| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

| (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 |
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| F 242 SS=D | 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident and staff interviews the facility failed to honor a resident's preference regarding frequency of showers per week for 1 of 4 residents reviewed for choices (Resident #182).<br><br>The findings included:<br><br>Review of the medical record revealed Resident #182 was admitted on 05/11/15 with diagnoses including chronic obstructive pulmonary disease and aphasia.<br><br>Review of a facility document titled "Resident Preferences Evaluation" revealed Nurse #2 completed the evaluation with Resident #182 on 05/12/15. During the evaluation Resident #182 indicated she wanted showers afternoon showers on Monday, Wednesday, Thursday, and Saturday.<br><br>Review of a Brief Interview for Mental Status (BIMS) completed on 05/15/15 revealed Resident #182 was cognitively intact.<br><br>Review of the shower schedule posted on a door | F 242 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion 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 law.<br><br>It is our facility policy that the resident has the right to choose activities, schedules, and health care consistent with her or his interests, assessments and plans of care, interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>1.Corrective action was accomplished for the alleged deficient practice by honoring the choices assessed for Resident #182 following admission to the facility on 5/11/15. Resident #182 requested | 6/12/15 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/12/2015

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| F 242 | Continued From page 1<br>in the nurse's station revealed Resident #182's room and bed number was scheduled for showers on Monday and Thursday during the 3:00 PM to 11:00 PM shift<br><br>Review of the Resident #182's bath type detail report from 05/12/15 through 05/20/15 revealed she received a shower on 05/14/15 (Thursday) and 05/18/15 (Monday) and was assisted by NA #8.<br><br>During an interview on 05/19/15 Resident #182 indicated on her communication board she did not choose how many times a week she took a shower. Resident #182 further communicated she received two showers a week on Monday and Thursday but would like a shower on Wednesday and Saturday as well.<br><br>An interview with Nurse #2 on 05/19/15 at 5:00 PM revealed residents received two showers a week which was determined by their room number and bed. Nurse #2 stated if a resident wanted more than two showers a week they would need to ask the nurse aide (NA).<br><br>An interview with NA #8 on 05/20/15 at 4:08 PM revealed most of the residents received two showers a week and if a resident requested an additional shower she would complete the scheduled showers first and then additional showers if she had time.<br><br>During a follow up interview on 05/21/15 at 2:30 PM Nurse #2 reviewed Resident #182's "Resident Preference Evaluation" and confirmed she completed it on 05/12/15. Nurse #2 stated she should have added Resident #182's shower preference to the daily assignment sheet so the | F 242 | independent showers during second shift on Monday, Tuesday, Thursday and Saturday during the initial preference assessment conducted on 5/12/15. The DON and Unit Manager completed the initial assessment and evaluation period for resident #182 on 5/21/15 and established an acceptable shower schedule to include showers as requested during second shift on Monday, Tuesday, Thursday and Saturday with supervision. The Director of Nursing updated the shower schedule to reflect the assessed preferences on 5/21/15.<br><br>2.All residents requiring assistance with showering have the potential to be affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing or Unit Manager have completed or reviewed Resident Preference Evaluation tool for residents requiring assistance with showers to ensure choices are being honored in regard to scheduled showers. This audit will be completed by 6-12-15.<br><br>3.The Nursing staff were re-educated by the Director of Nursing or Staff Development Coordinator regarding the completion of the Resident Preference Assessment tool on admission and honoring the Resident¿s choice of shower schedule. This education was completed by 6-12-15. The Director of Nursing, Assistant Director of Nursing or Unit Manager will randomly interview five residents requiring assistance with showers, weekly for twelve weeks to | |

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| F 242 | Continued From page 2<br>NAs would be aware she wanted a shower on Monday, Wednesday, Thursday, and Saturday. Nurse #2 explained it had been a busy week and she had neglected to to update the assignment sheet.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/21/15 at 4:18 PM. During the interview the DON stated the facility had started using the "Residents Preference Evaluation" the end of April 2015 or the beginning of May 2015. The DON further stated Resident #182's shower preference should have been placed on the daily assignment by Nurse #2. | F 242 | validate choices are being honored with regard to preferred shower schedules. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 6/12/15. | |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interview, staff interviews and review of facility records, the facility failed to repair the right brake and arm rests on a resident's wheel chair for 1 of 9 sampled residents' wheel chairs observed. (Resident #45)<br><br>The findings included:<br><br>Resident #45 was re-admitted to the facility on 10/24/14. Diagnoses included severely impaired vision.<br><br>Review of resident council minutes from a | F 253 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion 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 law.<br><br>It is our facility policy to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly | 6/12/15 |

