PRINTED: 04/10/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE STREET_ADDRESS, CITY, STATE, 2IP CODE S20 VALLEY STREET STATESVILLE, NC 28877 TAG PREDULATORY OR LSC IDENTIFYING INFORMATION) FREITY TAG INITIAL COMMENTS A follow up to complaint (Event 8II112) and complaint (Event 8II112) and complaint (Event 2BD211) was conducted 02/26/18 through 02/28/18. Immediate jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. Tag F684 constituted substandard quality of care. Immediate jeopardy began on 02/12/18 and was removed on 02/28/18. A extended survey was completed. F 580 Notify of Changes (injuny/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) \$483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident representative(s) when there is. (A) An accident involving the resident which results in injury and has the potential for requiring physical intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment (c) (i) A decision to transfer or discharge the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS. CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NO 28677 STATESVILLE			345128	B. WING _			C 02/28/2018	
FREETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A follow up to complaint (Event 8II112) and complaint (Event 2B0711) was conducted 02/26/18 through 02/28/18. Immediate jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. CFR 483.35 at F726 at a scope and severity of J. CFR 483.35 at F726 at a scope and severity of J. CFR 883.10 (g)(14) (h)(-(v)(15) SS=J CFR(s): 483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident sphysical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment), or (D) A decision to transfer or discharge the			ABILITATION/STATESVILLE		520 VALLEY STREET	DDE	02/25/2010	
A follow up to complaint (Event 8II112) and complaint (Event ZBD211) was conducted 02/26/18 through 02/28/18. Immediate jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. CFR 483.35 at F726 at a scope and severity of J. Tag F684 constituted substandard quality of care. Immediate jeopardy began on 02/12/18 and was removed on 02/28/18. A extended survey was completed. Notify of Changes (Injury/Decline/Room, etc.) SS=J CFR(s): 483.10(g)(14)(n)-(iv)(15) \$483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION	
complaint (Event ZBDZ11) was conducted 02/26/18 through 02/28/18. Immediate jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. Tag F684 constituted substandard quality of care. Immediate jeopardy began on 02/12/18 and was removed on 02/28/18. A extended survey was completed. Notify of Changes (injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) \$483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter freatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 000	INITIAL COMMENT	S	F 0	00			
commence a new form of treatment); or (D) A decision to transfer or discharge the		complaint (Event ZE 02/26/18 through 02 was identified at: CFR 483.10 at tag F of J. CFR 483.25 at tag F of J. CFR 483.35 at F726 Tag F684 constitute Immediate jeopardy removed on 02/28/1 completed. Notify of Changes (I CFR(s): 483.10(g)(14) Notif (i) A facility must immediate in the consult with the resist consistent with his consult with the resist consistent with his consults in injury and physician intervention (B) A significant chamental, or psychosod deterioration in head status in either life-tolinical complication (C) A need to alter to a need to discontinuation.	BDZ11) was conducted 2/28/18. Immediate jeopardy F580 at a scope and severity Gat a scope and severity of J. d substandard quality of care. began on 02/12/18 and was 8. A extended survey was injury/Decline/Room, etc.) 14)(i)-(iv)(15) fication of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident then there is- oliving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a th, mental, or psychosocial threatening conditions or is); reatment significantly (that is, a e an existing form of	F 5	80		3/27/18	
	1005:55	(D) A decision to tra	nsfer or discharge the				00.57	

Electronically Signed 03/23/2018

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/28/2018		
	ROVIDER OR SUPPLIER	IABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/20/2010		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
F 580	§483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informations available and prophysician. (iii) The facility must resident and the rewhen there is- (A) A change in resident and the rewhen there is- (A) A change in resident and the rewhen there is- (A) A change in resident and the rewhen there is- (B) A change in resident and the rewhen there is- (IV) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a conthat is a composite §483.5) must disclosite physical configuing locations that compart, and must sper room changes between the second reductor interviews the medial doctor of a for 1 of 3 residents prevent accidents (from the bed during #2 did not notify the	oridity as specified in origination under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the origination to the sident representative, if any, and or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph or in the facility of the sident representative. It record and periodically is (mailing and email) and the resident or the facility distinct part (as defined in the see in its admission agreement the ration, including the various orise the composite distinct before the total or the policies that apply to oveen its different locations	F 58	#1 Corrective Action for the resident found to be affected Resident was assessed by the nurs doctor called and resident sent to the #2 Corrective action taken for these residents having the potential to be	e , e ER		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C	
NAME OF D	DOVIDED OD SUDDI IED	040120		CTREET ADDRESS CITY STATE ZID CODE	0	2/28/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		520 VALLEY STREET			
				STATESVILLE, NC 28677			
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F 580	Continued From page	2 2	F 58	30			
	requesting to go to th			affected			
		- · · · · · · · · · · · · · · · · · · ·					
	Nursing Assistant (Naroom to provide incorrection Resident #1 to roll on the pad to assist. Resover her left leg and i and onto the floor. Resof pain to her left side hospital. Nurse #2 did doctor at the time of twas not notified until Nurse #1 assessed Repain and was notified fallen out of bed on the notified the on call me #1's complaints and a send her to the Emer	pegan on 02/12/18 when A) #1 entered Resident #1's attinent care. NA #1 asked to her left side and grabbed sident #1 flung her right leg to propelled her off the bed esident #1 was complaining and requested to go the donot notify the medical he fall. The Medical Doctor 02/13/18 at 1:00 AM when desident #1's complaints of by Resident #1 that she had the previous shift. Nurse #1 edical doctor of Resident an order was received to gency Room for evaluation.		On 2/27/18 the Director of Nurse Nurse Managers conducted an residents with changes in cond the last 30 days. The 24 hour I Incident/Accident Logs were reidentify residents that have falle the last 30 days. The resident record was then reviewed to vais Nursing documentation pressupporting the completion of a assessment following a fall or a change in condition and notifical Physician following a fall or signification to the Physician for opportunities identified a result review.	audit of ition during reports and viewed to en during s medical alidate there ent nursing a significant ation to the nificant completed any		
	6:20 PM when the fac			#3 Measures and systemic cha			
	compliance. The facil	ptable credible allegation of		into place to ensure practice do	Jes HUL		
		r scope and severity of D		reoccur On 2/27/18 The Director of	f Nureina		
		potential for more than		and Nurse Managers re-educate	•		
	•	not immediate jeopardy) to		current Licensed Nurses and A			
		and ensure monitoring		Nurses currently working in the	• •		
	systems put into plac			regarding the facility policy for	-		
	notification are effecti			Resident Condition, with a focu			
		-		Notification of the Physician fol			
	The findings included	:		Incident/Accident.	3 -		
	3			A new process was implemented	ed on		
	Resident #1 was initia	ally admitted to the facility on		2/27/18 requiring the Licensed			
		cently readmitted to the		notify the Unit Manager on Duty			
		ith diagnoses that included		Nurse Manager on Call when a			
		oma, history of pulmonary		has a fall. The Unit Manager o		 	
		irtery disease, dementia,		the Nurse Manager on Call will			
	diabetes mellitus and	_		on the Daily Assignment Sheet			
	The state of the s	- -		contact information. This will b			

Facility ID: 922999

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345128	B. WING _			02/	28/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN OF	NTED HEALTH & DEHA	DILITATION/OTATEOVILLE		52	20 VALLEY STREET		
BRIAN CE	NIER HEALIH & REHA	BILITATION/STATESVILLE		S	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Review of the most recent quarterly Minimum Data Set (MDS) dated 12/30/17 revealed that Resident #1 was mildly cognitively impaired and required extensive assistance of 1 staff member with bed mobility and toileting. The MDS further revealed that Resident #1 had received 7 days of anticoagulant therapy. Review of a facility document titled Incident/Accident Report dated 02/12/18 at 9:00 PM read in part, Nursing Assistant (NA) #1 was preparing to provide incontinent care to Resident		F t	580	each Nurses Station. The Nurse Mana	ger	
					will review the event with the Licensed Nurse, validate the Physician was notif as well as making any recommendation for ongoing interventions and treatmen	าร	
					On 2/27/18 the Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses		
					currently working in the facility regardin this new process for notification of the Physician for residents having a fall. On 2/28/17 the Director of Nursing and		
	her left side, Residen the left leg propelling	asked by NA #1 to roll onto t #1 flung her right leg over her body off the left side of . The report indicated that			Nurse Managers re-educated the Nurse Aides regarding their observation of a f or a significant change in condition. The education included that Nurse Aides wi	all iis	
	the on call Medical De	octor (MD) was notified on by Nurse #1. The report was			immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident	"	
	02/26/18 at 2:24 PM. was caring for Reside	n interview was conducted with NA #1 on No. 2/26/18 at 2:24 PM. NA #1 confirmed that she re as caring for Resident #1 on 02/12/18 for the		room for further evaluation. No staff shall work after 2/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff			
	to Resident #1. NA # instructed Resident #	to provide incontinent care 1 stated that she had 1 to turn onto her left side f the pad, Resident #1 took			to be completed prior to beginning worl after 2/27/18. New Agency staff that have not received training will be require to report for duty 2 hours prior to their s	red	
	her right leg and flung propelled her body of the floor. NA #1 state	g it over her left leg and it f the left side of the bed onto d she immediately asked			to receive this education from the Scheduling Nurse prior to accepting a resident assignment.		
