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 09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and medical record review the facility failed to provide correct documentation of the use of a pressure relieving mattress for bed, pressure reducing device to chair, and turning/repositioning program on the Minimum Data Set (MDS) for 1 of	F 278	F278 SS=D This plan of correction is the center¿s credible allegation of compliance. Preparation and/or execution of this plan	10/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/15/2015

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.

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F 278	Continued From page 1 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 01/17/14 with diagnoses which included paraplegia, sepsis, pressure ulcer - stage IV, DM, neurogenic bladder, neurogenic bowel, pressure ulcer - low back, anemia, osteomyelitis - pelvis and personality disorder. The annual MDS for 07/22/15, noted Resident #3 was alert and oriented. Resident #3 required extensive assistance with bed mobility, transfers, dressing, toileting and limited assistance with personal hygiene. The following skin and ulcer treatments are not documented on this assessment: pressure reducing device for bed, pressure reducing device for chair, and turning/repositioning program. During an observation on 09/29/15 at 11:10 AM, Resident #3 was noted sitting up in his hospital bed on an air mattress giving himself a bed bath. Review of medical records indicate a physician's order for an air mattress to the bed due to sacral pressure ulcer was written on 1/8/14. On 3/8/14, a physician's order was written to replace the pressure reduction mattress or repair the one on the bed. No further medical orders regarding the air mattress were found per review through 09/29/15. The care plan developed for the annual review for 7/22/15 indicates that there was a pressure reducing mattress to the bed. During an observation on 09/29/15 at 2:40 PM, Resident #3 was noted to be sitting up on a cushion in his wheelchair seat while playing Bingo. When Resident #3 had completed this activity, he returned to his room. During an interview with Resident #3 on 09/29/15 at 3:35 PM, he was then asked what type of cushion was in the wheelchair. Resident #3 leaned to the left side of his wheelchair, showing me the cushion	F 278	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 law. 1. Corrective action was accomplished for the alleged deficient practice for Resident # 3 on 10/14/2015. The care plan was reviewed by the IDT at Risk meeting on 10/13/2015 and adjusted to meet his needs. The MDS was reviewed and modified with a correction submitted on 10/14/2015 by the Regional Care Management Director. 2. All residents with pressure ulcers have the potential to be affected by the alleged deficient practice. An audit of MDS section M for current residents with pressure ulcers was completed 10/14/2015 by the RCMD to ensure that data present is coded correctly on the MDS. 3. The MDS staff was re-educated by the DON on 10/12/2015 regarding coding on the MDS for section M to include all pressure relieving mattresses for the bed, pressure relieving devices/cushions for the chair, and turning/repositioning orders. The RCMD will audit MDS section M for all residents in their assessment period each week for 12 weeks. Audit records will be reviewed each week by the Risk	

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F 278	Continued From page 2 and stated it was a special air cushion because of all the sores he had on his butt. When Resident #3 was asked about how long he had this on his chair, he stated it had been over a year, but he wasn ' t sure how long it had been there. The care plan developed for the annual review for 7/22/15 indicated the presence of a pressure reduction device to chair or wheelchair. When Resident #3 was asked how long he had the air mattress had been present on his bed, he stated it had been over a year, but he wasn ' t sure how long it had been there either. Review of medical records indicate a physician's order to turn and reposition per facility protocol was written on 2/20/14. No further medical orders regarding turning and repositioning were found per review through 09/29/15. The care plan developed for the annual review of 7/22/15 indicated to turn and reposition while in bed frequently for comfort. On 09/29/15 at 4:02 PM, an interview was conducted with the Wound Care Nurse. She reviewed the Pressure Ulcer Record Documentation that she completed on 7/22/15. She acknowledged that there was no documentation of special interventions such as a specialized wheelchair cushion, a specialized bed or mattress, or a turning and repositioning program in her weekly documentation. She stated that she knew Resident #3 had both the air mattress and the special wheelchair cushion for over 5 months, because he had them both before she became the Wound Care Nurse which was 5 months ago. On 9/29/15 at 5:10 PM, an interview was conducted with the MDS Coordinator regarding MDS documentation. The MDS Coordinator was shown the MDS skin and ulcer treatment section. The MDS Coordinator was asked about the	F 278	committee. 4. Measures to ensure that corrections are reviewed and sustained include: weekly audits for 12 weeks by the MDS staff of section M for all residents in the current assessment period; review of the audits at the Risk committee meeting; and submission of audits by the DON to the QAPI committee for review. The QAPI committee will evaluate effectiveness and amend as needed. 5. Date of compliance is: 10/16/2015	

