STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide meals concurrently for residents sitting at the same table and serve food so that some residents completed and exited the dining room prior to others being served for 3 of 3 dining observations The findings included: 1) On 7/17/16 at 5:50 PM 9 residents were observed seated in the dining room waiting for meal service. Nursing Assistant (NA) #9 was seated at table #5. She talking with the 3 residents seated there. At 5:55 PM the first tray cart arrived in the dining room. There were only 3 trays removed from the first cart and served to 3 residents seated at 3 different tables. NA #9 began feeding a resident seated at table #6. The other residents who received trays were independent with eating after the tray were set up. At 5:57 PM a tray was delivered from the kitchen to table #1 for a resident who had a family member present. At 6:05 PM a tray was delivered from the kitchen to the resident seated alone at table #4. The resident was independent with eating and did not require set up. At 6:08 PM a second tray cart was pushed through the dining room and was taken down the hall way to be delivered. No trays were removed	F 241	1. It is the practice of the Brian Center Health and Rehabilitation Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. a. Nursing Assistants #8 and #9 were provided re- education regarding providing meals concurrently for residents sitting at the same table to promote dignity and respect to the facility residents on 7/21/16 by Facility Director of Nursing. 2. The facility administrator , Director of Nursing and Assistant Director of Nursing observed trays being passed in dining room and each unit on variances shifts on 7/22/16 to ensure that trays were being delivered in concurrent order to promote t each resident s dignity and respect . a. On 7/21/16 an in-service was started to the facility staff on the process of passing out meal trays at the same time; for residents that are seated at the same table; in the dining room in order; which enhances resident dignity and respect. The in-service was completed on 7/24/16 by the Assistant Director of Nursing. 3. The assigned department manager	8/16/16

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

Electronically Signed | 08/14/2016

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F 241	Continued From page 1 from the cart when it was pushed through the dining room. At 6:14 PM Resident #79 who was seated at table #5 with 2 other residents stated "Can we get something to eat." At this same time the third tray cart was pushed through the dining room and taken to the hall for delivery. No trays were removed from the cart when it was pushed through the dining room. At 6:17 PM Nursing Assistant #8 came into the dining room and provided a tray to Resident #53 seated at table #5. She provided set up as needed. At 6:17 PM the resident who was seated at table #4 was observed to leave the dining room. A staff member asked him if he was finished eating. He responded yes. At 6:19 PM a tray was delivered to Resident #79 seated at table #5. She was the resident who had called out for something to eat at 6:14 PM. The NA provided tray set up as needed. At 6:20 PM NA #8 removed the soiled dishes from table #4. At 6:44 PM the third resident seated at table #5 received her tray. She was provided set up and was observed to start feeding herself. At 6:49 PM a resident who was sitting alone at table #7 was taken from the dining room. He had not received a tray while in the dining room. The staff member who was pushing his wheel chair stated his tray was in his room. 2) On 7/19/16 at 12:40 PM the facility staff were observed passing trays to the residents in the dining room. The trays were not delivered to the residents seated at the same table at the same time. The Dietary Manager was observed talking to the facility staff who then began to deliver the trays to the residents seated at the same table. On 7/19/16 at 12:50 PM the Dietary Manager	F 241	(administrator, Director of Nursing, Assistant Director of Nursing, Activity Director, Medical Record Coordinator, Administrative Assistant and Social Service Director) will complete the dining observation review forms daily Monday thru Friday during the lunch time and the Manager on duty will complete the dining observation review form on Saturday and Sunday for thirty days, weekly times four weeks. 4. The facility Administrator will report finding of dining observations to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 241	Continued From page 2 stated she had reminded the staff to deliver the trays to the same table before delivering to another table. On 7/20/16 at 3:55 PM the speech therapist stated she was in the dining room on 7/19/16. She stated it took a long time for the residents to receive their meal trays and one of the residents she was working with did not receive his tray in a timely manner so he was calling out for his tray.	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272		8/16/16

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F 272	Continued From page 3 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to complete a comprehensive assessment for 1 of 1 sampled resident (#79) who required an assessment after admission. The findings included: Resident #79 was admitted to the facility on 3/22/16 with diagnoses which included stroke with left hemiplegia, diabetes and severe mood dysregulation disorder. A review of the Minimum Data Set (MDS) for Resident #79 revealed she was discharged with return not anticipated on 3/12/16. The MDS revealed she was discharged to the community. When Resident #79 was admitted to the facility on 3/22/16 and an entry tracking record was completed. The next MDS assessment was a significant change assessment dated 4/15/16. An admission assessment record was due by day 14 from the readmission which was 4/5/16. An admission assessment was not present. A review of the Resident Assessment Instrument (RAI) manual revealed an " Admission assessment must occur in any of the following admission situations ...when the resident has been in this facility previously and was discharged	F 272	1. It is the practice of the Brian Center to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 2. The facility MDS Director completed an Comprehensive Assessment Admission on resident #79 on 8/4/16. 3. The facility MDS Director completed review of residents identified with admission or re- admission over last sixty days to ensure that comprehensive assessment were per requirements on 8/4/16. 4. The Director of Nursing Services and the MDS Coordinator will meet with the Administrator to review the newly admitted and readmitted residents to en protocols regarding resident assessment including policies and practices to ensure all	

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F 272	Continued From page 4 return not anticipated. On 7/21/16 at 9:32 AM the MDS nurse stated she had completed a significant change MDS based on a chart review and information she received from other staff. On 7/21/16 at 9:57 AM the MDS nurse state Resident #79 was readmitted within 30 days from her previous discharge so she thought the assessments would continue the previous schedule. She stated she did not understand that the return not anticipated meant she needed to do a new initial admission assessment. After reading the RAI manual she stated an admission assessment should have been done within 14 days of admission.	F 272	sections of the resident assessment instrument specified by the State are accurately completed as required. Weekly times four and monthly times two. a. The Facility Director of MDS will be provided re- education on 7/20/16 by District Director of Care Management The re-education will include conducting initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The re-education also will include a comprehensive assessment of a resident's needs, using the resident assessment instrument(RAI) specified by the state 5. The facility Administrator will report finding of reviews to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		8/16/16

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F 278	Continued From page 5 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 7 of 16 residents reviewed (Residents #46, #102, #108, #4, #68, #63, and #81). Findings included: 1. Resident #46 had been admitted on 6/16/2016. Diagnoses included major depressive disorder, anxiety, chronic back pain and hypertension. Record review indicated Resident #46 had been evaluated as a Level II Preadmission Screening and Resident Review (PASRR) status (a resident identified as having a serious mental illness as defined by state and federal guidelines). The Admission MDS dated 6/23/2016 indicated Resident #46 had been alert and oriented. The assessment did not indicate Resident #46 had been evaluated as a Level II PASRR status.	F 278	Resident #46 MDS assessment ARD 6/23/16 was modified on 7/20/16 to reflect Level II PASRR status Resident # 46 MDS assessment ARD 6/23/16 KO200 was modified to reflect weight of 252#. Modification was completed on 7/20/16. Resident # 102 MDS assessment ARD 4/26/16 was modified to reflect Level II PASRR. Modification was completed on 7/20/16. Resident #108 MDS assessment ARD 6/18/16 H0400 was modified to reflect always incontinent of bowel. Modification was completed on 7/19/16 Resident #63 MDS assessment ARD 3/8 RCMD reviewed medical record dates 3/2/16-3/8/16. Nurse□s note dated 3/2/16	