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| F 253 | Continued From page 3<br>03/02/15 meeting revealed the facility's process for wheel chair repairs was discussed. The minutes documented that if a wheel chair could be repaired, maintenance staff would repair it or if another wheel chair was available, it would be provided. Resident #45's name was recorded next to the comment regarding wheel chair repairs.<br><br>A quarterly Minimum Data Set, dated 04/28/15 assessed Resident #45 with intact cognition, dependent for extensive staff assistance for transfers and the use of a wheel chair for locomotion on the unit.<br><br>During an observation and interview with Resident #45 on 05/19/2015 at 4:08 PM, he stated that the arm rests to his wheel chair were torn and the right brake did not work. Resident #45 was noted to apply both brakes to his wheel chair and attempted to propel in his wheel chair. The wheel chair moved forward on the right side when both brakes were applied. The arm rests were noted with torn cloth hanging and tears in the vinyl covering the arm rests. Resident #45 stated that he discussed his concerns in March 2015 regarding his wheel chair with a staff member in therapy and was told that therapy could repair the arm rests, but maintenance would have to fix his brakes. Resident #45 further stated that to date, his wheel chair had not been repaired. Resident #45 further stated that he then asked the activity director (AD) during a March 2015 resident council meeting to explain the process for getting wheel chairs repaired, but still nothing was done.<br><br>Resident #45 was observed again on 05/20/15 at 12:04 PM seated in a wheel chair in his room. His | F 253 | and comfortable interior.<br><br>1.Corrective action was accomplished for the alleged deficient practice by the Maintenance Director repairing the wheelchair breaks and the wheelchair arm rests for Resident #45 on 5/22/15.<br><br>2.All residents utilizing wheelchairs have the potential to be affected by this alleged deficient practice. An audit of all wheelchairs was conducted by the Maintenance Director by 6-12-15. Identified repairs were completed and wheelchairs unable to be repaired were removed from service by the Maintenance Director by 6-12-15.<br><br>3.All Staff will be re-educated by the Maintenance Director or Administrator on recognizing and reporting a maintenance request for needed repairs, included wheelchair repairs. This education will be completed by 6-15-15. The Maintenance Director will randomly monitor 5 wheelchairs weekly for twelve weeks to identify any needed repairs and maintenance concerns. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Maintenance Director for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 6/15/15. | |

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| F 253 | Continued From page 4 | F 253 | | |

wheel chair was observed still in need of repair as previously described.

During an interview on 05/21/2015 at 12:16 PM, the AD stated that she coordinated resident council meetings and recorded the minutes. The AD reviewed minutes from the 03/02/15 meeting and stated that two residents, which included Resident #45 asked about the process for repairing wheel chairs during this meeting. The AD stated that at the time of the meeting, Resident #45 did not express that his wheel chair needed to be repaired.

During an interview on 05/21/2015 at 3:01 PM with occupational therapist #1 (OT #1) revealed he recalled having a conversation with Resident #45 about repairing his wheel chair brakes and arm rests. OT #1 stated that he informed Resident #45 that maintenance staff could repair his wheel chair brakes and that therapy staff could repair the wheel chair arm rests. OT #1 stated that since Resident #45 was not receiving therapy services at the time of the discussion regarding repairs to his wheel chair, OT #1 encouraged Resident #45 to inform his nurse so that the request could be recorded on the maintenance log for repair. OT #1 stated he also told a nurse about the repairs, but could not recall which nurse.

During an interview with the administrator on 05/21/15 at 3:35 PM, the administrator stated that requests for wheel chair repairs should be documented on the maintenance logs which were kept at each nurse's station. He stated that the logs were reviewed daily by maintenance staff for

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| F 253 | Continued From page 5<br>repairs needed and the administrator reviewed the logs daily to ensure repairs were completed. The administrator stated he expected the maintenance director to review the logs daily for any repairs needed and to make the necessary repairs. Review of the maintenance logs revealed there was no documentation in the months of February 2015 to May 2015 of the request from Resident #45 to have his wheel chair repaired. The administrator stated Resident #45's request should have been documented on the maintenance log.<br><br>During an interview with the maintenance director on 05/21/2015 at 3:46 PM, he stated that he started employment about a month ago. The maintenance director stated that when he started employment he rounded to identify wheel chairs in need of repair, but that he missed identifying the wheel chair for Resident #45. The maintenance director stated that wheel chair repairs were completed about two weeks prior, but the wheel chair for Resident #45 did not get repaired at that time, he stated it was missed. The maintenance director confirmed that the wheel chair for Resident #45 needed to be repaired. | F 253 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the | F 278 | | 6/12/15 |

