PRINTED: 05/31/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHABIGASTO (MA) ID SUMMARY STATEMENT OF DEFICIENCES SOUR ROAD GASTONIA, NC 28854 PREPIX FACILIFECTION OF DEFICIENCE SUPPLIER SOURCES FOR PROVIDERS PLAN OF CORRECTION (PA) ID SUMMARY STATEMENT OF DEFICIENCES SOURCES FOR ROAD GASTONIA, NC 28854 PREPIX (PA) ID (PA) ID SUMMARY STATEMENT OF DEFICIENCES SOURCES FOR PROVIDERS PLAN OF CORRECTION (PA) ID SOURCES FOR PAN OF CORRECTION SO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
STREET ADDRESS. CITY. STATE. 2P CODE BRIAN CTR HEALTH & REHABIGASTO (PA) 1D REGULATION OR LISC IDENTIFYING INFORMATION) E 000 Initial Comments A recertification survey was conducted on 05/06/19 through 05/09/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #CYSE211 F 558. Reasonable Accommodations Needs/Preferences CSS-D F(Rs): 483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REOUREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to place a resident's specialty call light within reach to allow the resident to request staff assistance if needed for 1 of 3 residents reviewed for accommodation of needs (Resident #485). The findings included: Resident #486 was admitted to the facility on 7/29/14 with diagnoses including hemiplegia, seizure disorder and diabetes. The quarterly Minimum Data Set (MDS) assessment. completed on 4/3/19, requiredly infact. The resident required extensive assistance with bed mobility and 2 plus people for transfers, was totally dependent for toileting, personal hygiene and dressing.	345169		B. WING _	B. WING				
CASTONIA, NC 28054 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES TAG	NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	703/2013
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EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERINCED TO THE APPROPRIATE DEFICIENCY	BRIAN CT	R HEALTH & REHAB/G	ASTO					
A recertification survey was conducted on 05/06/19 brungh 05/06/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 48.3-73. Emergency Preparedness. Event ID #CYB2/11 F 558 Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) \$483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to place a resident's specialty call light within reach to allow the resident to request staff assistance if needed for 1 of 3 residents reviewed for accommodation of needs (Resident #485). The findings included: Resident #485 was admitted to the facility on 7/29/14 with diagnoses including hemiplegia, seizure disorder and diabetes. The quarterly Minimum Data Set (MDS) assessment, completed on 4/3/19, revealed the resident was alert and oriented and cognitively intact. The resident required extensive assistance with bed mobility and 2 plus people for transfers, was totally dependent for tolleting, personal hygiene and dressing.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	((EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Os/06/19 through 05/09/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 493.73, Emergency Preparedness. Event ID #CVB211 F 558 Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to place a resident's specialty call light within reach to allow the resident to request staff assistance if needed for 1 of 3 residents reviewed for accommodation of needs (Resident #485). The findings included: Resident #485 was admitted to the facility on 7/29/14 with diagnoses including hemiplegia, seizure disorder and diabetes. The quarterly Minimum Data Set (MDS) assessment, completed on 4/3/19, revealed the resident twas alert and oriented and cognitively intact. The resident required extensive assistance with bed mobility and 2 plus people for transfers, was totally dependent for toileting, personal hygiene and dressing.	E 000	Initial Comments		E 0	000			
services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to place a resident's specialty call light within reach to allow the resident to request staff assistance if needed for 1 of 3 residents reviewed for accommodation of needs (Resident #485). The findings included: Resident #485 was admitted to the facility on 7/29/14 with diagnoses including hemiplegia, seizure disorder and diabetes. The quarterly Minimum Data Set (MDS) assessment, completed on 4/3/19, revealed the resident was alert and oriented and cognitively intact. The resident required extensive assistance with bed mobility and 2 plus people for transfers, was totally dependent for toileting, personal hygiene and dressing.		05/06/19 through 05/ Health Service Regul Section. The facility requirements of CFR Preparedness. Even Reasonable Accomm	09/19 by the Division of ation, Nursing Home was in compliance with the 483.73, Emergency t ID #CYB211 lodations Needs/Preferences	F 5	558			6/6/19
ADODATORY DIDECTOR'S OR DROWIDED/SLIDDLIED DEDDESSNITATIVE'S SIGNATURE.		S483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to place a resident's specialty call light within reach to allow the resident to request staff assistance if needed for 1 of 3 residents reviewed for accommodation of needs (Resident #485). The findings included: Resident #485 was admitted to the facility on 7/29/14 with diagnoses including hemiplegia, seizure disorder and diabetes. The quarterly Minimum Data Set (MDS) assessment, completed on 4/3/19, revealed the resident was alert and oriented and cognitively intact. The resident required extensive assistance with bed mobility and 2 plus people for transfers, was				Specialty call light within reach for Resident #485 to allow Resident #485 ability to request staff assistance if needed. All Residents with the need for a Specical light identified as having the potent to be affected by the deficient practice. On 5/30/19, an audit completed by the Resident Care Management Director (For to identify current Residents with the new for a Specialty call light. Inservice provided by Staff Developme Coordinator (RN)to direct care staff (licensed staff and c.n.a.s) on 5/31/19 related to specialty call light placement	alty ial RN) eed nt	
	ADODATODY	DIDECTORIS OF PROVINCES	CLIDDLIED DEDDECENTATIVE O OLONATUS			TITLE		(Y6) DATE

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

05/30/2019 **Electronically Signed**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CUDDUED	040100		STREET ADDRESS, CITY, STATE, ZIP CO		05/09/2019	
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	DE		
BRIAN CT	R HEALTH & REHAB/GA	STO		969 COX ROAD			
				GASTONIA, NC 28054			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 558	Continued From page	: 1	F 5	58			
				assistance if needed.			
