### Summary Statement of Deficiencies

**E 000 Initial Comments**

An unannounced Recertification/complaint survey was conducted on 6/10/19 through 6/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YQW711.

**F 585 Grievances**

CFR(s): 483.10(j)(1)-(4)

§483.10(j) Grievances.

§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through

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

NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HEALTH & REHAB/HE

STREET ADDRESS, CITY, STATE, ZIP CODE
1300 DON JUAN ROAD
HERTFORD, NC  27944

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 585 Continued From page 1
postings in prominent locations throughout the
facility of the right to file grievances orally
(meaning spoken) or in writing; the right to file
grievances anonymously; the contact information
of the grievance official with whom a grievance
can be filed, that is, his or her name, business
address (mailing and email) and business phone
number; a reasonable expected time frame for
completing the review of the grievance; the right
to obtain a written decision regarding his or her
grievance; and the contact information of
independent entities with whom grievances may
be filed, that is, the pertinent State agency,
Quality Improvement Organization, State Survey
Agency and State Long-Term Care Ombudsman
program or protection and advocacy system;
(ii) Identifying a Grievance Official who is
responsible for overseeing the grievance process,
receiving and tracking grievances through to their
conclusions; leading any necessary investigations
by the facility; maintaining the confidentiality of all
information associated with grievances, for
example, the identity of the resident for those
grievances submitted anonymously, issuing
written grievance decisions to the resident; and
coordinating with state and federal agencies as
necessary in light of specific allegations;
(iii) As necessary, taking immediate action to
prevent further potential violations of any resident
right while the alleged violation is being
investigated;
(iv) Consistent with §483.12(c)(1), immediately
reporting all alleged violations involving neglect,
abuse, including injuries of unknown source,
and/or misappropriation of resident property, by
anyone furnishing services on behalf of the
provider, to the administrator of the provider; and
as required by State law;
NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HEALTH & REHAB/HE

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<td>F 585</td>
<td>Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide written grievance decisions to the resident and family of the resident for 1 of 1 resident (Resident #31) reviewed for grievances. The findings included: Resident #31 was admitted to the facility on 1/10/2019 with diagnoses to include paraplegia, multiple pressure ulcers and hypertension. Resident #31’s quarterly Minimum Data Set (MDS) assessment date 5/15/2019 revealed his cognition was intact, and he required extensive to</td>
<td>F 585</td>
<td>Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal &amp; State Law. F585 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. Resident # 31 was provided a written response to his grievance on 6/26/19. 2. The procedure for implementing the</td>
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F 585 Continued From page 3

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|           |     | F 585 total assistance from staff for activities of daily living. \nA "Concern Form" dated 4/4/2019 revealed a meeting was held with Resident #31, family member, and 5 facility staff members present. Grievances were noted on the form. The 2nd page of the form titled "Concern Form - Action" was dated as 4/4/2019, the day the concern came to the attention of the facility. The date the form was completed was 4/5/2019 or 4/6/2019, (the 5 and 6 were written on top of each other). Actions taken were documented on the form and noted the date of the follow up as 4/6/2019. The bottom of the form listed a question - "Is the individual who raised the concern satisfied with the resolution: yes or no", which was left blank and not answered. The form was signed by the Administrator and dated on 4/6/2019. The 3rd page of the form titled "Concern Decision Form" was documented and signed by the Administrator on 4/6/2019. A hand-written note at the bottom of the form read: "gave to Activity to deliver with Amazon Package."

On 6/12/2019 at 2:36 PM, an interview conducted with Resident #31 and his family representative regarding a meeting that was conducted on 4/4/2019 at the facility to voice grievances of Resident #31's care. Resident #31 stated he had not heard how the complaints were handled, did not know of the outcome of the grievance and had not received a written decision of the results of the grievance investigation from the facility. Resident #31's family representative stated she had not heard how the complaints were handled, did not know the outcome of the grievances filed, and had not received a written decision of the results of the grievance investigation from the facility.

