

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 224} SS=E	<p>483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility neglected to implement the correct treatment order for a resident with a pressure ulcer (Resident #69), neglected to provide incontinent care (Resident #145), and neglected to provide nail care (Resident #130) for 3 of 4 sampled residents.</p> <p>The findings included:</p> <p>1. Resident #69 was most recently readmitted to the facility on 08/28/17. Review of Resident #69's medical record revealed that he had been present in the facility 08/01/17 through 08/08/17 and again from 08/14/17 through 08/22/17. His</p>	{F 224}	<p>F224</p> <p>1. On 9/5/17 thru 9/8/17 resident#130 observed with long nails, with brown debris under the nails. Resident #130 nails trimmed and cleaned on 9/8/17.</p> <p>Resident #69 was readmitted to the facility on 8/14/17 review of medical records revealed no order for treatment to the pressure ulcer to left ear. Physician's order obtained on 9/5/17 for pressure ulcer to Left ear for resident #69.</p> <p>On 9/6/17 observation of Resident #145 revealed resident's brief to be heavy with urine. Resident #145 received incontinent care and will receive incontinent care routinely.</p> <p>2. Residents dependent on staff for nail care have the potential to be affected. Current residents nails were checked by Ambassadors for cleanliness and length and service provided as needed.</p> <p>All residents with pressure areas have the potential to be affected by the alleged deficient practice. Administrative RN (DON,ADON,Nurse Manager, Unit Coordinator) will</p>	10/22/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 224}	<p>Continued From page 1</p> <p>diagnoses included hemiplegia/hemiparesis, sepsis, pressure ulcer of the sacrum, retention of urine, and others.</p> <p>Review of the most recent quarterly minimum data set (MDS) dated 07/31/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #69 required total assistance of 2 staff members for bed mobility and had 1 Stage 3 pressure ulcer and 1 Unstageable pressure ulcer.</p> <p>Review of a wound assessment by the Wound Nurse Practitioner (WNP) dated 08/01/17 indicated that Resident #69 had 4 stage 3 pressure ulcers. The locations of the wounds were: left heel, left ankle, left sacrum, and left ear. The recommended treatment to the left ear wound was calcium alginate and hydrocolloid dressing.</p> <p>Review of a physician order dated 08/01/17 read, hydrocolloid to left ear every Tuesday and Saturday for wound to left ear.</p> <p>Review of the Treatment Administration Record (TAR) dated 08/01/17 through 08/31/17 contained the following: hydrocolloid to left ear every Tuesday and Saturday for wound to left ear. The order date was 08/01/17 and the discontinue date was 08/14/17.</p> <p>Review of the physician orders from Resident #69's readmission to the facility on 08/14/17 revealed no order for the treatment to the pressure ulcer to the top of the left ear.</p> <p>Review of the TAR dated 08/01/17 through</p>	{F 224}	<p>complete an audit of all residents with pressure areas by 10/22/17 to ensure treatment initiated and Practitioner notification occurred.</p> <p>Residents dependent on staff for incontinent care have the potential to be affected. Observations made by Ambassadors of current residents requiring incontinent care and service provided as needed.</p> <p>Certified Nursing assistants will be re-educated by DON or designee by 10/22/17 regarding ADL care to include trimming and cleanliness of resident</p> <p>finger nails. All nursing staff will be re-educated regarding resident neglect in relation to ADL care and treatment of pressure ulcers.</p> <p>3. Nursing staff will be re-educated by Director of Nursing or designee r/t proper resident nail care. Licensed Nursing Staff will be educated by the Director of Nursing or designee r/t obtaining physician orders for Pressure Ulcer treatments. Nursing staff will be re-educated by Director of Nursing or designee r/t proper Incontinent Care.</p>

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{F 224}	<p>Continued From page 2</p> <p>08/31/17 revealed no documentation of the treatment to Resident #69's left ear during Resident #69's stay in the facility between 08/14/17 and 08/22/17 at which point he was discharged to the hospital.</p> <p>Review of the facility assignment sheet revealed that Nurse #6 was responsible for Resident #69 on 08/19/17 when the treatment was due to be completed.</p> <p>Observation and interview of Resident #69's left ear wound was made on 09/06/17 at 3:29 PM with the TN present. The left ear was noted to have a light violet colored transparent covering the wound bed. The oxygen tubing was resting on top of the transparent covering. The TN stated that the current treatment for Resident #69 was weekly marathon skin prep that created a light violet shade of transparent covering so you know that the entire wound was covered with the skin prep. She added the weekly treatment had been completed early in the morning on 09/05/17 just before Resident #69 was sent to the emergency room for evaluation.</p> <p>Attempts to interview Nurse #6 on 09/07/17 at 10:49 AM were unsuccessful.</p> <p>An interview was conducted with the Treatment Nurse (TN) on 09/08/17 at 10:35 AM. The TN confirmed that she had incorrectly transcribed the initial order for treatment to Resident #69's top of left ear. She stated that the WNP recommended calcium alginate with hydrocolloid and she entered just the hydrocolloid into the system. The TN also confirmed that when Resident #69 readmitted to the facility on 08/14/17 all of his orders were removed from the electronic system</p>	{F 224}	<p>4. Administrative RN (DON,ADON,Nurse Manage,Unit Coordinator) or designee will audit all residents with pressure ulcers for changes, notification and active treatment 2 times a week for 4 weeks, then weekly x 2 months. Administrative RN (DON,ADON,Nurse Managers) or designee will make random observations of 5 residents for incontinent care 2 times a week x 4 weeks then weekly x 2 months. Ambassadors will observe 5 residents' nails 2 times a week x 4 weeks then weekly x 2 months during visits to ensure cleanliness and proper length.</p> <p>Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the Director of Nursing for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.</p> <p>10/22/17</p>

