STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 from 08/26/19 to 08/29/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID NXO811.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was completed on 08/26/19 through 08/29/19. There were a total of 16 allegations investigated and they were all unsubstantiated.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		9/23/19

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

Electronically Signed | 09/23/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 690	Continued From page 1 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Medical Doctor interview the facility failed to arrange for a urology follow up appointment for possible removal of a indwelling urinary catheter (Resident #5) and failed to anchor indwelling urinary catheter tubing (Resident #59). This affected 2 of 4 residents sampled for urinary catheters. The findings included: 1. Resident #5 was admitted to the facility on 05/11/19 with diagnoses that included urinary tract infection, chronic kidney disease, and neuromuscular dysfunction of the bladder. Review of a Discharge Summary report from the local hospital dated 05/11/19 read in part, a catheter was maintained and Resident #5 was seen by urology who recommended outpatient follow-up with eventual discontinuation of indwelling urinary catheter and in and out catherization's afterwards. The Discharge Summary Report further read, Discharge information: follow up with Urology.	F 690	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report, our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal requirements. The transportation aide scheduled an appointment for resident #5 to see a Urologist on 9/16/19. Resident #59 had the catheter tubing anchored by RCS/CNA#1 on 8/29/19. The transportation aide will review every new admission for follow-up appointments starting on 9/23/19. A clarification order for the use of the catheter for resident #5 was written on 9/17/19. Securement devices for the catheters for resident #59 were applied on 8/29/19. Licensed nursing staff were reeducated, to include new hires regarding the requirement to have a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 690	Continued From page 2 Review of a History and Physical dated 05/16/19 read in part, history of present illness, a urinary catheter was placed and Resident #5 was to follow up with urology. The plan read, "genic bladder with catheter in place to follow up with urology". The history and physical was signed by the Medical Doctor (MD). Review of the most recent quarterly Minimum Data Set (MDS) dated 08/13/19 indicated that Resident #5 was cognitively intact and required extensive assistance with toileting. The MDS further indicated that Resident #5 had an indwelling urinary catheter during the assessment reference period. Review of Resident #5's medical record on 08/26/19 revealed no follow up report from Urology. An interview was conducted with Resident #5 on 08/26/19 at 2:35 PM. Resident #5 stated that when she was at home her family member performed in and out catherization on her twice a day until the family member got sick and was admitted to the hospital. Resident #5 explained she got a urinary tract infection and was admitted to the hospital and they placed a urinary indwelling catheter in her and it has been in ever since she admitted to the facility on 05/11/19. She added that she does not like the catheter at all and really wanted it removed and to go back to the in and out catheterizations that she was accustomed too. Resident #5 stated that the next time she saw the MD she was going to ask if the urinary indwelling catheter could be removed. She also stated that she had not seen the Urologist since she was in the hospital in May 2019.	F 690	supporting diagnosis for ongoing catheter use. All residents who currently use catheters were reviewed by facility Director of Nursing to ensure a securement device was applied for all residents who use a Foley catheter as indicated by the residents plan of care. ADON, DON will conduct care observations of residents with catheters weekly to ensure residents with catheters have a supporting diagnosis for their use and securement devices are in place as indicated. A QI audit tool will be utilized. Results of audits will be submitted to the monthly quality committee for review to ensure continued compliance. The Director of Nursing and/or Assistant Director of Nursing will audit all current residents with catheters requiring Urology follow up have been scheduled. The foley catheter care plans are accurate in reflecting that the catheter securing device is in place. The Director of Nursing and/or Area Staff Development Manager conducted an inservice / re-education for Licensed Nursing Staff, which included documentation for follow up appointments with the Urologist and placement of a catheter securing device. Completed 9/23/19. The Director of Nursing and/or Area Staff Development Manager will review new admissions and readmissions with catheters to ensure follow up Urology appointments are scheduled, foley	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 690	Continued From page 3 An interview was conducted with Nurse #1 on 08/28/19 11:32 AM. Nurse #1 confirmed that she was familiar with Resident #5 and stated that she has had a urinary indwelling catheter ever since she had been working at the facility for approximately 3 months. She stated that Resident #5 was very anxious about her catheter and needed constant reassurance that her catheter was functioning properly, and her urine was clear. Nurse #1 added that Resident #5's catheter was only changed if it was leaking or became dislodged and to her knowledge that had not occurred since she had been at the facility. Nurse #1 stated that she was unaware of any Urology appointments that had been scheduled for Resident #5 because she thought she came from the mountains and was not local to the facility. An interview was conducted with the Transportation Aide (TA) on 08/28/19 at 12:30 PM. The TA stated that she had not scheduled or transported Resident #5 to any follow up appointments since her admission on 05/11/19. A follow up interview was conducted with Resident #5 on 08/28/19 at 2:11 PM. Resident #5 again confirmed that she had not been back to the Urologist since her admission on 05/11/19 and really wanted the catheter removed and to resume her previous in and out catheterization schedule. An interview was conducted with Nurse #2 on 08/28/19 at 4:38 PM. Nurse #2 confirmed that he had admitted Resident #5 to the facility on 05/11/19. Nurse #2 stated that when residents admitted to the facility with follow up	F 690	catheters are anchored and a care plan is in place. An audit on new admission charts for catheters/orders/approved diagnosis of catheter and catheter securing device upon admission starting on 9/13/19 for three (3) times per week for twelve (12) weeks to ensure continued compliance. The Administrator and Director of Nursing will review data obtained from audits, analyze the data and report patterns/trends to the QAPI committee every month for three (3) months. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/ outcomes to ensure continued compliance. Completion date is 9/23/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 690	Continued From page 4	F 690		