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|           |     | F 585 acceptable plan of correction for the specific deficiency cited. \na) On 6/26/19 the Director of Nursing (DON) in-serviced the Administrator and the Social Services Manager were in-serviced on the grievance policy. On 6/26/19 the DON conducted an in-service with the Department Managers including the Administrator, Social Services Manager, Business Office Director, Admissions Coordinator, Activity Director, Maintenance Director, and Minimum Data Set Coordinator on the Grievance Policy to ensure that all grievances are reported to the Grievance Official (Nursing Home Administrator) promptly; and the Grievance Official thoroughly investigates and provides a written grievance decisions to residents and or families; according to the grievance policy. \nb) On 6/26/19 the DON conducted an in-service with the Department Managers including the Administrator, Social Services Manager, Business Office Director, Admissions Coordinator, Activity Director, Maintenance Director, and Minimum Data Set Coordinator on the Grievance Policy to ensure that within 72 hours of receiving the grievance, the Department Manager who is responding to the grievance will have verbal communication with the individual who voiced the grievance. Validation decisions of satisfaction will be determined via verbal communication with the individual who voiced the grievance at that time. \nc) On 6/26/19 the Director of Nursing and Social Services Manager reviewed the grievances for the last thirty days to
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
345262

**State:**

**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**Statement of Deficiencies and Plan of Correction**

**Date Survey Completed:**
06/13/2019

**Printed:** 07/15/2019

**Form Approved:**

**OMB No.:** 0938-0391

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**Name of Provider or Supplier:**
Brian Center Health & Rehab/HE

**Street Address, City, State, Zip Code:**
1300 DON JUAN ROAD
HERTFORD, NC 27944

### Summary Statement of Deficiencies

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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**Event ID:** YQW711

**Facility ID:** 943003

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**Facility:**
Brian Center Health & Rehab/HE

On 6/13/2019 at 11:47 AM, an interview was conducted with the Administrator who stated she did not have the residents sign the results of the written decision of grievances. The Administrator stated she or the Social Worker (SW) would go over the results of the grievance with the person who filed the grievance after the grievance was investigated. The Administrator stated she would have had the Activity Director take a copy of the grievance to the resident’s room with his Amazon package, as he frequently received packages from Amazon, but she could not verify if the resident had received a copy of the grievance.

**Summary of Deficiencies:**

**F 585**
Continued From page 4
determine if written grievance decisions were provided to residents and or families as indicated. There were no grievances found to not have a written response.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.

a) The Administrator will review the grievances twice weekly for three months to validate grievance decisions were provided to resident and or families.

b) The findings will be reviewed weekly for three months by the DON for validation.

c) The DON will report findings of the audits monthly, for three months, to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will analyze the data and provide any necessary recommendations to ensure sustained compliance ongoing.

4. The Administrator will be responsible for the implementation of the acceptable plan on correction.

5. Dates when corrective action will be completed 6/27/19. The corrective action dates must be acceptable to the State.

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**F 655**
Baseline Care Plan

CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning

§483.21(a) Baseline Care Plans

§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide...
Effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-

(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-

(i) Is developed within 48 hours of the resident's admission.

(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(i) The initial goals of the resident.

(ii) A summary of the resident's medications and dietary instructions.

(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

This REQUIREMENT is not met as evidenced by:

Preparation and/or execution of this Plan
F 655 Continued From page 6

interview the facility failed to develop an accurate base line care plan for 1 of 1 sampled residents (Residents # 97) observed for tracheostomy care.

The findings included:

Resident # 97 was admitted to the facility on 6/5/19 with diagnoses including acute respiratory failure.

Review of the Physician order dated 6/6/19 revealed Resident #97 was to receive oxygen at 6 Liters per minute (LPM) via tracheostomy (trach) collar continuously. Staff were to change the trach inner cannula with # 6 Shiley cuffless.

Review of the baseline care plan completed on 6/6/19 did not address Resident #97's tracheostomy status.

During an interview on 6/12/19 at 1:40 PM the Minimum Data Set nurse stated she had completed the 48 hour baseline care plan and not care planned the resident's tracheostomy. She stated it would be two days before she had the time to care plan the tracheostomy.