	she was not ok and to She added that Resid	is ok and she replied that o get her out of the floor. Ient #1 was lying on her ne bed and was complaining			On 2/28/18 a new process was initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of		
	of pain and stated "m added that Mediation room at the same tim	y ribs are broken." She Aide (MA) #1 was in the e administering medications nmate. MA #1 heard the fall			Nursing and Nurse Managers, of residents listed on the 24 hr report and with Incident/Accident reports to validate the following process was completed as	te	

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		345128	B. WING			C 02/28/2018	
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP COD 520 VALLEY STREET STATESVILLE, NC 28677	E	<u> </u>	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 580	02/26/18 at 2:44 PM. was working on the uresided on 02/12/18. entered Resident #1' 9:00 PM to medicate provided care to Reside she heard NA #1 ask left side and then heafloor. MA #1 stated the hallway and motioner room. She stated Nuroom and observed hith that Resident #1 was mechanical lift from the stated that she was reabout the fall that wa #2. MA #1 again controon contacted the MD ab 02/12/18. An interview was concordinator (UC) on UC stated that Nurse 02/13/18 at 1:00 AM had fallen from bed a pain and they had se Room (ER). The UC know that she was read MD of Resident #1's Nurse #2 should have call MD after Resider 02/12/18. An interview was concordinator was concordinator and they had se Room (ER). The UC know that she was read MD of Resident #1's Nurse #2 should have call MD after Resider 02/12/18. An interview was concordinator was concordinator was concordinator and they had se Room (ER). The UC know that she was read MD of Resident #1's Nurse #2 should have call MD after Resider 02/12/18.	aducted with MA #1 on MA #1 confirmed that she unit where Resident #1 MA #1 stated that she had so room at approximately her roommate while NA #1 ident #1. MA #1 stated that Resident #1 to turn onto her ard Resident #1 fall to the nat she went out to the d for Nurse #2 to come to the rise #2 entered Resident #1's ner on the floor. She stated a transferred with the he floor back to bed. MA #1 not able to contact the MD is the responsibility of Nurse firmed that she had not out Resident #1's fall on	F 5	implemented: -the Physician was notified of -the Director of Nursing or Nu was notified and a review of the assessment and notification was completed at the time of the eare the Director of Nursing will refer results of this monitoring during weekly QAPI meeting and the will make recommendations at a Yvonne Washburn, LNHA responsible for implementing acceptable plan of correction	rise Mana he was event. eport the ng the e committe as needed A is	ee	

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		345128	B. WING		C 02/28/2018	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 580	that at approximately that Resident #1 was stated that she entered NA #1, NA #2, and M She stated that Resident get off the floor. Nursistated something but was but it was nothing. Nurse #2 stated that members transferred the bed and exited this he assumed MA #1 obtain any new ordershe had not notified the she assumed that M An interview was con 02/26/18 at 5:17 PM. directly was not notific 02/12/18 until Reside She stated that the or 02/13/18 at approximated that she would call MD would have bettime frame within 1 he 4 hours of the fall and of pain. The MD explays who was receiving an request closer monitor would have been true 02/12/18. An interview was con 02/26/18 at 6:06 PM. #2 should have notific she assessed Reside complaints of pain. The MD pain. The MD explays who was receiving an request closer monitor would have been true 02/12/18.	ent #1 resided. She stated 9:00 PM she was alerted on the floor. Nurse #2 ed Resident #1's room and A #1 were all in the room. lent #1 was requesting to e #2 stated that Resident #1 she could not recall what it g that was concerning to her. she waited until the 3 staff Resident #1 off the floor to e room. Nurse #2 stated that would contact the MD and s. Nurse #2 confirmed that he MD of the fall because	F 58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING			C 02/28/2018	
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		520	REET ADDRESS, CITY, STATE, ZIP CODE O VALLEY STREET ATESVILLE, NC 28677	1 02	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pag	e 6	F:	580			
	was not familiar with and could not do and would contact the MI obtained. An interview was cor 02/27/18 at 8:47 AM she worked 3rd shift on 02/13/18 at appro #1 complained of pai was unusual for Res so she went to her rogoing on. When quester pain Resident #1 when they pushed m stated that upon assolower rib area and ledistended and hurtin Resident #1 was not requested to go to the she called the on cal Resident #1's complato send Resident #1 Review of the local hod/13/18 read in partial at the facility and and swelling. Upon eather than the sident #1 had ecchymosis (discolor resulted from bleedir lower leg and soft tis induration, and ecchymosis in the sident #1 had ecchymosis (discolor resulted from bleedir lower leg and soft tis induration, and ecchymosis (discolor leg and soft tis induration, and ecchymosis)	MAs and what they could I she assumed that MA #1 D and handle any new orders of and handle and					
	abdomen that was co	ed Tomography (CT) of the ompleted in the ER on hat Resident #1 had a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/28/2018		
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 32/20/20 10		
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F 580	notified of immediat 2:12 PM. The Admir acceptable credible 02/28/18 at 4:02 PM. Credible Allegation 1. On February 1 PM Nurse Aide (NA room to provide income Medication Aide (CM room to administer in Resident #1 require and while NA #1 was bed her leg "flopped causing her to fall to left the room to get NA #2 (who gathere came to the room), went to the door and placed back in bed explained that she cassessment on Resident Portion Age on-coming Nurse#1 information regarding 2018 at 1:00am Nurroom, at which time of pain in her left fla from the bed severa 13, 2018 at 1:15am Physician regarding assessment of Resident Policy P	atoma with active and of fluid). DON, and the UC were be jeopardy on 02/27/18 at anistrator provided an allegation of compliance on allegation of an allegation of an allegation of compliance of a sassistance with bed mobility as attempting to turn her in the allegation of the bed of the side of the bed of the floor. At 9:05pm CMA #1 Nurse #2 and then went to get do the mechanical lift and Agency Nurse #2 stated she distributed until Resident #1 was by NA #2. Agency Nurse #2 completed no further ident #1 after she fell from allegation of the port and the provided at 11:00 pm report ancy Nurse #2 to the	F 58				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 580	Continued From pag	ge 8	F t	580			
	Interdisciplinary Tea determined that Age regarding the deline a Nurse is working valide which resulted to the incident that of Agency Nurse #2 staccustomed to work CMA #1 was comple notifying the physicial identified that Agency orientation or training nurse's responsibiliting need to assess a regresident's physician a fall or a significant to beginning her work which was her first of the significant to be affect practice. On 2/27/18 Nurse Managers conwith changes in condition the significant to the significant to the affect practice. On 2/27/18 Nurse Managers conwith changes in condition the significant to the significant to the affect practice. On 2/27/18 Nurse Managers conwith changes in condition the significant following the compassessment following assessment following assessment following and the Nurse Manager.	•					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		520 VALLI	DDRESS, CITY, STATE, ZIP CODE EY STREET //ILLE, NC 28677	1 02/	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	3. On 2/27/18 The Nurse Managers re-en Nurses and Agency Managers in Residen Notification of the Philocident/Accident. A new process was in requiring the License Manager on Duty or the Nurse Manager on This will Station. The Nurse Managers educated the recommendations for treatments. On 2/27/18 the Direct Managers educated the Physician for recommendation. This education. This educate their observation of a in condition. This educate their observation. Nurse Aides will immor a significant changaccompany the Nurse further evaluation. No staff shall work aft this education.	Director of Nursing and Educated all current Licensed Nurses currently working in the facility policy for t Condition", with a focus on sysician following an emplemented on 2/27/18 d Nurse to notify the Unit the Nurse Manager on Call a fall. The Unit Manager on anager on Call will be listed ent Sheet along with contact be posted at each Nurses Manager will review the event are, validate the Physician as making any congoing interventions and tor of Nursing and Nurse the current Licensed Nurses currently working in the new process for notification esidents having a fall. Itor of Nursing and Nurse and the Nurse Aides regarding fall or a significant change fall or a significant change fall or a resident fall are to the Nurse and the tothe Nurse and the tothe resident room for the 2/27/18 before receiving aducation has been added to an program for all new hires	F	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345128	B. WING				28/2018
NAME OF PR	ROVIDER OR SUPPLIER	0.0.20			TREET ADDRESS, CITY, STATE, ZIP CODE	1 021	20/2010
BRIAN CE	NTER HEALTH & REHAI	BILITATION/STATESVILLE		5	20 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	will be required to rep their shift to receive the		F	580			
	On 2/28/18 a new process will be initiated during the morning clinical meeting. This will include a review, by the Director of Nursing and Nurse Managers, of residents listed on the 24 hour report and/or with Incident/Accident reports to validate the following process was completed as implemented: -the Physician was notified of the event -the Director of Nursing or Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing will report the results of this monitoring during the weekly QAPI meeting and the committee will make recommendations as needed.						
F 684 SS=J	Immediate jeopardy v 6:20 PM when nursin that they had received revised procedure for or significant change Quality of Care CFR(s): 483.25 § 483.25 Quality of ca	eeptable plan of correction vas removed on 02/28/18 at g staff interviews revealed d education on the facility's notifying the MD after a fall in condition.	F	684			3/27/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		ONSTRUCTION	` '	X3) DATE SURVEY COMPLETED	
		345128	B. WING _				28/2018	
NAME OF PI	ROVIDER OR SUPPLIER	L	<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	, , ,	20/2010	
				520	VALLEY STREET			
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		STA	ATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 11	F 6	684				
	applies to all treatment facility residents. Base assessment of a resident residents received accordance with professor practice, the comprehence plan, and the resident resident resident for the REQUIREMENT by: Based on record revided Medical Doctor intervassess a resident foll resulted in injury and oncoming shift for 1 consupervision to prevent limited in the supervision to prevent for the Emergency Roon discovered that Resident #1. Several hours late the Emergency Roon discovered that Resides subcutaneous hemat required evacuation awound vacuum. Immeremoved on 02/28/18 provided and implement allegation of compliance at a low (no actual harm with minimal harm that is complete education asystems put into place.)	nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices. T is not met as evidenced liews, resident, staff and liews the facility failed to liews the facility failed to liewing a fall from bed that failed to report the fall to the of 3 residents sampled for lit accidents (Resident #1). Degan on 02/12/18 when the bed to the floor and no assessment of Resident ler Resident #1 was sent to on for evaluation where it was dent #1 sustained a loma to the abdomen that and required placement of			#1 Corrective Action for the resident found to be affected Resident was assessed by the nurse, doctor called and resident sent to the E #2 Corrective action taken for these residents having the potential to be affected On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of residents with changes in condition dur the last 30 days. The 24 hour reports a Incident/Accident Logs were reviewed identify residents that have fallen durin the last 30 days. The resident □s medi record was then reviewed to validate this Nursing documentation present supporting the completion of a nursing assessment following a fall or a significant change in condition and notification to Physician following a fall or significant change. The Nurse Managers completion to the Physician for any opportunities identified a result of this review.	f ring and to g cal nere cant		
	The findings included				#3 Measures and systemic changes pu	ıt		
	Resident #1 was initia	ally admitted to the facility on			into place to ensure practice does not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L , LIDENTIEICATION NITIMBED:		IPLE C	(X3) DATE SURVEY COMPLETED		
						(
		345128	B. WING _			02/	28/2018
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				520	VALLEY STREET		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		STA	ATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TAG		(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 12	F 6	84			
	08/31/11 and most re	ecently readmitted to the rith diagnoses that included			reoccur		
	_	oma, history of pulmonary			On 2/27/18 The Director of Nursing and	d	
		artery disease, dementia,			Nurse Managers re-educated current		
	diabetes mellitus and	others.			Licensed Nurses and current Agency		
					Nurses regarding the facility policy for		
	Review of a physicial	n order dated 08/28/16 read,			"Changes in Resident Condition", with	a	
		t used to prevent deep vein			focus on assessment following a fall.		
		ams (mg), give ½ tablet (2.5			Licensed Nurses were re-educated		
	mg) by mouth 2 times a day.				regarding the components of a nursing		
					assessment following a fall to include:		
		ecent quarterly Minimum			-vital signs		
	` ,	d 12/30/17 revealed that			-neuro checks when a head injury is		
		dly cognitively impaired and			suspected, changes in level of	20	
		ssistance of 1 staff member I toileting. The MDS further			consciousness occurs or subtle change in cognition	55	
		nt #1 had received 7 days of			-check the skin for bruising, abrasions,		
	anticoagulation medi				changes in sensation and deformity		
	antiooagalation mear	odion.			-range of motion of extremities		
	Review of a facility de	ocument titled			-evaluate pain for severity and location		
	_	port dated 02/12/18 at 9:00			,		
		sing Assistant (NA) #1 was					
	-	incontinent care to Resident			A new process was implemented on		
	#1. Resident #1 was	asked by NA #1 to roll onto			2/27/18 requiring the Licensed Nurse to	o	
	her left side, Residen	nt #1 flung her right leg over			notify the Unit Manager on Duty or the		
	the left leg propelling	her body off the left side of			Nurse Manager on Call when a resider		
		r. The report was signed by			has a fall. The Unit Manager on Duty		
	the Director of Nursir	ng (DON).			the Nurse Manager on Call will be liste		
					on the Daily Assignment Sheet along v		
		nducted with NA #1 on			contact information. This will be poster		
		NA #1 confirmed that she			each Nurses Station. The Nurse Mana	iger	
		ent #1 on 02/12/18 for the			will review the event with the Licensed	ind	
		she had entered Resident I to provide incontinent care			Nurse, validate the Physician was notif		
	to Resident #1. NA #	•			as well as making any recommendation for ongoing interventions and treatment		
		t1 to turn onto her left side			On 2/27/18 the Director of Nursing and		
		of the pad, Resident #1 took			Nurse Managers educated the current		
	_	g it over her left leg and it			Licensed Nurses and Agency Nurses		
		ff the left side of the bed onto			currently working in the facility regardir	ıg	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				29/2049
NAME OF P	ROVIDER OR SUPPLIER	0.10.20	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	28/2018
NAME OF T	NOVIDEN ON 3011 LIEN						
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE			20 VALLEY STREET		
				<u> </u>	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 13 the floor. NA #1 stated she immediately asked Resident #1 if she was ok and she replied that she was not ok and to get her out of the floor. She added that Resident #1 was lying on her back partially under the bed and was complaining		F	684	this new process for notification of the Physician for residents having a fall.		
