STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	969 COX ROAD GASTONIA, NC 28054

(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
E 000	Initial Comments A recertification survey was conducted on 05/06/19 through 05/09/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #CYB211	E 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to place a resident's specialty call light within reach to allow the resident to request staff assistance if needed for 1 of 3 residents reviewed for accommodation of needs (Resident #485). The findings included: Resident #485 was admitted to the facility on 7/29/14 with diagnoses including hemiplegia, seizure disorder and diabetes. The quarterly Minimum Data Set (MDS) assessment, completed on 4/3/19, revealed the resident was alert and oriented and cognitively intact. The resident required extensive assistance with bed mobility and 2 plus people for transfers, was totally dependent for toileting, personal hygiene and dressing.	F 558	On 5/9/19, Director of Nursing placed Specialty call light within reach for Resident #485 to allow Resident #485 the ability to request staff assistance if needed. All Residents with the need for a Specialty call light identified as having the potential to be affected by the deficient practice. On 5/30/19, an audit completed by the Resident Care Management Director (RN) to identify current Residents with the need for a Specialty call light. Inservice provided by Staff Development Coordinator (RN)to direct care staff (licensed staff and c.n.a.s) on 5/31/19 related to specialty call light placement to allow Residents to request staff	6/6/19

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

Electronically Signed | 05/30/2019

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F 558	Continued From page 1 The care plan for Resident #485, last reviewed on 4/12/19, revealed the following goals and interventions: "Be free of fall related injury. Be sure the resident's call light is within reach and encourage resident to use it." "Maintain dignity with staff assistance for toileting needs. Have call light within reach" and "Assist staff with ADLs as much as able. I utilize a pancake call bell. Keep within reach of hands or elbows." During the survey the following observations were made of the Resident #485's specialty "pancake" call light not within the resident's reach: - On 05/7/19 at 9:27 AM the resident was in bed with the pancake call light laying in the upper left corner of the bed and the resident was unable to reach call light. The resident specified he was unable to reach his call bell at this time. - On 5/7/19 at 1:48 PM the resident was in bed with the pancake call light clipped to the privacy curtain between Bed 1 and Bed 2, behind the resident's headboard and not within the resident's reach. - On 5/8/19 at 8:24 AM the resident was in bed with the pancake call light draped over the bed's headboard not within reach of the resident. - On 5/08/19 at 9:17AM the resident was in bed with the pancake call light draped over the bed's headboard not within the resident's reach. On 5/8/19 at 9:27 AM an interview was conducted with Nursing Assistant (NA) #1, who regularly cared for Resident #485. The NA stated the resident was totally dependent on staff for his care and used a special call light to call for help. The NA explained the resident's hands were contracted so he used his left elbow to press on the call light to activate it. At 9:32 AM NA #1 and surveyor observed the resident's call light draped	F 558	assistance if needed. Specialty Call Light Monitoring Tool implemented, and to be completed by the Unit Coordinator each shift, daily for 4 weeks; then once daily for 4 weeks; then 3 times weekly for 4 weeks. The Specialty Call Light Monitoring Tool will validate proper placement of the Specialty call light by observation to ensure the Resident's ability to request staff assistance if needed The results of the Specialty Call Light Monitoring Tool will be presented by the Director of Nursing for 3 months at the facility QAPI Meeting to evaluate effectiveness. The QAPI Committee will make changes and recommendations as indicated. The Administrator is responsible for implementing the plan of correction.	

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F 558	Continued From page 2 over the headboard of the bed and out of the resident's reach. NA #1 placed the pancake call light under the resident's left elbow. The NA stated the call light was not under the resident's elbow because she had not yet been in the room to give resident care. On 5/9/19 at 10:05 AM an interview was conducted with Resident #485. The resident stated "yes" when asked if he wanted the call light to be within his reach. The resident specified that in order to utilize his pancake call bell it needed to be positioned under his elbow or hands. On 5/8/19 at 10:30 AM, an interview with the Director of Nursing revealed the nursing assistants and all staff should have made sure the call light was within reach of the resident #458's elbow because the resident cannot independently move himself to reach the call bell if it is positioned out of his reach. On 5/9/19 at 10:01 AM an interview was conducted with the Administrator. She stated that Resident #485 was debilitated and therefore needed the pancake call light. However, the staff know him well and check on him frequently.	F 558		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		6/6/19

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F 684	Continued From page 3 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and nurse practitioner interviews and record review, the facility failed to change a dressing as ordered for 1 of 2 sampled residents with a skin tear (Resident #3). The findings included: Resident #3 was admitted to the facility on 01/31/19 with diagnoses that included acute respiratory failure, type 2 diabetes and others. The most recent Minimum Data Set (MDS) dated 02/07/19 specified the resident's cognition was intact and he had no skin problems. Resident #3's medical record revealed a nurse's entry related to a change in condition dated 04/30/19 that read in part the resident had sustained a skin tear to his left knee. The nurse documented that the area was cleaned and treated, and the physician was notified. A physician's order dated 04/30/19 specified Resident #3's skin tear to the left knee was to be cleansed with wound cleanser and triple antibiotic ointment applied and covered with a dry dressing every other day. Resident #3's May 2019 Treatment Administration Record (TAR) revealed the resident's dressing to his left knee had been changed on 05/01/19, 05/03/19 and 05/05/19. On 05/06/19 at 2:14 PM Resident #3 was interviewed in his room. During the interview, the Resident pulled his left pant leg up and pointed to	F 684	Skin Tear dressing change completed for Resident #3's left knee on 5/6/19 by Nurse #1. All Residents with dressing orders have been identified as having the potential to be affected by the deficient practice. Audit completed to identify current Residents with dressing orders completed by Director of Nursing on 5/30/19. Education provided to Nurse #1 and Nurse #3 (Treatment Nurses) by Staff Development Coordinator (RN) on 5/31/19 regarding the importance of changing dressings as ordered. Dressing Changes Monitoring Tool implemented and to be completed by the Director of Nursing 3 times weekly for 12 weeks. The Dressing Change Monitoring Tool will ensure dressing changes are completed as ordered by verifying the order with the actual dressing applied to the identified area. The results of the Dressing Change Monitoring Tool to be presented by the Director of Nursing monthly for 3 months at the monthly facility QAPI Meeting to evaluate effectiveness. The QAPI Committee will make changes and recommendations as indicated. The Administrator is responsible for	