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F 278	Continued From page 6 An interview with the MDS nurse on 07/19/2016 at 4:36 PM was conducted. The nurse stated she had been unaware of Resident #46's Level II PASRR status. The nurse stated she apparently had missed this information for Resident #46. An interview with the director of nursing (DON) was conducted on 7/21/2016 at 10:30 AM. The DON stated the MDS should be coded correctly and accurately. 2. Resident #46 had been admitted on 6/16/2016. Diagnoses included major depressive disorder, anxiety, chronic back pain and hypertension. Resident #46's vital sign sheet noted he weighed 152.1 pounds on 6/16/2016. The admission MDS assessment dated 6/23/2016 indicated Resident #46 had been alert and oriented. Resident #46's weight was noted as 152 pounds. Resident #46's nutritional assessment dated 6/23/16 indicted he weighed 252 pounds. The 14 day MDS assessment dated 6/30/2016 indicated Resident #46 weighed 252 pounds. The June 2016 weight tracker form indicated Resident #46's weight had been 252 pounds. A nurse's note dated 7/18/2016 indicated Resident #46's hospital weight had been 250 pounds and the June admission weight had been documented as 152.1 pounds in error. An interview with the MDS nurse was conducted on 7/19/2016 at 4:36 PM. The MDS nurse stated she had been made aware the weight noted on the admission assessment was incorrect. The nurse stated she had intended to correct it but had overlooked making the correction. An interview with the DON was conducted on 7/21/2016 at 10:30 AM. The DON stated the MDS	F 278	documented that the resident is alert and verbal and able to make needs known. Resident is continent of bowel and bladder. Nurse□s notes on 3/7/16 and 3/8/16 reflect incontinent of bowel. H0400 modified to be frequently incontinent of bowel. Resident # 81 MDS assessments with ARDs 2/26/16, 4/29/16, 5/19/16 bowel incontinence was coded as not rated on MDS assessments. Assessments with ARDs 2/26/16, 4/29/16 and 5/19/16 modified on 8/12/16 to reflect HO400 always continent based on staff interview. Resident #68. Diagnosis update was completed on 7/20/16. Re-education was completed by Regional Care Manager on 7/20/16 re- education will include adequate coding of section H-9 thru 13, level 2 PASSAR and accurate assessment that reflects the resident□s status to include weights. The Facility Director of Care Management will complete review facility resident last 90 days for assessments to ensure that level 2 PASSARS, accurate weights and section H 9 thru 13 coded per RAI guidelines. The facility Director of Nursing and/or District Director of Care management w will review two sampled residents weekly times four, monthly times two to ensure that the coding is accuracy for section H 9 thru 13, level 2 PASSARS and weights of the most current MDS assessment.	

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F 278	Continued From page 7 should be coded correctly and accurately. 3. Resident #102 had been admitted to the facility on 4/19/16. Diagnoses included bipolar disorder and depression. Record review indicated Resident #102 had been evaluated as a Level II Preadmission Screening and Resident Review (PASRR) status (a resident identified as having a serious mental illness as defined by state and federal guidelines). The Admission MDS dated 4/26/2016 indicated Resident #102 had been alert and oriented. The assessment did not indicate Resident #102 had been evaluated as a Level II PASRR status. An interview with the MDS nurse on 07/19/2016 at 4:36 PM was conducted. The nurse stated she had been unaware of Resident #102's Level II PASRR status. The nurse stated she apparently had missed this information for resident #102. An interview with the DON was conducted on 7/21/2016 at 10:30 AM. The DON stated the MDS should be coded correctly and accurately. 4. Resident #108 had been admitted on 6/01/2016. Diagnoses included: altered mental status, acute renal failure and dehydration. Resident #108's admission MDS dated 6/8/2016 indicated he was alert and oriented, and required extensive assist with toileting. Noted to be frequently incontinent of urine. Bowel continence was "not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days." Review of Resident 108's medical record indicated he had been incontinent of bowel. No notation of an ostomy had been observed in the	F 278	The facility Director of Nursing will report finding of reviews to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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medical record.
An interview with Nurse #4 was conducted on 7/19/2016 at 2:38 PM. The nurse stated Resident #108 had been incontinent of bowel and did not have a colostomy.

An interview with nurse aide (NA) #1 was conducted on 7/19/2016 at 2:57 PM. The NA stated Resident #108 had been incontinent of bowel and required incontinent care about every two hours.

An interview with the MDS nurse on 07/19/2016 at 4:36 PM was conducted. The nurse stated the MDS had been miscoded and Resident #108 should have been coded as always incontinent of bowel.

An interview with the DON was conducted on 7/21/2016 at 10:30 AM. The DON stated the MDS should be coded correctly and accurately.

#5. Resident #63 was admitted on 3/1/2016 with diagnoses to include stroke.
Her admission Minimum Data Set (MDS) assessment date 3/8/2016 revealed the resident to be severely cognitively impaired. She required extensive assistance for Activities of Daily Living (ADLs), was occasionally incontinent of bladder, and had no bowel movement for the entire 7 day look back period.
A Nursing weekly/monthly summary dated March 2016 revealed Resident #63 was alert and oriented to person and time, and was continent of bowel and bladder.
A nurses note dated 3/2/2016 documented the

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"resident is alert and verbal and makes needs known. Resident continent of bowel and bladder. Walks with assistance."
A nurse's note dated 3/7/2016 documented the resident was alert and oriented and used the call bell for assistance with toileting needs.
An interview was conducted on 7/20/2016 at 10:44 AM with the MDS nurse. The MDS nurse stated she coded the MDS as no bowel movement in 7 days because there were no bowel movements recorded in the care tracker by the nursing assistants. She stated she had not documented anything during that time for the resident, so she did not know if the MDS was correct or not. She stated she usually interviewed staff, and the residents usually had bowel movements within the 7 day look back, but if no one had actually witnessed a BM, then she believed she was coding the section correctly.
On 7/21/2016 at 8:40 AM, an interview was conducted with the Administrator. The Administrator stated it was her expectation the MDS was coded correctly.
#6. Resident # 81 was admitted to the facility on 2/16/2016 diagnoses to include diabetes.
His admission Minimum Data Set (MDS) assessment 2/26/2016. His cognition was moderately impaired, and he required supervision for activities of daily living (ADLs). His assessment indicated he was always continent of bladder, but the bowel was coded as not rated, which meant no bowel movement (BM) for 7 days.
The resident's discharge MDS dated 4/29/2016 was coded as not rated for bowel, or no BM for 7 days.
The resident's quarterly MDS dated 5/19/2016 was coded as not rated for bowel, or no BM for 7 days.