During an interview on 6/12/19 at 2:25 PM the Administrator stated that she would have expected the tracheostomy to have been care planned.

of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law.

F655

1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. Resident # 97 care plan was updated by the Minimum Data Set Coordinator to reflect the tracheostomy on 6/19/19.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

a) On 6/27/19 the Director of Nursing (DON) and a District Director of Care Management provided in-service education to the Minimum Data Set Coordinators (MDSC) on development of accurate baseline care plans.

b) The DON audited the baseline care plans for the residents who were admitted in the last twenty one days to validate accurate baseline care plans were developed. Any care plan needing to be updated to accurately reflect the resident's status was updated at that time by the DON or MDSC. Three patients were admitted during that timeframe. The audits revealed each of the three resident medical records audited had accurate baseline care plans in place.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the
F 655 Continued From page 7

regulatory requirements.

4. Date when corrective action will be completed is 6/27/19. The corrective action dates must be acceptable to the State.

F 679 Activities Meet Interest/Needs Each Resident

CFR(s): 483.24(c)(1)

§483.24(c) Activities.

§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence
F 679 Continued From page 8

and interaction in the community. This REQUIREMENT is not met as evidenced by:

Based on record review and staff and resident interviews, the facility failed to provide community outings/activities for 8 of 8 residents reviewed in resident council group meeting and failed to provide ongoing activities for 3 of 19 sampled residents reviewed for activities. (Resident #19, Resident #26 and Resident #31).

The findings included:

During a Resident Council Group Meeting held on 6/4/19 at 11:00 AM, the eight residents in the meeting revealed they had not gone on community outings in over one year. Most revealed they had not been on an outing in about three years.

During an interview on 6/11/19 at 11:00 AM, in Resident Council Meeting, Resident #13 said they do not go on outside trips. She stated she had been in the facility for 2 1/2 years and she had not been on an outing for over a year. She revealed during that time she went to a ball game and went to see Christmas lights over a year ago. Resident #13 said she did not know why they did not go on community outings. The other residents in the Resident Council Meeting agreed that they had not been on community outings.

During an interview on 6/12/19 at 9:22 AM, the facility Activity Director stated the last time she took residents on community outings was 2 1/2 years ago. She stated they had been having transportation problems with their own van and had been sharing a van with another facility. She revealed the shared van was used for

Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law.

F 679

1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. On 6/4/19 during Resident Council Meeting, residents expressed a concern during annual survey have not been on community outings.

The facility will utilize the facility van, as well as the Nursing Home Administrator has sought alternative methods of transportation services to accommodate residents who wish to participate in community outings.

A Resident Council Meeting was held on 6/26/19 to discuss what type of outings the residents would like to attend. Residents #31, #26, #19 had their activities of interest likes and dislikes reviewed by the Activity Director on 6/26/19. Residents #31, #26, #19’s respective Care Plans were updated by the Activity Director or Minimum Data Set Coordinator on 6/26/19 to reflect their specific activities of interest.

The Monthly Activity Calendar was updated for the month of July to reflect community outings chosen by Resident
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

345262

**B. WING MULTIPLE CONSTRUCTION**

**NAME OF PROVIDER OR SUPPLIER**

BRIAN CENTER HEALTH & REHAB/HE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1300 DON JUAN ROAD

HERTFORD, NC 27944

**DATE SURVEY COMPLETED**

06/13/2019

**NAME OF PROVIDER OR SUPPLIER**

BRIAN CENTER HEALTH & REHAB/HE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1300 DON JUAN ROAD

HERTFORD, NC 27944

**DATE SURVEY COMPLETED**

06/13/2019

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appointments. The Activity Director stated the facility van had been broken for a month or two and now it was fixed.