appointments that need to be scheduled, he would make a copy of the order and give it to the TA, and she would handle making the appointment and transporting the resident to the appointment. Nurse #2 could not explain why the Urology appointment had never been scheduled for Resident #5 as noted in the hospital Discharge Summary Report dated 05/11/19.

An interview was conducted with the MD on 08/29/19 at 9:10 AM. The MD stated that Resident #5 should have been seen by Urology as indicated in the Discharge Summary Report and his recommendations followed. The MD added that he was uncertain if Resident #5 would be a candidate for removal of the indwelling urinary catheter or not but that the facility should make that referral so the Urology recommendations could be followed.

An interview was conducted with the Assistant Director of Nursing (ADON) on 08/29/19 at 11:10 AM. The ADON stated she recalls nothing about any follow up appointment with Urology that had been scheduled for Resident #5. She stated she believed the indwelling urinary catheter was placed long term but stated the follow up appointment should have been scheduled on admission to the facility for possible removal of the indwelling urinary catheter.

An interview was conducted with the Director of Nursing (DON) on 08/29/19 at 2:25 PM. The DON stated that she expected the staff to make the follow up Urology appointment as stated in the Discharge Summary Report for possible remove of the urinary indwelling catheter. She added that Resident #5's family would often take her out and was not sure why they had not taken Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 690	Continued From page 5	F 690		

to the Urologist. The DON stated she expected Nurse #2 to enter the follow up appointment into the electronic record and then make a copy for the TA who would then schedule the follow up appointment.

2. Resident #59 was admitted to the facility on 09/10/18 with diagnoses that included acquired absence of right and left leg above the knee, chronic kidney disease and a pressure ulcer of sacral region.

A review of Resident #59's most recent quarterly Minimum Data Set Assessment dated 07/23/19 revealed Resident #59 to be cognitively intact for daily decision making. He was coded as requiring extensive assistance with most activities of daily living and was totally dependent for bathing assistance. Resident #59 was coded with a urinary catheter.

A review of Resident #59's physician orders revealed an active order written 05/0919 that read "use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Every shift."

A review of Resident #59's care plan last updated 07/23/19 revealed a care plan for the use of a urinary catheter. Interventions included "anchor catheter to prevent excess tension" among others.

During an observation of Resident #59 on 08/26/19 at 12:29 PM, it was revealed that his catheter was not anchored.