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On 7/19/22016 at 3:07 PM, an interview was conducted with the nursing assistant (NA #1). The nursing assistant stated Resident # 81 was alert and oriented and could go to the bathroom on his own, but did have accidents at times. She indicated he went to the bathroom in inappropriate places at times, but would not have gone 7 days without a bowel movement (BM).
On 7/20/2016 at 4:22 PM, an interview was conducted with the nurse (Nurse #1). The nurse stated the resident would go to the bathroom on his own and would have accidents sometimes of urine. She stated there was never a time he did not have a BM for 7 days, as he would have been having signs and symptoms of no BM.
On 7/20/2016 at 10:50 AM an interview was conducted with the MDS nurse. The MDS nurse stated Resident # 81 could go to the bathroom on his own, and was not always in appropriate places. She indicated if the BM was not documented by the NA in the care tracker, she could not have put it in the MDS assessment. She stated she did interview staff, and was told he went to the bathroom by himself. The MDS nurse stated she coded the MDS as not rated, no BM for 7 days, because no one actually observed the BM, and she thought the coding was correct.
On 7/20/2016 at 1:49 PM an interview was conducted by the Director of Nursing (DON). The DON stated no BM for 7 days on the MDS would have been inaccurate, because the resident did have a BM before 7 days.
On 7/21/2016 at 8:40 AM, an interview was conducted with the Administrator. The Administrator stated it was her expectation the MDS was coded correctly.

7. Resident # 68 was admitted to the facility on 6/10/16. Diagnoses included dementia and

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F 278	Continued From page 11 hypertension. The Admission Minimum Data Set (MDS), dated 6/27/16, indicated Resident #68 had short and long term memory impairment and severely impaired cognitive skills for daily decision making. Active diagnoses did not include any type of psychiatric disorder including anxiety. The MDS revealed the resident had received an antipsychotic medication for 1 day during the assessment period and an antidepressant 7 days during the assessment period. The MDS nurse was interviewed on 7/20//16 at 3:12 PM. The MDS nurse reviewed the medication section of the MDS and confirmed the resident had received an antipsychotic and an antidepressant during the assessment period. She confirmed there were no psychiatric diagnoses coded. The MDS nurse added not adding a diagnosis was an oversight.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		8/16/16

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F 279	Continued From page 12 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Resident #75 was admitted to the facility on 1/21/16 with diagnoses that included hypertension and cardiac arrhythmia. Nurse's notes written on 3/26/16 at 2:35 PM indicated Resident #75 refused her medications and was combative. At 9:00 PM, the notes indicated the resident continued to refuse her medications and verbally threatened staff. Nurse's notes for 4/4/16 at 8:00 PM indicated Resident #75 refused her antibiotic stating she was a government nurse that knew what she needed. The nurse documented she had been unable to redirect the resident. The Quarterly Minimum Data Set,with an assessment reference date of 4/21/16, indicated Resident #75 was severely cognitively impaired. Hallucinations, delusions or behaviors were not captured during the assessment period. On 4/27/16 at 8:00 PM, the nurse documented in the daily notes that Resident #75 was searching for her husband. The care plan for Resident #75, last reviewed on 4/28/16, indicated the resident was cognitively impaired. The care plan indicated the resident	F 279	It is the practice of the Brian Center to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care. Resident #75 care plans were reviewed on 7/22/16 by Director of Care management. The residents care plans were updated to include behaviors of Hallucinations and delusions, refusal of care related to medication and assistances with activities of daily living. The facility MDS nurse will review current facility residents over next ninety days to ensure that residents comprehensive care plans include measurable objective and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment on 7/22/16. The District Coordinator of Care management will be provide re – education to the facility Social worker and MDS staff (Director and Coordinator) regarding the development of a comprehensive care plan for each resident that includes measurable	

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F 279	Continued From page 13 had the potential for depression, anxiety or a sad mood. Hallucinations and delusions were not care planned. Rejection of care had not been care planned. On 4/29/16 at 11:00 PM, the nurse documented Resident #75 was in and out of other resident's rooms. The nurse documented the resident stated she was a government nurse and limits did not apply to her. The notes also indicated Resident #75 attempted to hit and claw the nurse when her wheelchair was removed out of a male resident's room. Nurse's notes dated 4/30/16 at 2:00 AM indicated Resident #75 continued to walk the halls going in and out of other resident's rooms. The nurse documented the resident thought she worked in the facility and treated to call the government to report the staff. Nurse's notes for 5/7/16 indicated the resident continued to wander in and out of other resident's rooms. The nurse stated she was unable to Redirect Resident #75. An observation was made on 7/19/16 at 3:15 PM. Flies were on the resident's bed. Resident #75 stated while she had no problem with the flies, she did lie awake at night sometimes and see different colored bugs climbing up and down the walls. Nurse #1 was interviewed on 7/20/16 at 10:12 AM. The nurse stated Resident #75 refused her antibiotic and fussed about people being in her room. Nurse #1 added the resident talked about "off the wall" things such as a bullet being in her jaw. The nurse stated Resident #75 also thought	F 279	objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment on 7/20/16. The facility licensed nursing staff will be provided re- education on documentation of behaviors to include hallucinations , delusions and refusal of care by the Assistant Director of Nursing to be completed on 8/16/16. The director of nursing or her designee will bring the 24 hour report to the morning meeting Monday thru Friday for review with members of the interdisciplinary team (Social worker, Activity Director , Administrator) for thirty days . The review will include discussion of documented behaviors to ensure that that residents care plans reviewed and updated if indicated of in the resident's care plan. The facility administrator and /or director of nursing will review two sampled residents care plans to ensure that care plans reflect residents mental and psychosocial needs for four weeks and monthly times two months. The facility Administrator will report finding of reviews to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance	

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one of the male residents was her husband and would wander into his room.

On 7/20/16 at 10:37 AM, Nursing Assistant #5 was interviewed. She acknowledged Resident #75 thought one of the male residents was her husband and thought she owned the facility. At times, the NA added, the resident refused care. The NA added the resident frequently packed her clothing to either go home or go the hospital to work.

The MDS Nurse was interviewed on 7/20/16 at 3:24 PM. The MDS nurse stated that she and the Social Worker (SW) were responsible for careplanning behaviors. She stated she had not been aware of the resident going in other resident's room, was not aware of the verbal and physical aggression and unaware of the hallucinations and delusions.

The SW was interviewed on 7/20/16 at 3:41 PM. She stated she and the MDS nurse were responsible for care planning residents' behaviors. The SW added behaviors exhibited by Resident #75 included stating she was calling the government because she was a government nurse and accused the room mate of sleeping with her husband. The SW acknowledged Resident #75 had hallucinations and delusions. She stated she was unaware the resident wandered into other residents' rooms and was unaware of the resident's aggressive behavior. The SW stated she had not care planned the resident's behavior because she thought the MDS nurse had care planned the behaviors. The SW added although the care plan had been reviewed in April 2016, she was unaware the resident had no behavior care plan.