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F 684	Continued From page 4	F 684	implementing the plan of correction.	

a dressing on his left knee. The dressing was dated 05/03 (no year) and initialed by Nurse #1. The Resident stated he hit his knee and it was sore. Resident #3 stated the dressing was supposed to be changed every other day but had not been changed over the weekend and he was not sure why.

On 05/06/19 at 3:41 PM Nurse #1 was interviewed and explained she worked Friday through Tuesday 7:00 am to 3:00 pm and was assigned to treatments. She stated that she was able to complete all the treatments during her shift. The Nurse was asked about Resident #3's dressing orders and she used the electronic medical to review the order. Nurse #1 reported that Resident #3 was to have a dressing for a skin tear to his left knee changed every other day. The Nurse was asked about the dressing dated 05/03 that was on the resident's knee and stated that she performed the dressing change to the resident's knee on 05/03/19. The nurse further explained that she marked the 5/05/19 dressing change as completed on the TAR but forgot to do the dressing change on that date. She stated it was an oversight.

On 05/09/19 at 10:13 AM the nurse practitioner (NP) was interviewed and explained that it was important for dressings to be completed as ordered for skin tears to reduce the risk of infection. He added he would expect dressings to be competed as ordered.

On 05/09/19 at 10:25 AM Resident #3 gave permission to observe Nurse #2 change his dressing to the left knee. Observations of the skin tear revealed the area was slightly red and the skin was intact.

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F 684	Continued From page 5 On 05/09/19 at 10:40 AM the Director of Nursing (DON) was interviewed and explained that the facility had a nurse assigned to treatments 7 days a week. She added that if the nurse was unable to complete a dressing during the shift, then the oncoming shift should be notified of the need to complete a dressing. The DON stated she expected all dressings to be completed as ordered.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		6/6/19

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F 842	Continued From page 6	F 842		

representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to correctly document that a treatment was not completed for 1 of 2 sampled residents (Resident #3). The findings included: Resident #3 was admitted to the facility on 01/31/19 with diagnoses that included acute respiratory failure, type 2 diabetes and others. The most recent Minimum Data Set (MDS) dated 02/07/19 specified the resident's cognition was intact and he had no skin problems. Resident #3's May 2019 Treatment Administration Record (TAR) revealed the resident's dressing to his left knee had been changed on 05/01/19, 05/03/19 and 05/05/19. On 05/06/19 at 2:14 PM Resident #3 was interviewed in his room. During the interview, the Resident pulled his left pant leg up and pointed to a dressing on his left knee. The dressing was dated 05/03 (no year) and initialed by Nurse #1. The Resident stated he hit his knee and it was sore. Resident #3 stated the dressing was supposed to be changed every other day but had not been changed over the weekend and he was not sure why. On 05/06/19 at 3:41 PM Nurse #1 was interviewed and explained she worked Friday through Tuesday 7 am to 3 pm and was assigned to treatments. She stated that she was able to complete all the treatments during her shift. The Nurse was asked about Resident #3's dressing	F 842	On 5/31/19 Nurse #1 verified that the dressing change to the left knee of Resident #3 was not completed on 5/5/19. On 5/31/19 Nurse #1 updated the Medical Record to accurately reflect and correctly document that the identified treatment was not completed on 5/5/19. All Residents with treatment orders are identified as having the potential to be affected by this deficient practice. Audit completed by the Director of Nursing on 5/31/19 to identify current Residents with treatment orders. On 5/31/19, Education provided to Nurse #1 by Staff Development Coordinator (RN) regarding the importance of accurately documenting treatment orders in the Medical Record. Treatment Documentation Accuracy Tool implemented and completed by the Director of Nursing 3 times weekly for 12 weeks. The Treatment Documentation Accuracy Tool will validate the documentation accuracy in the medical record with the observation of the treatment to the identified skin area. The Treatment Documentation Accuracy Tool will be presented by the Director of Nursing at the monthly facility QAPI Meeting for 3 months to evaluate effectiveness. The QAPI Committee will make changes and recommendations as	

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F 842	Continued From page 8 orders and she used the electronic medical to review the order. Nurse #1 reported that Resident #3 was to have a dressing for a skin tear to his left knee changed every other day. The Nurse was asked about the dressing dated 05/03 that was on the resident's knee and stated that she performed the dressing change to the resident's knee on 05/03/19. The Nurse further explained that she marked the 5/05/19 dressing change as completed on the TAR but forgot to do the dressing change on that date. She stated it was an oversight. On 05/09/19 at 10:40 AM the Director of Nursing (DON) was interviewed and stated she expected all dressings to be completed as ordered and documented after completing the treatment.	F 842	indicated. The Administrator is responsible for implementing the plan of correction.	