STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/LEXI	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(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 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to make a call bell accessible to 3 (Residents #85, # 108, and # 153)) of 35 residents. Findings included: 1A.) Resident #85 was admitted to the facility on 9/29/15. A review of the 14 day assessment Minimum Data Set (MDS) revealed Resident #85 was slightly cognitively impaired, required extensive assistance with 2 or more people for all activities of daily living (ADLs) including bed mobility and transfers, was always incontinent of bladder (urine) and stool (bowel), and had a functional limitation related to (r/t) range of motion (ROM) which resulted from impairment of 1 upper and 1 lower extremity. Active diagnoses included aphasia (inability to speak), cerebrovascular accident (CVA), and hemiplegia/hemiparesis (paralysis). A review of the care plans dated 10/8/15 revealed care plans for: " communication impairment (can say yes or no and nod head yes or no and gives a ' thumbs up '), a potential for injury during transfers r/t weakness, gait (walk), balance, and right sided paralysis, ADLs, and falls. All care plans included measureable goals, and	F 246	F246 1- Residents #85, #108, and #153 had their call bell cords restored to a position accessible to the resident at the time of notification. 2- All residents who have the capabilities to utilize a call bell have the potential to be affected by the alleged deficient practice. A review of all residents with potential to be affected was conducted by the Director of Nursing and unit managers on 11/5/15 and appropriate corrective actions were taken. 3- Nursing staff was re-educated on facility policy regarding call bell placement and accessibility by the Director of Nursing and Unit Managers, completed 11/5/15.The Director of Nursing and or Unit Managers will conduct call bell audits 5 times a week x2 weeks, then 10 residents randomly every week x 1 month, then randomly every month x2months to ensure ongoing compliance.	12/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/20/2015

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F 246	Continued From page 1 interventions for each care plan included " place call light within reach " A review of the nursing notes included an admission note dated 9/29/15 and read, in part, " The resident (Resident #85) is alert and oriented to person and time. Noted splint to right hand/arm. Resident is unable to move right upper and right lower extremity r/t stroke. Resident is non-verbal-able to answer questions yes/no by motion of his head and give a thumbs up. " An observation on 11/4/15 at 9:50 AM of Resident #85 revealed the resident in bed with both upper side rails raised. The call bell was on the floor beside the right side of the bed. An interview was conducted with Resident #85 on 11/4/15 at 9:51 AM. Resident #85 indicated by shaking his head that he would be unable to reach the call bell because his right arm was paralyzed and was unable to call out for help. He also stated the call bell was usually on the floor. An interview on 11/4/15 at 10:10 AM with NA #1, usually assigned to the same hall where Resident #85 resided revealed call bells were used by residents when they needed help. She also stated the call bell was kept where the residents could reach them and staff checked ' periodically ' for call bell placement. She could not state why the call bells where on the floor. B.) On 11/4/15 at 2:00 PM, the call bell was observed on the floor under the left side of the bed of Resident #108. The resident was lying in bed with 2 quarter side rails raised. A review of the quarterly MDS dated 7/20/15 revealed the resident had no cognitive impairment. Resident #108 had no impairment of any upper or lower limbs, and was not steady without human assistance moving from a seated to a standing position. An interview was conducted with Resident #108	F 246	4- These measures are to ensure corrections are achieved and sustained. The director of nursing will report the results of these audits and observation during the Quality Assessment and Process Improvement meeting monthly x3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.	

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F 246	Continued From page 2	F 246		

on 11/4/15 at 2:05 PM and revealed he was unable to reach his call bell and was not able to call for help if needed. Resident #108 also stated the call bell was usually on the floor.
An interview was conducted on 11/4/15 at 11:10 AM with NA #2, who was usually assigned to the same hall where Resident #108 resided revealed residents used call bells to call for help. She also stated the facility used clips or hooks to keep the call bells from falling on the floor and it was the responsibility of every staff member to make sure the call bells were attached to the bed and within reach for the residents. She stated if the clips where missing the staff wrapped the call bell around the side rail and she could not state why the call bells were on the floor.
C.) On 11/5/15 at 10:05 AM, an observation was made of Resident #153. The resident was sitting in a wheelchair beside the bed. The call bell was observed on the floor beneath the bed. A review of the 14 day MDS assessment dated 10/29/15 revealed the resident had no cognitive impairment, the resident required extensive assistance for all ADLs except eating, had no functional impairment of any limb, and was not steady for transfers or walking without human assistance.
An interview was conducted with Resident #153 on 11/5/15 at 10:10 AM and she stated she called for help because she could not reach her call bell. She further stated she wanted her call bell placed where she could reach it if needed, but it was usually on the floor.
An interview with Nurse #1 (the unit manager assigned to the unit where Resident #153 resided) on 11/4/15 at 10:25 AM revealed every staff member was responsible to check for call bell placement and ensure residents were able to reach them. Nurse #1 further stated if a resident