					On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nursing Aides regarding their observation of a f	е	
	of pain and stated "m	ny ribs are broken." She Aide (MA) #1 was in the			or a significant change in condition. The education included that Nurse Aides wi	nis	
		ne administering medications			immediately report a resident fall or a		
		nmate. MA #1 heard the fall			significant change to the Nurse and		
		Nurse #2. NA #1 stated that			accompany the Nurse to the resident		
		Nurse #2 do any assessment observed her on the floor and			room for further evaluation. No staff shall work after 2/27/18 before		
		ner back to bed Nurse #2			receiving this education. This education		
	exited the room.				has been added to the Facility Orientat		
					program for all new hires and agency s	taff	
		iducted with MA #1 on			to be completed prior to beginning world		
		MA #1 confirmed that she			after 2/27/18. New Agency staff that		
	_	init where Resident #1 MA #1 stated that she had			have not received training will be require to report for duty 2 hours prior to their s		
		s room at approximately			to receive this education from the	iiiit	
		her roommate while NA #1			Scheduling Nurse prior to accepting a		
		ident #1. MA #1 stated that			resident assignment.		
		Resident #1 to turn onto her			On 2/28/18 a new process was initiated	t	
	left side and then hea	ard Resident #1 fall to the			during the morning clinical meeting 5		
	floor. MA #1 stated th	nat she went out to the			times per week for 12 weeks. This will		
		d for Nurse #2 to come to the			include a review, by the Director of		
		rse #2 entered Resident #1's			Nursing and Nurse Managers, of	,	
	room and observed h				residents listed on the 24 hr report and		
	•	ment of Resident #1. She #1 was transferred with the			with Incident/Accident reports to validate the following process was completed a		
		he floor back to bed and at			implemented:	5	
		xited the room. MA #1 stated			-the Physician was notified of the even	t	
		e to assess Resident #1 that			-the Director of Nursing or Nurse Mana		
		of the nurse. MA #1 stated			was notified and a review of the	J	
		the medication cart with			assessment and notification was	ĺ	
	Nurse #1 at that end	of her shift, but Nurse #2			completed at the time of the event.		
	was responsible for g	giving report to Nurse #1			The Director of Nursing will report the		
	about the residents a	nd their condition.			results of this monitoring during the weekly QAPI meeting and the committee	ее	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		، ا	c
		345128	B. WING				28/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2010
				5:	20 VALLEY STREET		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		s	STATESVILLE, NC 28677		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	· · ·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 684	Continued From page	e 14	F	684			
	An interview was con	iducted with NA #2 on			will make recommendations as needed	1.	
	02/26/18 at 3:02 PM.	NA #2 confirmed that she			4. Yvonne Washburn, LNHA is		
	routinely cared for Re	esident #1 on day shift. She			responsible for implementing this		
	added that on the eve	ening of 02/12/18 she was			acceptable plan of correction. Data from	n	
	working over on the u	unit but was not responsible			monitor will be brought to the weekly A	d	
	for Resident #1 that e	evening. NA #2 stated that at			Hoc QAPI meeting for 12 weeks and the	ian	
		PM MA #1 stated "I need your			Monthly for 3 months.		
		#1 up off the floor." NA #2					
		and got the lift and entered					
		She stated that when she					
		s room her bed was elevated					
		lying on her back under the					
		at Resident #1 stated "get					
		te my ribs and get me to the that Nurse #2 was in the					
		erve her do any type of					
		ent #1. NA #2 stated that					
		assisted Resident #1 back					
	-	shed providing incontinent					
		ed that Resident #1 was very					
		nted to go to the hospital					
		was in the room. NA #2					
	stated that MA #1 sta	ated to Resident #1 that she					
	could not make the ca	all to send her to the					
	Emergency Room (El	R) but would again let Nurse					
	#2 know that she war	nted to go.					
	An interview was con	ducted with Nurse #2 on					
		Nurse #2 confirmed that					
	_	02/12/18 and was working on				ſ	
		ent #1 resided. She stated				ĺ	
		9:00 PM she was alerted				ſ	
		on the floor. Nurse #2				ſ	
		ed Resident #1's room and				ſ	
		IA #1 were all in the room.				ſ	
		dent #1 was requesting to				ſ	
	•	se #2 stated that Resident #1				ĺ	
		she could not recall what it a that was concerning to her.					
	i was dulii was hollilli	u mar was concenting to net.	1		I .		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _				C 28/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		20/2010
				520 VALLEY ST	REET		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		STATESVILLE	, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page		F	884			
	members transferred the bed and exited the completed no assess during report to Nurse Resident #1 had falle #2 stated she assum. Resident #1 for any in fall to Nurse #1 at the An interview was con 02/26/18 at 6:06 PM. had received a call at 02/13/18 from the sta #1 had fallen and had to the ER. The DON statements from the I discovered that NA # care and asked Resident #1 off the flower and got Nurse #Resident #1 off the flower than 1 and notify the on complete a head to to #1 and notify the on corders. She also state requesting to go to the should have also notion Doctor (MD) of her resident #1 off her resident #1 off the resident #1 off the flower and she stated that she would complete a head to to #1 and notify the on corders. She also state requesting to go to the should have also notion Doctor (MD) of her resident #1 off her resid	ducted with the DON on The DON stated that she t around 1:00 AM on off alerting her that Resident d a hematoma and had gone stated that she obtained NAs and the MA and 1 was providing incontinent dent #1 to turn onto her side					
	Background, Assessi	ument titled Situation, ment, and Recommendation ed 02/13/18 at 1:56 AM and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _				C 28/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	, , ,		
DDIAN OF	NITED HEALTH & DELIA	DU ITATION/OTATEO//U I E		520 VALLEY STREET				
BRIAN CE	NIER HEALIH & REHA	BILITATION/STATESVILLE		STATESVILLE, NC 28677				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 684	indicated that Reside and when questioned stated she had broke Nurse #1 inquired ho #1 stated that "she go the day staff and thro #1's vital signs were: pulse: 100, respiratio 96.9. The SBAR indicated that experiencing abdomin Nurse #1 indicated that experiencing abdomin Nurse #1 indicated the distended left lower reabdominal area and a lower leg. Resident # both areas. The on canew order was obtain evaluation.	#1 was reviewed. The SBAR nt #1 complained of pain I where she was hurt she n ribs and her right leg hurt. w she got hurt and Resident of thrown onto the floor by wn back into bed." Resident blood pressure: 194/78, ns: 20, and temperature: cated that Resident #1 had nd had pain when moved I her right leg. The SBAR Resident #1 was nal pain and distention. at Resident #1 had a	F	DEFICIENCY)				
	she worked 3rd shift on 02/13/18 at approx #1 complained of pair was unusual for Resi so she went to her ro going on. When quester pain Resident #1 when they pushed mustated that upon assel lower rib area and left distended and hurting Resident #1 was not requested to go to the she called the on call	on 02/12/18. She stated that ximately 12:30 AM Resident n. Nurse #1 stated that it dent #1 to complain of pain om to find out what was attoned by Nurse #1 about stated "they broke my ribs to out of bed." Nurse #1 to ssment Resident #1's left tupper abdominal area were						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	\ '\'		X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/28/2018	
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	'	22.23.23.10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	Nurse #1 confirmed from Nurse #2 at the report contained not A follow up interview on 02/27/18 at 9:28 not cross her mind come and assess Farusted that Nurse #4. An interview was concluded to 31 AM from the bed but con and did not rememble Resident #1 stated attached to my side me. Resident #1 stated attached to go to begging for a while the hospital." Review of the local 02/13/18 read in particular fall at the facility and and swelling. Upon that Resident #1 has ecchymosis (discolors)	I to the ER for evaluation. I that she had received report the beginning of her shift but the thing about Resident #1's fall. I was conducted with MA #1 AM. MA #2 stated that it did to go and get another nurse to tesident #1 because she the was going to take care of it. I have this wound vacuum that drains the fluid out of the ded "I told them I was hurt to the hospital and finally after they sent me out of here to thospital ER report dated rt, that Resident #1 reported a d complained of left flank pain evaluation the MD indicated d soft tissue swelling and oration of the skin that	F	684			
	lower leg and soft ti induration, and eccl abdomen consistent hematoma. Review of a Computabdomen that was a						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
		345128	B. WING			C 02/28/2018
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	DE	02/20/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From pag	e 18	F	684		
	02/26/18 at 5:17 PM when a resident who anticoagulation experequest closer monit would have been tru 02/12/18. She adde would have included assessment of Resider any changes that assessment. The stathe formation of the however closer mon certainly warranted. would have been to hemodynamically (fluand tissues in the bottom and ti	erienced a fall, we always oring of the resident and that e of Resident #1's fall on d that the closer monitoring				
	notified of immediate 2:12 PM. The Admin	allegation of compliance on				
	Credible Allegation F	F684:				
	9:00pm Nurse Aide (#1's room to provide Certified Medication same room to admin roommate. Residen bed mobility and whi turn her in the bed h the bed causing her	2, 2018 at approximately (NA) #1 entered Resident incontinent care and Aide (CMA) #1 entered the ister medications to the t #1 requires assistance with le NA #1 was attempting to er leg "flopped" off the side of to fall to the floor. At 9:05pm in to get Nurse #2 and then				

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	COMPI		TE SURVEY MPLETED
345128	B. WING _			C 2/28/2018
LITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 0	2/20/2010
SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE
ogathered the mechanical m). Agency Nurse #2 door and waited until d back in bed by NA #2. Alined that she completed on Resident #1 after she ruary 12, 2018 at 11:00 pm Agency Nurse #2 to the at did not include this fall. On February 13, #1 entered Resident #1's resident #1 was complaining area, and reported a fall pours earlier. On February rise #1 notified the on call refall and subsequent for fall and subsequent for further was conducted by the (IDT) on 2/27/18 and it was an a Certified Medication for responsibilities when a Certified Medication for lack of timely response for further with CMAs and thought go the assessment and the root cause analysis for the facility, including the cent and to notify a fer a resident experienced ange in a condition, prior	F6	84		
	ILITATION/STATESVILLE TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTIFYING INFORMATION) 19 or gathered the mechanical om). Agency Nurse #2 door and waited until d back in bed by NA #2. ained that she completed on Resident #1 after she ruary 12, 2018 at 11:00 pm Agency Nurse #2 to the aut did not include his fall. On February 13, #1 entered Resident #1's esident #1 was complaining area, and reported a fall ours earlier. On February ares #1 notified the on call the fall and subsequent the #1, orders were received argency Room for further was conducted by the (IDT) on 2/27/18 and it was by Nurse #2 was confused on of responsibilities when the a Certified Medication her lack of timely response turred on 02/12/18. In the root cause analysis with CMAs and thought the gather was not the facility, including the tent and to notify a ter a resident experienced tange in a condition, prior assignment on 2/12/18	ILITATION/STATESVILLE TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL COLDENTIFYING INFORMATION) 19 19 19 19 10 19 10 19 10 10	STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677 EMENT OF DEFICIENCIES MUSTS BEPRECEDED BY FULL C IDENTIFYING INFORMATION) 19 19 19 20 gathered the mechanical m). Agency Nurse #2 door and waited until d back in bed by NA #2. ained that she completed on Resident #1 after she ruary 12, 2018 at 11:00 pm Agency Nurse #2 to the at did not include his fall. On February Irse #1 notified the on call e fall and subsequent in #1, roders were received Irgency Room for further was conducted by the (IDT) on 2/27/18 and it was y Nurse #2 was confused on of responsibilities when in a Certified Medication her lack of timely response urred on 02/12/18. d that she was not juith CMAs and thought ig the assessment and The root cause analysis Nurse #2 did not receive room the facility regarding a at the facility, including the ent and to notify a er a resident experienced lange in a condition, prior assignment on 2/12/18	A BUILDING 345128 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE \$20 VALLEY STREET STATESVILLE, NC 28677 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) 19 19 19 19 19 19 20 10 10 11 11 12 13 14 15 15 16 16 17 18 18 19 20 19 20 19 20 19 31 31 41 41 41 41 41 41 41 41

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRU	JCTION	(X3) DATE COMP	SURVEY PLETED
		345128	B. WING _			1	C 28/2018