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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: The facility failed to obtain an urinalysis (UA) in a timely fashion, failed to notify the medical doctor (MD) of a resident's refusal to take an antibiotic and failed to notify the MD of a resident's hallucinations and delusions for 1 of 1 sampled resident (Resident #75) who was reviewed for hallucinations and delusions. Findings included: Resident #75 was admitted on 1/21/16 with diagnoses that included aortic arch aneurysm, back pain, hypertension and cardiac arrhythmia. Daily Skilled notes for 3/18/16 at 6:25 PM revealed the resident was more confused. The nurse documented she notified the MD who ordered a UA with a culture and sensitivity (C&S). Review of nurse's notes did not document an attempt to collect the urine as ordered by the MD. Lab results reported on 3/24/16 at 5:40 PM revealed the urine for the UA, C&S was collected on 3/21/16. The final culture indicated greater than 100,000 colony forming units per milliliter of	F 309	1. It is the practice of the Brian Center that each resident of the facility receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment plan of care. The facility Director of Nursing and Assisted Director of Nursing completed a review of current facility residents' physician orders for past sixty days to ensure that physician orders for urinalysis were obtained and the attending physician had been notified of results on 8/4/16. The facility Director of Nursing and Assisted Director of Nursing completed review on the facility current facility resident medication records for past sixty days to ensure that if residents had refused medication or treatment that physician had been made aware on 8/10/16. The facility Director of Nursing or	8/16/16

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F 309	Continued From page 16 urine of Proteus mirabilis (a type of bacteria that causes urinary tract infections). The MD was notified and Cipro (an antibiotic) 500 milligrams twice daily for 7 days was ordered for the infection. Review of nurse's notes for 3/25/16 at 10:00 PM indicated the nurse attempted to give Resident #75 her antibiotic. The nurse documented the resident became very loud and refused the medication. Nurse's notes written on 3/26/16 at 2:35 PM indicated Resident #75 was refusing the antibiotic, was confused and combative. At 9:00 PM, the nurse documented the refusal of medication continued with verbal threats to staff. Review of the March 2016 Medication Administration Record (MAR) indicated Resident #75 received 3 of 14 doses of Cipro. No indication the MD was notified had been documented on the MAR or in the nurse's notes. Nurse's notes for 4/4/16 at 8 PM indicated the resident refused her antibiotic stating she was a government nurse that knew what she needed. The nurse documented she had been unable to redirect the resident. On 4/27/16 at 8:00 PM, the nurse documented in the daily notes the resident was searching for her husband. The care plan, last reviewed on 4/28/16, had not identified refusal of medication as a problem. Hallucinations and delusions with goals and interventions were not indicated.	F 309	Assistant Director of nursing will review the facility lab tracking log to ensure that labs were collected per physician orders. The audit will be conducted daily for thirty days, weekly times two months. The facility director of Nursing or Assisted Director of nursing will review current facility resident's medication records daily for thirty days and weekly times two months. The review will be completed to ensure that the physician had been made aware of medication refusals. The facility Director of Nursing or Assistant Director of Nursing will review the 24 hour reports daily for documented behaviors and MD notification for thirty days and weekly times two months. The review will be completed to ensure that the physician has been made aware of behavior changes. On 7/20/16 the facility provided re-education to licensed nurses on Medication Refusal Documentation/MD Response Notification and completed on 7/25/16 by the Assistant Director of Nursing. On 8/15/16 the facility provided re-education to licensed nurses on Behavior Documentation/MD Notification to be completed by 8/17/16 by the Assistant Director of Nursing. 7/20/16 the facility licensed nursing staff were provided re- education regarding obtaining labs per physician orders and notification of physician if unable to obtain. The re- education was completed on	

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F 309	Continued From page 17 On 4/29/16 at 11:00 PM, the nurse documented the resident was in and out of other resident's rooms. Resident #75 stated she was a government nurse and limits did not apply to her. The nurse documented Resident #75 attempted to hit and claw her when she removed Resident #75's wheelchair from the male resident's room. Verbal abuse received from resident was also documented by the nurse. Nurse's notes dated 4/30/16 at 2:00 AM indicated the resident continued to walk the halls going in and out of other residents' rooms. The nurse documented Resident #75 thought she worked for the facility and threatened to call a government agency to report the nurse. The Quarterly Minimum Data Set (MDS), dated 5/3/16, indicated Resident #75 was severely cognitively impaired. Hallucinations and delusions were not captured. No behaviors were identified. Rejection of care was not identified. Nurse's notes for 5/7/16 indicated the resident continued to wander in and out of other resident's rooms. The nurse stated she was unable to redirect the resident. Review of the 5/23/16 MD's progress note indicated the MD had documented Resident #75 had a diagnosis of dementia without behavioral disturbance. On 7/18/16 at 8:50 AM, the resident was observed and interviewed. During the observation, the resident stated she felt fine with the exception of her right jaw. When asked what happened to her jaw, the resident stated she had been shot through the forehead 3 weeks prior	F 309	7/25/16 by the Assistant Director of Nursing. The facility Director of Nursing will report finding of weekly reviews to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance F278 Resident #46 MDS assessment ARD 6/23/16 was modified on 7/20/16 to reflect Level II PASRR status Resident # 46 MDS assessment ARD 6/23/16 KO200 was modified to reflect weight of 252#. Modification was completed on 7/20/16. Resident # 102 MDS assessment ARD 4/26/16 was modified to reflect Level II PASRR. Modification was completed on 7/20/16. Resident #108 MDS assessment ARD 6/18/16 H0400 was modified to reflect always incontinent of bowel. Modification was completed on 7/19/16 Resident #63 MDS assessment ARD 3/8 RCMD reviewed medical record dates 3/2/16-3/8/16. Nurse's note dated 3/2/16 documented that the resident is alert and verbal and able to make needs known. Resident is continent of bowel and bladder. Nurse's notes on 3/7/16 and 3/8/16 reflect incontinent of bowel. H0400 modified to be frequently incontinent of bowel. Resident # 81 MDS assessments with ARDs 2/26/16, 4/29/16, 5/19/16 bowel incontinence was coded as not rated on	

