

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>345115</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>5/6/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CTR HEALTH &amp; REHAB/SALISBURY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 STATESVILLE BOULEVARD SALISBURY, NC</b>
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<b>F 514</b>	<p>483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>(i) Medical records.</p> <p>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to consistently document treatments and medication administration in the treatment administration record (TAR) for 1 of 15 sampled residents (Resident #2). The findings included:</p> <p>Resident #2 was admitted 3/24/17. Diagnoses included: multiple sclerosis, neuromuscular dysfunction of bladder, pressure ulcer, neurogenic bowel, and candidiasis of the skin.</p> <p>A review of the Resident #2's most recent Minimum Data Set (MDS) revealed an admission comprehensive assessment with an Assessment Reference Date (ARD) of 3/31/17. The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The resident was coded as having had an indwelling catheter and an ostomy appliance. The resident's coded diagnoses included: neurogenic bladder and multiple sclerosis. The resident was coded as having had received applications of ointments/medications other than to feet.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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<b>F 514</b>	<p>Continued From Page 1</p> <p>A review of the April 1, 2017 through May 5, 2017 Treatment Administration Records (TAR's) for Resident #2 revealed a physician order dated 3/24/17 in the April and May TAR's that read "Colostomy care every shift and as needed every shift." No documentation or staff initials were present in the TAR for 34 of 90 opportunities to provide colostomy care from 4/1/17 through 4/30/17. No documentation or staff initials were present in the TAR for 13 of 15 opportunities to provide colostomy care from 5/1/17 through 5/5/17.</p> <p>Further review of the April 1, 2017 through May 5, 2017 Treatment Administration Records (TAR's) for Resident #2 revealed a physician order dated 3/24/17 in the April and May TAR's that read "Catheter care every shift and as needed every shift." No documentation or staff initials were present in the TAR for 35 of 90 opportunities to provide catheter care from 4/1/17 through 4/30/17. No documentation or staff initials were present in the TAR for 13 of 15 opportunities to provide catheter care from 5/1/17 through 5/5/17.</p> <p>Further review of the April 1, 2017 through May 5, 2017 Treatment Administration Records (TAR's) for Resident #2 revealed a physician order dated 3/24/17 in the April and May TAR's that read "Anchor catheter with leg strap to prevent excessive tension. Every shift." No documentation or staff initials were present in the TAR for 35 of 90 opportunities to verify the indwelling catheter being anchored from 4/1/17 through 4/30/17. No documentation or staff initials were present in the TAR for 13 of 15 opportunities to verify the indwelling catheter being anchored from 5/1/17 through 5/5/17.</p> <p>Further review of the April 1, 2017 through May 5, 2017 TAR's for Resident #2 revealed a physician order dated 3/24/17 in the April and May TAR's that read, Zinc Oxide Cream 6%. Apply to the right ischium (lower buttock) topically every evening shift related to pressure ulcer. No documentation or staff initials were present in the TAR on 4/1/17, 4/3/17 through 4/7/17, 4/9/17 through 4/13/17, 4/17/17 through 4/19/17, 4/23/17, 4/27/17, and 4/29/17. There were initials present for the dates of 4/2/17, 4/8/17, 4/14/17 through 4/16/17, 4/20/17 through 4/22/17, 4/24/17 through 4/26/17, 4/28/17, and 4/30/17. From 5/1/17 through May 5, 2017 there was no documentation or staff initials present in the May TAR for 5/1/17 through 5/5/17.</p> <p>Further review of the April 1, 2017 through May 5, 2017 TAR's for Resident #2 revealed a physician order dated 3/24/17 in the April and May TAR's that read, "Irrigate suprapubic catheter daily with 30 cubic centimeters (cc's) of normal saline." No documentation or staff initials were present in the TAR on 4/1/17, 4/2/17, 4/2/17, 4/5/17, 4/6/17, 4/8/17 through 4/14/17, 4/16/17 through 4/19/17, and 4/21/17 through 4/30/17. There were initials present for the dates of 4/3/17, 4/4/17, 4/7/17, 4/15/17, and 4/20/17. From 5/1/17 through May 5, 2017 there was no documentation or staff initials present in the May TAR for 5/1/17 through 5/5/17.</p> <p>Further review of the April 1, 2017 through May 5, 2017 TAR's for Resident #2 revealed a physician order dated 3/24/17 in the April and May TAR's that read, ciclopirox shampoo 1%, apply to hair topically every day shift, every Tuesday and Friday for itching. No documentation or staff initials were present in the TAR on 4/14/17, 4/21/17, 4/25/17, and 4/28/17. There were initials present for the dates of 4/4/17, 4/7/17, 4/11/17 and 4/18/17. From 5/1/17 through May 5, 2017 there were staff initials present in the May TAR for 5/2/17. There were no initials or staff documentation for 5/5/17.</p>