During an interview on 6/13/19 at 9:28 AM, the Administrator stated a bus company would volunteer once a year to take residents in the facility to see festival of lights. She stated she was working on a PIP (Performance Improvement Plan) to see how to take residents on community outings. She stated two months ago residents in a Resident Council Meeting voiced their concerns about not going on community outings. The Administrator said the facility van could accommodate two residents when there were no appointments and could take residents to where they wanted to go. She stated in order to take residents on group outings they would have to do multiple trips because of the size of the van. She stated the van could accommodate two non-ambulatory residents and one ambulatory resident. The Administrator stated that was the only option except for paying for additional transportation or using personal automobiles. She stated staff go shopping and purchase items and go to the bank for residents when needed. She revealed one resident used the city transit bus once a month to go shopping.

1. Resident #19 was admitted to the facility on 9/28/15, with diagnoses including Quadriplegia, Calculus of kidney, Neuromuscular Dysfunction of bladder, Muscle Weakness, Muscle Wasting and Atrophy and Acute Osteomyelitis. According to Resident #19's Quarterly Minimum Data Set dated 4/19/19, Resident #19's cognition was intact and he required extensive assistance in most areas of activities of daily living.

Council.

The Monthly Activity Calendar was updated for the month of July to reflect the additional activities being provided to meet the interest of Residents #31, #26, #19.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

a) On 6/26/19 the Nursing Home Administrator provided one on one education to the Activity Director on meeting activity programming needs of the residents, beginning activities on time as scheduled, and documenting resident participation in activities.

b) On 6/26/19 the Nursing Home Administrator provided education to the staff members assisting in activities on meeting activity programming needs of the residents, beginning activities on time as scheduled, and documenting resident participation in activities.

c) During Resident Council Meeting monthly, the residents will be asked about community outings of interest and be provided an update by the Activity Director or Social Services Director as to how the facility will work to accommodate their requests by using the facility van and contracted transportation services to assist residents to attend community outings.

d) During Resident Council Meeting monthly, the residents will be asked if the activities being provided are meeting their interests by the Activity Director or Social Services Director. If the activities are not meeting the interests, the Activity Director
Review of Resident #19’s Care Plan which was revised on 6/2/19 revealed Resident #19 enjoyed being outdoors, music and rap music. He was safe to go out without supervision. Interventions included listening to music on his play station, visiting his friends outside and going to college off grounds.

Review of the Individual Activity Participation Record for Resident #19 from January through June, 2019 are noted as follows:

January, 2019- Blank Activity Participation Record
No month or year listed-Cards/other games-Refused-1st, 4th, 6th, 11 th, 15 th, 18 th, 20 th, 22 th, 25 th, and 27 th
Music-Active-23rd and 27 th
TV/Radio/Movies-Active-4th, 18 th and 25 th
Parties/Socials/Special events-Active-14 th
Nails- Active-5th, 12 th, 19 th and 26 th
No month or year listed-Blank Activity Participation Record

May, 2019- Exercise/Sports-Active-1st, 3rd, 7th, 9th, 13 th and 15 th
TV/Radio/Movies-Active-6th and 13 th
Nails-Active-7th and 14 th
Bingo-Observed-1st, 3rd, 6th, 8th and 10 th
June, 2019-Blank Activity Participation Record

During an interview on 6/10/19 at 2:03 PM, Resident #19 revealed he does his own activities in his room. He said the activity room was not open after 5:00 PM and he stated he liked to record music in the activity room. Resident #19 said there were no outings. He stated 1 1/2 years ago outings used to be scheduled on Tuesdays and Thursdays. He revealed he and other facility members will review activities of interest with Resident Council monthly, to ensure activities are meeting the interests of the residents. The Activity Director will subsequently update the Activity Calendar, as needed, to reflect activities of interest per the Resident Council. The Activity Director or Minimum Data Set Coordinator will update the residents’ care plans to reflect their activities of interest.

e) On 6/26/19, the Activity Director or Social Services Director will conduct a new baseline interview with resident representatives, for residents who are not alert and oriented, to review activities of interest likes and dislikes and if the resident representative would like the resident to participate in community outings. The Activity Director or Minimum Data Set Coordinator will update the residents’ care plans to reflect their activities of interest as well as community outings.

f) On 6/26/19, the Activity Director or Social Services Director will interview alert and oriented residents to review activities of interest likes and dislikes for residents residing in the facility. The Activity Director or Minimum Data Set Coordinator will update the residents’ care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents’ activities of interest as well as community outings.