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| F 278 | Continued From page 6<br>assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set accurately to reflect hospice care for 1 of 1 resident reviewed for hospice care (Resident #53).<br>The findings included:<br>Review of the medical record revealed Resident #53 was admitted on 05/25/11 with diagnoses including dementia, failure to thrive, seizures, diabetes mellitus, and cerebrovascular accident (CVA).<br>Further review of the medical record revealed hospice services were initiated on 03/17/15 due to vascular dementia and failure to thrive.<br>Review of a significant change Minimum Data Set (MDS) dated 03/19/15 revealed the section titled | F 278 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion 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 law.<br><br>It is our facility policy that the assessment must accurately reflect the resident¿s status. | |

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| F 278 | Continued From page 7<br>"Special Treatments, Procedures, and Programs" was checked for respite care. The Care Area Assessment (CAA) Summary for feeding tube completed on 03/25/15 stated Resident #53 had been transferred to hospice services due to late effects of a CVA and advanced dementia.<br>An interview was conducted with the MDS Nurse on 05/21/15 at 4:01 PM. The MDS Nurse reviewed Resident #53's significant change MDS dated 03/19/15 and stated a travel MDS Nurse had completed the MDS. The MDS Nurse confirmed hospice care should have been checked on the significant change MDS instead of respite care and thought this was a data entry error.<br>During an interview on 05/21/15 at 4:35 PM the Administrator indicated it was his expectation for the MDS to accurately reflect resident information and should be coded correctly before it was transmitted. | F 278 | 1.Corrective action was accomplished for the alleged deficient practice by the Resident Care Management Director completing a modification to correct the keying error to the MDS with ARD 3/19/15 for Resident #53 to accurately reflect Hospice Services as provided. This modification was completed 5-21-15.<br><br>2.All residents receiving Hospice Services have the potential to be affected by this alleged deficient practice. The Resident Care Management Director and MDS Coordinator conducted an audit of the most recent MDS completed for residents currently receiving Hospice Services to ensure accurate documentation of these services was accurately reflected on the MDS. This audit was completed by 5-22-15.<br><br>3.The Resident Care Management Director has re-educated the MDS Coordinator regarding accurate completion of the MDS to reflect Hospice Services as provided. This education was completed by 5-22-2015. The Resident Care Management Director will randomly audit 2 residents with Hospice Services weekly for twelve weeks to ensure accurate completion of the MDs to reflect Hospice Services as provided. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Resident Care | |

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| F 278 | Continued From page 8 | F 278 | Management Director for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 5-22-2015. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to develop a care plan for a pressure ulcer for 1 of 5 residents reviewed for pressure ulcers (Resident #26).<br>The findings included:<br>Resident #26 was admitted to the facility on | F 279 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion | 6/12/15 |

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| F 279 | Continued From page 9<br>11/13/14 with diagnoses of a stage 2 pressure ulcer to the sacrum. The admission Minimum Data Set (MDS) dated 11/20/14 revealed Resident #26 had moderately impaired cognition. The MDS further revealed Resident #26 had one Stage 2 pressure ulcer upon admission to the facility and was at risk for developing pressure ulcers.<br>The Care Area Assessment (CAA) Summary dated 12/03/14 revealed Resident #26 had a stage 2 pressure ulcer. The summary stated the facility would assist with toileting as needed in order to decrease incontinent episodes and maintain skin integrity. The summary stated pressure ulcer would proceed to care plan.<br>An interview was conducted on 05/21/15 at 4:34 PM with the MDS Nurse. She stated if a resident had a stage 2 pressure ulcer that was documented on the MDS and the CAA summary stated pressure ulcer should proceed to care plan a care plan should have been developed for pressure ulcers for Resident #26. | F 279 | 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 law.<br><br>It is our facility policy to use the result of the assessment to develop, review and revise the resident¿s comprehensive plan of care that includes measurable objectives and timetables to meet a resident¿s medical, nursing and mental and psychosocial needs that identified in the comprehensive assessment.<br><br>1.Resident #26 expired in the facility on 12//10/14.<br><br>2.All residents with pressure ulcers have the potential to be affected by this alleged deficient practice. The Resident Care Management Director and MDS Coordinator conducted an audit of care plans for residents with pressure ulcers to validate these residents have a pressure ulcer care plan in place. Audit completed on 6-5-2015.<br><br>3.The Resident Care Management Director has re-educated the Administrative Nursing Staff and the MDS Coordinator regarding developing care plans to address pressure ulcers. This education will be completed by 6-15-15. The Resident Care Management Director or MDS Coordinator will randomly audit 5 residents with pressure ulcers weekly for twelve weeks to validate these residents have a care plan in place to address | |