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F 309	Continued From page 18 and the bullet was still in her jaw. Resident #75 added she had been shot by the uncle of an employee from the back door as he was having a heart attack. An observation was made on 7/19/16 at 3:15 PM. Flies were on the resident's bed. Resident #75 stated while she had no problem with the flies, she did lie awake at night sometimes and see different colored bugs climbing up and down the walls. Nurse #5 was interviewed on 7/19/16 at 4:50 PM. Nurse #5 stated she was the primary nurse for Resident #75 on the 7:00 AM to 7:00 PM shift. The nurse stated Resident #75 had been telling her since admission she had been shot in the jaw at a post office and was also a nurse. The nurse stated she had confirmed with the resident's family member that neither of these statements were true. Nurse #5 added she considered the hallucinations part of the resident's dementia and had not notified the MD about the hallucinations. Nurse #5 stated when she received an order for a UA, she would try to get the urine specimen. If she was unable, she passed it along to the next shift. She added she documented in the nurse's notes the attempt to collect the needed specimen and any conversations held with the MD. The nurse added if she had not obtained the specimen in 2 to 3 days she would notify the MD. She added she had given the resident a urine collection hat because Resident #75 was continent. The resident used the hat and then sat the collection hat on the floor. Nurse #5 stated she threw the urine away because she was unsure how long the urine had sat. The nurse reviewed the notes and added she had not informed the MD about the inability to collect the	F 309	MDS assessments. Assessments with ARDs 2/26/16, 4/29/16 and 5/19/16 modified on 8/12/16 to reflect HO400 always continent based on staff interview. Resident #68. Diagnosis update was completed on 7/20/16. Re-education was completed by Regional Care Manager on 7/20/16 re- education will include adequate coding of section H-9 thru 13, level 2 PASSAR and accurate assessment that reflects the resident's status to include weights. The Facility Director of Care Management will complete review facility resident last 90 days for assessments to ensure that level 2 PASSARS, accurate weights and section H 9 thru 13 coded per RAI guidelines. The facility Director of Nursing and/or District Director of Care management w will review two sampled residents weekly times four, monthly times two to ensure that the coding is accuracy for section H 9 thru 13, level 2 PASSARS and weights of the most current MDS assessment. The facility Director of Nursing will report finding of reviews to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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urine specimen. Nurse #5 added if a resident refused 1 to 2 doses of medication, she notified the MD. The nurse reviewed the 3/18/16 order for a UA for Resident #75 and stated she remembered. The nurse reviewed the MAR for Resident #75 and stated it appeared she had not received more than 3 doses of Cipro of the 14 ordered. The nurse verified she had worked during the time the resident refused the medication, but had not called the MD regarding the resident's refusal.

Nurse #1 was interviewed on 7/20/16 at 10:12 AM. Nurse #1 stated night shift nurses were responsible for collecting lab specimens including urine for UAs. Nurse #1 added if the nurse was unable to obtain the specimen, the MD should be notified within a few days. She added if a resident refused medications, the MD should be notified. Nurse #1 also added the nurse should have documented the inability to collect the ordered specimen. The nurse reviewed the MAR for March 2016 and verified she had worked during the time the resident had been ordered the antibiotic. She stated she did not think she called the MD to notify him Resident #75 had refused the antibiotic. Nurse #1 stated Resident #75 talked about things such as a bullet being in her jaw. She acknowledged the resident wandered in and out of other residents' rooms, thinking one of the male residents was her husband. Nurse #1 stated she had not reported the resident's hallucinations and delusions to the MD.

Nursing Assistant (NA) #5 was interviewed on 7/20/16 at 10:37 AM. The NA cared for the resident and stated she was familiar with the resident. The NA stated at times the resident refused care. She added Resident #75 talked to

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herself, thinks she owns the facility and also thought one of the male residents was her husband. At times, the NA stated, the resident talks as if she's talking to someone when in reality there is no one in her room. The NA added on an almost daily basis, Resident #75 packed her clothing saying she was either going home or going to the hospital to work. The NA stated another behavior exhibited by Resident #75 was threatening to call the FBI on the staff frequently.

On 7/20/16 at 3:41 PM, the Social Worker (SW) was interviewed. The SW stated behaviors exhibited by Resident #75 included "talking out of her head" most of the time. Examples given by the SW included calling the government on the staff, saying she was a government nurse and had accused a former room mate of sleeping with her husband. The SW had not reported the resident's behaviors to the MD.

The Director of Nursing (DON), was interviewed on 7/20/16 at 3:51 PM. The DON stated when the MD gave an order for a UA, an attempt should be made within 24 hours to collect the specimen. If the nurses were unable, then a call should be placed to the MD for further orders. The DON added if a resident refused an ordered medication, she expected the nurses to notify the MD immediately. The DON added she considered Resident #75's conversations about being a government nurse and being shot as a hallucination or delusion since both issues had been clarified with a family member who confirmed the resident had not been shot and had not been a nurse. The DON added psychiatric services were available to the residents in the facility. The DON reviewed the 3/18/16 MD

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order for collection of a UA and stated waiting 3 days to collect the urine was not acceptable. She stated she would have expected to find nurse's notes that indicated attempts were made. The nurse reviewed the nurse's notes and acknowledged there was no documentation that indicated urine collection was attempted or the MD notified. After review of the MAR for March 2016, the DON stated the best she could tell was Resident #75 may have received a few doses of the Cipro, which would have really been ineffective towards her infection. The DON added she would have expected staff to notify the MD and then document the conversation in the nurse's notes. The DON stated she had not informed the MD about the resident's hallucinations and delusions; adding most staff thought that behavior was normal for the resident; although, it was not normal behavior. She stated undiagnosed mental illness and lack of assessment and/or treatment could impact Resident #75's quality of life.

On 7/21/16 at 7:32 AM, Nurse #2 was interviewed. The nurse stated Resident #75 was drawn to residents that yelled out. In particular, there was one male resident that Resident #75 believed to be her husband. When he yelled out, Resident #75 would tell the nurses something needed to be done for him. Additionally, the resident would sit quietly by the male resident's bedside. She stated the resident did have delusions and hallucinations and gave the example of the resident stating she had been shot and was a government nurse as examples. The nurse stated she had verified with the daughter than neither of these stories were truth. She added the resident would show her AARP card and say it was proof she was a government

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F 309	Continued From page 22 nurse. The nurse stated she doesn't remember receiving an order for a UA but was sure she had not collected a urine from the resident. She stated she was sure she had not heard anything passed on in report about the need to collect a urine. On review of the MAR the nurse stated at most the resident had received 2-4 doses of the Cipro, but added the Cipro had been reordered and the resident received this in April 2016. Review of the April 2016 MAR revealed the Cipro had been re-ordered, but again the resident had not taken the ordered amount. The nurse stated during report both she and the day nurse had spoken of the resident's delusions or hallucinations, but she had not spoken with the DON about her concerns. The nurse stated she felt the delusions and hallucinations were due to age and progression of the resident's disease process. The nurse stated there had only been one episode when the resident had kicked and screamed and that was when a resident had asked she be removed from the room. Nurse #2 confirmed she had not reported to the MD the resident's refusal to take the ordered medication and had not reported her delusions or hallucinations.	F 309		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 469	It is the practice of the Brian Center to	8/16/16