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		520 VALLE	DRESS, CITY, STATE, ZIP CODE Y STREET ILLE, NC 28677	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	change in condition of affected by this alleg 2/27/18 the Director Managers conducted changes in condition 24 hour reports and reviewed to identify a significant change of a nursifall or a significant change. To completed notification to the Phisignificant change. To completed notification opportunities identified 3. On 2/27/18 The Nurse Managers reviewed and current Afacility policy for "Chawith a focus on assee Licensed Nurses well components of a nurfall to include: -vital signs -neuro checks when changes in level of coubtle changes in level of coubtle changes in concheck the skin for bein sensation and deference of motion of evaluate pain for see A new process was in	o have had a fall or significant have a potential to be ed deficient practice. On of Nursing and Nurse If an audit of residents with during the last 30 days. The Incident/Accident Logs were esidents that have fallen esidents that have fallen esidents that have fallen est to validate there is on present supporting the engrassessment following a fall or The Nurse Managers in to the Physician for any ed a result of this review. Director of Nursing and educated current Licensed engrey Nurses regarding the enges in Resident Condition", essment following a fall. The re-educated regarding the engres in Resident Condition and	F	584			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345128	B. WING				28/2018
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		520 V	ET ADDRESS, CITY, STATE, ZIP CODE ALLEY STREET 'ESVILLE, NC 28677	1 02/	20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	when a resident has Duty or the Nurse Ma on the Daily Assignm information. This will Station. The Nurse Ma with the Licensed Nu assessment was conguidelines listed above recommendations for treatments. On 2/27/18 The Direct Managers educated and Agency Nurses of facility regarding this assessment of reside On 2/28/17 the Direct Managers re-educated their observation of a in condition. This ed Nurse Aides will imm or a significant changaccompany the Nurse further evaluation. No staff shall work aft this education. This ed	the Nurse Manager on Call a fall. The Unit Manager on anager on Call will be listed ent Sheet along with contact be posted at each Nurses Manager will review the event rese, validate the nursing apleted according to be as well as making any rongoing interventions and actor of Nursing and Nurse the current Licensed Nurses currently working in the new process for ents following a fall. It to of Nursing and Nurse and the Nurse Aides regarding fall or a significant change funcation will include that the ediately report a resident fall the to the Nurse and the to the resident room for the contact of the	F	584			
	and agency staff to b beginning work after that have not receive report for duty 2 hour receive this education prior to accepting a reconstruction of 2/28/18 a new present the property of the state of of the	2/27/18. New Agency staff d training will be required to s prior to their shift to n from the Scheduling Nurse					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345128	B. WING		C 02/28/2018
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 684	review, by the Director Managers, of resident report and/or with Incomplemented. -an Situation Background Recommendation (Stantant and Stantant and	or of Nursing and Nurse ts listed on the 24 hour ident/Accident reports to process was completed as and Assessment BAR) or Nursing progress cument completion of a as outlined in the guideline. Ing and Nurse Manager was of the assessment and aleted at the time of the and will report the results of a the weekly QAPI meeting all make recommendations ar is responsible for ceptable plan of correction.	F 68	34	
F 689 SS=G	6:20 PM when nursin that they had receive revised procedure for fall or significant char a head to toe assess neurological checks, Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(1) The reas free of accident has	and pain assessment. ards/Supervision/Devices (2)	F 68	39	3/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			1	28/2018	
NAME OF PR	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	20/2010	
				5	20 VALLEY STREET			
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		S	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	Continued From page supervision and assis	e 23 stance devices to prevent	F 6	889				
	by:	is not met as evidenced						
		n, record reviews and staff			F689			
		failed to prevent a resident			#1 Corrective Action for Resident # 1			
		and sustaining injury for 1 of			Danidantia na sabina sina antinanta ana t	_		
		for accidents (Resident #1). the bed during incontinent			Resident is receiving incontinent care t prevent injury.	0		
		subcutaneous hematoma			preventingary.			
		ion (removal) and required						
	placement of a wound				#2 Corrected action taken for those			
	The findings included:				residents having the potential to be affected			
	08/31/11 and most re facility on 02/20/18 w subcutaneous hemat	ally admitted to the facility on cently readmitted to the ith diagnoses that included oma, history of pulmonary artery disease, dementia,			All residents requiring incontinent care while in bed are at risk for this alleged deficient practice. On 3/22/18 an audit was conducted by the DON and Nurse Managers to identify current residents requiring assistance with incontinent cat while in bed.			
	in part, Resident #1 v confusion, incontinen The goal of stated ca	n initiated on 09/20/17 read was at risk for falls related to ce, and decreased mobility. re plan was Resident #1			#3 Measures and systematic changes into place to ensure no further re-occurrence	put		
	The interventions incl Resident #1's needs,	through the review date. uded: anticipate and meet be sure call light was within Resident #1 to use it for			The Director of Nursing or Nurse Managers will re-educate current Licensed and Certified Nursing staff			
	assistance, educate tresident/family/careg	he ivers about safety reminders Il occurs, and follow facility			including Agency staff, regarding safe a effective techniques for turning and repositioning while providing incontiner care for residents in bed. This education will be completed 3/27/18.	nt		
		ssessment dated 12/28/17 nt #1 was at high risk for			This training will occur to new staff in sorientation and agency orientation before they can care for residents.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345128	B. WING				28/2018
NAME OF D	ROVIDER OR SUPPLIER	0.10.120	1	27	FREET ADDRESS, CITY, STATE, ZIP CODE	02/	20/2010
NAME OF T	NOVIDEN ON 3011 EIEN				20 VALLEY STREET		
BRIAN CE	NTER HEALTH & RE	HABILITATION/STATESVILLE					
				3	TATESVILLE, NC 28677		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	age 24	F6	889			
	Review of the mos	t recent quarterly Minimum					
		ated 12/30/17 revealed that			#4 Corrective actions will be monitored	to	
		nildly cognitively impaired and assistance (resident is			ensure there are no further occurrence	S	
	· •	ivity and staff provides weight			The Director of Nursing and Nursing		
		f 1 staff member with bed			Managers will monitor 10 NAs weekly	for	
		ng. No falls were reported on			12 weeks, on varying shifts, to observe		
	the MDS.				care provided to residents remaining ir	l	
					bed during incontinent care. These		
		gnment Sheet for the unit			observations will validate safe and		
		resided revealed that she assistance of 1 staff member			effective techniques for turning and repositioning are utilized. Opportunitie	c	
	with turning and re			will be corrected as identified.	3		
		de that Resident #1 was able to			The DON will report the results of these	е	
		and repositioning by crossing			audits and monitoring to the weekly Ad		
		ner left leg and reaching for the			Hoc QAPI committee meeting for 12		
	•	on the bed. It also did not			weeks and then monthly for 3 months		
		lent #1 should be turned toward					
	staff instead of awa	ay from staff.			#5 Date of alleged compliance March 2 2018	27,	
	Review of facility of	locument titled					
		Report dated 02/12/18 at 9:00					
		ursing Assistant (NA) #1 was					
		de incontinent care to Resident					
		as asked by NA #1 to roll onto					
	· ·	lent #1 flung her right leg over					
		ng her body off the left side of oor. The report was signed by					
	the Director of Nur						
	Review of the loca	I hospital ER report dated					
		art, that Resident #1 reported a					
		nd complained of left flank pain					
		n evaluation the MD indicated					
		ad soft tissue swelling and					
		loration of the skin that					
		ding underneath) right mid					
		tissue swelling with tenderness, chymosis to the left lower					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/28/2018	
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	'	92,20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 689		ge 25 t with probable subcutaneous	F 6	89			
	abdomen that was of 02/13/18 confirmed subcutaneous hemale extravasation (leaking the subcutaneous hemale extravasation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _			C 02/28/2018
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		02/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689		ge 26 sitioned down towards the e grab bar was not even	F 6	89		
	there to slow her do out of the bed. NA # completed walking r	wn as she propelled herself 1 stated that by the time she ounds at the end of her shift sting quietly in her bed.				
	02/26/18 at 2:44 PM was working on the resided on 02/12/18 entered Resident #1	nducted with MA #1 on I. MA #1 confirmed that she unit where Resident #1 . MA #1 stated that she had 's room at approximately				
	provided care to Res she heard NA #1 as left side and then he floor. MA #1 stated t	PM to medicate her roommate while NA #1 ded care to Resident #1. MA #1 stated that leard NA #1 ask Resident #1 to turn onto her de and then heard Resident #1 fall to the MA #1 stated that she went out to the				
	room. She stated Nuroom and observed that Resident #1 wa	ed for Nurse #2 to come to the urse #2 entered Resident #1's her on the floor. She stated s transferred with the the floor back to bed. She				
	hospital. MA #1 state	and wanted to go to the ed that she would tell Nurse anted to go to the hospital but				
	An interview was co 02/26/18 at 3:37 PM she was working on the unit where Resident at approximately that Resident #1 wastated that she enter NA #1, NA #2, and NA She stated that Resident Resid	nducted with Nurse #2 on I. Nurse #2 confirmed that 02/12/18 and was working on dent #1 resided. She stated by 9:00 PM she was alerted s on the floor. Nurse #2 red Resident #1 s room and MA #1 were all in the room. ident #1 was requesting to se #2 stated that Resident #1 at she could not recall what it				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345128	B. WING			C 02/28/2018		
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, Z 520 VALLEY STREET STATESVILLE, NC 28677	IP CODE	02/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 689	She added she did to go to the hospital waited until the 3 sta Resident #1 off the room. Nurse #2 did time of the fall becan MA #1 would comple notify the Medical D. An interview was co 02/26/18 at 3:02 PM routinely cared for Radded that on the exworking over on the for Resident #1 that approximately 9:00 help to get Resident stated that she went Resident #1's room. entered Resident #1 wabed. NA #2 stated the me off the floor I bro hospital." NA #2 stated resident #1 was assisted Resident # finished providing in	ng that was concerning to her. not hear Resident #1 request . Nurse #2 stated that she aff members transferred floor to the bed and exited the not assess Resident #1 at the use Nurse #2 assumed that eted the assessment and	F	689	ENCY)			
	she wanted to go to Nurse #2 was in the #1 stated to Resider the call to send her? Nurse #2 know that stated that it was ron her right leg over her assisted with turning stated that she took was used to watchir	the hospital even when room. NA #2 stated that MA at #1 that she could not make to the ER but would again let she wanted to go. NA #2 utine for Resident #1 to fling or left leg that was how she go and repositioning. NA #2 care of her so often that she ag for that because Resident by fling her right leg over her						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/28/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	, CODE		
DDIAN CE	NTED HEALTH & DEHA	DII ITATION/STATESVII I E		520 VALLEY STREET			
BRIAN CE	NIEK NEALIN & KENA	BILITATION/STATESVILLE		STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA		
F 689	Continued From page	e 28	F 6	689			
		she knew to watch for that e kept Resident #1 safe in					
	on 02/28/18 at 5:46 F that she routinely pro and during bed mobil towards her instead of she kicks her right leg #2 stated that she did with NA #1 because so the first time that NA NA #2 stated she wo	was conducted with NA #2 PM. NA #2 again confirmed vided care to Resident #1 ity NA #2 rolled Resident #1 of away from her, because g up and over the left leg. NA d not share that information she was not aware that was #1 had provided care to her. uld have told NA #1 during knew that NA #1 had never					
	(SBAR) dated 02/13/completed by Nurse: Resident #1 complain questioned where sh had broken ribs and linquired how she got that "she got thrown and thrown back into signs were: blood pre respirations: 20, and SBAR indicated that mobility and had pair moved her right leg." that Resident #1 was pain and distention. Nesident #1 had a diand left upper abdom bruise to left lower leg complaining of pain to	ment, and Recommendation 18 at 1:56 AM that was #1. The SBAR indicated that ned of pain and when e was hurt she stated she ner right leg hurt. Nurse #1 hurt and Resident #1 stated onto the floor by the day staff bed." Resident #1's vital essure: 194/78, pulse: 100, temperature: 96.9. The Resident #1 had decreased in when moved side to side or The SBAR further indicated experiencing abdominal durse #1 indicated that stended left lower rib area uinal area and also purple					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345128	B. WING				C (20/2040
NAME OF P	ROVIDER OR SUPPLIER	040120		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	28/2018
TO THE OT THE	to vibert of tool i eleft				O VALLEY STREET		
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		STATESVILLE, NC 28677			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 29	F	689			
	for evaluation. EMS v	he Emergency Room (ER) vas notified at 1:15 AM on rted Resident #1 to the ER.					
