DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/22/2012 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB N	OMB NO. 0938-03	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345080	B, WI	B. WING				
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE	10/10/2012		
BRIAN CI	ENTER HEALTH & REHAI	B HICKORY VIEWMONT		ı	220 13TH AVE PLACE NW			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES			HICKORY, NC 28601			
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE CO		
F 282 SS=D	CONTOCO DI GONLIFIED		F	282				
	The services provided	lean			F-282		!	
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.				Care plans			
					1. 1.How Corrective:	ation.	İ	
					will be accomplished			
	This REQUIREMENT	is not met as evidenced			win be accompasin	eu;	t 	
	by:	is not met as evidenced	İ		The tab alert was re-applied	l +a	-	
	Based on medical rec	ord review, observations			the wheelchair and bed of	1 10		
	and interviews the facil	lity failed to implement a				<u>.</u>		
	tab alert (as identified i	in the care plan) to prevent			Resident #3 by Nursing state			
	falls for 1 of 5 sampled (Resident #3)	residents.			following identification on			
	(see see see see see see see see see se				afternoon of October 10, 20	12.		
	The findings are:				2 TT /2 C 111.	•		
	Pooldont # 2				2. How the facility wi			
	Resident # 3 was originally admitted to the facility 5/21/08 with diagnoses which included anxiety				identify other resid	t t		
	disorder, schizoaffectiv	e disorder, tardive		i	having the potentia			
	dyskinesia, dementia, p	sychosis and bipolar			be affected by the s	ame		
	disorder. The current N	Minimum Data Set			deficient practice.	ĺ		
	assessment dated //16 had no falls since admir	i/12 indicated Resident #3 ssion. The current care						
	plan included a problem	area dated 5/11/12			All residents have the poten	tial to		
	identifying Resident #3,	"At risk for falls related to			be affected by this alleged			
	mental status, history of	f previous falls, poor			deficient practice. The Dire			
	vision, utilizes assistive	devices and	İ		of Nursing or Designee will	i		
	psychotropics." Approaches to prevent falls included a tab alert which was added as an				complete an audit of all curr			
	approach on 8/12/12.	on Mad dadda as an	İ		care plans to identify individe			
					safety interventions and ver			
	Review of the medical re	ecord of Resident #3			these interventions are in plant	ace ;		
	evealed on 8/12/12 at 1 was found sitting on the	12:00 PM that Resident #3			by November 7, 2012.			
	vheelchair. A change of	front of her						
	completed on 8/12/12 w	hich identified an				İ		
)RATORY D	BEOTODIO OD FO	<u> </u>						
יייייייייייייייייייייייייייייייייייייי	RECTUR'S OR PROVIDER/SUF	PLIER REPRESENTATIVE'S SIGNATURE			TIT: E			