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F 469	Continued From page 23 interviews and record review, the facility failed to maintain an effective pest control program for ants on 1 of 4 halls observed and failed to maintain an effective pest control program for flies on 4 of 4 halls observed and the dining areas. Findings included: 1. Resident #11 was admitted on 7/2/12 with dementia, psychosis and seizures. His most recent Minimum Data Set, a quarterly, indicated the resident was severely cognitively impaired and required assistance with all activities of daily living. An observation was made on 7/19/16 at 3:00 PM. Resident #11 was lying in bed with the long edge of the bed against the wall. Above the bed were seen numerous small black bugs; too numerous to count, approximately 6 inches above the edge of the bed. No bugs were seen on the resident's bed or the resident. At 3:45 PM on 7/19/16, an observation was made with the Administrator. The small black bugs, that the Administrator identified as ants, were still on the wall above the resident's bed. There were no ants observed on the resident or his bed. The Administrator immediately moved the resident had the room cleaned. She stated the nursing assistant (NA), nurse or the staff ambassador assigned to Resident #11 should have reported the ants to the Maintenance Director. Nurse #5, who had been assigned to care for Resident #11, was interviewed on 7/1916 at 4:50 PM. The nurse stated she had not been in Resident 11's room since 9:00 AM and at that	F 469	maintain an effective pest control program so that the facility is free of pests and rodents. A facility round to include all facility resident rooms was completed with Ecolab and the Maintenance Director of the Brian Center 7/21/16. On 7/21/16 corrective action was taken by Ecolab Pest Control by treating the building for flies with a spot application in the exterior of the building, the exterior courtyard, and the garbage area-exterior for Resident #16,#42,#56,#6,#16,#55,,#65,,#52,#21,#88,#21,#112,#60,#79,#5,#45,#102,#5. EcoLab Pest control also treated for ants in the cracks and crevice of patient/guest rooms interior; the room for Resident #11. The Brian Center also commissioned Ecolab to replace the ultraviolet bug lights owned by the Brian Center, with the stronger more effective ultraviolet bug lights that Ecolab installs and monitors on a monthly basis. The purchase and installation is set to be completed by 8/12/16. Ecolab will also apply a full exterior treatment for ants to the exterior of the building. The facility staff will be provided re-education regarding the action to be taken if resident is observed or communications any issue regarding pest on 7/19/16 and completed 7/21/16 the assistant director nursing. Facility staff that does not receive the re- education will receive prior to	

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F 469	Continued From page 24 time, she had not seen any bugs on the wall. The nurse stated had she seen the bugs, she would have notified the Director of Nursing and would have completed a maintenance request form. On 7/20/16 at 8:21 AM, Nursing Assistant (NA) #5 was interviewed. She acknowledged she had been the NA for Resident #11 on 7/19/16. The NA stated she had last been in the resident's room around 2:15 PM when she had placed him in bed. The NA stated she had not seen any bugs on the resident's wall. NA #5 added if she had seen bugs, she would have reported it to the Maintenance Director. The Social Worker (SW) was interviewed on 7/20/16 at 1:47 PM. She acknowledged she had been the Ambassador (the ambassador program is a program that provided a facility advocate to check on residents daily to allow verbalization of concerns and check for environmental issues includes lights, safety issues, broken items, spills or need of immediate care) on 7/19/16 for Resident #11. She stated she had been in Resident #11's room between 7:30 AM and 8:00 AM on 7/19/16 and had seen no bugs on the wall above the bed. The SW added if she had seen any bugs on the resident's wall she would have reported the problem to the Maintenance Director. 2. On initial entry to the facility on 7/17/16 at 4:45 PM, Resident #16 was seen going down the hall in his wheelchair, using a flyswatter as he went to kill flies. The resident stated the flies were terrible and he could not get ahead of them. During an observation beginning on 7/17/16 at	F 469	working next scheduled shift. Maintenance staff will monitor the presence of flies, ants and all other insects within the building; and the Ambassador rounds will to be completed daily M-F to report any insects to the Maintenance Director of the Brian Center; and the Manager on Duty will report any findings on the weekends. For sixty days. The facility Administrator will report finding of observation audits to the facility Quality Improvement Committee monthly times two months. The Committee will evaluate the results and implement additional interventions as needed to ensure continued compliance	

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6:08 PM, Resident # 42 had 3 flies crawling on his bed while the resident was in bed.

At 6:10 PM on 7/17/16, Resident #56 was sitting in his wheelchair by his bed. His dinner had been placed on his over bed table. While the resident was difficult to understand due to his disease process, he stated the flies were a mess. At this time, flies were seen on the lip of his beverage glass. Resident #56 demonstrated he was unable to use his right upper extremity, but stated he tried his best to shoo the flies off his food tray using his left hand.

During and interview with Resident #6 on 7/19/16 at 2:45 PM, the resident was observed sitting in the entry to her room with a fly swatter. She stated she was not aware of anything the facility had done to control flies other than give residents a fly swatter.

Nursing Assistant (NA) #6 was interviewed 7/19/16 at 2:39 PM. The NA stated the flies had been bad since the weather had turned so hot. She added she thought the flies came in through the door to the smoking area when the door was held open for residents to go in and out. She stated facility measures to control flies included staff using fly swatters; adding some residents had fly swatters given to them by the Activity Director, the Maintenance Director (MD) and family members brought fly swatters to residents. The NA stated she had seen the flies on residents that could not shoo them off and during meals. NA #6 added flies landed on the food trays and occasionally got on the resident's food. The residents that complained the most about the flies lived on the 100 hall that was closest to the exit to the smoking area.

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Resident #16 was interviewed on 7/19/16 at 2:50 PM. The resident was swatting at flies with his fly swatter. He stated he could not get ahead of the flies and what the facility really needed was to spray. He stated the flies got on his food when he ate and on his beverages. The resident stated he should not have to complain about the flies, adding, "everyone can see them". In Resident #16's bathroom, there were 2 bed pans uncovered with fluid in the bedpans. Flies were observed on the edges and inside the bed pans.

Resident #55 was observed on 7/19/16 at 3:00 PM. The resident was sitting in his chair by the bed. He had flies on his face, but made no attempt to shoo the flies away. The resident did not respond to questions.

The facility receptionist was interviewed on 7/20/16 at 1:38 PM. The receptionist stated she was also a NA had had been in the dining room during lunch the day before. She stated she had seen flies on the resident's tables and had tried to shoo them away. The receptionist stated the flies had been really bad for about a month. Fly swatters had been given to the residents by the previous administrator. The receptionist added she had heard residents comment on the number of flies and added she thought the majority of the flies entered. She added there was a device over the door to help keep flies out, but it never made a noise. The receptionist stated she had made the previous administrator aware residents had complained about the number of flies and knew the current administrator was aware because she had purchased more fly swatters a few weeks back. The receptionist added she had spoken to the MD a while back and informed him a lot of

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flies were entering the building through the door to the smoking area. She was unaware if any measures had been placed to reduce the number of flies after she had spoken to him.