	02/27/18 at 8:47 AM. she worked 3rd shift on 02/13/18 at approx #1 complained of pair was unusual for Resiso she went to her rogoing on. When quester pain Resident #1 when they pushed mostated that upon asselower rib area and left distended and hurting Resident #1 was not requested to go to the she called the on call Resident #1's complato send Resident #1 to notified Emergency Murse #1 confirmed to from Nurse #2 at the	ducted with Nurse #1 on Nurse #1 confirmed that on 02/12/18. She stated that kimately 12:30 AM Resident in. Nurse #1 stated that it dent #1 to complain of pain om to find out what was tioned by Nurse #1 about stated "they broke my ribs e out of bed." Nurse #1 essment Resident #1's left t upper abdominal area were g her. She added that able to rate her pain but e hospital. Nurse #1 stated MD and notified him of ints and received an order o the ER for evaluation at ledical Services at 1:15 AM. hat she had received report beginning of her shift but the ing about Resident #1's fall.					
	PM of NA #3 and NA from chair to bed. Re pad that was then ho via loops at 4 points of loops were attached raised up and moved was lowered and the the mechanical lift. At been removed NA #3 turn onto her left side	made on 02/26/18 at 1:17 #4 transferring Resident #1 sident #1 was sitting on a lift oked to the mechanical lift on the lift pad. Once the to the lift Resident #1 was over to her bed, where she lift pad loops removed from firer the mechanical lift had instructed Resident #1 to the Resident #1 was observed over the left and reach for the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING_			C 02/28/2018
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, 2 520 VALLEY STREET STATESVILLE, NC 28677	ZIP CODE	02.20.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 689	standing on the left seriod Resident #1 was swift Resident #1 required turn over far enough underneath her. After the lift pad and proving Resident #1 was very down in the bed towarequested that her het that she had used to side. NA #4 was obsided down towards the endough down for Respulled down in the bed per her request. An interview was coreously 226/18 at 6:06 PM had received a call at 02/13/18 from the start and fallen and had to the ER. The DON statements from the discovered that NA #1 care and asked Resiand she flung one lecaused her to roll our MA #1 was in the roomommate and heard went and got Nurse and Resident #1 off the fithen later they sent in stated that she would	vards NA #4 who was ide of the bed. The motion of ft almost reflexive in nature. It assistance from the staff to to remove the lift pad from r NA #3 and NA #4 removed ded incontinent care y emphatic that she be pulled ands the foot of the bed, she head be below the grab bar assist in turning onto her left herved to pull Resident #1 do fthe bed, it was not far sident #1 and she was again hed closer to the foot of the hold that she that around 1:00 AM on aff alerting her that Resident do a hematoma and had gone stated that she obtained	F	689		
F 726 SS=J	her safely in the bed Competent Nursing S CFR(s): 483.35(a)(3)	while providing care. Staff	F7	726		3/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 2/28/2018	
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP 520 VALLEY STREET STATESVILLE, NC 28677	•	2/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 726	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the rat at §483.70(e). §483.35(a)(3) The facil icensed nurses have and skill sets necessaneeds, as identified thassessments, and de §483.35(a)(4) Providi limited to assessing, implementing resident to resident's needs. §483.35(c) Proficience The facility must ensi- to demonstrate comp techniques necessar- needs, as identified thassessments, and de This REQUIREMENT by: Based on record rev- facility failed to ensur- trained and competer	vices e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required cility must ensure that the specific competencies ary to care for residents' nrough resident scribed in the plan of care. Ing care includes but is not evaluating, planning and at care plans and responding by of nurse aides. In that nurse aides are able etency in skills and at to care for residents'	F7	#1 Corrective Action for the found to be affected Resident was assessed by doctor called and resident	y the nurse ,		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID IVC	7. 0936-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345128	B. WING _			02/	28/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN CE	NTED HEALTH & DEHA	DILITATION/CTATECVILLE		52	20 VALLEY STREET		
BRIAN CE	NIER HEALIH & REHA	BILITATION/STATESVILLE		S	TATESVILLE, NC 28677		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 726	Continued From pag	e 32	F	726			
		began on 02/12/18 when			#2 Corrective action taken for these		
		the bed during incontinent			residents having the potential to be		
	I .	t perform an assessment, did			affected		
	I .	Il Doctor (MD), and did not					
	_	oncoming shift. Nurse #2 was			On 2/27/18 the Director of Nursing and		
	a new agency nurse	to the facility and had			Nurse Managers conducted an audit of	i	
	received no orientation	on to the facility and received			residents with changes in condition du	ing	
	no competency skills	check to ensure that she			the last 30 days. The 24 hour reports a		
	was competent to ca			Incident/Accident Logs were reviewed			
	Nurse #2 was not cle			identify residents that have fallen durin	-		
I	responsibilities to a N			the last 30 days. The resident is medi			
	assumed that MA #1			record was then reviewed to validate the	iere		
	assessment of Resid			is Nursing documentation present			
	MD, and report it to t	was removed on 02/28/18 at			supporting the completion of a nursing assessment following a fall or a signific	ant	
	6:20 PM when the fa				change in condition and notification to		
	I .	eptable credible allegation of			Physician following a fall or significant		
	compliance. The faci	-			change. The Nurse Managers comple	ted	
	1	er scope and severity of D			notification to the Physician for any		
		potential for more than			opportunities identified a result of this		
		not immediate jeopardy) to and ensure monitoring			review.		
	· ·	ce for ensuring all staff are			#3 Measures and systemic changes pu	ut	
		nt before caring for residents			into place to ensure practice does not		
	in the facility.				reoccur On 2/27/18 The Director of Nursin	a	
	The findings included	d:			and Nurse Managers re-educated all	9	
	The minutes				current Licensed Nurses and Agency		
	Review of the facility	contract from Nurse #2's			Nurses currently working in the facility,		
		d 06/16/17 read in part, client			regarding the facility policy for Change		
		o provide proper orientation			Resident Condition, with a focus on		
	1	ne client's facility to which the			Notification of the Physician following a	ın	
		nal (Nurse#2) is assigned,			Incident/Accident.		
