DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	C 08/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHABI HICK	3031 TATE BLVD SE HICKORY, NC 28602

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F 000	INITIAL COMMENTS NO deficiencies were cited as a result of the complaint investigation in this survey, event ID # M3SD11.	F 000	This Plan of Correction is the facility's credible allegation of compliance. Corrective action has been accomplished for Resident #192 related to the alleged deficient practice. Footrests were placed to the wheelchair for resident #192 on August 11, 2011, and a thinner pressure reducing cushion was placed in the wheelchair. Resident #192 was evaluated by therapy services for additional treatment and services to address wheelchair positioning, management, and mobility. Resident Care Specialist assignment sheet was updated on August 11, 2011, to include the usage of footrests on the wheelchair for Resident #192. Upon any changes in adaptive equipment to help aide in positioning or mobility, the Resident Care Specialist assignment sheet will be updated to include the change or addition in equipment. All non-ambulatory residents have the potential to be affected by the same alleged deficient practice. Administrative Nurses inclusive of the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Registered Nurse Unit Manager, have reviewed all non-ambulatory residents within the facility to ensure that proper adaptive means such footrests are applied to the wheelchair to assist in mobility and comfort. Any resident requiring footrests or other equipment to assist with proper	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews with a resident and staff the facility failed to address wheelchair positioning for one (1) of fourteen (14) sampled residents. (Resident #192) The findings are: Resident #192 was admitted to the facility for healing of a wound from bypass surgery on her left lower leg. The latest wound measurement on 8/8/11 assessed the size of the wound on her left lower legas 6.2 X 2.3 x .7 centimeters. Admitting diagnoses also included deep vein thrombosis and peripheral vascular disease. The admission assessment dated 5/25/11 for Resident #192 assessed her as cognitively intact of both short and long term memory. The Activity of Daily Living (ADL) Assessment dated 5/25/11	F 246		

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherry L. Smithey	Administrator	9/1/11

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 correction is requisite to continued program participation.

