STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 12/11/2015

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BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide wheelchair legs rests for positioning according to the care plan for one of one sampled residents for positioning. Resident #20. The findings included: Resident #20 was admitted to the facility on 6/28/12 with diagnoses of dementia without behavior disturbance, history of a stroke, and hypertension. Review of the Occupational Therapy (OT) progress note dated 9/22/15 indicated Resident #20 was seated in a high back wheelchair with elevated leg rests. Resident #20 was discontinued from OT on 9/25/15 and education had been provided to staff on proper positioning in the wheelchair. The quarterly Minimum Data Set (MDS) dated 9/25/15 indicated Resident #20 had long and short term memory impairment, required extensive assistance of two staff for bed mobility, transfers and toileting. This MDS assessed the	F 309	Brian Center Salisbury acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of Quality of Care of residents. The Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted the week of December 7-11, 2015. Brian Center Salisbury□s response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Brian Center Salisbury reserves the right to refute any deficiency on this Statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F 309:	1/6/16

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

Electronically Signed | 01/06/2016

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F 309	Continued From page 1 resident with functional impairment in movement on one side of his body. The updated care plan of 9/25/15 included the resident required extensive assistance for completion of most activities of daily living. This care plan addressed a problem of short and long term memory impairment with staff to provide cues, reminders and redirection as needed. Review of the " Resident Care Specialist Assignment Sheet " dated 12/11/15 indicated Resident #20 ' s positioning needs included the use of a high back wheelchair with leg rests. Observations on 12/8/15 at 12:22 PM revealed Resident #20 was seated in a high back wheelchair, his legs were dangling from the wheelchair and did not touch the floor. The leg rests were not applied to the wheelchair to provide support for his feet and legs. Observations on 12/10/15 at 8:30 AM revealed Resident #20 was assisted by two staff members into his wheelchair. The leg rests were not applied. Resident #20 was wheeled into the dining room. Resident #20 remained in the dining room for breakfast, an activity and then lunch without the leg rests being applied to the wheelchair. Interview with nurse aide #1 on12/10/2015 at 12:23 PM revealed Resident #20 did not have leg rests applied to his wheelchair. Nurse aide #1 explained she was not aware he was to have them. Nurse aide #1 further explained she knew what the resident required by an assignment sheet. Review of the assignment sheet with	F 309	1. The leg rests were re-applied to Resident #20 wheelchair by the Charge Nurse on 12/11/2016 the Resident Care Specialist (RCS) was re-educated by the Director of Nursing on 12-14-15 regarding following the residents Care Plan for the application of adaptive equipment. 2.On 12-14-15 the Unit Managers and Director of Nursing reviewed current residents requiring the application of adaptive equipment to validate equipment is applied according to the care plan. 3. The Nursing Staff will be re-educated by Director of Nursing, Administrator or Unit Managers regarding the application of adaptive equipment according to the care plan. This education will be complete by 1-6-16. The Director of Nursing or Unit Managers will randomly audit 10 residents requiring adaptive equipment per week for 4 weeks then monthly for 2 months to ensure that the resident□s adaptive equipment is being placed according to the care plan. Opportunities will be corrected daily as identified by the DON or Unit Manager during these audits. 4.The Administrator and Director of Nursing will review data obtained from adaptive equipment audits and analyze the data and report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on	

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F 309	Continued From page 2 nurse aide #1 revealed no information about positioning of the resident in his wheelchair. Further interview revealed she was not aware of the Resident Care Specialist Assignment Sheet. Interview with the therapy coordinator on 12/10/2015 at 12:24PM confirmed Resident #20 was to have leg rests on his wheelchair. Further interview revealed the leg rests were provided upon discharge from OT. The therapy manager was not aware the leg rests were not being used and explained they might be in the room. Interview with the Director of Nursing on 12/11/2015 at 10:47 AM regarding the care plan for Resident #20, she would expect the care to be provided according to the care plan. The information for the aides was on the Resident Care Specialist Assignment sheet. Further interview revealed nurse aide #1 would have received in-service during training to get the sheets from the book which was kept at the desk.	F 309	identified outcomes to ensure continued compliance.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews the facility failed to secure a full oxygen	F 323	F323:	1/6/16