On 7/19/16 at 3:10 PM, an observation was made in Resident #52's room. While the resident was not in her room, her lunch tray remained. Flies were observed crawling all over the tray.

Resident #65 was interviewed on 7/19/16 at 3:15 PM. Resident #65 stated there were lots of flies all over the building. The resident stated she thought the flies were coming in the building through the employee entrance since there was a lot of activity through that entrance. She described the flies as aggravating and stated she was unaware of any action by the facility to control the flies.

Resident #21 was observed sitting in his room in his wheelchair on 7/20/16 at 3:16 PM. There was an odor coming from his bathroom. Sitting in wheelchair in room . Flies were crawling on the resident's pants and shirt. Resident #21 made no attempt to shoo the flies away.

Resident #88 was interviewed on 7/19/16 at 3:16 PM as she sat in the hall in her wheelchair. Resident #88 stated the flies had been bothering her for a couple of weeks.

On 7/19/16 at 3:20 PM, Resident #112 was interviewed. The resident lived in a room close to the front entrance of the building. The resident stated the flies were all over the place and had been for a week or two. Resident #112 added she thought there were a lot of flies in her room because her room was near the front door. She

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added someone from the facility had given her a fly swatter. The resident added the only reason the flies did not get on her food or beverages was because she was constantly shooing them away.

Resident #60 was interviewed while lying in her bed on 7/19/16 at 3:30 PM. At the time of the interview 3 flies were seen on the resident's pillow above her head. The resident stated the facility had given her a fly swatter, but she was not very good at using it. She added it was just easier to try to chase the flies away. Resident #60 added she kept the flies off her food and beverages by trying to keep an eye on them.

On 7/19/16 at 4:08 PM, the Maintenance Director (MD) was interviewed. He stated a contracted pest control company visits the facility monthly. He stated he remembered during past surveys flies being an issue that had been discussed. Since then, fly boards had been placed outside and a few fly lights had been placed inside the facility in the dietary department and in the service hall. Additional interventions included pest lights on each hall. The MD added the contract company sprayed up 3 feet on the side of building and 3 feet out about 6 months ago was done for ants. The MD stated in the past, he had requested the contract company spray inside the building, but had not done that since the previous summer. He stated he had called yesterday to get someone to come in to spray for flies. The MD stated the flies had not been bad until this week.

Nurse #4 was interviewed on 7/20/16 at 11:00 AM. She acknowledged the flies in the building were bad and seemed to be worse at this time. The nurse added she thought it was due to the

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door being held open for residents going in and out of the building to smoke.

3. Resident #79 was admitted to the facility on 2/10/16 with diagnoses which included stroke with left sided hemiplegia, diabetes and blindness in the left eye. Her most recent MDS, a quarterly assessment dated 6/21/16, revealed she was moderately cognitively impaired, required extensive assistance with ADLs and had functional limitation impairment on one side of both the lower and upper extremity.
On 7/19/16 at 12:40 PM Resident #79 was observed in the dining room attempting to feed herself. A fly was observed on the side of her bowl containing pudding. During this same observation, the facility receptionist stated she saw flies in the dining room. The receptionist was observed shooing a fly after Resident #79 had unsuccessfully attempted to shoo the fly away from her food.
NA #6 was interviewed 7/19/16 at 2:39 PM. The NA stated the flies had been bad since the weather had turned so hot. She added she thought the flies came in through the door to the smoking area when the door was held open for residents to go in and out. She stated facility measures to control flies included staff using fly swatters; adding some residents had fly swatters given to them by the Activity Director, the Maintenance Director (MD) and family members brought fly swatters to residents. The NA stated she had seen the flies on residents that could not shoo them off and during meals. NA #6 added flies landed on the food trays and occasionally got on the resident's food. The residents that complained the most about the flies lived on the 100 hall that was closest to the exit to the

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smoking area.
On 7/19/16 at 4:08 PM, the Maintenance Director (MD) was interviewed. He stated a contracted pest control company visited the facility monthly. He stated he remembered during past surveys flies being an issue that had been discussed. Since then, fly boards had been placed outside and a few fly lights had been placed inside the facility in the dietary department and in the service hall. Additional interventions included pest lights on each hall. The MD stated in the past, he had requested the contract company spray inside the building, but had not done that since the previous summer. He stated he had called yesterday to get someone to come in to spray for flies. The MD stated the flies had not been bad until this week.
The facility receptionist was interviewed on 7/20/16 at 1:38 PM. The receptionist stated she was also a NA that had had been in the dining room during lunch the day before. She stated she had seen flies on the residents ' tables and had tried to shoo them away. The receptionist stated the flies had been really bad for about a month. Fly swatters had been given to the residents by the previous administrator. The receptionist added she had heard residents comment on the number of flies and added she thought the majority of the flies entered from the smoking area exit door. She added there was a device over the door to help keep flies out, but it never made a noise. The receptionist stated she had made the previous administrator aware residents had complained about the number of flies and knew the current administrator was aware because she had purchased more fly swatters a few weeks back. The receptionist added she had spoken to the MD a while back and informed him a lot of flies were entering the

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building through the door to the smoking area. She was unaware if any measures had been placed to reduce the number of flies after she had spoken to him.
4. Resident #5 was readmitted to the facility on 4/14/16 with diagnoses which included diabetes, end stage renal disease, hemodialysis, right above the knee amputation and left below the knee amputation. Her most recent MDS, a 60 day assessment dated 6/15/16, revealed she was cognitively intact and required extensive to total assistance with all ADLs.
On 7/19/16 at 4:46 PM Resident #5 stated she had observed flies in her room since she was readmitted in April and had to use a fly swatter to try to kill them. She stated she even had a "fly strip" hidden near her bulletin board but a staff member told her it was not allowed. She stated the "fly strip" was removed while she was not present. Resident #5 stated the flies were a problem all during the day and night.
NA #6 was interviewed 7/19/16 at 2:39 PM. The NA stated the flies had been bad since the weather had turned so hot. She added she thought the flies came in through the door to the smoking area when the door was held open for residents to go in and out. She stated facility measures to control flies included staff using fly swatters; adding some residents had fly swatters given to them by the Activity Director, the Maintenance Director (MD) and family members brought fly swatters to residents. The NA stated she had seen the flies on residents that could not shoo them off and during meals. NA #6 added flies landed on the food trays and occasionally got on the resident's food. The residents that complained the most about the flies lived on the 100 hall that was closest to the exit to the smoking area.

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On 7/19/16 at 4:08 PM, the Maintenance Director (MD) was interviewed. He stated a contracted pest control company visits the facility monthly. He stated he remembered during past surveys flies being an issue that had been discussed. Since then, fly boards had been placed outside and a few fly lights had been placed inside the facility in the dietary department and in the service hall. Additional interventions included pest lights on each hall. The MD stated in the past, he had requested the contract company spray inside the building, but had not done that since the previous summer. He stated he had called yesterday to get someone to come in to spray for flies. The MD stated the flies had not been bad until this week.