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| F 279 | Continued From page 10 | F 279 | pressure ulcers. Opportunities will be corrected as identified.<br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Resident Care Management Director for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 6/15/15. | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and resident and staff interviews the facility failed to provide nail care for 2 of 9 residents reviewed for activities of daily living (Resident #42, #8).<br>The findings included:<br>1. Resident #42 was admitted to the facility on 06/06/13 with diagnoses of hypertension and chronic kidney disease. The quarterly Minimum Data Set (MDS) dated 01/19/15 revealed Resident #42 had moderately impaired cognition. The MDS further revealed Resident #42 required extensive assistance with personal hygiene, toileting and bathing.<br>Review of Resident #42's care plan dated 01/05/15 revealed she needed extensive | F 312 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion 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 law.<br><br>It is our facility policy that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and | 6/12/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

| (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 |
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| F 312 | Continued From page 11<br>assistance with most activities of daily living.<br>Observations made on 05/18/15 at 3:45 PM, 05/20/15 at 8:37 AM, 05/21/15 at 10:12 AM and 05/22/15 at 8:45 AM revealed Resident #42's fingernails to be ½ to ¾ inch long with brown matter under her fingernails and chipped pink nail polish on both hands.<br>An interview was conducted on 05/20/15 at 12:00 PM with nurse aide (NA) #1. She stated she helped Resident #42 get out of bed and dressed today and did not notice her fingernails being too long with brown matter under the fingernails and chipped nail polish on both hands. She stated nail care should be done on the resident's shower days and as often as needed.<br>An interview was conducted on 05/22/15 at 8:45 AM with Resident #42. She stated her fingernails were too long and they were getting caught on her bedcovers. She stated she would like to have her fingernails trimmed and cleaned.<br>An interview conducted on 05/22/15 at 8:55 AM with NA #6 revealed nail care was provided for residents on their shower days and cleaned as needed.<br>An interview was conducted on 05/22/15 at 9:02 AM with the Director of Nursing (DON). She stated it was her expectation that fingernails were cleaned and trimmed on shower days and as needed.<br>2. Resident #8 was admitted to the facility on 05/04/06 with diagnoses of cerebral vascular accident and non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 02/27/15 revealed Resident #8 was severely cognitively impaired. The MDS further revealed Resident #8 required extensive assistance with personal hygiene, toileting and bathing.<br>Review of Resident #8's care plan dated 05/19/15 revealed she needed extensive assistance with | F 312 | personal and oral hygiene.<br><br>1.Corrective action was accomplished for the alleged deficient practice by the Unit Manager ensuring nail care was provided to Resident #42 and Resident #8 according to their preferences by 5-22-15.<br><br>2.All residents requiring assistance with nail care have the potential to be affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing or Unit Manager completed an audit of residents requiring assistance with nail care to ensure nail care was completed as required according to the Resident¿s preferences. This audit was completed by 6-12-15.<br><br>3.The Nursing staff were re-educated by the Director of Nursing or Staff Development Coordinator regarding the completion of nail care according to the Resident¿s preferences. This education was completed by 6-12-15. The Director of Nursing, Assistant Director of Nursing or Unit Manager will randomly observe five residents requiring assistance with nail care, weekly for twelve weeks to validate nail care is provided according to the resident¿s preferences. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month. The QAPI committee will evaluate | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 312 | Continued From page 12<br>most activities of daily living.<br>Observations made on 05/18/15 at 1:05 PM and 05/20/15 at 8:36 AM revealed Resident #8's fingernails to be ¾ to 1 inch long with brown matter under fingernails on both hands.<br>An interview was conducted on 05/19/15 at 10:12 AM with Resident #8's family member. She stated she had to ask staff to trim and clean Resident #8's fingernails weekly. She further stated Resident #8 had brown/black matter under her fingernails at almost every weekly visit.<br>An interview was conducted with nurse aide (NA) #1 on 05/20/15 at 12:00 PM. She stated she had not noticed Resident #8's fingernails being too long or having brown matter underneath the nails. NA #1 stated nail care should be provided on shower days and as needed.<br>An interview conducted on 05/22/15 at 8:55 AM with NA #6 revealed nail care was provided for residents on their shower days and cleaned as needed.<br>An interview was conducted on 05/22/15 at 9:02 AM with the Director of Nursing (DON). She stated it was her expectation that fingernails were cleaned and trimmed on shower days and as needed. | F 312 | the effectiveness and amend as needed.<br>Date of compliance is 6/12/15. | |
| F 325 SS=D | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when there is a nutritional problem. | F 325 | | 6/12/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