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F 278	Continued From page 3 documentation for the air mattress, wheelchair cushion, and turning and repositioning program. The MDS Coordinator verbally validated that these areas had been coded incorrectly by not checking they were currently being used for treatment. On 9/29/15 at 5:40 PM, an interview was conducted with the Director of Nursing (DON). The DON acknowledged her expectation that the MDS would contain accurate documentation.	F 278		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide podiatry services for 1 of 1 resident reviewed for podiatry services (Resident #5). The findings included: Resident #5 was admitted to the facility on 03/25/15 with diagnoses of renal failure and diabetes. The quarterly Minimum Data Set (MDS) dated 09/22/15 revealed Resident #5 was cognitively intact and required extensive	F 328	F328 SS=D 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 of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is	10/16/15

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F 328 Continued From page 4

assistance with personal hygiene and was dependent for bathing. The MDS further revealed Resident #5 had no behaviors of refusing care.
Review of the care plan dated 09/15/15 revealed Resident #5 required staff assistance for completion of activities of daily living (ADL) needs. The goal was for Resident #5 to have ADL needs identified and met with staff assistance while maintaining highest level of independent function possible. The interventions included gather and provide needed supplies, allow adequate time to complete tasks, praise all efforts, provide cueing with tasks as needed, refer to therapy as indicated and ensure effective pain management prior to ADL activities.
Review of the nurse's notes from 03/2015 through 09/29/15 revealed no refusal of care from Resident #5.
Review of the medical record revealed no documentation that Resident #5 had been seen by the Podiatrist.
An observation was made on 09/29/15 at 12:57 PM of Resident #5 propelling himself in his wheelchair with bare feet on the 100 hall. Resident #5 was observed to have ¼ to ½ inch long, thick, yellowish, jagged toenails.
An interview was conducted on 09/29/15 at 12:58 PM with Resident #5. He stated his toenails had not been trimmed since being admitted to the facility. He further stated his toenails needed to be trimmed because his shoes did not feel good due to his long toenails.
An interview was conducted with the 100/200 Hall Unit Manager on 09/29/15 at 3:44 PM. She stated staff were not responsible for trimming toenails. She stated all residents were referred to the Podiatrist for foot and toenail care and the nurse on the hall lets the Social Worker know when a resident needed to see the Podiatrist.

F 328

prepared and/or executed solely because it is required by the provisions of federal and state law.

1. Corrective action was accomplished for the alleged deficient practice for Resident #5 on 9/30/2015. Resident #5 toenails were trimmed by nursing staff. Resident is now wearing shoes and socks and is not offering complaints of pain. He has been placed on the podiatrist list for the next visit, which is 10/16/2015.

2. All residents have the potential to be affected by this alleged deficient practice. An audit of all resident toenails was completed by the Unit Managers on 10/13/2015. Any resident with toenails in need of care was placed on the podiatry list for the 10/16/2015 visit.

3. The Nursing staff was re-educated by the DON or Unit Managers regarding reporting to the charge nurses when a resident is in need of podiatry services for long or thick toenails. The charge nurses were re-educated to report all need for podiatry services to the Social Worker, to be placed on the schedule for the next visit. The nurses were re-educated to examine any reported long or thick toenails to determine if services are needed before the next podiatry date so that services may be obtained. Education was completed on 10/14/2015. A weekly check of 5 residents on each nursing unit will be conducted by the Unit Managers each week for 12 weeks to ensure toenails are in appropriate condition.