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F 246	Continued From page 1 included the following: Admission is short term. For rehabilitation and wound care before return home. She is able to propel self in wheelchair but has had a fall since admission due to not calling staff for assist with transfers. She has potential for improved activities of daily living and mobility as well as wound healing. The resident's care plan dated 5/31/11 included the following problem areas: 1. Requires staff assistance and intervention for completion of ADL needs. Requires limited assistance-extensive assistance of one staff member. 2. At risk for falls related to new admission, recent fall, history of previous falls, ambulatory incontinent, balance problem while standing, utilizes assistive device (wheelchair), decreased muscle coordination, narcotics, sedatives and psychotropics. The care plan did not specifically address positioning devices for use in the wheelchair. The resident was observed throughout the survey propelling herself around the facility in a wheelchair utilizing her hands to mobilize the wheels. There was an approximate five inch cushion in the seat of the wheelchair. There was approximately a five inch gap between the resident's feet and the ground which resulted in her feet being unsupported and not touching the ground Medical record review revealed Resident #192 received physical therapy from 5/19/11-7/21/11. At the completion of therapy Resident #192 was assessed as independent with wheelchair management/mobility and had left lower extremity	F 246	positioning to facilitate mobility or comfort has had their resident specific information identified on the Resident Care Specialist Assignment Sheet. Any resident identified as not exhibiting proper positioning conducive to mobility and/or comfort has been referred to skilled Therapy Services for evaluation and treatment. Upon determination of necessary services and the need for equipment by the licensed therapist, these changes will be updated to the Resident Care Specialist assignment sheet by members of Administrative Nursing. Licensed Nurses and Resident Care Specialists received education on August 30, 2011, provided by the Rehabilitation Program Manager, Occupational Therapist, and Occupational Therapist Assistant on the importance of positioning specific to the needs of each resident. Education was provided to include how improper positioning can impact the well-being of each resident and their ability to comfortably perform activities of daily living. Education was provided to facility staff on what to observe for to assure that positioning is adequate, and if not, the procedure for referring a resident for skilled therapy evaluation and treatment services. Additional education was provided to Resident Care Specialists (certified nurse aides) on the importance of reviewing the Resident Care Specialist Assignment Sheet daily for any changes, Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 246	Continued From page 2 edema. On 8/11/11 at 9:25 AM the physical therapy assistant (LPTA) that worked with Resident #192 observed her positioning in the wheelchair. The LPTA commented that her unsupported legs were not good for circulation. The LPTA stated while Resident #192 was seen for therapy there were footrests in place on the wheelchair which supported her legs. At the time of the interview the LPTA went to the room of Resident #192 and located the footrests under the resident's bed. The footrests were put on the wheelchair by the LPTA and Resident #192 reported that staff had taken the footrests off the wheelchair "awhile back" and they were never put back on again. Resident #192 was observed on 8/11/11 at 1:45 PM and 3:00 PM with the footrests in place and stated, "they are working well". On 8/11/11 at 11:40 AM Nursing Assistant (NA) # 1 (identified as someone who routinely works with Resident #192), Licensed Nurse #2 and the Assistant Director of Nursing (manager over the unit Resident #192 resides on) all stated they did not know why the footrests might have been taken off the wheelchair of Resident #192. NA #1 stated when the footrests were in place Resident #192 was able to "flip them up" which allowed the resident to easily stand and ambulate out of the wheelchair. NA #1 stated staff will often take footrests off a wheelchair when assisting residents to bed and they may have forgotten to put them back on the resident's wheelchair. On 8/11/11 at 2:30 PM the Director of Nursing (DON) stated she had not noticed that Resident #192's feet did not touch the ground when in her wheelchair. The DON stated either foot rests should be in place or the cushion should be	F 246	or necessary information pertaining to positioning and/or adaptive equipment. Director of Nursing and members of Administrative Nursing inclusive of the Assistant Director of Nursing, Registered Nurse Unit Manager, and Staff Development Coordinator, will perform daily walking rounds to assure that all residents are provided with necessary equipment to facilitate proper positioning and mobility. Director of Nursing and members of Administrative Nursing will verify that resident specific positioning and adaptive equipment is identified on the Resident Care Specialist Assignment sheet and provided for the resident. Director of Nursing and members of Administrative Nursing will refer any resident upon admission and/or identification of improper positioning for evaluation and treatment by skilled therapy services. Director of Nursing will report to Quality Assessment and Assurance with identified trends or patterns. The identified trends or patterns will be reported to the Quality Assessment and Assurance Committee weekly for four weeks and then monthly for three months. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of close observation and monitoring of Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 246	Continued From page 3 changed to provide proper positioning in the wheelchair for Resident #192.	F 246	proper positioning will occur with additional staff education. Date of Completion: September 7, 2011	9/7/11
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 observation, staff interview and facility record review, the facility failed to provide nectar thickened liquids per physician's order while administering medication to 1 of 4 sampled residents receiving thickened liquids. (Resident #40) The findings are: Resident #40 was admitted to the facility with diagnoses that included chronic pain secondary to rheumatoid arthritis, neuropathy and abdominal pain. Medical record review revealed Resident #40 had a physician's order dated 4/29/10 for a pureed consistency diet with nectar thickened liquids (NTL). A minimum data set, dated 7/15/11 assessed Resident #40 as having impaired short-term memory, modified impaired daily decision-making	F 309	Corrective action has been accomplished related to the alleged deficient practice for Resident #40. All medications have and will continue to be administered by nursing personnel with the appropriate physician ordered thickened consistency of liquids. Licensed Nurse #1 has been provided remedial education on August 11 and August 30, 2011. Licensed Nursing Personnel will administer medications with the appropriate consistency of liquids as indicated on the Medication Administration Record. All facility residents with orders for thickened liquids have the potential to be affected by the same alleged deficient practice. All medications have and will continue to be administered by nursing personnel with the appropriate physician ordered thickened consistency of liquids. Licensed Nursing Personnel will administer medications with the appropriate consistency of liquids as indicated on the Medication Administration Record. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 309	Continued From page 4 skills and no problems with her long-term memory. Additionally, a care plan updated 7/19/11 identified Resident #40 was noted with a swallowing deficit requiring thickened liquids and a pureed diet to provide safety with meal consumption and swallowing. Care plan interventions included to provide Resident #40 with a diet and fluid consistency as ordered. Further medical record review revealed a physician's order dated 8/8/11 for Resident #40 to receive two tablets of Tylenol Extra Strength 500 mg every two hours, as needed, twice daily for chronic pain. On 8/8/11 at 4:10 PM, Resident #40 was observed seated in her wheel chair in her room visiting with a family member. Licensed nurse #1 (LN #1) entered the Resident's room at 4:15 PM and asked the Resident if she was experiencing any pain. Resident #40 confirmed that she was in pain and requested something for her pain. LN #1 exited the Resident's room and returned with medication crushed in applesauce and a cup of thin water. LN #1 informed the Resident that she had some Tylenol for her pain. LN #1 provided Resident #40 with the crushed Tylenol in applesauce and then offered the Resident the thin water. Resident #40 was observed to drink two small sips of the thin water with her medication. Resident #40 coughed three times after taking the medication with thin water. LN #1 asked Resident #40 if she was okay, the Resident responded "yes" and LN #1 left the Resident's room. Further observation revealed Resident #40 was seated in front of an over bed table (OBT) in her room feeding herself snacks. In front of her was a four ounce container of	F 309	Education provided to licensed nurses on August 31, 2011, by the North Caroline Board of Nursing in regards to medication administration in reference to physician orders. Staff Development Coordinator provided additional education to licensed nurses in regards to determining the physician ordered thickened consistency by reviewing the Medication Administration Record, Physician Order Reconciliation, and/or the Resident Care Assignment Sheet. Director of Nursing and members of Administrative Nursing inclusive of the Assistant Director of Nursing, Registered Nurse Unit Manager, and Staff Development Coordinator, will conduct daily observations of medication nurses to assure that medications are being provided with the appropriate consistency of liquids for those residents requiring thickened liquids. Director of Nursing will report to Quality Assessment and Assurance with identified trends or patterns. The identified trends or patterns will be reported to the Quality Assessment and Assurance Committee weekly for four weeks and then monthly for three months. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	