	*	e profession taking any			A new process was implemented on		
	patient load.				2/27/18 requiring the Licensed Nurse to)	
					notify the Unit Manager on Duty or the		
		s employee file at the facility			Nurse Manager on Call when a resider		
		me, references, and skills			has a fall. The Unit Manager on Duty of		
	Linecklist that were p	rovided by Nurse #2's			the Nurse Manager on Call will be liste	u	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			1	28/2018	
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2010	
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				<u> </u>	TATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 726	Continued From pag	ne 33	F7	726				
F 726	staffing agency. The licensed nurse comporientation material of that Nurse #2 had recompetency skills sinduty on 02/12/18. An interview was con 02/26/18 at 2:44 PM was working on the 02/12/18. MA #1 star PM Resident #1 fell hall and motioned for room. She stated Nursom and observed completed no assess Resident #1 was traillift from the floor back Nurse #2 exited the was not able to asser responsibility of Nurse had counted the narwith Nurse #1 at thar #2 was responsible to about the residents at An interview was con 02/26/18 at 3:37 PM she arrived to the factime. She entered the to the unit where she could not recall who Nurse #2 confirmed the unit from Nurse #3	re was no education, no betency checklist, or from the facility to indicate acceived any orientation or ince arriving at the facility for anducted with MA #1 on and MA #1 confirmed that she unit with Nurse #2 on the ted that at approximately 9:00 and she stepped out in the range with the range with the resident's there on the floor but sment. She stated that the insferred with the mechanical of the to bed and at that point froom. MA #1 stated that she was Resident #1 that was the see #2. MA #1 stated that she cotics on the medication cart the end of her shift, but Nurse for giving report to Nurse #1	F7	726	on the Daily Assignment Sheet along verification. This will be posted each Nurses Station. The Nurse Manawill review the event with the Licensed Nurse, validate the Physician was notifias well as making any recommendation for ongoing interventions and treatment On 2/27/18 the Director of Nursing and Nurse Managers educated the current Licensed Nurses and Agency Nurses currently working in the facility regarding this new process for notification of the Physician for residents having a fall. On 2/28/17 the Director of Nursing and Nurse Managers re-educated the Nurse Aides regarding their observation of a form a significant change in condition. The education included that Nurse Aides with immediately report a resident fall or a significant change to the Nurse and accompany the Nurse to the resident room for further evaluation. No agency staff shall work after 2/27/1 before receiving this education. This education has been added to the Facil Orientation program for all new hires a agency staff to be completed prior to beginning work after 2/27/18. New Agency and new contracted housekeeping and dietary staff that has not received training will be required to report for duty 2 hours prior to their shi receive this education from the Scheduling Nurse prior to accepting a resident assignment.	d at ager fied ns ts. I e fall his ill 8 ity nd ve ft to		
	she had worked in o been exposed to wo	d of the unit. Nurse #2 stated ther states but had never rking with an MA and was not hat they could do and could			On 2/28/18 a new process was initiated during the morning clinical meeting 5 times per week for 12 weeks. This will include a review, by the Director of			

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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Continued From pag	e 34	F 72	26			
PM Resident #1 fell at the fall but she assure the assessment, the to the oncoming shift. An interview was corouz/27/18 at 1:26 PM she gave Nurse #2 rarrived to the unit to she recalled giving Noresidents on the entire new staff she tried to of how the unit ran at had any questions should any questions should be was a good Nurse #3 stated that Nurse #2 a good reputhe survival book at the stated that she information about the MA that income the management of the management of the survival book at the MA administered.	and the staff did notify her of med that MA #2 would handle MD notification, and report it in a moducted with Nurse #3 on a Nurse #3 confirmed that report on 02/12/18 when she work. Nurse #3 stated that report on 02/12/18 when she work. Nurse #3 stated that report on 02/12/18 when she work. She added that with require unit. She added that with require them a brief description and always told them if they he could ask MA #1 on the resource for information. She believed she had given ort and directed Nurse #2 to the nurse's station. Nurse #3 med Nurse #2 general things cluded which part of the unit medication too but not		residents listed on the 24 hr with Incident/Accident report the following process was complemented: -the Physician was notified of the Director of Nursing or N was notified and a review of assessment and notification completed at the time of the The Director of Nursing will results of this monitoring dur weekly QAPI meeting and the will make recommendations 4. Yvonne Washburn, LNH responsible for implementing acceptable plan of correction monitor will be brought to the	report and/or is to validate ompleted as of the event urse Manager the was event. The report the ring the le committee as needed. HA is go this hand to be a seekly Ad		
Coordinator (UC) on UC confirmed that sh unit where Nurse #2 stated that Nurse #3 on the residents on thow the unit worked any questions she confirmed the UC stated she to before she left for the unit and told her abuse coordinator ar	02/27/18 at 12:53 PM. The ne was responsible for the worked on 02/12/18. The UC had given report to Nurse #2 he unit and brief over view of and instructed her if she had ould ask MA #1 on the unit. buched based with Nurse #2 e day and welcomed her to the Administrator was the nd if any issues arose to call					
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag not do. Nurse #2 sta PM Resident #1 fell a the fall but she assur the assessment, the to the oncoming shift An interview was cor 02/27/18 at 1:26 PM. she gave Nurse #2 re arrived to the unit to she recalled giving N residents on the entin new staff she tried to of how the unit ran a had any questions sh unit, she was a good Nurse #3 stated that Nurse #2 a good rep the survival book at t stated that she inforr about the MA that ind the MA administered specifically what else not do. An interview was cor Coordinator (UC) on UC confirmed that sh unit where Nurse #2 stated that Nurse #3 on the residents on th how the unit worked any questions she co The UC stated she to before she left for the the unit and told her abuse coordinator ar the DON and made s	An interview was conducted with Nurse #3 on 02/27/18 at 1:26 PM. Nurse #3 confirmed that she gave Nurse #2 report on 02/12/18 when she arrived to the unit to work. Nurse #3 stated that with new staff she tried to give them a brief description of how the unit ran and always told them if they had any questions she could ask MA #1 on the unit, she was a good report and directed Nurse #2 to the survival book at the nurse 's station. Nurse #3 stated that she informed Nurse #2 to the unit to MA that included which part of the unit the MA that included which part of the unit the MA administered medication too but not specifically what else the MA could do or could	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 not do. Nurse #2 stated that on 02/12/18 at 9:00 PM Resident #1 fell and the staff did notify her of the fall but she assumed that MA #2 would handle the assessment, the MD notification, and report it to the oncoming shift. An interview was conducted with Nurse #3 on 02/27/18 at 1:26 PM. Nurse #3 confirmed that she gave Nurse #2 report on 02/12/18 when she arrived to the unit to work. Nurse #3 stated that she recalled giving Nurse #2 a run down on the residents on the entire unit. She added that with new staff she tried to give them a brief description of how the unit ran and always told them if they had any questions she could ask MA #1 on the unit, she was a good resource for information. Nurse #3 stated that she believed she had given Nurse #2 a good report and directed Nurse #2 to the survival book at the nurse's station. Nurse #3 stated that she informed Nurse #2 general things about the MA that included which part of the unit the MA administered medication too but not specifically what else the MA could do or could not do. An interview was conducted with the Unit Coordinator (UC) on 02/27/18 at 12:53 PM. The UC stated that Nurse #3 had given report to Nurse #2 on the residents on the unit and brief over view of how the unit worked and instructed her if she had any questions she could ask MA #1 on the unit. The UC stated she touched based with Nurse #2 before she left for the day and welcomed her to the unit and told her the Administrator was the abuse coordinator and if any issues arose to call the DON and made sure she had the phone	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO S20 VALLEY STREET STATESVILLE, NC 28677 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 34 not do. Nurse #2 stated that on 02/12/18 at 9:00 PM Resident #1 fell and the staff did notify her of the fall but she assumed that MA #2 would handle the assessment, the MD notification, and report it to the oncoming shift. An interview was conducted with Nurse #3 on 02/27/18 at 1:26 PM. 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The UC stated that Vurse #3 and given report to Nurse #2 on the residents on the unit and brief over view of how the unit worked and instructed her if she had any questions she could ask MA #1 on the unit. The UC stated that Vurse #3 and given report to Nurse #2 before she left for the day and welcomed her to the unit and told her the Administrator was the abuse coordinator and if any issues arose to call the DON and made sure she had the phone	A BUILDING 345128 345128 STREET ADDRESS, CITY, STATE, ZIP CODE 220 VALLEY STREET STATESVILLE, NC 28677 SUMMARY STATEMENT OF DEFICIENCIES CONTINUED AND OF CORRECTION PRESIDENCIES OF THE APPROPRIATE CONTINUED AND OF CORRECTION PROVIDERS PLAN OF CORRECTION FROMEN SHAPPOOPRIATE F726 Nursing and Nurse Managers, of residents listed on the 24 hr report and/or with Incident Nocident reports to validate the following process was completed as implemented: - the Physician was notified of the event - the Director of Nursing or Nurse Manager was notified and a review of the assessment and notification was completed at the time of the event. The Director of Nursing or Nurse Manager was notified and a review of the weekly QAPI meeting and the committee will make recommendations as needed. 4. Yonner Washburn, LNHA is responsible for the weekly Ad Hoc QAPI meeting and the committee will make recommendations as needed. 4. Yonner Washburn, LNHA is responsible for the weekly Ad Hoc QAPI meeting for 12 weeks and than Monthly for 3 months. Which was a good report to Nurse #2 to the residents on the unit and brief over view of how the unit worked and instructed her if she had any questions she could ask MA #1 on the unit. The UC stated that Nurse #3 had given report to Nurse #2 to the residents on the unit and brief over view of how the unit worked and instructed her if she had any questions she could ask MA #1 on the unit. The UC stated that Out Page 1 and 1 and 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING				C /28/2018	
	ROVIDER OR SUPPLIER	HABILITATION/STATESVILLE		STREET ADDRESS 520 VALLEY STR STATESVILLE,		02/	20/2016	
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F 726	aware that she did responsibilities were sponsibilities were An interview was conceived by the sesentially receive facility's employees that it would be a lineed all the person immunization pape employees, their determined by their prospective age ach employee incompanies like abuse/n safety, grievances, the nurses should nursing like abuse/n safety, grievances, the nurses should nursing like blood by mediation pass, and licensed nurse constated that the general oriental pieces of the facility like a una ASDM stated that should be allowed to take receiving any of the An interview was constated that during hyperson that the self-ball that occurrent that Nurse #2 had she needed prior to 02/12/18. The DON	tion to the facility and was not not know what her re if a resident fell. onducted with the Area Staff ager (ASDM) on 02/28/18. The he agency staff should the same orientation as the swould receive. She added ttle less because we would not	F	726				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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they are doing more staff that included the of the MAs and what The DON stated that 02/12/18 the facility book" at each nursin Nurse #2 was not or and did know about give her information A follow up interview DON on 02/27/18 at that prior to the incide facility assumed that general knowledge of we found that most of stated that Nurse #2 with so much agency hard to keep up with that changed daily. The realized that they has what they had been An interview was con Administrator on 02/Administrator stated including agency stated orientation and compassuming care for the The Administrator, Double of immediate 2:12 PM. The Administrator on 02/28/18 at 4:02 PM	education with the agency e delineation responsibilities they could and could not do. It prior to the incident on had put together a "survival g station but unfortunately iented to the facility or unit the survival books that would on what do if a resident fell. Was conducted with the 8:34 AM. The DON stated ent on 02/12/18 that the the agency staff had a of policy and procedures and of them did not. The DON "fell through cracks" and y staff in the building it was the competency level of staff The DON stated that they we to do more education then doing. Inducted with the 28/18 at 6:38 PM. The that she expected all staff ff to receive the proper petency's required prior to be residents in the facility. ION, and the UC were geopardy on 02/27/18 at istrator provided an allegation of compliance on .	F	726					