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GJ7V11

Facility ID: 923004RECEIVE Introduction sheet Page 1 of 4

Administrator

BY:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES WID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB NO. 0938-039	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345080			B. WING			С	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT				2:	REET ADDRESS, CITY, STATE, ZIP CODE 20 13TH AVE PLACE NW IICKORY, NC 28601	(10,	/10/2012
(X4) ID PREFIX TAG	(EACH DEFICIEN	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ON SHOULD BE COM HE APPROPRIATE	
	intervention in responsate all times". The new Resident #3 was incompleted by the Direct in the whole of the was not in place in the wheelchair was in the wheelchair was in the wheelchair was in the whole in place in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in the wheelchair was in an Resident #3 was obsetors o back and forth; 12:55 PM Resident #12:55 obsetors o back and forth; in place in the whole wheelchair was in an Resident #3 was obsetors o back and forth; in place in the whole wheelchair was in an Resident #3 was obsetors o back and forth; in Resident #3 was obsetors back and forth; in Resident #3 was obsetors back and forth; in Resident #3 was obsetors back and forth; in Resident #3 was obsetors back and forth; in Resident #3 was obsetors back and forth; in Resident #3 was obsetors back and forth; in Resident #3 was obsetors back and forth; in Resident #3	ense to the fall for a "tab alert bed for the tab alert for sluded on the Resident Care int Sheet under the heading. On 10/10/12 at 9:15 AM the slalist Assignment Sheet was actor of Nursing as the tool in sistants to know of residents. Ations were made of Resident in ack wheelchair. A tab alert in a forward motion. At was observed alone, in an upright position and in a forward motion. At wheelchair. A tab alert in a forward motion. At was observed alone, in ack wheelchair. The back of in an upright position and in a forward motion. At was observed alone, in her wheelchair. A tab alert was eelchair. The back of the upright position and in a forward motion. At was observed alone, in her wheelchair. A tab alert was eelchair. The back of the upright position and in a forward motion. At was observed alone, in her wheelchair. A tab alert was eelchair. The back of the upright position and in a forward motion. At was observed alone, in her wheelchair. A tab alert was eelchair. The back of the upright position and erved rocking her upper in a forward motion.	F	282	3. The following me will be put into p systemic changes to ensure that the deficient practice not recur. The Director of Nursing of Designee will re-educate a Nursing Staff on developicare plan and the applicationare planned safety intervby November 7, 2012. 4. The facility will mits performance to sure solutions are	lace or made would or all on of centions onitor o make	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORPECTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING A BUILDING	STATEMENT	OF DEFICIENCIES	WILDICAID SERVICES			OMB	NO. 0938-039		
MAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) F 282 Continued From page 2 Resident #3 her lunch meal. A tab alert was not in place in the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. NA #1 was asked if a tab alert was not in place. At the time of the observation NA #1 verified she had been responsible for Resident #3 during her shift which started at 7:00 AM. NA #1 was asked again about a tab alert for Resident #3. NA #1 located the Resident Care Specialist Assignment STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVE PLACE NW HICKORY, NC 28601 PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREVIDER'S PLAN OF CORRECTION (ASSOCIATIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Sustained in the following manner. The Director of Nursing or Designee will randomly observe 10 residents with care planned safety interventions, weekly for 4 weeks then monthly for 2 months, to verify placement and review these 10 care plans to	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY	
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVE PLACE NW HICKORY, NC 28601	345090			B. WNG			С		
STREET ADDRESS, CITY, STATE, ZIP CODE 220 13TH AVE PLACE NW HICKORY, NC 28601 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 2 Resident #3 her lunch meal. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. NA #1 was asked if a tab alert was not in place. At the time of the observation NA #1 verified she had been responsible for Resident #3 during her shift which started at 7:00 AM. NA #1 was asked again about a tab alert for Resident #3. NA #1 located the Resident Care Specialist Assignment							10	/10/2012	
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F 282 Continued From page 2 Resident #3 her lunch meal. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. NA #1 was asked if a tab alert was used for Resident #3 and she indicated she did not know. 2:40 PM Resident #3 was observed alone, in her room, in bed. A tab alert was not in place. At the time of the observation NA #1 verified she had been responsible for Resident #3 during her shift which started at 7:00 AM. NA #1 was asked again about a tab alert for Resident #3. NA #1 located the Resident Care Specialist Assignment		SUMMARY S	TATEMENT OF DEFICIENCIES	ID.	<u>—</u>				
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Sheet, reviewed it, and noted a tab alarm was supposed to be used for Resident #3. NA #1 stated she would have to check with the nurse to know if the tab alert was supposed to be in place in the bed and/or wheelchair. NA #1 noted velcro on the headboard of the bed and a holder on the back of the wheelchair of Resident #3. NA #1 stated the velcro and holder were used for placement of a tab alert. NA #1 looked for the tab alert in the room of Resident #3 and was not able to locate it. 2:55 PM A tab alert was brought to the room of Resident #3 by another staff member and put into place on the bed and clipped to Resident #3. NA #1 could offer no explanation why the tab alert had not been in place for Resident #3. On 10/10/10 at 7:10 PM the Assistant Director of Nursing (ADON) stated care guides were printed off daily for use by nursing assistants. The ADON stated hursing assistants were expected to follow all identified needs for residents. The ADON stated she recently started updating the		Resident #3 her lunc in place in the wheel wheelchair was in ar Resident #3 was obstorso back and forth; was asked if a tab all and she indicated sh 2:40 PM Resident #1 room, in bed. A tab a At the time of the obshad been responsible shift which started at again about a tab ale located the Resident Sheet, reviewed it, ar supposed to be used stated she would have know if the tab alert win the bed and/or when on the headboard of the back of the wheelchait stated the velcro and placement of a tab alert in the room of able to locate it. 2:55 PM A tab alert with Resident #3 by another place on the bed and #1 could offer no explain and to been in place On 10/10/10 at 7:10 P Nursing (ADON) stated off daily for use by nur ADON stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follow all identified need for the stated nursing follows.	chair. The back of the upright position and served rocking her upper in a forward motion. NA #1 sert was used for Resident #3 e did not know. Be was observed alone, in her alert was not in place. Servation NA #1 verified she for Resident #3 during her 7:00 AM. NA #1 was asked of the for Resident #3. NA #1 Care Specialist Assignment and noted a tab alarm was for Resident #3. NA #1 e to check with the nurse to was supposed to be in place selchair. NA #1 noted velcro the bed and a holder on the r of Resident #3. NA #1 holder were used for ert. NA #1 looked for the for Resident #3 and was not was brought to the room of ear staff member and put into collipped to Resident #3. NA anation why the tab alert for Resident #3. M the Assistant Director of dicare guides were printed sing assistants. The assistants were expected to leds for residents. The	F	282	sustained in the following manner. The Director of Nursing or Designee will randomly of 10 residents with care plant safety interventions, weekly weeks then monthly for 2 months, to verify placement review these 10 care plans verify accuracy. The result these observations and review ill be documented on the tool. Opportunities identified as result of these observations reviews will be corrected do by the DON and Designee. These results will be reported during the monthly QAPI meeting for 3 months by the Director of Nursing, the committee will evaluate an make recommendations as indicated. Date of Compliance is Novertices.	oserve ned y for 4 at and to ts of iews audit a and aily ed		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/22/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING С 345080 NAME OF PROVIDER OR SUPPLIER 10/10/2012 STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT 220 13TH AVE PLACE NW HICKORY, NC 28601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ΙĐ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION **PREFIX** PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 3 F 282 specific if the tab alert should be used in a chair and/or bed. The ADON stated the tab alert should have been in place at all times for Resident #3 as indicated on the 8/12/12 post fall report.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GJ7V11

Facility ID: 923004

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