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F 309	Continued From page 5 commercially prepared nectar thickened water, a cup of soda (thickened by a family member) to a nectar consistency and snacks provided by a visiting family member. Resident #40 also had a cooler in her room of NTL. On 8/8/11 at 4:32 PM, LN #1 confirmed in interview that Resident #40 was to receive NTL and explained that her usual practice was to provide Resident #40 with thin water with medication "because I just give her a sip (of water)." LN #1 confirmed that Resident #40 "coughed a little" after receiving the thin water and stated "but she was eating candy just before I gave her the medication." On 8/11/11 at 3:10 PM, the director of nursing (DON) stated that LN#1 should have given Resident #40 NTL with medication. She further stated that to give thin liquids with medication for a resident on thickened liquids was not the expectation. The DON further stated that she was not aware that this (providing thin liquids with medication) was the Nurse's usual practice. The DON stated that a cough should have been an indication that thin liquids were not appropriate for Resident #40. On 8/11/11 at 4:20 PM, the staff development coordinator (SDC) stated in interview that if a resident has an order for thickened liquids, medications should be administered with thickened liquids. The SDC further stated that nurses were observed on a quarterly basis during medication administration. Review of a Medication Pass Evaluation dated 6/1/11, documented that LN #1 was observed to provide the right consistency of fluids during the quarterly	F 309	close observation and monitoring of proper positioning will occur with additional staff education. Date of Completion: September 7, 2011 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	9/7/11

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F 309	Continued From page 6 evaluation. The SDC stated that the quarterly evaluation was based on just a sample of residents during the medication pass. The SDC further stated that the family of Resident #40 provided the Resident with foods that were not part of her diet, but that nurses were trained and responsible for providing foods according to a resident's diet order.	F 309		