	The care plan for Resident #485, last reviewed on 4/12/19, revealed the following goals and interventions: "Be free of fall related injury. Be sure the resident's call light is within reach and encourage resident to use it." "Maintain dignity with staff assistance for toileting needs. Have call light within reach" and "Assist staff with ADLs as much as able. I utilize a pancake call bell. Keep within reach of hands or elbows." During the survey the following observations were made of the Resident #485's specialty "pancake" call light not within the resident's reach: On 05/7/19 at 9:27 AM the resident was in bed with the pancake call light laying in the upper left corner of the bed and the resident was unable to reach call light. The resident specified he was unable to reach his call bell at this time. On 5/7/19 at 1:48 PM the resident was in bed with the pancake call light clipped to the privacy			Specialty Call Light Monitoring implemented, and to be communit Coordinator each shift, weeks; then once daily for 4 3 times weekly for 4 weeks. Call Light Monitoring Tool with proper placement of the Special by observation to ensure the ability to request staff assistanceded The results of the Specialty of Monitoring Tool will be present Director of Nursing for 3 monitoring Tool will be present Director of Nursing fo	pleted by the daily for 4 weeks; then The Specialty II validate exialty call light executive Resident's ance if Call Light ented by the ented by the luate ommittee will endations as		
	reach On 5/8/19 at 8:24 Al with the pancake call headboard not within - On 5/08/19 at 9:17A with the pancake call headboard not within On 5/8/19 at 9:27 AM with Nursing Assistan cared for Resident #4 resident was totally do care and used a spectified the contracted so he used the call light to activate	M the resident was in bed light draped over the bed's		implementing the plan of cor			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY PLETED	
		345169	B. WING _		05	C 5/09/2019
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/GASTO				STREET ADDRESS, CITY, STATE, ZIP CODE 969 COX ROAD GASTONIA, NC 28054		703/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684 SS=D	resident's reach. NA a light under the reside stated the call light was elbow because she had to give resident care. On 5/9/19 at 10:05 Al conducted with Reside stated "yes" when as to be within his reach in order to utilize his pube positioned under had be positioned under had be positioned under had be positioned under had be a light was with a light was wit	of the bed and out of the #1 placed the pancake call nt's left elbow. The NA as not under the resident's ad not yet been in the room M an interview was lent #485. The resident ked if he wanted the call light. The resident specified that bancake call bell it needed to his elbow or hands. M, an interview with the evealed the nursing ff should have made sure in reach of the resident enteresident cannot himself to reach the call bell of his reach. M an interview was diministrator. She stated that ebilitated and therefore call light. However, the staff leck on him frequently.	F 5			6/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD SUDDUED	343169	B. WING _		TDEET ADDRESS CITY STATE ZID CODE	05	/09/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & REHAB/	GASTO			69 COX ROAD			
				G	GASTONIA, NC 28054			
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F 684	Continued From pa	nge 3	F 6	384				
	care plan, and the	-						
	This REQUIREME	NT is not met as evidenced						
	by:	tions resident staff and access			Chin Tana dranning above a completed	£		
		tions, resident, staff and nurse ws and record review, the			Skin Tear dressing change completed Resident #3's left knee on 5/6/19 by	TOF		
	·	nge a dressing as ordered for			Nurse #1.			
		dents with a skin tear			Nuise #1.			