g) Quarterly, the Activity Director or Social Services Director will interview alert and oriented residents to review activities of interest likes and dislikes and if the resident representative would like the resident to participate in community outings. The Activity Director or Minimum Data Set Coordinator will update the residents’ care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents’ activities of interest as well as community outings.

h) Monthly, the Activity Director or Social Services Director will interview alert and oriented residents to review activities of interest likes and dislikes and if the resident representative would like the resident to participate in community outings. The Activity Director or Minimum Data Set Coordinator will update the residents’ care plans to reflect their activities of interest. The Activity Director will update the monthly Activity Calendar, as needed, to reflect residents’ activities of interest as well as community outings.
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cognition. He required extensive to total
dependence in most areas of activities of daily
living.

Review of Resident #26's Care Plan dated
2/15/19 revealed he attended activities of choice,
liked choirs, dances and large groups. Resident
#26 was to participate in movies with dancing in
it 1 time a week. The goal was Resident #26
would enjoy activities three times a week over the
next 90 days, which was revised on 4/13/19.
Interventions included remind and encourage to
attend, assist in activities as needed. Provide in
room activities as needed and required.

Review of the activity calendar revealed a bingo
activity was scheduled on 6/10/19 at 2:00 PM.

During an observation on 6/10/19 at 2:08 PM
Resident #26 and other residents were sitting out
in the hallway next to the nursing station. There
were no residents in the dining room or activity
room.

Staff member took Resident #26 in dining room to
purchase item from vending machine.

During an observation on 6/10/19 at 2:25 PM, the
facility Social Worker and other staff started going
from room to room asking residents if they
wanted to play bingo.

During an observation on 6/10/19 at 2:35 PM the
Social Worker and other staff took residents to the
activity room to play bingo.

During an observation on 6/10/19 at 3:15 PM, four residents were in the activity room playing
bingo and Resident #26 was not in the activity
room.

activities of interest as well as community
outings.

3. The monitoring procedure to ensure that the plan of correction is effective and
that specific deficiencies cited remains
corrected and/or in compliance with the
regulatory requirements.

a) The Administrator will audit the
Resident Council Meeting Minutes after
each Resident Council Meeting for three
months to determine any concerns with
residents regarding community outings or
activity programming. If concerns are
noted, the Administrator will request to
attend the next Resident Council Meeting
to address the concerns.
b) The Administrator will audit the Activity
Calendar monthly for three months, then
as needed ongoing, to ensure the Activity
Calendar includes community outings that
meet the residents' interest.
c) The Social Services Director will
randomly interview three alert and
oriented residents per week for twelve
weeks, then as needed, to validate
activities being provided are meeting the
residents' interest.
d) The Administrator will randomly
observe two activities per week for twelve
weeks to validate residents are attending
activity programming per their individual
choice.
e) The Administrator will report audit
findings from the Resident Council
Meetings, review of the Activity Calendar,
resident interviews and activity
observations monthly, for three months, to
the Quality Assurance Performance
Improvement (QAPI) Committee. The
During an interview on 06/10/19 at 8:08 PM, Resident #26's family member said she had never seen him in the activity room playing bingo.

Review of the Individual Activity Participation Record for Resident #26 from January through June, 2019 are noted as follows:

January, 2019- Blank Activity Participation Record
No month or year listed-
1st-Arts/Crafts-observed, exercise sports-active, bingo-observed
3rd- Arts/crafts-active, bingo-active,
5th-Spiritual/Religious-active, 6th-bingo-observed
7th-Exercise/sports-active, Nails-observed,
8th-Nails-observed,
9th-Exercise/religious-observed, 10
th-bingo-observed, 12 th-Spiritual/religious-active,
13 th-exercise/sports-active, bingo-observed
No month or year listed- 17 th- cards/other games/bingo-wanders in & out, 8th-Music-active,
Spiritual/religious activities- Active- 7th, 14 th, 1st and 28 th
Parties/Socials/Special events- Active-11 th and 12 th
Pet visits- Active-30 th, Nails- Active-2nd, 9th, 16 th, 23rd, and 30 th
New chat- Wandering in and out- 1st, 3rd, 5th, 9th, 11 th, 15 th, 17 th and 19 th
No month or year listed-Blank Activity Participation Record
No Activity Participation Record