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| F 325 | Continued From page 13<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident, staff and nurse practitioner interviews, and record review, the facility failed to monitor weight loss for 1 of 4 sampled residents with weight loss (Resident #91).<br><br>The findings included:<br><br>Resident #91 was readmitted to the facility on 01/12/15 with diagnoses which included chronic obstructive pulmonary disease, depression and diabetes mellitus.<br><br>Review of Resident #91's 5 day scheduled Minimum Data Set (MDS) dated 01/19/15 revealed an assessment of moderately impaired cognition. Resident #91 required the physical assistance of one person and supervision with meals.<br><br>Review of Resident #91's medical nutritional therapy assessment dated 01/19/15 revealed an average intake of 77% of meals with a readmission weight of 130 pounds. The medical nutritional therapy assessment recommended addition of a nutritional supplement related to an albumin level of 2.7 grams per deciliter on 01/16/15 and to monitor weight pattern. (Albumin levels measure the amount of protein in the blood; a low albumin level may indicate malnutrition.)<br><br>Review of a nurse practitioner's order dated | F 325 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion 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 law.<br><br>It is our facility policy that we must ensure that a resident 1) maintains acceptable parameters of nutritional status, sush as body weight and protein levels, unless the resident¿s clinical condition demonstrates that this is not possible and 2) receives a therapeutic diet when there is a nutritional problem.<br><br>1.Corrective action was accomplished for the alleged deficient practice by the Director of Nursing implementing weekly weights for Resident #91 on 5-21-15, according to the care plan.<br><br>2.All residents have the potential to be affected by this alleged deficient practice. The Registered Dietician and Director of Nursing conducted an audit of all current residents to validate weekly weights were conducted according the care plan. This audit was completed by 6-12-15. | |

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| F 325 | Continued From page 14<br>01/19/15 revealed direction to give 120 cubic centimeters of a nutritional supplement daily to Resident #91.<br><br>Review of Resident #91's care plan dated 1/19/15 and updated on 02/16/15 revealed a potential for weight loss. Interventions included provision of preferred foods, nutritional supplement and weekly weight measurements.<br><br>Review of Resident #91's weekly weights measurements revealed the following: 02/04/15: 132 pounds (lbs.); 02/12/15: 131 lbs.; 02/16/15: 130 lbs.; and on 02/24/15: 128 lbs. (Resident #91 lost 4 lbs., a 3% weight loss.)<br><br>Review of a nutrition services progress note dated 02/24/15 revealed Resident #91's meal intake averaged 61% and recommended continuance of current plan of care and weight monitoring.<br><br>Review of the weight flow sheet revealed Resident #91 weighed 128.5 lbs. on 03/02/15. There was no documentation of weekly weight measurements during March 2015.<br><br>Review of a nutritional progress note dated 03/04/15, written by a nutritionist, revealed documentation of a weight of 128.5 lbs. with a 54% average intake of meals. The nutritionist recommended to continue the current plan of care.<br><br>Review of Resident #91's quarterly Minimum Data Set (MDS) dated 03/17/15 revealed an assessment of intact cognition. The MDS indicated Resident #91 ate independently after meal set up. | F 325 | 3.The Unit Managers and the Registered Dietician were re-educated by the Director of Nursing by 6-12-15, regarding the completion of weekly weights according to the care plan. The Registered Dietician or Director of Nursing will conduct an audit of five residents, weekly for twelve weeks, to validate the completion of weekly weights according to the care plan. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 6/12/15. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 325 | Continued From page 15 | F 325 | | |

Review of Resident #91's care plan updated on 03/19/15 revealed documentation to continue the plan of care which included weekly weight monitoring.

Review of the weight flow sheet revealed Resident #91 weighed 126.5 lbs. (a loss of 2 lbs., a 4.1% weight loss since 02/04/15) on 04/08/15. There was no documentation of weekly weight measurements during April 2015.

Review of a nurse practitioner (NP) note dated 04/28/15 revealed Resident #91 approached the NP and complained of a poor appetite. The NP ordered Remeron 7.5 milligrams to be administered at bedtime for anorexia and depression.

Review of the weight flow sheet revealed Resident #91 weighed 122.4 lbs. (a loss of 4.1 lbs., a 7.2% weight loss since 02/04/15) on 05/06/15. There was no documentation of weekly weight measurements during May 2015.