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F 323	Continued From page 3 tank in 1 of 40 rooms observed (Room 124). The findings included: A review of the facility ' s policy and procedure, " Storage Area Safety " dated June 2007 revealed in part: Paragraph #8- Oxygen Storage C. Secure all tanks. An observation on 12/7/15 at 3:09 PM during day 1 of the survey revealed a full oxygen tank not secured sitting on the dresser between two closets in room 124. On 12/10/15 at 5:20 AM a second observation revealed a full oxygen tank not secured sitting on the dresser between two closets in room 124. An observation on 12/11/15 at 9:30 AM on day 5 of the survey revealed a full oxygen tank not secured sitting on the dresser between two closets in room 124. During an interview with both residents in room 124 on 12/11/15 at 9:35 AM revealed that they do not use oxygen tanks and they do not know how long the oxygen tank have been sitting on the dresser. An interview and observation with Nurse #2 on 12/11/15 at 9:40 AM revealed that the oxygen tank in room 124 should not be left that way and the tank should be secured. When the oxygen tanks are needed or returned the oxygen tanks go to the oxygen closet located on the 300 hall where they are secured. Nurse #2 removed the oxygen tank from the dresser. During an interview with the Director of Nurses on 12/11/15 at 11:30 AM indicated that her expectations were that oxygen tanks were to be secure or in a holder at all times.	F 323	1. The oxygen e-cylinder was immediately removed from Room 124 by the charge nurse and stored in the appropriate area/container on 12/11/15. 2. The Unit Managers and Director of Nursing audited current resident rooms for other oxygen e-cylinders stored and secured incorrectly on 12/11/15. 3. The facility staff will be re-educated by Director of Nursing,Administrator, and Unit Managers on appropriately storing and securing oxygen e-cylinders. The education will be completed by 1-6-16. The Interdisciplinary Team will randomly audit 10 resident□s receiving oxygen weekly for 4 weeks then monthly for 2 months to validate appropriate securing and storage of oxygen e-cylinders. Opportunities will be corrected daily as identified by the Interdisciplinary team. 4. The Administrator and Director of Nursing will review data obtained from the storage of e-cylinder audits and analyze the data and Report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan and will add interventions based on identified outcomes to ensure continued compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		1/6/16

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F 441	Continued From page 4 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 5 Based on observations, resident and staff interviews and record reviews the facility failed to maintain isolation precautions for two of two sampled residents on isolation. Residents #147 and 165. The findings included: 1. Resident # 147 admitted to the facility on 12/12/14 with recent diagnosis of Clostridium Difficile (C diff) infection. Review of the Minimum Data Set (MDS) a quarterly, dated 9/2/15 indicated Resident #147 had long and short term memory impairment, required extensive to total care for all activities of daily living (ADLs) and she was always incontinent of bowel and bladder. Review of the care plan dated 9/2/15 for problems of ADL deficits that required extensive to total care by staff for completion. Review of a telephone order dated 11/27/15 for C diff specimen to be obtained due to diarrhea. Review of a telephone order dated 12/1/15 to administer Flagyl (antibiotic) 250 milligrams, 1 per feeding tube three times a day for days, then repeat specimen. Enteric isolation precautions to be used by staff. Review of the lab results dated 11/27/15 for C. diff toxin were "detected." The Care Plan updated on 12/1/15 included a problem of actual infection related to positive C-Diff. The aproaches included use of contact/enteric precautions by staff. Observations on 12/7/15 at 12:47 PM revealed an	F 441	F441: 1. Resident #165 was immediately placed on enteric precautious on 12-11-15 by the Director of Nursing, pending the results of the stool culture. Resident #147 and #165 experienced no adverse reactions. 2. On 12-11-15 the Director of Nursing reviewed other residents with pending culture results to ensure no further isolation needs were identified. 3. Licensed Nurse□s will be re-educated by the Director of Nursing and Unit Managers on the timely implementation of isolation precautions and isolation precaution procedures to prevent infection. This education will be completed by 1-6-16. The Unit Managers and Director of Nursing will review MD orders for culture to validate the appropriate implementation of isolation 3 times per week for x 4 weeks and then weekly for 8 weeks to ensure that residents with pending culture results are being placed on isolation precautions timely and following the isolation procedures as required. Opportunities will be corrected daily as identified by the Unit Manager and Director of Nursing. Facility team was educated on proper hand washing procedures related to isolation precautions. Infection Control Hand washing audits will be conducted by the Director of Nursing and Unit managers 3 times per week for 4 weeks and then weekly for 8 weeks.	