	(Resident #3).	dente with a civil teal			All Residents with dressing orders have	e		
	(1 (33)33).				been identified as having the potential			
	The findings include			be affected by the deficient practice.				
	Resident #3 was ad	dmitted to the facility on			Audit completed to identify current			
	_	noses that included acute			Residents with dressing orders comple	ted		
		type 2 diabetes and others.			by Director of Nursing on 5/30/19.			
		inimum Data Set (MDS) dated						
		the resident's cognition was			Education provided to Nurse #1 and			
	intact and he had n			Nurse #3 (Treatment Nurses) by Staff				
	Resident #3's medi			Development Coordinator (RN) on 5/31/19 regarding the importance of				
		hange in condition dated			changing dressings as ordered.			
		in part the resident had			changing areasings as ordered.			
		ar to his left knee. The nurse			Dressing Changes Monitoring Tool			
	documented that th	ne area was cleaned and			implemented and to be completed by the	he		
	treated, and the ph	ysician was notified.			Director of Nursing 3 times weekly for			
					weeks. The Dressing Change Monitor	ing		
	A physician's order	dated 04/30/19 specified			Tool will ensure dressing changes are			
		tear to the left knee was to be			completed as ordered by verifying the			
		nd cleanser and triple antibiotic			order with the actual dressing applied t	.О		
		nd covered with a dry dressing			the identified area.			
	every other day.				The second of the Decesion Observe			
	Posident #2's Marc	2010 Treatment Administration			The results of the Dressing Change			
		2019 Treatment Administration aled the resident's dressing to			Monitoring Tool to be presented by the Director of Nursing monthly for 3 monthly			
	, ,	een changed on 05/01/19,			at the monthly facility QAPI Meeting to			
	05/03/19 and 05/05	•			evaluate effectiveness. The QAPI			
	33,00,10 and 00,00				Committee will make changes and			
	On 05/06/19 at 2:14	4 PM Resident #3 was			recommendations as indicated.			
		oom. During the interview, the			To the state of th			
	Resident pulled his			The Administrator is responsible for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345169	B. WING _			l	09/2019	
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/GASTO				96	REET ADDRESS, CITY, STATE, ZIP CODE 69 COX ROAD ASTONIA, NC 28054	, 00.	00.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	dated 05/03 (no yea The Resident stated sore. Resident #3 s supposed to be char not been changed or not sure why. On 05/06/19 at 3:41 interviewed and exp through Tuesday 7:0 assigned to treatment able to complete allishift. The Nurse was dressing orders and medical to review that Resident #3 was skin tear to his left k. The Nurse was aske 05/03 that was on that she performed to the tresident's knee on 0 explained that she in change as complete the dressing change was an oversight. On 05/09/19 at 10:13 (NP) was interviewed important for dressing ordered for skin tear infection. He added be competed as ordered for 9/19 at 10:24 (NP) was interviewed important for dressing ordered for skin tear infection. He added be competed as ordered for 9/19 at 10:25 (NP) was interviewed infection. He added be competed as ordered for skin tear infection. He added be competed as ordered for 9/19 at 10:25 (NP) was interviewed infection. He added be competed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed and 9/19 at 10:25 (NP) was interviewed and 9/19 at 10:25 (NP) was interviewed as ordered for 9/19 at 10:25 (NP) was interviewed and 9/	t knee. The dressing was r) and initialed by Nurse #1. he hit his knee and it was tated the dressing was nged every other day but had wer the weekend and he was PM Nurse #1 was lained she worked Friday 10 am to 3:00 pm and was hts. She stated that she was the treatments during her as asked about Resident #3's she used the electronic to order. Nurse #1 reported as to have a dressing for a hee changed every other day. It about the dressing dated the resident's knee and stated the dressing change to the 5/03/19. The nurse further harked the 5/05/19 dressing d on the TAR but forgot to do on that date. She stated it 3 AM the nurse practitioner d and explained that it was the treatments during her and explained that it was the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the was the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatments during her the saked about Resident #3's the treatment #10 the was the treatment #10 the the treatment #10	F	684	implementing the plan of correction.			