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F 328	Continued From page 5 An interview was conducted on 09/29/15 at 4:47 PM with the Director of Nursing (DON). She stated all residents see the Podiatrist unless they refuse. An interview was conducted on 09/29/15 at 4:59 PM with the Social Worker (SW). She stated the nurses give her a list of residents that need to be seen by the Podiatrist and she placed them on the list for the next visit. She stated Resident #5 was on the list to be seen by the Podiatrist 05/2015 and 07/2015 and the consult from the visit should have been in Resident #5's medical record. A follow up interview was conducted with the SW on 09/29/15 at 6:04 PM. She stated she was unable to find any documentation that Resident #5 had been seen by the Podiatrist and had called the Podiatrist office and they had no record of ever seeing Resident #5. The SW stated she did not know why Resident #5 had not been seen by the Podiatrist.	F 328	Residents will be referred for podiatry services as needed. 4. Measures to ensure that corrections are achieved and sustained include: A weekly check of 5 residents will be conducted on each nursing unit by the Unit Managers for 12 weeks to ensure toenails are in appropriate condition. The result of these weekly checks will be submitted monthly to the QAPI committee by the DON for review. The QAPI committee will evaluate the effectiveness and amend as needed. 5. Date of compliance is 10/16/2015	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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.	F 520		10/16/15

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F 520	Continued From page 6 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions put in place in June 2015 after the Recertification Survey. This was for one recited deficiency which was originally cited in June 2015 and subsequently recited in September 2015 on a complaint investigation. The repeated deficiency was in the area of resident assessment. The continued failure during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is crossed referred to: F278: Accuracy of Assessment. Based on observations, resident and staff interviews, and medical record review the facility failed to provide correct documentation of the use of a pressure relieving mattress for bed, pressure reducing device to chair, and turning/repositioning program on the Minimum Data Set (MDS) for 1 of 3	F 520	F520 SS=D 1. Corrective action was accomplished for the alleged deficient practice by the Administrator at the monthly QAPI meeting on 10/17/2015 to discuss the outcomes of the annual and potential repeat citations of F278 related to correct documentation on the MDS of the use of pressure relieving mattress for bed, pressure reducing device to chair, and turning/repositioning program for resident #3. The Interdisciplinary Department Team reviewed the previous plan of correction related to Hospice coding on the MDS. 2. All residents have the potential to be affected by the alleged deficient practice. An audit of MDS section M for all residents in the current assessment period was completed 10/14/2015 to ensure that data present is coded correctly on the MDS.	

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F 520	Continued From page 7 sampled residents (Resident #3). The facility was recited for F278 for failing to provide correct documentation for the use of a pressure relieving mattress, pressure relieving device to chair and a turning/repositioning program on the Minimum Data Set (MDS). F278 was originally cited during the recertification survey in June 2015 for failing to provide correct documentation of Hospice services on the MDS. An interview was conducted on 09/29/15 at 6:04 PM with the Administrator. He stated the Quality Assessment and Assurance Committee had monitored the coding for hospice only on the Minimum Data Set Assessments (MDS) and did not review the MDS for other coding problems. He stated they should have monitored the entire MDS for coding errors.	F 520	3. The MDS staff was re-educated by the DON on 10/12/2015 regarding coding on the MDS for section M to include all pressure relieving mattresses for the bed, pressure relieving devices/cushions for the chair, and turning/repositioning orders. MDS staff will audit all MDS section M for all residents in their assessment period each week for 12 weeks. Audit records will be reviewed each week by the Risk committee. 4. Measures to ensure that corrections are reviewed and sustained include: weekly audits for 12 weeks by the MDS staff of section M for all residents in the current assessment period; review of the audits at the Risk committee meeting; and submission of audits by the DON to the Qapi committee for review. The QAPI committee will evaluate effectiveness and amend as needed. 5. Date of compliance is: 10/17/2015	