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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	C 12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHABI HICK	3031 TATE BLVD SE HICKORY, NC 28602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=B	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interviews, the facility failed to notify the responsible party of medical changes for 1 of 4	F 157	This Plan of Correction is the facility's credible allegation of compliance. It is the practice of this facility to promptly inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly. It is the practice of this facility to notify legal representatives or interested family members of changes in condition, additions of antibiotics due to acute episode, physician ordered laboratory and diagnostic testing, requested appointments for specialty consultation, and injuries that require additional physician intervention. Interested family member for Resident #167 was notified on 12/12/13 of the ordered and completed CT scan with no identified areas of concern, physician ordered and completed urine analysis with residual antibiotic treatment, completed psychiatrist appointment with recommendations for changes in the dosing of Valium, physician orders for physical therapy treatment five times per Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley L. Smithey — TITLE: Administrator — (X6) DATE: 1/9/14

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.

DHHS Received JAN 13 2013 by: WRO Mountain

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F 157	Continued From page 1 sampled residents. Resident #167's responsible party was not notified of a CT (Computed Tomography) scan, a urinalysis, the addition of an antibiotic, changes in medications and notified timely of a fall. The findings included: Resident #167 was admitted to the facility on 10/26/12 with diagnoses including dementia with behaviors, anxiety, depressive disorder, cerebral vascular accident, schizoaffective disorder, panic disorder and hypertension. The most recent Minimum Data Set (MDS), an annual dated 10/04/13, coded him with moderately impaired decision making skills and having behaviors in the previous 1 to 3 days. Lack of notification to Resident #167's responsible party included the following situations: a. A communication sheet dated 12/03/13 noted that the certified physician's assistant (PAC) was called about frequent falls and an order was written to send Resident #167 for a CT scan. A nursing note dated 12/3/13 at 11:30 AM noted the CT scan (unidentified area) was scheduled for this date. There was no documentation that the responsible party was notified of this test. The CT scan of the brain was completed on 12/03/13 and reviewed by the physician assistant on 12/04/13. Results revealed no CT evidence for intracranial pathology. b. Review of the medical record revealed a communication sheet dated 12/03/13 which was	F 157	week that began on December 3, 2013, and that resident has been experiencing frequent falls with the most current being 12/7/13. Other facility residents have the potential to be affected by the same alleged deficient practice of failure to notify legal representatives or interested family members upon identification of changes in condition, additions of antibiotics due to acute episode, physician ordered laboratory and diagnostic testing, requested specialty consultation appointments, and injuries that require additional physician intervention. Director of Nursing and Assistant Director of Nursing generated a mailing list of all resident Legal Representatives or interested family members for those residents that are not their own Responsible Party. Each identified individual was mailed on 1/9/14 an invitation to contact the facility to inquire about any changes that may have occurred with their identified resident in regards to acute episode, upcoming or completed physician appointments, any recent antibiotic treatments, or incidents such as falls or skin tears requiring physician intervention that may have occurred. A synopsis review of the resident specific medical records have been completed and Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 157	Continued From page 2 faxed to the certified physician's assistant (PAC) which informed her of Resident #167 having frequent falls. A telephone order was written by the PAC on 12/03/13 at 2:50 PM which included: 1. urinalysis and culture and sensitivity; 2. labs including a complete blood count and complete metabolic panel in the am; 3. an antibiotic of Cipro 500mg by mouth twice a day for 7 days for a urinary tract infection; 4. referral to physical therapy and neurologist for frequent falls; 5. a referral back to his psychiatrist as soon as possible for increased anxiety. There were no nursing notes in the medical record that indicated the responsible party was notified of the above physician orders. Physical Therapy records revealed Resident #167 was evaluated on 12/03/13 and began services 5 times per week. Another telephone order dated 12/04/13 noted that an appointment with the psychiatrist was made for this date and a neurology appointment was made for 1/21/13 (sic). A physician's telephone order dated 12/06/13 changed the type of antibiotic ordered for the urinary tract infection based on the results of the urinalysis culture. Review of the nursing notes dated 12/04/13 at 10:00 AM revealed the psychiatry and neurology appointments were made, but there was no documentation related to notification to the responsible party. Review of the physician telephone orders from the psychiatrist dated 12/04/13 revealed an increase in Valium (an	F 157	his will allow the legal representative, or interested family member, the opportunity to obtain additional information or ask specific questions. Licensed Nurses have been inserviced beginning on 12/13/13 by the Director of Nursing on the facility expectation of notifying legal representatives or interested family members of changes in the resident. These changes include, but are not limited to, upon identification of changes in condition, additions of antibiotics due to acute episode, physician ordered laboratory and diagnostic testing, requested specialty consultation appointments, and injuries that require additional physician intervention. It is also the expectation of the facility that the notifying nurse document in the medical record who was notified, and to complete the documentation and notification timely. Members of Administrative Nursing inclusive or the Director of Nursing, Assistant Director of Nursing, and/or designee will review physician telephone orders 5 out of 7 days weekly to ensure that notification has occurred for changes in the residents. The notification should occur timely and be indicated on the telephone order. Incident Reports will be reviewed 5 out 7 days weekly by the Director of Nursing, Assistant Director of Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 157	Continued From page 3 antianxiety medication) at night and the discontinuation of 2 other medications. Another nursing note dated 12/04/13 at 11:00 PM revealed Resident #167 was receiving the antibiotic as ordered, and that there were new physician orders from the psychiatrist with medication changes. The nursing notes did not include any notification of this visit or these changes to the responsible party. c. On 12/07/13 at 9:00 PM a post fall review in the medical record noted that Resident #167 was stumbling and stomping in the hall and fell to his knees. The section to document notification of the responsible party was blank. Review of the nursing notes dated 12/07/13 at 11:30 PM mentioned the fall with no injury but did not include notification of the responsible party. Review of the Incident Report for this fall revealed Nurse #1 noted the responsible party was notified at 5:00 PM but listed no date. Interview with the staff member responsible for making and transporting residents to appointments stated on 12/12/13 at 3:23 PM that he received an in-house communication of needed appointments, he set up the appointments, placed the scheduled appointment in the accu-nurse system (which communicated via computer to the nurses), and the nurses were then responsible for contacting the responsible party. On 12/12/13 at 3:51 PM with Nurse #1 revealed responsible parties were notified of resident falls, behavior changes such as an increase in anxiety levels, changes in urine or need for testing. She further stated that she left a message for the responsible party last night (12/11/13) related to	F 157	Nursing, and/or designee to ensure notification has occurred timely and is documented properly. Change of Condition Physician Communication forms will be reviewed 5 out of 7 days weekly by the Director of Nursing, Assistant Director of Nursing, and/or designee to ensure notification has occurred timely and is documented properly. Any missed notifications will be logged onto an audit tool with notification completed and entered into the medical record at the time the notification was completed. Director of Nursing or designee will review the audit tool and the Director of Nursing will report to Quality Assurance with identified trends or patterns. The patterns or trends will be reported to the Quality Assurance and Assessment Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan based on trends identified and adjust the plan if negative trends are identified. If negative trends are identified, additional months of close observation and monitoring of the audit tool will occur. Date of Completion: January 10, 2014 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	1/10/14