Observation on 05/20/15 at 8:48 AM and 9:39 AM revealed Resident #91 slept. Resident #91's uneaten, covered breakfast tray remained at the bedside. Nurse Aide #9 removed the uneaten breakfast tray at 9:43 AM.

Observation on 05/20/15 at 1:22 PM revealed Resident #91 independently consumed 50 % of the lunch meal.

Interview with Resident #91 on 05/20/15 at 4:09 PM revealed the facility provided foods she enjoyed but her appetite was poor. Resident #91 reported she received snacks during the day but

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
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| F 325 | Continued From page 16 | F 325 | | |

continued to lose weight. Resident #91 explained she preferred to sleep late and usually did not eat breakfast. Resident #91 explained she spoke to the NP regarding her appetite and hoped the new medication worked.

Interview with restorative aide (RA) #1 on 05/21/15 at 9:25 AM revealed she received a list of residents who required weekly weights from the dietary manager every week. RA #1 explained Resident #91 was not on the list for weekly weight measurements. RA #1 reported the Director of Nursing (DON) received the monthly and weekly weight measurements after completion.

Interview with the dietary manager (DM) on 05/21/15 at 9:42 AM revealed the consultant Registered Dietician (RD) determined which residents required weekly weight measurements. The DM explained he gave a list each week to the restorative aides who then gave the weight measurements to the DON. The DM was unable to provide the date the RD discontinued the weekly weight measurements for Resident #91. The DM reported either the RD or the nutritionist developed and revised the nutritional care plan. The DM provided a weight sheet which listed Resident #91's May 2015 weight as 123.1 lbs. instead of the 122.4 lbs. recorded on the weight flow sheet. The DM reported the 123.1 lbs. was the most recent May weight according to the dietary record (a 6.7% weight loss since 02/04/15).

Interview with the dietary district manager on 05/21/15 at 9:57 AM revealed the facility's consultant RD was not available for interview. The dietary district manager reported the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

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|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

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|---|---|---|---|---|
| F 325 | Continued From page 17<br>nutritionist reviewed Resident #91's care plan. The dietary district manager explained Resident #91's weight loss did not reach 7.5% which did not trigger a weight review by the RD.<br><br>Telephone interview with the nutritionist on 05/21/15 at 10:19 AM revealed she reviewed Resident #91's care plan and the weekly weight measurements should continue.<br><br>Interview with the NP on 05/21/15 at 10:59 AM revealed Resident #91 asked her for assistance to gain weight and complained of a poor appetite. The NP explained Resident #91's weights should be monitored in addition to recorded meal intake.<br><br>Interview with the DON on 05/21/15 at 11:21 AM revealed she received residents' weight measurements from the restorative aides weekly. The DON reported nursing and dietary shared responsibility for monitoring weights. The DON reported Resident #91's weight should be monitored weekly as written on the care plan.<br><br>On 05/21/15 at 4:28 PM, RA #1 weighed Resident #91. RA #1 reported Resident #91 weighed 121.9 lbs. (a 7.65% weight loss since 02/04/15). | F 325 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | 6/12/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

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|---|---|
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| F 371 | Continued From page 18<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to clean and sanitize ice scoops and date thawed nutritional supplement shakes intended for resident consumption in 2 of 2 nutrition pantries.<br><br>The findings included:<br><br>1. a. Observations of the B wing nutrition pantry on 05/18/15 at 10:56 AM revealed a clear plastic ice scoop holder with a clear plastic ice scoop inside on the counter adjacent to the ice machine. The top of the ice scoop rested in 1/4 of an inch of water and a green film was noted on the bottom of the holder extending up 1/4 of an inch on all four sides of the container. There were no drainage holes noted on the ice scoop holder. The green film wiped off the inside of the ice scoop holder on to a paper towel.<br><br>Observations of the B wing nutrition pantry on 05/19/15 at 8:42 AM revealed a clear plastic ice scoop holder with a clear plastic ice scoop inside on the counter adjacent to the ice machine. The top of the ice scoop rested in 1/4 of and inch of water and a green film was noted on the bottom of the holder extending up 1/4 of an inch on all four sides of the container. There were no drainage holes noted on the ice scoop holder.<br><br>An interview with Housekeeper #1 on 05/19/15 at 8:38 AM revealed cleaning the nutrition pantry included: wiping the counters, emptying the trash, filling the paper towels, and sweeping and | F 371 | This plan of correction is the center¿s credible allegation of compliance. 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 conclusion 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 law.<br><br>It is our facility policy to 1) procure food from sources approved or considered satisfactory by federal, state or local authorities and 2) store, prepare, distribute and serve food under sanitary conditions.<br><br>1.Corrective action was accomplished for the alleged deficient practice by the Dietary Manager cleaning and sanitizing the ice scoops from both pantries on 5-19-15 and immediately discarding the undated nutritional supplements identified on 5-19-15.<br><br>2.All residents have the potential to be affected by this alleged deficient practice. The Dietary Manager clean and sanitized all ice scoops on 5-22-15 and audited all nutritional supplements for appropriate thawing and labeling on 5-22-15.<br><br>3.The Dietary Manager will re-educate all | |