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	ROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENC REGULATORY OR Continued From pag they are doing more staff that included the of the MAs and what The DON stated that 02/12/18 the facility book" at each nursin Nurse #2 was not or and did know about give her information A follow up interview DON on 02/27/18 at that prior to the incid facility assumed that general knowledge owe found that most of stated that Nurse #2 with so much agency hard to keep up with that changed daily. The realized that they had what they had been An interview was con Administrator on 02/2 Administrator stated including agency stated orientation and compassuming care for the The Administrator, Double of immediate 2:12 PM. The Administrator, Double of immediate 2:12 PM. The Administrator in College of the College of t	A follow up interview was conducted with the DON on 02/27/18 at 8:34 AM. The DON stated that prior to the incident on 02/12/18 that the facility assumed that most of them did not. The DON stated that through captain that they realized that they assumed that they assumed that they assumed that they assumed that they could and not stated that prior to the incident on 02/12/18 the facility had put together a "survival book" at each nursing station but unfortunately Nurse #2 was not oriented to the facility or unit and did know about the survival books that would give her information on what do if a resident fell. A follow up interview was conducted with the DON on 02/27/18 at 8:34 AM. The DON stated that prior to the incident on 02/12/18 that the facility assumed that the agency staff had a general knowledge of policy and procedures and we found that most of them did not. The DON stated that Nurse #2 "fell through cracks" and with so much agency staff in the building it was hard to keep up with the competency level of staff that changed daily. The DON stated that they realized that they have to do more education then what they had been doing. An interview was conducted with the Administrator on 02/28/18 at 6:38 PM. The Administrator stated that she expected all staff including agency staff to receive the proper orientation and competency's required prior to assuming care for the residents in the facility. The Administrator, DON, and the UC were notified of immediate jeopardy on 02/27/18 at 2:12 PM. The Administrator provided an acceptable credible allegation of compliance on 02/28/18 at 4:02 PM. Credible Allegation F726:	A BUILDII 345128 ROVIDER OR SUPPLIER NTER HEALTH & REHABILITATION/STATESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 they are doing more education with the agency staff that included the delineation responsibilities of the MAs and what they could and could not do. 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The Administrator, DON, and the UC were notified of immediate jeopardy on 02/27/18 at 2:12 PM. The Administrator provided an acceptable credible allegation of compliance on 02/28/18 at 4:02 PM. Credible Allegation F726:	A BUILDING 345128 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE \$20 VALLEY STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 36 they are doing more education with the agency staff that included the delineation responsibilities of the MAs and what they could and could not do. The DON stated that prior to the incident on 02/12/18 the facility about the start would give her information on what do if a resident fell. A follow up interview was conducted with the 20NO no 02/27/18 at 8:34 AM. The DON stated that prior to the incident on 02/12/18 at the facility sasumed that the agency staff had a general knowledge of policy and procedures and we found that most of them did not. The DON stated that they have to do more education then what they had been doing. An interview was conducted with the Administrator on 02/28/18 at 6:33 PM. The Administrator stated that she expected all staff including agency staff to receive the proper orientation and competency level of the proper orientation and competency level of the proper orientation and competency be required prior to assuming care for the residents in the facility. The Administrator, DON, and the UC were notified of immediate jeopardy on 02/27/18 at 2:12 PM. The Administrator provided an acceptable credible allegation of compliance on 02/28/18 at 4:02 PM. Credible Allegation F726:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
			A. BOILD	_			C	
		345128	B. WING	B. WING			02/28/2018	
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			5	TREET ADDRESS, CITY, STATE, ZIP CODE 20 VALLEY STREET STATESVILLE, NC 28677			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 726	#1's room to provide Certified Medication same room to admin roommate. Resident bed mobility and whiturn her in the bed her the bed causing her CMA #1 left the room then went to get NA mechanical lift and concentration with the mechanical lift and concentration with the went to get NA mechanical lift and concentration with the went to get NA mechanical lift and concentration with the went to get NA mechanical lift and concentration with the went to get NA mechanical lift and concentration with the well and	NA) #1 entered Resident incontinent care and Aide (CMA) #1 entered the ister medications to the #1 requires assistance with le NA #1 was attempting to er leg "flopped" off the side of to fall to the floor. At 9:05pm in to get Agency Nurse #2 and #2 (who gathered the ame to the room). Agency went to the door and waited is placed back in bed by NA	F	726				
	Aide which resulted it to the incident that of Agency Nurse #2 state accustomed to working	rith a Certified Medication In her lack of timely response CCUTTED ON 12/12/18. Ited that she was not Ing with CMAs and thought Iting the assessment and						

	(X3) DATE SURVEY COMPLETED	
345128 B. WING	C 02/28/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	02/20/2010	
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE 520 VALLEY STREET STATESVILLE, NC 28677		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 726 Continued From page 38 notifying the physician. The root cause analysis identified that Agency Nurse #2 did not receive orientation or training from the facility regarding a nurse's responsibilities at the facility, including the need to assess a resident and to notify a resident's physician after a resident experienced a fall or a significant change in a condition, prior to beginning her work assignment on 2/12/18 which was her first day working at the facility. 2. Residents receiving care form Agency Nurses may be affected by this alleged deficient practice. On 2/27/18 the Director of Nursing and Nurse Managers conducted an audit of current Agency staff to create a list of active Agency Nurses who have worked during the last 30 days. An interview was conducted with these Nurses to discuss the previous orientation process. The Nurse Managers covered the resident assignments to allow for an updated orientation program to be provided by the Area Staff Development Manager on 2/27/18 beginning with 3p-11p shift. 3. On 2/27/18 The Area Staff Development Manager re-educated current Agency Nurses regarding the facility policy for "Changes in Resident Condition", with a focus on assessment after a resident has a fall and Notification of the Physician following a fall. Licensed Nurses were re-educated regarding the components of a nursing assessment following a fall to include: -vital signs -neuro checks when a head injury is suspected,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		345128	345128 B. WING			C 2/28/2018	
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP C 520 VALLEY STREET STATESVILLE, NC 28677		•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 726	in sensation and derange of motion of evaluate pain for sea. A new process was requiring the Licens Manager on Duty or when a resident has condition. The Unit Nurse Manager on Occasional Assignment Sheet at This will be posted at Nurse Manager will Licensed Nurse, val was completed accordance as well as may for ongoing interven Nurse Managers conew process. On 2/27/18 The Are educated current Agnew process for assignificant characteristics.	ognition orusing, abrasions, changes formity extremities everity and location implemented on 2/27/18 ed Nurse to notify the Unit the Nurse Manager on Call a fall or significant change in Manager on Duty or the Call will be listed on the Daily along with contact information. In each Nurses Station. The review the event with the idate the nursing assessment ording to guidelines listed aking any recommendations tions and treatments. The impleted the education for this a Staff Development Manager inency Nurses regarding this essment of residents after a lange of condition and	F 7				
	No Agency staff shareceiving this educa orientation checklist added to the Facility new hires and agen to beginning work at New Agency staff the will be required to retheir shift to receive	Il work after 2/27/18 before tion in addition to the Agency. This education has been or Orientation program for all cy staff to be completed prior					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345128	B. WING		C 02/28/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/20/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 726	assignment. On 2/28/18 a new prothe morning clinical in review, by the Director Managers, of resident and/or with Incident/Athe following process implemented. -an Situation Backgro (SBAR) or Nursing process implemented. -an Situation Backgro (SBAR) or Nursing process implemented. -an Situation Backgro (SBAR) or Nursing process implemented in the guidelighter Nurse Manager of the assessment and at the time of the eventhe Physician was not the Director of Nursi this monitoring during and the committee was needed 4. The Administrator implementing this accommediate jeopardy of 6:20 PM when nursing that they had received orientation and had rewhat to do if a reside	ocess will be initiated during neeting. This will include a per of Nursing and Nurse its listed on the 24 hr report accident reports to validate was completed as found Assessment Response rogress note is present to a of a nursing assessment as ine. Was notified and a review of notification was completed int	F 72			
F 842 SS=D	CFR(s): 483.20(f)(5), §483.20(f)(5) Reside	nt-identifiable information. elease information that is	F 84	2	3/27/18	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345128	B. WING _		02/28	3/2018
	NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	1 02/20	<i></i>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	Continued From pag	e 41 elease information that is	F 8	42		
	resident-identifiable taccordance with a coagrees not to use or					
	professional standar must maintain medic that are-	ecords. rdance with accepted ds and practices, the facility al records on each resident				
	(i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or	le; and				
	all information containegardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, page 1	or their resident e permitted by applicable law; syment, or health care				
	with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research purposes, research purposes, research purposes a serious threat to he	tted by and in compliance 5; activities, reporting of abuse, violence, health oversight d administrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512.				
	, , , ,	cility must safeguard medical gainst loss, destruction, or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C			
	345128 B. WING				02/28/2018		
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677	02/20/2010		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION		
F 842	for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The ment (ii) Sufficient informat (ii) A record of the receive (iii) The comprehens provided; (iv) The results of an and resident review of determinations cond (v) Physician's, nurse professional's progrec (vi) Laboratory, radio services reports as	I records must be retained required by State law; or he date of discharge when ent in State law; or ars after a resident reaches e law. Redical record must containion to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and fucted by the State; e's, and other licensed logy and other diagnostic required under §483.50. To is not met as evidenced riew and staff interviews the ment a residents fall in the of 3 residents sampled for #1).	F8	F842 #1 Corrective Action for Reside Resident record now reflect her #2 Corrected action taken for the residents having the potential to affected All residents who have had a fal	fall ose be I have a		
	Review of the most r	ecent quarterly Minimum ed 12/30/17 revealed that		potential to be affected by this a deficient practice. On 2/27/18 the of Nursing and Nurse Managers conducted an audit of residents	ne Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _	VING			C 02/28/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.0.20	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2010	
TO UNIC OF TH	TO VIDERY OIL OIL OIL I EIER				20 VALLEY STREET			
BRIAN CE	NTER HEALTH & REH	ABILITATION/STATESVILLE			TATESVILLE, NC 28677			
				- 3	 			
(X4) ID PREFIX TAG			ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From pa	ge 43	F	842				
F 842	Resident #1 was m required extensive a with bed mobility ar reported on the MD Review of facility do Incident/Accident RPM read in part, Nu preparing to provide #1. Resident #1 wa her left side, Reside the left leg propelling the bed onto the floothe Director of Nurs Review of Resident 02/26/18 revealed in that occurred on 02 An interview was confirmed that she confirmed that she will be sident #1. Not instructed to Resident #1. Not instructed to Resident and grabbed a hold her right leg and flu propelled her body	idly cognitively impaired and assistance of 1 staff member and toileting. No falls were S. ocument titled eport dated 02/12/18 at 9:00 arsing Assistant (NA) #1 was a incontinent care to Resident as asked by NA #1 to roll onto ent #1 flung her right leg over ag her body off the left side of or. The report was signed by sing (DON). #1's medial record on no documentation of the fall /12/18 at 9:00 PM. onducted with Nursing no 02/26/18 at 2:24 PM. NA #1 was caring for Resident #1 on and she had entered Resident #1 to turn onto her left side of the pad, Resident #1 took ng it over her left leg and it off the left side of the bed onto	F	842	changes in condition during the last 30 days. The 24 hour reports and Incident/Accident Logs were reviewed identify residents that have fallen during the last 30 days. The resident smed record was then reviewed to validate the is Nursing documentation present supporting the completion of a nursing assessment following a fall or a signification to Physician following a fall or significant change in condition and notification to Physician following a fall or significant change. The Nurse Managers complete notification to the Physician for any opportunities identified a result of this review. #3 Measures and systematic changes into place to ensure no further re-occurrence On 2/27/18 The Director of Nursing and Nurse Managers re-educated all curred Licensed Nurses and Agency Nurses currently working in the facility, regard the facility policy for Changes in Resid Condition, with a focus on Notification the Physician following an Incident/Accident, on assessment following a fall and completion of documentation as follows:	to g ical here cant the ted put d nt ing ent		
	Resident #1 if she was not ok and #1 stated that Medi room at the same ti to Resident #1's roo and went to summo. An interview was co	ted she immediately asked was ok and she replied that to get her out of the floor. NA ation Aide (MA) #1 was in the me administering medications ommate. MA #1 heard the fall ons Nurse #2.			Licensed Nurses were re-educated regarding the components of a nursing assessment and documentation follow a fall to include: -vital signs -neuro checks when a head injury is suspected, changes in level of consciousness occurs or subtle chang in cognition -check the skin for bruising, abrasions	ing es		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			، ا	С	
		345128	B. WING	B. WING		02/28/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	20/2010	
				52	20 VALLEY STREET			
BRIAN CE	NTER HEALTH & REHA	BILITATION/STATESVILLE		s	TATESVILLE, NC 28677			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)			COMPLETION DATE	
F 842	Continued From page	e 44	F	842				
	was working on the u	init where Resident #1			changes in sensation and deformity			
		MA #1 stated that she had			-range of motion of extremities			
	entered Resident #1's	s room at approximately			-evaluate pain for severity and location			
	9:00 PM to medicate	her roommate while NA #1			-an Situation Background Assessment			
	provided care to Resi	ident #1. MA #1 stated that			Recommendation (SBAR) or Nursing			
	she heard NA #1 ask	Resident #1 to turn onto her			progress note is complete to document			
		ard Resident #1 fall to the			the nursing assessment as outlined in t	:he		
		at she went out to the			guideline			
		d for Nurse #2 to come to the			On 2/28/18 a new process will be initial			
		rse #2 entered Resident #1's			during the morning clinical meeting. The			
		er on the floor. She stated			will include a review, by the Director of			
		was transferred back to			Nursing and Nurse Managers, of			
	bed Nurse #2 exited t	the room.			residents listed on the 24 hr report and			
					with Incident/Accident reports to valida			
		ducted with Nurse #2 on			the following process was completed a	S		
		Nurse #2 confirmed that			implemented.			