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F 246	Continued From page 3 could not use his or her right arm the call bell should be on the left side, and never on the floor. She could not say why the call bells where on the floor. An interview was conducted with the director of nursing (DON) on 11/4/15 at 10:30 AM., The DON stated, " If a resident is able to use a call bell it should be within reach. If a resident is paralyzed on the right side I would expect the call bell to be on the left side. The call bell should not be on the floor. My expectation is for every staff member to make sure the call bell is reachable for all residents able to use them. " An interview with Nurse #2 on 11/5/15 at 10:10 AM revealed the facility used clips or hooks to secure the call bells to the bed. She stated, " If the clip or hook is missing we wrap the call bell cord around the side rail. The call bells should not be on the floor. " Nurse #2 was not to state why the call bells were on the floor.	F 246		
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	F 278		12/2/15

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F 278	Continued From page 4 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 record review and staff interviews, the facility failed to accurately code on the Minimum Data Set (MDS) assessments to reflect Preadmission Screening and Resident Review (PASRR) for 2 of 4 resident in the sample reviewed for PASRR II. (Resident #5 and #23). Findings included: 1.) Resident #5 was admitted on 6/9/10 with cumulative diagnoses which included: Depression, anxiety, dementia and bipolar disease. Review of the PASRR Determination notification form revealed that Resident #5 was determined to be a PASRR level II since 6/8/10 with an expiration date of 6/8/11. Resident #5 ' s PASRR was renewed on 4/2/13 with no expiration date. Review of Resident #5 ' s Admission Minimum Data Set (MDS) assessment dated 1/9/15 revealed Section A of the MDS was not coded to reflect PASRR determination. An interview with the facility ' s social worker on 11/5/15 at 10:16 AM indicated that the Letter B was continuous on the PASRR notification and	F 278	F278 1- Residents #5 and #23 have had their most recent Comprehensive MDS modified to reflect the level II PASRR by the Resident Care Director on 11-5-15. 2- All residents with level II PASRR have the potential to be affected by the alleged deficient practice. The resident Care Management Director will complete an audit of all residents with level II PARSS to validate the MDS assessment has been coded accurately to reflect the resident status. The audit was completed on 11-19-154 3- The District Care Management Director re-educated all MDS staff on the accurate completion of section A on 11/5/15. The Resident Care Management Director will randomly review 5 completed MDS weekly for 1 month then bi weekly	

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F 278	Continued From page 5 there was no need for renewal. An interview on 11/5/15 at 11:30 AM with the MDS Coordinator revealed that she thought that because he was coded as a B, the MDS Coordinator did not think he was a PASRR II. She continued that he had never been coded as PASRR II. She indicated she would make the corrections and modify the last comprehensive assessment. An interview on 11/5/15 at 11:45 AM with the administrator revealed that his expectation was that the MDS coding would be correct. 2. Resident #23 was admitted to the facility on 2/4/15 with diagnoses of schizophrenia, anxiety, depression and psychotic disorder. A record review of the PASRR Level II Determination Notification dated 5/6/15 revealed that the Nursing Facility Placement was appropriate. A review of the admission MDS dated 2/4/15 revealed Section A of the MDS was not coded to reflect PASRR II determination, An interview on 11/05/2015 at 10:16 AM with the facility ' s social worker indicated that the Letter B was continuous. There was no need for renewals. Resident #23 became PASARR II on 5/6/15 with the renewal. When Resident #23 came to the facility, the PASRR was level F and expired on 5/6/15. When renewal came in, it came back as PASARR B which was continuous. An interview on 11/5/15 at 11:30 AM with the MDS coordinator revealed she missed the	F 278	for 2 months to verify accurate completion. The results of the monitoring will be documented on the PASRR QA Audit Tool. Opportunities will be corrected by the Resident Care Director or MDS coordinator as identified during audits. 4- The measures put in place are to ensure corrections are achieved and sustained: the Resident care Management Director will report the results of these audits to the QAPI meeting monthly for 3 months then quarterly. The QAPI team will evaluate and make further recommendations as indicated.	

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F 278	Continued From page 6 coding. She was not aware Resident #23 was level 2 when she came in. She would send in corrections. An interview on 11/5/15 at 11:45 AM with the administrator revealed that his expectation was that the MDS coding would be correct.	F 278		