	dressing to the left k	nee. Observations of the e area was slightly red and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
			7 55.25.			С	
		345169	B. WING			05/	09/2019
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/GASTO			96	REET ADDRESS, CITY, STATE, ZIP CODE 9 COX ROAD ASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	(DON) was interviewed facility had a nurse as a week. She added to complete a dressing	AM the Director of Nursing ed and explained that the ssigned to treatments 7 days hat if the nurse was unable g during the shift, then the does notified of the need to The DON stated she	F	684			
F 842 SS=D	ordered. Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not resident-identifiable to accordance with a coagrees not to use or coagrees.	dentifiable Information 483.70(i)(1)-(5) nt-identifiable information. elease information that is to the public. lease information that is	F	842			6/6/19
	must maintain medica that are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically org §483.70(i)(2) The fac all information contain	rdance with accepted als and practices, the facility al records on each resident ented; e; and ganized fility must keep confidential fined in the resident's records, an or storage method of the frelease is-					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
345169 B. WII		B. WING _			C 05/09/2019			
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HEALTH & REHAB/GASTO				STREET ADDRESS, CITY, STATE, ZIP CODE 969 COX ROAD GASTONIA, NC 28054	I	03/03/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842	representative where (ii) Required by Law; (iii) For treatment, pa operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research p medical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The factorecord information agunauthorized use. §483.70(i)(4) Medical for- (ii) The period of time (iii) Five years from the there is no requireme (iii) For a minor, 3 yealegal age under State §483.70(i)(5) The med (i) Sufficient informati (ii) A record of the resi (iii) The comprehensi provided; (iv) The results of any and resident review edeterminations conductive (v) Physician's, nurse professional's progre (vi) Laboratory, radio	yment, or health care ted by and in compliance; activities, reporting of abuse, violence, health oversight administrative proceedings, coses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Ility must safeguard medical ainst loss, destruction, or required by State law; or e date of discharge when ent in State law; or ars after a resident reaches a law. dical record must containon to identify the resident; sident's assessments; ve plan of care and services or preadmission screening evaluations and acted by the State; tes, and other licensed	F8	42				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345169 B. V		B. WING			C 05/09/2019	
NAME OF PROVIDER OR SUPPLIER				ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2013	
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BRIAN CT	R HEALTH & REHAB/G	ASTO		G	ASTONIA, NC 28054			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ICY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	e 7	F8	342				
	This REQUIREMENT	is not met as evidenced						
	by: Based on observation interviews and record correctly document the	ns, staff and resident I review the facility failed to nat a treatment was not sampled residents (Resident			On 5/31/19 Nurse #1 verified that the dressing change to the left knee of Resident #3 was not completed on 5/5/On 5/31/19 Nurse #1 updated the Medi Record to accurately reflect and correct document that the identified treatment	ical		
	The findings included			was not completed on 5/5/19.				
	01/31/19 with diagnorespiratory failure, typ. The most recent Mini 02/07/19 specified the intact and he had no Resident #3's May 20 Record (TAR) revealed	019 Treatment Administration ed the resident's dressing to n changed on 05/01/19,			All Residents with treatment orders are identified as having the potential to be affected by this deficient practice. Audit completed by the Director of Nursing on 5/31/19 to identify current Residents with treatment orders. On 5/31/19, Education provided to Nursing by Staff Development Coordinator (RN) regarding the importance of			
	Resident pulled his let a dressing on his left dated 05/03 (no year The Resident stated sore. Resident #3 sta supposed to be chan	PM Resident #3 was m. During the interview, the eft pant leg up and pointed to knee. The dressing was) and initialed by Nurse #1. he hit his knee and it was ated the dressing was ged every other day but had er the weekend and he was			accurately documenting treatment order in the Medical Record. Treatment Documentation Accuracy To implemented and completed by the Director of Nursing 3 times weekly for weeks. The Treatment Documentation Accuracy Tool will validate the documentation accuracy in the medical record with the observation of the treatment to the identified skin area.	ol 12		
	through Tuesday 7 at to treatments. She si complete all the treat	PM Nurse #1 was ained she worked Friday on to 3 pm and was assigned tated that she was able to ments during her shift. The but Resident #3's dressing			The Treatment Documentation Accuracy Tool will be presented by the Director of Nursing at the monthly facility QAPI Meeting for 3 months to evaluate effectiveness. The QAPI Committee we make changes and recommendations a	ill		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345169	B. WING _	B. WING			C 09/2019	
	ROVIDER OR SUPPLIER	ASTO		STREET ADDRESS, CITY, STATE, ZIP CODE 969 COX ROAD GASTONIA, NC 28054				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	orders and she used review the order. Nu Resident #3 was to h tear to his left knee of The Nurse was asked 05/03 that was on the that she performed the resident's knee on 05 explained that she may change as completed the dressing change was an oversight. On 05/09/19 at 10:40 (DON) was interviewed all dressings to be contained to the contained that the may change as completed the dressing change was an oversight.	the electronic medical to	F8	342	indicated. The Administrator is responsible for implementing the plan of correction.			