	_	02/12/18 and was working on			-an Situation Background Assessment			
		ent #1 resided. She stated			Recommendation (SBAR) or Nursing			
	1	00 PM she was alerted that he floor. Nurse #1 stated			progress note is present to document completion of a nursing assessment as			
		ident #1's room and NA #1,			outlined in the guideline.	'		
		ere all in the room. She			-the Director of Nursing and Nurse			
	1	#1 was requesting to get off			Manager was notified and a review of t	ho		
		ated that she waited until the			assessment and notification was	110		
		sferred Resident #1 off the			completed at the time of the event.			
		exited the room. She stated			-Recording falls has been included in the	ne		
		at MA #1 would document			orientation of all new facility staff and			
	the fall in Resident #1	1's medical record. Nurse #2			agency staff as of March 27, 2018.			
	confirmed that she di	d not document the fall in						
	Resident #1's medica	al record.			4. The Director of Nursing will report the	ıe		
					results of this monitoring during the			
		ducted with the DON on			weekly QAPI meeting for 12 weeks the			
	02/26/18 at 6:06 PM.	The DON stated that when			monthly for 3 months and the committe			
		f the fall she spoke with			will make recommendations as needed	l.		
		d that she was not familiar						
	I .	ney could and could not do.			#5 Date of alleged compliance March 2	<u>'</u> 7,		
	I .	she expected that Nurse #2			2018			
		ited the fall it the medical						
	record. The DON stat	ted that MAs are not able to	1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			C 02/28/2018		
	ROVIDER OR SUPPLIER	HABILITATION/STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	ODE	<u> </u>	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 842	Continued From particular document falls or comedical record that nurse.	hange of condition in the twas the responsibility of the	F8	342				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	-	(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			R-C 02/28/2018
	ROVIDER OR SUPPLIER	ABILITATION/STATESVILLE		STREET ADDRESS, CITY, S 520 VALLEY STREET STATESVILLE, NC 286		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRE CROSS-REFERE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 880 SS=D	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the follo §483.80(a)(1) A system of communicable staff, volunteers, vis providing services a arrangement based conducted accordinaccepted national signature for the put are not limited to (i) A system of surv possible communic infections before the persons in the facili (ii) When and to who communicable dise reported; (iii) Standard and truto be followed to provident; including the signature of the put are not limited to be followed to provide the persons in the facili (iii) When and to who communicable dise reported; (iiii) Standard and truto be followed to provide the persons in the facili (iii) When and how it resident; including the signature of the persons in the facili (iii) Standard and truto be followed to provide the persons in the facili (iii) Standard and the persons in the facili (iiii) Standard and the persons in the facili (iiiii) Standard and the	control tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual lupon the facility assessment in the same and	F	TITLE		3/27/18 (X6) DATE

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

03/23/2018

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED										
		345128	B. WING	B. WING		R-C 02/28/2018										
	ROVIDER OR SUPPLIER	BILITATION/STATESVILLE		520	REET ADDRESS, CITY, STATE, ZIP CODE VALLEY STREET ATESVILLE, NC 28677	02	1/26/2016									
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From pag (A) The type and dur depending upon the involved, and (B) A requirement the least restrictive poss circumstances. (v) The circumstance must prohibit employ disease or infected s contact with resident contact will transmit (vi)The hand hygiene by staff involved in d §483.80(a)(4) A syst identified under the f corrective actions tal §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual re The facility will condu IPCP and update the This REQUIREMEN' by: Based on observation	e 1 ation of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the es under which the facility lees with a communicable kin lesions from direct s or their food, if direct the disease; and e procedures to be followed irect resident contact. em for recording incidents acility's IPCP and the ken by the facility. dle, store, process, and is to prevent the spread of		380												
	washing during a wo that was on Enteric p difficile colitis (C-Diff residents on isolation The findings included	n precautions (Resident #3).			F880 SS=D #1: Corrective Action for the resider found to be affected by the alleged deficient practice: Resident #3 had soap ar paper towels stocked in her room, or February 27, 2018, by the HSG Environmental Services Supervisor a	d I										

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345128	B. WING		R-C 02/28/2018		
NAME OF PROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP COD		720/2010	
TO WILL OF THE VIDER ON OUT FIELD				520 VALLEY STREET			
BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			STATESVILLE, NC 28677				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 2	F 88	30			
	Difficile (C-diff) revise	ed in 2017 read in part,		was verified by the DON.			
		utions to 48 hours after		The Nurse and RCS were ref	trained		
		Special considerations read		regarding hand hygiene techr			
	in part, wash hands v	with soap and water. Do not		immediately report to the DOI	N or Nurse		
		rub. Alcohol based hand		Managers if hand hygiene sup	oplies are		
	rubs are not effective	e in killing C-Diff.		unavailable.			
				Based on the IPCP crite			
		n order for Resident #3 dated		contact precautions, specifica	•		
		, clean stage 4 pressure wound cleaner, pat dry with		precautions, Resident #3 was March 3, 2018, as she no long			
	_	Iginate (antimicrobial wound		criteria.	ger met		
		with border gauze every day.		cinteria.			
	producty, and cover t	mar berder gadze every day.		#2: Corrective action taken	for those		
	Review of a physicia	n order for Resident #3 dated		residents having the potential	to be		
		ct precautions for C-Diff.		affected by the same alleged			
				practice:			
		made of Resident #3's door		There are curr	-		
		AM. The door contained a		residents on contact precaution			
	_	ct Precautions then under it		affected by the alleged deficie			
	·	utions: Perform hand hygiene		of proper hand washing with r			
		or cubicle and wash hands for 15 seconds before		contact precautions. Howeve audit of all resident rooms and			
	-	e sign also indicated that		care areas was conducted to			
		when entering the room and		soap, paper towels and hand			
	_	for direct patient care or		was available. The HSG Env			
	-	ay contact surfaces in the		Services Supervisor and Reg			
	room.	,		Supervisor conducted this ho			
				audit. It was then verified by			
	An observation of wo	ound care was made on		Nursing Leadership staff. Any	y opportunity		
		1. The facility's Wound Nurse		identified was corrected imme	ediately.		
	, ,	to enter Resident #3's					
		nd dry her hands. The WN		#3: Measures and systemic			
		nser on the wall and pressed		into place to ensure the allege	ed deficient		
		s and clear gel emerged into		practice does not re-occur:	•		
		ibbed her hands together no		The housekeeping staff will be			
	shook the excess wa	them under the water. She		re-educated on daily monitoring refilling of hand hygiene supp			
		towel to dry her hands and		March 22, 2018 by the SPICE			
		owels available for use in the		Staff.	- Corunca		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OIVID INC	7. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						R	-C
		345128	B. WING _			02/	28/2018
NAME OF P	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIAN CE	NTED UEALTH & DEUA	BILITATION/STATESVILLE		52	20 VALLEY STREET		
DINIAN CL	INTERTIEAETH & REHA	BEHATION/STATESVILLE		S	TATESVILLE, NC 28677		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 880	Continued From pag	e 3	F8	80			
	bathroom. The WN held her hands up and				All nursing staff was re-educated on ha	end	
	walked across the hall to a common room and				hygiene techniques and reporting of	ii i d	
	obtained paper towels to dry her hands. The WN				missing supplies and correction by the		
	1	lent #3's room and applied a			SPICE certified staff by March 27, 2018		
	gown and gloves and						
	perform wound care.			Infection Control has been included in	:he		
	was on Enteric Preca			orientation of all new staff including			
	had just had a loose			housekeeping and agency staff as of			
	up by the staff and the			March 27, 2018.			
	Resident #3 was obs			A SPICE Certified Staff Member trained	4		
	coccyx with wound c			each department	,		
	removed her gloves			The Infection Prevention and Contro	ol		
	hands applied new g			Program (IPCP) will be reviewed by the			
	silver alginate and co			SPICE certified staff and they will upda			
	border gauze. After t			the program, as necessary.			
	place the WN remov	ed her gloves and proceed to					
	the bathroom in Resi			#4: Corrective actions will be monitore			
	her gown and wash I			to ensure the alleged deficient practice	will		
	soap dispenser on th			not re-occur.			
		a clear gel emerged, she			NHA and Housekeeping Superviswill monitor 10 resident rooms per Nurs		
	1	gether no suds formed and paper towel to dry her hands.			Unit weekly for 12 weeks to validate	sing	
		towel available for use in the			supplies are readily stocked and availa	ble	
		again held her hands up and			DON and Nurse Managers will rando		
		walked across the hall to a			observe 10 facility staff members from	,	
		otained paper towels to dry			varying shifts weekly for 12 weeks to		
	her hands.				validate hand hygiene techniques. All		
					findings will be recorded on the provide	ed :	
		nducted with the WN on			audit form and given to the		
		I. The WN stated that she			DON/Administrator to be reviewed and		
	1	e for the wound program at			presented at monthly QAPI. QAPI will		
	_	ember 2017. The WN stated			make further recommendations as		
		t she used to wash her ent #3's room "looked funny"			needed based on any findings.		
		ht maybe it was hand			#5: Date of alleged compliance: Mar	ch	
	_	ated that while performing			27, 2018	J. 1	
	I .	been instructed to wash her			,		
		water before and after the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING _			R-C 02/28/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE				STREET ADDRESS, CITY, STATE, ZIP CO 520 VALLEY STREET STATESVILLE, NC 28677	DDE	32/20/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		ON SHOULD BE HE APPROPRIA		
F 880	instructed to wash he the old dressing and there was no different resident was on isolated confirmed that she has a resident was on isolated dressing and be dressing. The WN stands and sanitizer and passend and sanitizer and passend and dried he washed and dried he An interview was conflusekeeping (DOH The DOH confirmed contained hand sanitizer and dry their hands. The DOH immediately put soap Resident #3's bathroom An interview with Hold conducted on 02/27/confirmed that she was Resident #3 resided sanitizer in her bathrostated that it should he dispenser and there it towels in the bathroom wash and dry their has An interview was confirmed that she wash and dry their has an interview was confirmed that she wash and dry their has an interview was confirmed that it should he dispenser and there it towels in the bathroom wash and dry their has an interview was confirmed that she wash and dry their has an interview was confirmed that it should he dispenser and there it towels in the bathroom wash and dry their has a confirmed that it should he dispenser and there it towels in the bathroom wash and dry their has a confirmed that it should he dispenser and there it towels in the bathroom wash and dry their has a confirmed that was confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and dry their has a confirmed that the bathroom wash and the confirmed that th	atted that she had not been er hands between removing applying a new dressing and ice in her method if the ition. The WN again ad not been informed that if plation for C-Diff that she hands after she removed the before applying a clean atted that the bathroom room p in the dispenser and not aper towels should have ecould have properly in hands. Inducted with the Director of on 02/27/18 at 11:18 PM. Ithat Resident #3's bathroom izer instead of soap and no vailable to the staff to wash The DOH stated that he was hand sanitizer in the that it should have been it stated he would on and paper towels in om. Juse Keeper #1 was 18. House Keeper #1 as working the hall where but she had not put the hand from. House keeper #1 have been hand soap in the should have been paper m so staff could adequately	F	380			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345128	B. WING			R-C 02/28/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			,	STREET ADDRESS, CITY, STATE, ZIP COE 520 VALLEY STREET STATESVILLE, NC 28677		02/20/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	facility and that inclustated that Resident until she had formed have a loose stool ear precautions remained with C-Diff the staff whands with soap and providing care. The I would have expected after she removed he wound and before a Resident #3. She addeen soap, water, and #3's bathroom so the as directed by the signal of the bathroom available. An interview was confursing (DON) on O2 stated that she expendands with soap and providing wound care the wound and befor The DON added that be soap, water, and	was responsible for ion control program at the ded isolation rooms. She #3 would stay on isolation stool and she was noted to arlier on the shift so the d in effect. She stated that was expected to wash their water before and after CN also stated that she if the WN to wash her hands or gloves after cleaning the oplying a clean dressing to ded that there should have and paper towels in Resident estaff could wash their hands on on the door. It is at 5:21 PM. The inthat soap had been placed there was no paper towels in ole for use. Inducted with the Director of 2/28/18 at 6:38 PM. The DON octed the WN to wash her water before and after ea, and after she had cleaned a applying a clean dressing. It is he fully expected that there opaper towels available for bathroom and any room that	F8				