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F 157	Continued From page 4 the fall he had on 12/07/13. When asked why the call was made 4 days after the actual fall, Nurse #1 stated that staff do not call responsible parties after 10:00 PM unless the fall resulted in injury. The next day shift was responsible for calling the responsible party. She stated that she did not talk to the family but thought that Nurse #2 on first shift called the responsible party about the psychiatrist, medication changes and urine testing. Nurse #1 stated that notification to responsible parties were to be documented in the medical record. On 12/12/13 at 5:48 PM, Resident #167's responsible party (RP) was contacted by telephone. The RP stated the facility usually did a good job with contacting her when Resident #167 fell. She stated the facility last called her about medication changes in conjunction with falls but did not recall being contacted anytime in December 2013. The RP stated she was unaware of any psychiatrist visit and asked if Resident #167 was seen in house or out of house. The RP further stated she was not aware of the medication changes made by the psychiatrist, the referral to physical therapy and the therapy services being provided. The RP stated she was unaware that Resident #167 was tested for and was receiving an antibiotic for a urinary tract infection. The RP stated she would have liked to be notified of these things. On 12/12/13 at 6:04 PM the Assistant Director of Nursing/Unit Manager stated nursing staff were responsible for notifying the responsible party of changes like skin tears, urinalysis, testing and falls, Notification should be included on the communication fax sheet or in the nursing notes. She further clarified that Resident #167 went out	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 157	Continued From page 5 of the facility to see the psychiatrist. She confirmed that Resident #167's RP should have been notified of the recent evaluations, referrals, and the fall notification should have been more timely. On 12/12/13 at 6:51 PM Nurse #2 met with the surveyor. Nurse #2 stated that she called the RP about the psychiatrist and possible medication changes the psychiatrist may make. Nurse #2 stated that when she has told Resident #167 she was going to call his RP about different issues he has always stated not to call her.	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	