During an interview with Resident #59 on 08/26/19 at 12:29 PM he revealed that his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 690	Continued From page 6 catheter tubing was not anchored and had not been anchored while he had been a resident During an observation of Resident #59 on 08/29/19 at 1:36 PM revealed his catheter tubing was not anchored. During an interview with Resident #59 on 08/29/19 at 1:36 PM he revealed that his catheter tubing continued to be unanchored. During an interview with RN #2 on 08/29/19 at 3:32 PM, she verified that Resident #59's catheter tubing was not anchored and verified that there was an active physician order for the catheter tubing to be anchored. She reported she was supposed to check the tubing each shift and that there were times when she would look at the treatment record and if it had been signed off that the tubing had been checked and anchored, then she "may not go in and make sure" it was anchored. She reported it was the responsibility of the hall nurse to ensure that the catheter tubing was anchored. During an interview with the Director of Nursing on 08/29/19 at 3:38 PM, she reported it was her expectation that catheter tubing be anchored as ordered and that she expected her hall nurses to verify treatments instead of assuming the treatment had been completed.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		9/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 761	Continued From page 7 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to remove expired medications from 2 of 2 medications cart reviewed during medication storage. The findings included: 1. An observation of the 300-hall medication cart was conducted on 08/29/19 at 11:37 AM with Nurse #3. In the left bottom drawer of the medication cart and available for use 57 Antivert (used to treat dizziness) 12.5 milligrams (mg) that expired on 06/20/19 were discovered and given to Nurse #3. An interview was conducted with Nurse #3 on	F 761	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report, our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal requirements. The Director of Nursing removed from the 300 hall cart, Fifty Seven (57) Antivert 12.5 milligrams (mg) medication that expired on 6/20/19. On the 400 hall nursing cart the Director of Nursing removed ten (10) Zofran (antiemetic) 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 761	Continued From page 8 08/29/19 at 12:07 PM. Nurse #3 stated that the Antivert had not been administered in several months. She added that the staff were expected to go through the medication carts once a month and check the new medication as it arrived from the pharmacy. Nurse #3 states that she had checked the medications as she administered them for expired medications but had not checked any house stock or as needed medications. Nurse #3 stated that the expired medication should have been removed from the medication cart and returned to the pharmacy. B. An observation of the 400-hall medication cart was conducted on 08/29/19 at 1:55 PM with Nurse #1. In the large second drawer of the medication cart and available for use 10 Zofran (antiemetic) 4 milligrams (mg) that expired on 05/31/19 were discovered and given to Nurse #1. An interview with Nurse #1 was conducted on 08/29/19 at 1:55 PM. Nurse #1 stated that she was unaware that the expired Zofran were on the medication cart. She explained that if a medication was discontinued, she would remove it from the medication cart. Nurse #1 stated that she went through her medication cart everyday and check expiration dates and also checks new medication as it arrived from the pharmacy. Nurse #1 stated that she overlooked the expired medication when she went through her cart earlier on her shift. An interview was conducted with the Director of Nursing (DON) on 08/29/19 at 2:20 PM. The DON stated that night shift nurses were expected to go through each medication cart and medication room nightly and check for expired medication. If any medications were discovered to be expired or	F 761	milligrams (mg) that expired on 5/31/19. The Area Staff Development Manager conducted a complete audit for all four (4) nursing carts in the facility on 9/13/19. All expired medications or those set to expire were removed from all of the medication carts. The Director of Nursing and/or the Area Staff Development Manager educated the licensed nurses on expired medications on the nursing carts. Completed 9/23/19. The Director of Nursing and/or Area Staff Development Manager re-educated the licensed nurses on the checking of the expiration dates on medications, removing expired medications and return them to the pharmacy. Completed 9/23/19. The Director of Nursing and/or Assistant Director, Designee will start on 9/13/19 an audit for the nursing carts three(3) times weekly for twelve (12) weeks to assure compliance. The results will be prepared by the Director of Nursing monthly for three (3) months to the facility QAPI meeting. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends / outcomes to ensure continued compliance. Completion date is 9/23/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 761	Continued From page 9 discontinued the medication should be removed from the medication cart and returned to the pharmacy. The DON stated that she expected the staff to check expiration dates of medications and remove expired medications from the medication cart and return them to the pharmacy. The interview further revealed expired medications should not be on the medication cart available for use.	F 761		