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F 441	Continued From page 6 aide #2 took a lunch tray into room 108 for Resident #147 ' s roommate. Aide #3 took the tray to the door of the room, stopped and returned the tray to the cart. Aide #3 returned with the tray on 12/7/15 at 12:48 PM. Aide #3 entered the room and did not wear gown/gloves. She was observed setting up Resident #147 ' s roommate ' s tray and exited the room without washing her hands. The signage on the door read in part Interview on 12/11/15 at 12:04 PM with aide #2, who worked with aide #3 on 12/7/15, revealed she would put on a gown and gloves prior to going in a room with enteric contact precautions. She further explained when leaving the room, she would remove the gown and gloves and wash her hands. Aide #3 was not available for interview. Interview with the Director of Nursing on 12/11/15 at 9:01 AM revealed she would expect aides, when passing trays to residents on enteric contact precautions, to wash their hands before leaving the room. She further explained if the aide did not provide direct care to the resident, the gown and gloves would not need to be worn. Further interview revealed the aide should have washed her hands before leaving the room. 2. Resident # 165 was admitted to the facility on 11/20/15 with diagnoses of infected surgical wound, severe sepsis, MDRO (multiple drug resistant organism), gangrene of foot, chronic osteomyelitis of right foot and diabetes. The Minimum Data Set (MDS) dated 11/26/15 indicated Resident #165 was cognitively intact,	F 441	4. The Administrator and Director of Nursing will review data Obtained from Infection Control and Isolation precaution list audits and analyze the data and report patterns/trends to the QAPI Committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on Identified outcomes to ensure continued compliance.	

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F 441	Continued From page 7	F 441		

required limited supervision for toileting and was continent of bowel and bladder.

A care plan was in process of being developed.

According to the hospital discharge summary dated 11/20/15, Resident #165 had received antibiotics in the hospital prior to discharge. Current physician orders did not include continued antibiotic therapy.

Review of a telephone order dated 12/4/15 revealed a stool culture for Clostridium difficile (C.diff) had been ordered. Flagyl (antibiotic) 250 milligrams (mg) three times a day for one week had been ordered.

Interview with Unit Nurse Manager #1 on 12/08/15 at 2:40 PM revealed Resident #165 should have been placed on contact isolation until the lab results were received. The Unit Nurse Manager #1 explained she was not aware he had an order for stool culture to test for C.diff. Further explanation provided included the stool culture and isolation precautions had not been done. During the interview, Unit Nurse Manager #1 explained she had spoken with the resident and he expressed he was still having loose stools. Resident #165 indicated the stools were brown, watery and frequent. During the interview, Unit Nurse Manager #1 was asked why isolation was not started, and she stated she did not know.

Interview with DON on 12/11/2015 9:01:10 AM revealed she would expect the nurse to place the resident on enteric contact precaution when the order was obtained for the stool culture.

Interview with nurse #3 on 12/11/15 at 9:10 AM

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F 441	Continued From page 8 revealed she had obtained the order for the stool culture late on Friday (12/4/15) due to the resident complaining of diarrhea. The necessary supplies to obtain the stool for culture had been provided to the resident. Further interview revealed nurse #3 had explained the procedure to the resident and why it was needed. Nurse #3 explained she was not aware she was expected to initiate contact precautions while awaiting for the results for C. Diff. Review of the lab results on 12/11/15 of a stool culture for C. Diff for Resident #165 were negative.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to document the bruit and thrill of the AV (arteriovenous) shunt and the condition of the access site for 1 of 1 dialysis	F 514	F514: 1. On 12-11-15 the Director of Nursing obtained a clarification order from the	1/6/16

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F 514	Continued From page 9 resident (Resident #105). Findings included: Resident #105 was admitted to the facility on 1/14/13. The resident's diagnoses included: Stage IV chronic kidney disease, diabetes mellitus, and congestive heart failure. The Significant Change MDS (Minimum Data Set) dated 10/19/15 indicated Resident #105 was cognitively intact; always incontinent of bowel and occasionally incontinent of bladder; and had a diagnosis of ESRD (end-stage renal disease). Review of the updated Care Plan dated 11/2/15 revealed the resident required hemodialysis related to renal failure. Approaches to the Care Plan included: after returning from dialysis, check for thrill and bruit per physician's orders; observe/document/report when necessary any signs or symptoms of infection to access site. The Physician's Order dated 11/6/15 revealed Resident #105's AV shunt was to be checked for bruit and thrill twice during the first eight hours after the resident's return from his dialysis treatment and daily; and, the condition of the resident's access site was to be checked for bleeding, redness, tenderness and swelling post-dialysis treatment and daily. There was no documentation available for the month of December 2015 indicating the thrill and bruit and the condition of the access site had been checked by the nursing staff as ordered by the Physician. During an interview on 12/9/15 at 3:42pm,	F 514	Physician for Resident # 105 to include dialysis orders on the December 2015 Physician□s Order Sheet and these orders were transcribed to the Medication Administration Record. A Medication Variance Form was completed on 12-11-15 by the Director of Nursing regarding the missing dialysis order. The Unit Manager was re-educated by the Director of Nursing on 12-11-15 regarding the monthly review of Physician□s Orders. 2. On 12-11-15 the Unit Manager and Director of Nursing reviewed other residents receiving dialysis to ensure current dialysis orders were in place. 3. Licensed Nurses that are assigned to the Monthly Physician□s Order Review process were re-educated by Director of Nursing on the facilities process for reviewing the Physician□s Orders at month end. This education will be completed by 1-6-16. 100% of physician orders for dialysis residents will be audited by the Director of Nursing monthly times 3 months to validate accurate review at month end. Opportunities will be corrected as identified by the Director of Nursing. 4.The Administrator and Director of Nursing will review data obtained from end of the month change over process audit and analyze The data and report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add	