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<b>F 514</b>	<p>Continued From Page 2</p> <p>Further review of the April 1, 2017 through May 5, 2017 TAR's revealed for Resident #2 a physician order dated 3/24/17 in the April TAR's that read, Menthol-Zinc Oxide 0.44-20.625%, apply to the affected area for itching topically one a day for itching. The order stop date was 4/18/17. No documentation or staff initials were present in the TAR on 4/10/17, 4/13/17, 4/14/17, 4/16/17, and 4/17/17. There were initials present for the dates of 4/1/17 through 4/9/17, 4/11/17, 4/12/17, 4/15/17, and 4/18/17.</p> <p>Further review of the April 1, 2017 through May 5, 2017 TAR's for Resident #2 revealed a physician order dated 4/18/17 in the April and May TAR's that read, Menthol-Zinc Oxide 0.44-20.625%, apply topically to the left lower quadrant of the abdomen one time a day for itching. No documentation or staff initials were present in the TAR from 4/19/17 through 4/28/17. There were initials present for the dates of 4/29/17 and 4/30/17. From 5/1/17 through May 5, 2017 there was no documentation or staff initials present in the May TAR for 5/1/17, 5/4/17, and 5/5/17. There were initials present for 5/2/17 and 5/3/17.</p> <p>Further review of the May 1, 2017 through May 5, 2017 TAR for Resident #2 revealed a physician order dated 4/25/17 in the April and May TAR's that read, clean the left ischial (lower buttock) with normal saline, then pack with silver alginate, then cover with an absorbent dressing with adhesive borders. The dressing was ordered to be applied on day shift every Monday, Wednesday, and Friday. From 5/1/17 through May 5, 2017 there was no documentation or staff initials present in the May TAR for 5/1/17. There were initials present for 5/3/17 and 5/5/17.</p> <p>On 5/4/17 at 11:45 AM, Nurse #6 was the assigned nurse for Resident #2. During an interview with Nurse #2 she stated she was a PRN (as needed) nurse and was unfamiliar with the hall. Nurse #5 further she did not know if she was going to put the ordered topical medications on Resident #2 or if it was the responsibility of another staff member.</p> <p>In an interview that was conducted with the Director of Nursing (DON) on 5/4/17 at 12:00 PM she stated that the floor nurses were responsible to complete the treatments for their assigned residents on that day.</p> <p>On 5/5/17 at 11:55 AM, Nurse #6 was the assigned nurse for Resident #2. During an interview with Nurse #2 she stated that it was the resident's assigned nurse who was responsible for applying topical medications that were in the resident's Treatment Administration Record (TAR). The nurse further clarified it was not the responsibility of the treatment nurse to apply topical medications.</p> <p>During an interview with Nurse #4 on 5/5/17 at 12:03 PM she stated she was the assigned treatment nurse that day. She stated on Resident #2's shower days she would give the nursing assistant Resident #2's prescribed ciclopirox shampoo. After Resident #2's shower was completed, the Nursing Assistant would return the ciclopirox shampoo to the nurse and inform the nurse if the shampoo was or was not applied to the resident's hair. The nurse would then record that information in the Treatment Administration Record (TAR).</p> <p>During an interview with Medication Aide (Med Aide) #1 on 5/6/17 at 10:49 AM she stated that it was the responsibility of the resident's assigned nurse to apply topical medications on their assigned residents.</p>
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<b>F 514</b>	<p>Continued From Page 3</p> <p>On 5/6/17 at 12:07 PM the Director of Nursing (DON) indicated the treatment nurse was responsible for the pressure ulcer dressing change on Resident #2. All treatment, i.e. catheter irrigation would be conducted by the assigned nurse. All topical prescriptions, ointments, and powders were only available through prescription were to be applied by the resident's nurse and any product that was available over the counter were to be applied by the resident's Nursing Assistant (NA). The DON stated she was unable to discover a correlating nurses' note to substantiate if treatments were or were not administered where no documentation was present. The DON stated her expectation was that if a medication or treatment was ordered by a resident's physician the assigned nurse needed to initial that the treatment was conducted or medication applied. If the treatment was not conducted or the medication was not applied there needed to be documentation regarding the reason the treatment had not been conducted or medication had not been applied.</p>
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