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 representative where permitted by applicable law;	F 842		9/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 842	Continued From page 10 (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. This REQUIREMENT is not met as evidenced by:	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 842	Continued From page 11 Based on record reviews and staff interviews the facility failed to document a resident's change in condition when a resident went to a Physician's appointment and was sent to the hospital for 1 of 2 resident's reviewed for discharge to a hospital (Resident #49). Findings included: Resident #49 was admitted to the facility on 06/21/19 with diagnoses which included high blood pressure, muscle weakness, a history of sepsis (bacterial infections in the blood stream), kidney stones and depression. A review of an admission Minimum Data Set (MDS) dated 06/28/19 indicated Resident #49 was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #49 required extensive assistance with bed mobiltiy and transfers. A review of a medication Administration Note with a created date of 07/06/19 at 12:56 AM indicated "hospital." Further review of Resident #49's medical record revealed there was no documentation of a change in condition or the reason Resident #49 was sent to the hospital. A review of a hospital History and Physical dated 07/06/19 indicated in part Resident #49's chief complaint was back pain and he had a history of high-grade Methicillin-susceptible Staphylococcus aureus bacteremia (bacterial infection) in his lumbar spine (lower back). A review of a Nurse's Progress note dated	F 842	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal requirements. Director of Nursing reviewed care plan that resident #49 went from the physician's office to the hospital and had a change of condition. The Director of Nursing and/or Assistant Director of Nursing has completed an audit on 9/13/19 of resident's transferred out of the facility during the last 30 days to validated accurate documentation of the transfer. The Director of Nursing and/or Area Staff Development Manager conducted and inservice/re-education to all Licensed Nursing Staff which includes new hires to document when a residents gets discharged from the physician office to the hospital or any discharge / change of condition will be documented. Re-Educated completion 9/23/19. The Director of Nursing and/or Area Staff Development Manager will start an audit on 9/16/19 of all discharges and transfers to validate accurate documentation weekly for 12 weeks. The Administrator and Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 842	Continued From page 12 07/06/19 at 5:35 PM indicated Resident #49 returned to the facility by Emergency Medical Services with a Peripherally Inserted Central Cather (PICC line) to continue intravenous antibiotics for Methicillin-susceptible Staphylococcus Aureus bacteremia in his lumbar spine. During an interview on 08/29/19 at 11:39 AM, Nurse #5 who was assigned to Resident #49, stated she recalled he had some abnormal laboratory results and a Physician wanted him sent to the hospital. She stated she could not recall which Physician wanted Resident #49 sent to the hospital, but nursing staff was supposed to document a note when that happened. She verified the Nurse who wrote the note which indicated "hospital" no longer worked at the facility. She stated she did not know why Resident #49 was sent to the hospital but thought it might have been because of a bacterial infection. During an interview on 08/29/19 at 1:49 PM, the Assistant Director of Nursing explained Resident #49 was admitted to the facility from the hospital because he had spinal surgery and an infection in his back. She stated she expected when there was a change in a resident's condition a Situation, Background, Assessment/Appearance and Request (SBAR) form should be completed. She further stated when Resident #49 went to the hospital he had obviously had a change in condition but there was no SBAR or progress notes to explain Resident #49's hospitalization. During an interview on 08/29/19 at 2:08 PM, the Director of Nursing (DON) stated it was her expectation that nursing staff would document	F 842	will review data obtained from audits, analyze the data and report patterns/trends to the QAPI committee every month for 3 months. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance. Completion date is 9/23/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 842	Continued From page 13 what was going on with a resident at the time of the occurrence. The DON further stated she thought Resident #49 had gone out for a Physician's appointment and may have been sent to the hospital from there. During a follow up interview on 08/29/19 at 2:56 PM, the Director of Nursing explained nursing staff utilized 24-hour reports to communicate with each other regarding changes in a resident's condition and these reports were kept for approximately 6 months as a reference tool. She verified a 24-hour report dated 07/03/19 indicated Resident #49 was sent to the hospital from a Physician's office for a stat (immediate) Magnetic Resonance Imaging Scan (MRI). She stated she would have expected for nursing staff to have documented in the progress notes that Resident #49 was sent to the hospital from the Physician's office, but that step was missed in documentation.	F 842		