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|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

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|---|---|---|---|---|
| F 371 | Continued From page 19<br>mopping floor.<br><br>An interview with Housekeeper #2 on 05/19/15 at 8:45 AM revealed cleaning the nutrition pantry included: wiping down the counter, wiping down the refrigerator, cleaning up spills, and sweeping and mopping the floor.<br><br>An interview was conducted with the Dietary Manager (DM) in the B wing nutrition pantry on 05/19/15 at 9:03 AM. The DM observed the ice scoop and holder and confirmed they needed to be cleaned and sanitized. The interview further revealed the ice scoop and holder were not on the kitchen's cleaning schedule and he was not sure who was responsible for maintaining the ice scoop and holder.<br><br>b. Observations of the A wing nutrition pantry on 05/19/15 at 8:34 AM revealed a clear plastic ice scoop holder with a clear plastic ice scoop and a white plastic scoop inside on the counter adjacent to the ice machine. The top of clear plastic scoop rested in a light brown crusty residue at the base of the holder. The residue could be scraped off the base of the holder using a finger nail.<br><br>An interview with Housekeeper #1 on 05/19/15 at 8:38 AM revealed cleaning the nutrition pantry included: wiping the counters, emptying the trash, filling the paper towels, and sweeping and mopping floor.<br><br>An interview with Housekeeper #2 on 05/19/15 at 8:45 AM revealed cleaning the nutrition pantry included: wiping down the counter, wiping down the refrigerator, cleaning up spills, and sweeping and mopping the floor. | F 371 | dietary staff on the procedures, frequency and documentation of cleaning specifically related to ice scoops and storage containers by 6-11-15. The Dietary Manager will review the cleaning documentation log and visually validate cleaning of the ice scoops two times per week for six weeks, then weekly for six weeks. The Dietary Manager will review all thawed nutritional supplements for dating and labeling 3 times per week for 6 weeks then weekly for 6 weeks. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 4/15/15. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BRIAN CENTER HEALTH & REHAB/CH | 5939 REDDMAN ROAD CHARLOTTE, NC 28212 |

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|---|---|---|---|---|
| F 371 | Continued From page 20 | F 371 | | |

An interview was conducted with the Dietary Manager (DM) in the A wing nutrition pantry on 05/19/15 at 9:10 AM. The DM observed the ice scoop and holder and confirmed they needed to be cleaned and sanitized. The interview further revealed the ice scoop and holder were not on the kitchen's cleaning schedule and he was not sure who was responsible for maintaining the ice scoop and holder.

2. a. Observations of the B wing nutrition pantry refrigerator on 05/18/15 at 10:56 AM revealed 4 vanilla and 4 strawberry thawed nutritional supplement shakes. The 4 ounce cartons were not dated to indicate when they had been the had been thawed.

Observations of the B wing nutrition pantry refrigerator on 05/19/15 at 8:42 AM revealed 6 vanilla and 8 strawberry thawed nutritional supplement shakes. The 4 ounce cartons were not dated to indicate when they had been thawed.

Review of manufacturer's recommendations revealed the nutritional supplement shakes had a shelf life of 14 days after thawing when stored refrigerated.

An interview was conducted with the Dietary Manager (DM) 05/19/15 at 8:57 AM. The DM stated the dietary aides were instructed to stock the refrigerator with 5 vanilla and 5 strawberry every morning and to maintain 5 of each at all times. The DM further stated the nutritional supplement shakes were good for 14 days once thawed and the cartons should be dated with a thaw date so the dietary aides could monitor the shakes and discard after 14 days according to the manufacturer's recommendations.