During an interview on 6/12/19 at 1:15 PM, the Activity Director stated she still came in and helped with activities, such as charting on the computer. She stated she tried to come in twice a
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<tr>
<td>F 679</td>
<td>Continued From page 14</td>
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<td>week and every other weekend. She stated random staff carried out activities and volunteers come in during the week. She stated documentation and activity calendars was something the staff did everyday. She stated the staff would write down each activity and list names below and put the information in her notebook. The Activity Director stated one-on-one had a book too. She stated she went to each room and she would document which rooms she went to such as doing nails. The Activity Director stated she had taken Resident #26 to bingo and he would not stay in the room. She stated she had Resident #26 participate in bingo at the table with her while she called out numbers. She stated Resident #26 liked to be out of his room socializing with other residents.</td>
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### PROVIDER'S PLAN OF CORRECTION

**F 679**

Continued From page 15

- to activities I enjoy, I need reminder to go to activities I enjoy, and I need someone to take me to the activities I enjoy.

A review of the activity book revealed monthly individual activity participation records as follows:

- January 2019 revealed no documentation of any activity for Resident #31 noted on the form.
- March 2019 revealed no documentation of any activity for Resident #31 noted on the form.
- Undated form revealed no documentation of any activity for Resident #31 noted on the form.
- May 2019 revealed no documentation of any activity for Resident #31 noted on the form.
- June 2019 revealed no documentation of any activity for Resident #31 noted on the form.

On 6/11/2019 at 11:33 AM an interview was conducted with Resident #31, who stated the facility did not have any activities for his age. The resident stated he did have his nails cleaned a few times one month, but he did not realize that was considered an activity. The Resident stated he had called out bingo numbers for the other residents one time, but the facility had not offered him any activities that he felt were something for younger people to do. The resident stated he could not remember if the Activity Director (AD) had talked to him when he was admitted, but he had not had one to one talks with her, and she...
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<th>Facility ID: 943003</th>
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<td>If continuation sheet Page 17 of 18</td>
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**BRIAN CENTER HEALTH & REHAB/HE**

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<td>F 679</td>
<td>Continued From page 16</td>
<td>had not offered him anything else to do. On 6/12/2019 at 9:59 AM, an interview was conducted with Nurse #1 who stated Resident #31 had told her there were only activities for old people and he wanted something to do. The nurse stated she responded for the resident to give the facility some ideas, but she had not yet heard of anything he had thought of to do. On 6/12/2019 at 9:22 AM, an interview was conducted with the Activity Director (AD) who stated she had resigned her position on 5/13/2019 but came back part time to help with activities and do the charting required. The AD stated Resident #31 was care planned for group activities and she encouraged him to come to group activities. The AD stated she did not do a one to one activity in his room, but she did talk to him in the hallway or out when he was smoking and considered that his one to one, although she had not documented that. The AD stated she had googled some activities to do with the younger residents of the facility and asked another facility for ideas for younger residents, but so far nothing had been done. The AD stated some residents had gone out to a basketball game 3 years ago, but the residents had not been taken out on an outing for 3 years as the facility van was being fixed. The SW stated there was a van available for appointments, but she had not asked if the van was available for outings. On 6/13/2019 at 11:55 AM, an interview was conducted by the Administrator. The Administrator stated she expected there to be an Activity Calendar posted in the hallway and residents' room monthly. The Administrator stated the facility did their best to announce an...</td>
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<td>F 679</td>
<td>Continued From page 17 activity before it started, and she had nursing assistants and other staff to volunteer to run the activity for the residents. The Administrator stated the van available for use by the facility could not accommodate 2 power wheelchairs and Resident #31 could participate in group activities but chose not to and stated he did not want one to one activity and that was in his care plan.</td>
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