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F 514	Continued From page 10 Resident #105 revealed his treatments at the dialysis center were on Tuesdays, Thursdays and Saturdays from 11:00am to 3:00pm. The resident indicated that he did not have any problems since starting dialysis; only a little tired sometimes. During an interview on 12/10/15 at 10:44am, Nurse #3 confirmed Resident #105 began dialysis on 10/14/15 and the resident went to the dialysis center on Tuesdays, Thursdays, and Saturdays. She also revealed the resident had a fistula in his left arm, midway. Nurse #3 revealed that the facility's nurses were required to check the thrill/bruit of the resident's AV shunt every shift and the condition of the access site every day and document that it was checked by recording their initials on the MAR (Medication Administration Record). Nurse #3 stated that she had checked Resident #105's fistula every day, but the reason she failed to document for the month of December 2015 the order was because it was not written on the MAR. During an interview on 12/11 at 9:40am, the DON (Director of Nursing) revealed that the original physician's order concerning Resident #105's dialysis was placed on the November 2015 Physician's Order Sheet, but when the Unit Manager completed the end of the month change over, she failed to carry the dialysis order over onto the December 2015 MAR.	F 514	interventions based on identified outcomes to ensure continued compliance.	
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	F 520		1/6/16

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F 520	Continued From page 11 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. 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 observations, record review and resident interviews and staff interviews the facility ' s Quality Assessment and Assurance committee failed to implement, monitor and revise the action plan developed for the deficiencies identified during the recertification survey dated 1/30/2015 in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies in F 323 Prevention of Accident Hazards and F 441 Establishing and Maintaining an Infection Control Program. The continued failure of the facility during two federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program. The findings included:	F 520	F520: 1. The oxygen e-cylinder was immediately removed from Room 124 by the charge nurse and stored in the appropriate area/container on 12/11/15. Resident #165 was immediately placed on enteric precautions 12/11/15. Facility staff were educated beginning 12/29/2015 on proper hand washing procedures for enteric precautions. Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting by 1-6-16 to discuss the outcomes of the annual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	C 12/11/2015

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F 520	Continued From page 12 This tag is cross-referenced to: F 323 Based on observations, staff and resident interviews the facility failed to secure a full oxygen tank in 1 of 40 rooms observed (Room 124). During the recertification survey of 1/30/2015 the facility was cited at F 323 due to their failure to implement fall prevention interventions for one resident with falls. F441 Based on observations, resident and staff interviews and record reviews the facility failed to maintain isolation precautions for two of two sampled residents on isolation. Residents #147 and 165. During the recertification survey of 1/30/2015, the facility was cited at F 441 due to a failure to properly sanitize glucometers between uses on 4 different residents. The Director of Nursing was interviewed on 12/11/2015 at 12:27 pm. She explained that the Quality Assessment and Assurance Committee met monthly and addressed any areas of concern. Falls were reviewed monthly, but no concerns had been identified in regards to safe oxygen storage prior to this survey. She also stated that infection control was not identified as a current problem area prior to this survey. She added that administration and management had changed recently and the new staff have worked on identifying and addressing new concerns.	F 520	survey and repeat citations of F323 and F441. The Interdisciplinary Department Head Team reviewed the previous plan of correction related F323. 2. The Unit Managers and Director of Nursing audited current resident rooms for other oxygen e-cylinders stored and secured incorrectly on 12/11/15. Unit Managers and Director Nursing audited current residents for any potential of not being placed on enteric precautions on 12/11/2015. 3. The Director of Nursing and Administrator will be re-educated by Divisional Director of Clinical Services on the QAPI process by 1-6-16. The Interdisciplinary Department Head Team will be re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F323 Providing Supervision to Prevent Accident, F441 Infection Control and the QAPI process. This education was completed by 1-6-16. The Administrator will hold a weekly Ad Hoc QAPI committee meeting to review F323 and F441 to ensure all regulatory aspects are addressed and in compliance. Opportunities will be corrected as identified. Audits and data analyzed from the QAPI monthly meeting will reviewed by the DDCS monthly x 3 months to evaluate the effectiveness of the indicated plans and ensure that interventions have been added when warranted. 4.The Administrator and Director of	

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F 520	Continued From page 13	F 520	Nursing will review data obtained from the auditing process and analyze the data and report patterns/trends to the QAPI committee monthly x 3 months. The QAPI committee will evaluate the effectiveness of the above Plan, and will add interventions based on identified outcomes to ensure continued compliance.	