns. District Director of Clinical Services will review monthly QAPI minutes x four months, and attend meetings as able. On 5/4/17, the Area Staff Development Coordinator conducted re-education for the Administrator on the facility's policy and procedures for assembling a QAPI committee, collecting data and analyzing trends, and development and implementation of a plan to improve with ongoing monitoring to sustain compliance. 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 quality improvement plans related to identified areas of opportunity. The committee has met monthly in the past to monitor ongoing compliance with F323, Supervision to Prevent Accidents and Elopement, but will begin meeting weekly on 5/4/17 to increase monitoring of F323 Supervision to Prevent Accidents with a focus on the review of Window Checks being conducted to correct and maintain	

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F 520	Continued From page 126 Maintenance was called on 2/25/17 at approximately 1:00 pm to facility and arrived within a half hour and immediately secured resident ' s window, and conducted an audit of all windows in secure unit to ensure that they were secure, several other windows were found not secured when checked by the nurse, the maintenance assistant put in new window stopper screws and then verified that they opened no more than 6 inches. Staff were re-educated 5/4/2017 on Elopement Process by the Area Staff Development Coordinator, no staff shall work until re-educated on process. On 2/27/17 there was education done with nursing staff who worked that day, conducted by the ADON. Nursing staff working 5/4/17 were educated by the Area Staff Development Coordinator that were currently in the facility and completed phone education for those not presently in facility. No staff members who have not received the education will work on the unit until they complete the education. Education includes Policy Procedure when there is an Elopement or suspected elopement, signs/symptoms of elopement risk, and supervision of residents with exit seeking behavior and intervention strategies. All new hires will also receive this education. On 5/4/17 the Administrator, Director of Nursing and Facility Interdisciplinary Team including the Administrator, DON, ADON, District Director of Clinical Services, Area Staff Development Coordinator and Maintenance Director conducted a root cause analysis regarding facility processes for elopement prevention with regards to Window Safety/Security. Based on the results	F 520	the elopement management process and to evaluate systems for effectiveness of the facility's overall compliance with F323 Supervision to Prevent Accidents and Elopements. The District Director of Clinical Services re-educated the IDT on 5/6/17 on Federal Regulation of F520 and QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI) program. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director and at least three other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire. Opportunities will be corrected as identified. Measures put into place or systemic changes made to ensure that the deficient practice will not occur: The District Director of Clinical Services or the District Director of Operations will monitor QAPI meetings monthly for three months to assure compliance with Federal Regulation F 520 to sustain and maintain compliance with Federal Regulation F 323- Resident Safety to include ongoing	

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F 520	Continued From page 127 of this root cause analysis a QA plan was developed to include re-education of all current facility staff regarding the Elopement policy, and systematic approach of more frequent Window Checks on the Secure Unit. This will include Weekly Audits by the Maintenance Director or Assistant, additionally the Administrator will conduct random weekly audits on his facility rounds. The Director of Nursing will implement increased supervision for any resident with an elopement or attempt to elope immediately to establish safety and continue until the investigation has been completed and required interventions have been implemented .Incident Reports will be reviewed by the Interdisciplinary Team daily during the morning Stand Up meeting led by the Administrator. The Interdisciplinary team will determine acceptable interventions and ensure the care plan is revised. Administrator, DON and ADON were educated on the QAPI Process by the District Director of Clinical Services on 5/4/2017. Administrator and IDT to complete monthly QAPI meetings with review of action plans and new areas of concern for Performance Improvement, with evidence of root cause analysis and action plans to address potential and actual concerns. District Director of Clinical Services will review monthly QAPI Minutes X 4 months, and attend meetings as able. On 5/4/17, the Area Staff Development Coordinator conducted re-education for the Administrator on the facility ' s policy and procedures for assembling a QAPI committee, collecting data and analyzing trends, and development and implementation of a plan to improve with ongoing monitoring to sustain	F 520	monitoring and revisions to the plan as necessary, and to maintain compliance with F 204, 251, and 284 as they relate to Social Service provisions and adequate discharge planning and coordination of a safe and orderly discharge for all residents leaving facility. Monitoring Process: The Administrator will report the results of these audits weekly for 12 weeks during the QAPI meeting and then monthly thereafter. The committee will review these results and make recommendations as required.	

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F 520	Continued From page 128	F 520		

compliance. 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 quality improvement plans related to identified areas of opportunity. The committee has met monthly in the past to monitor ongoing compliance with F323 Supervision to prevent Accidents and Elopement but will begin meeting weekly on 5/4/17 to increase monitoring with F323 Supervision to prevent Accidents with a focus on the review of Window Checks being conducted to correct and maintain the elopement management process and to evaluate systems for effectiveness of the facility ' s overall compliance with F323 Supervision to prevent Accidents and Elopements.

The Regional Director of Clinical Services reeducated the IDT on 5/6/17 on Federal Regulation F 520 and Consulates QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI) program. The QAPI Committee consists of the Executive Director, Director of Clinical Services, Medical Director and at least 3 other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising ongoing action plans for areas of deficiency that have been identified to attain and maintain substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire. The Regional Director of Clinical Services or the District Director of Operations will attend QAPI

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F 520	Continued From page 129 meetings at a minimum of quarterly to assure compliance with Federal Regulation F 520 to sustain and maintain compliance with Federal Regulation F 323-Resident Safety to include ongoing monitoring and revisions to the plan as necessary, and to maintain compliance with F204, 251, and F284 as they relate to Social Service provisions and adequate Discharge planning and coordination of a safe and orderly discharge for all residents leaving facility. The credible allegation was validated on 5/6/17 at 6:26 PM by the following: Staff members from the Management Team including the Administrator, Director of Nursing, Rehabilitation Manager, Social Services Director, Resident Care Management Director and Maintenance Director were interviewed. During these interviews they indicated that they received in-service training regarding Quality Assurance. The Administrator was interviewed and confirmed the facility ' s Quality Assurance monitoring plans for both F323 and the corporate oversight for F490. The Administrator verbalized his understanding of the need to identify issues or concerns within the facility, and the role of QAPI process in resolving and monitoring these concerns.	F 520		