5. Resident #45 was admitted to the facility on 1/6/12 with current diagnoses which included oral cancer, seizure disorder, wound care of her oral cancer and comfort care. Her MDS an annual assessment dated 5/5/16 revealed she was moderately cognitively impaired and required extensive to total assistance for ADLs except she was independent with eating.

On 7/20/16 at 1:29 PM 4 flies were observed in the room of Resident #45. On 7/20/20/16 at 2:14 PM Resident #45 stated she had finished eating and wanted to go back to sleep. She was observed to pull the covers over her head. She stated she put the covers over her head due to the flies bothering her while she was trying to sleep.

NA #6 was interviewed 7/19/16 at 2:39 PM. The NA stated the flies had been bad since the weather had turned so hot. She added she thought the flies came in through the door to the smoking area when the door was held open for residents to go in and out. She stated facility measures to control flies included staff using fly

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swatters; adding some residents had fly swatters given to them by the Activity Director, the Maintenance Director (MD) and family members brought fly swatters to residents. The NA stated she had seen the flies on residents that could not shoo them off and during meals. NA #6 added flies landed on the food trays and occasionally got on the resident's food. The residents that complained the most about the flies lived on the 100 hall that was closest to the exit to the smoking area.
On 7/19/16 at 4:08 PM, the Maintenance Director (MD) was interviewed. He stated a contracted pest control company visits the facility monthly. He stated he remembered during past surveys flies being an issue that had been discussed. Since then, fly boards had been placed outside and a few fly lights had been placed inside the facility in the dietary department and in the service hall. Additional interventions included pest lights on each hall. The MD stated in the past, he had requested the contract company spray inside the building, but had not done that since the previous summer. He stated he had called yesterday to get someone to come in to spray for flies. The MD stated the flies had not been bad until this week.

6. Resident #42 had been admitted on 2/16/2016. Diagnoses included hemiplegia, seizures, hypertension, diabetes, coronary artery disease and congestive heart failure. His most recent quarterly minimum data set (MDS) dated 5/16/2016 indicated he had severe cognitive impairment and required extensive to total assistance with activities of daily living (ADL).

On 7/21/2016 at 8:40 AM an observation was

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made of resident #42. Resident #42 was in his room eating breakfast and was observed shooing flies from coming near his food. Flies were observed to land on the table near his breakfast tray and on the bed sheets.

On 7/19/16 at 4:08 PM, the Maintenance Director (MD) was interviewed. He stated a contracted pest control company visits the facility monthly. He stated he remembered during past surveys flies being an issue that had been discussed. Since then, fly boards had been placed outside and a few fly lights had been placed inside the facility in the dietary department and in the service hall. Additional interventions included pest lights on each hall. The MD added the contract company sprayed up 3 feet on the side of building and 3 feet out about 6 months ago was done for ants. The MD stated in the past, he had requested the contract company spray inside the building, but had not done that since the previous summer. He stated he had called yesterday to get someone to come in to spray for flies. The MD stated the flies had not been bad until this week.

7. Resident #102 had been admitted on 4/19/2016. Diagnoses included bipolar disorder, depression, debility and anemia. Her admission minimum data set (MDS) dated 4/26/2016 indicated she was cognitively intact and required limited assistance with activities of daily living (ADL).

On 7/20/2016 at 4:10 PM an observation was made of Resident #102. Resident #102 was observed propelling herself in the hall in her wheelchair. She was holding a cup with a straw between her knees and a fly was observed on the

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	345262	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

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F 469	Continued From page 35 drinking end of the straw. Resident #102 stated she had to swat at the flies to keep them away. On 7/19/16 at 4:08 PM, the Maintenance Director (MD) was interviewed. He stated a contracted pest control company visits the facility monthly. He stated he remembered during past surveys flies being an issue that had been discussed. Since then, fly boards had been placed outside and a few fly lights had been placed inside the facility in the dietary department and in the service hall. Additional interventions included pest lights on each hall. The MD added the contract company sprayed up 3 feet on the side of building and 3 feet out about 6 months ago was done for ants. The MD stated in the past, he had requested the contract company spray inside the building, but had not done that since the previous summer. He stated he had called yesterday to get someone to come in to spray for flies. The MD stated the flies had not been bad until this week.	F 469		
F 520 SS=E	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 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	F 520		8/16/16

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F 520	Continued From page 36 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 record review and staff interview the facility's Quality Assurance (QA) Committee failed to maintain implemented procedures and effective monitoring practices to address accurate coding of the Minimum Data Set (MDS) to ensure compliance as sustained. The facility had a pattern of a re-cited deficiency which was originally cited in September 2015 on a recertification survey and on the current survey for accurate MDS coding. 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: This tag was cross referenced to: 2. F278- Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 7 of 16 residents who had their MDS reviewed. During the recertification survey of September 2015 the facility was cited for failing to accurately code the MDS for 5 of 15 residents whose MDS was reviewed. During an interview with the Administrator and the	F 520	It is the practice of the Brian Center to maintain a quality assessment and assessment committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The Quality Assurance and Performance Improvement (QAPI) committee met on 7-21-16 to discuss potential survey results to include discussion of repeat citation related to F278. The committee met on 8/10/16 and discussed final results of the surrey on 7/21/16. Discussion included actions already taken to correct procedures involved in the citations and plan for alleging compliance. The Division Director of Clinical Service will provide re-education to facility department managers and medical director regarding the Quality Assurance	

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F 520	Continued From page 37 Director of Nursing (DON) on 7/21/16 at 11:25 AM, the Administrator stated the Quality Assurance Performance Improvement Committee met monthly to discuss any concerns identified through resident/family interviews, audit results or monthly reports. The Administrator stated since she had been with the facility for one month, she was unsure how the QA committee had worked on the MDS accuracy issue from the year before. The DON stated MDS accuracy had been first discussed in the QA meeting held on 11/11/15 which indicated audits were continuing on completed assessments. The audits of MDSs had started at the completion of the September 2015 recertification survey. In review of the QA notes, the DON stated the committee had deemed the MDS accuracy issue resolved in December 2015 and no further audits were needed. The DON added the new MDS nurse had started in October 2015. The new MDS nurse came from another state where there she had completed the MDS too. The DON stated she was unsure if any audits had been completed on MDSs completed by the new MDS nurse.	F 520	and Performance Improvement process. The Division Director of Clinical Service and/or the Division Director of Operations will attend QAPI meeting weekly times four and monthly times two if possible to ensure that plan of correction has been implemented and maintained. If either is unable to attend the meeting; minutes and supporting documentation will be emailed to them. The facility QAPI committee will meet weekly times four and monthly times two to discuss results of audits related to the plan of correction for complaint survey July 21, 2016. The committee will analyze and trend the data to determine if revision to the plan of correction is needed. The Administrator will complete monthly audits for 6 months on the QAPI program to ensure that it meets all member requirements. Administrator will report findings from the monthly audits at the monthly QAPI meetings for review	