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| (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 |
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| F 371 | Continued From page 21<br><br>During a follow up interview on 05/19/15 at 9:03 AM the DM observed the 6 vanilla and 8 strawberry nutritional supplement shakes in the B wing refrigerator and stated he did not know when they had been thawed or when they should be discarded. The interview further revealed there was no system in place for dating the nutritional supplement shakes.<br><br>b. Observations of the B wing nutrition pantry refrigerator on 05/19/15 at 8:34 AM revealed 7 vanilla and 2 strawberry thawed nutritional supplement shakes. The 4 ounce cartons were not dated to indicate when they had been the had been thawed.<br><br>Review of manufacturer's recommendations revealed the nutritional supplement shakes had a shelf life of 14 days after thawing when stored refrigerated.<br><br>An interview was conducted with the Dietary Manager (DM) 05/19/15 at 8:57 AM. The DM stated the dietary aides were instructed to stock the refrigerator with 5 vanilla and 5 strawberry every morning and to maintain 5 of each at all times. The DM further stated the nutritional supplement shakes were good for 14 days once thawed and the cartons should be dated with a thaw date so the dietary aides could monitor the shakes and discard after 14 days according to the manufacturer's recommendations.<br><br>During a follow up interview on 05/19/15 at 9:10 AM the DM observed the 7 vanilla and 2 strawberry nutritional supplement shakes in the B wing refrigerator and stated he did not know when they had been thawed or when they should | F 371 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345243 | A. BUILDING _____ B. WING _____ | C 05/22/2015 |

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| F 371 | Continued From page 22<br>be discarded. The interview further revealed there was no system in place for dating the nutritional supplement shakes. | F 371 | | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these | F 520 | This plan of correction is the center¿s credible allegation of compliance. Preparation and/ or execution of this plan of correction does not constitute | 6/12/15 |

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| F 520 | Continued From page 23<br>interventions that the committee put into place in January 2014. This was for two deficiencies that were originally cited in December 2013 on a recertification survey. The deficiencies were in the areas of choices and meeting nutritional needs for residents. The continued failure of the facility during the federal survey of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br>The findings included:<br>This tag is cross referred to:<br>1. F 242: Choices: Based on record review and resident and staff interviews the facility failed to honor a resident's preference regarding frequency of showers per week for 1 of 4 residents reviewed for choices (Resident #182).<br><br>The facility was originally cited for F242 during the December 5, 2013 recertification survey for failing to honor resident's choices for type and frequency of baths.<br><br>2. F325: Nutrition: Based on observation, resident, staff and nurse practitioner interviews, and record review, the facility failed to monitor weight loss for 1 of 4 sampled residents with weight loss (Resident #91).<br><br>The facility was originally cited for F325 during the December 5, 2013 recertification survey for failing to provide a meal for a resident who was at risk for weight loss.<br><br>During an interview on 05/22/15 at 2:15 PM the Administrator stated he had been at the facility for one month and the Quality Assessment and Assurance (QAA) Committee met monthly. He stated he had implemented new items to monitor through the Quality Assurance Program and had | F 520 | admission or agreement by the provider of the truth of the facts alleged or conclusion 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 law.<br><br>It is our facility policy to maintain quality assessment and assurance committee consisting of the director of nursing services, Physician designated by the facility and at least three other members of the facility¿s staff.<br><br>1.Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 5-26-15 to discuss the outcomes of the annual and potential repeat citations of F242 related to resident choices and F325 related to nutrition. The Interdisciplinary Department Head Team reviewed the previous plan of correction related to resident choices and nutrition.<br><br>2.Residents requiring assistance with showers and residents requiring weekly weights have the potential to be affected by this alleged deficient practice. The Director of Nursing, Assistant Director of Nursing or Unit Manager have completed or reviewed Resident Preference Evaluation tool for residents requiring assistance with showers to ensure choices are being honored in regard to scheduled showers. This audit will be completed by 6-15-15. . The Registered Dietician and Director of Nursing | |

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| F 520 | Continued From page 24<br>many other to add to the list. The Administrator stated they have daily stand up meetings to discuss what issues needed to be monitored and reviewed through the QAA Committee. He further stated the facility had not corrected the recited deficiencies and they would be reviewed and corrected through the OAA Program. | F 520 | conducted an audit of all current residents to validate weekly weights were conducted according the care plan. This audit was completed by 6-15-15.<br><br>3.The Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F242 Resident Choices and F325 Nutrition. This education was completed by 6-15-15. The Administrator will hold a weekly Ad Hoc QAPI committee meeting to review F242 Resident Choices and F325 Nutrition to ensure all regulatory aspects are addressed and in compliance. Opportunities will be corrected as identified.<br><br>4.Measures to ensure that corrections are achieved & sustained include: The results of these weekly meetings will be submitted to the QAPI Committee by the Administrator for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 6/15/15. | |