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{F 224}	<p>Continued From page 3</p> <p>and the order for treatment to the left ear did not get entered back into the system and both errors were "just an honest mistake." The TN could not verify that the treatment was completed because there was no order for it in the system. She added that she had provided the treatment to Resident #69's left ear on 08/15/17.</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 09/08/17 at 1:57 PM. The interim DON stated that she expected for all orders to be transcribed correctly into the electronic system as well as the correct treatment provided to the resident as ordered.</p> <p>2. Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her left side. Her other diagnoses included history of malignant neoplasm of brain with surgical treatment, diabetes mellitus, and epilepsy. She also had surgical repair of embolus and skin grafting to her right arm with donor site to right thigh which had not healed and required dressing changes.</p> <p>A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she had adequate hearing and vision with glasses, clear speech, understood and understands and was cognitively intact. Resident #145 had no moods, no behaviors, and no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). The resident was frequently incontinent of urine and stool and was not on a toileting program.</p> <p>A review of Resident #145's admission Care Area</p>	{F 224}			

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{F 224}	<p>Continued From page 4</p> <p>Assessment (CAA) summary dated 05/10/17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain. She was alert and oriented but had presented with episodes of confusion that vary and has had some behaviors since admission that included yelling and screaming for assistance. Her behaviors were not easily altered so she had been referred to psychiatric services for counseling and medical management. She required extensive assistance with bed mobility and was incontinent of both bowel and bladder.</p> <p>A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having functional bladder incontinence related to her disease processes of cerebral infarction and malignant neoplasm of the brain. The goal for Resident #145 was to remain free from skin breakdown due to incontinence and brief use through the next review date of 08/10/17. Interventions included changing the resident frequently and as needed, and changing clothing as needed after incontinence episodes.</p> <p>During a continuous observation made on Resident #145 on 09/06/17 at 4:11 PM that started at the nurse's desk and continued to the resident's room, the observation revealed she was at the nurse's desk requesting to be changed and stated she was soaking wet and had not been changed since she got up in the wheelchair at 10:30 AM. The resident rolled in her wheelchair down to her room to be changed. Resident #145 who was assessed by the facility as cognitively intact and wore a watch on her right arm, stated the first shift NAs had not checked or changed her after they got her up in the</p>	{F 224}			

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{F 224}	<p>Continued From page 5</p> <p>wheelchair. Nurse Aide (NA) #6 and NA #7 came in the resident's room at 4:15 PM and provided incontinence care. The resident's pants were soaked with urine and wet to the touch and removed. Her brief was removed and observed to be heavy with urine, with the inside contents balled and there was an instant smell of urine coming from the brief. NA #6 and NA #7 cleaned the resident's perineum area using appropriate technique and washed her legs and dried them and applied a clean brief and clean pants. NA #6 wiped down her chair cushion and dried it so it would not smell or be wet when she got back up into the chair. The resident told NA #7 that she wanted a bed bath before she went to bed because she felt dirty after being wet so long and hated that feeling and felt like she smelled like urine and NA #7 told her she would give her a bath before bed.</p> <p>A phone interview on 09/07/17 at 8:47 AM with NA #4 revealed she had taken care of Resident #145 on first shift on 09/06/17. She stated she had given the resident a wash up in the bed on 09/06/17, combed her hair, changed her brief and assisted her up to the wheelchair around 10:30 AM. NA #4 stated she did not change the resident at lunch time because she was up in her wheelchair. NA #4 stated she checked with the resident before 3:00 PM while she was out smoking on 09/06/17 and the NA stated the resident was dry. The NA stated that she only had to change the resident once on her shift but she usually had to change her more often. NA #4 stated the resident was a heavy wetter and would sometimes soak her brief and pants if she wet her brief a couple of times before being changed. NA #4 also stated that the resident would usually let them know when she was wet and needed to</p>	{F 224}		

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{F 224}	<p>Continued From page 6 be changed.</p> <p>An interview on 09/08/17 at 1:59 PM with the Director of Nursing and Administrator revealed their expectation was for incontinence care to be done every 2 hours or as needed.</p> <p>3. Resident #130 was admitted to the facility on 05/26/17 and readmitted on 08/16/17 following a hospitalization for diabetic ketoacidosis. Other diagnoses included diabetes mellitus, end stage renal disease, depression, dysphagia, dementia and placement of a gastrostomy tube for feedings.</p> <p>A review of Resident #130's admission Minimum Data Set (MDS) dated 08/23/17 revealed he was cognitively intact and had no mood or behaviors. Resident #130 required extensive assistance of 1 person for most ADL and was frequently incontinent of urine and always incontinent of stool.</p> <p>A review of Resident #130's Care Area Assessment (CAA) summary for Activities of Daily Living (ADL) dated 08/28/17 revealed he required extensive assistance of 1 to 2 persons for transfers, dressing, personal hygiene, bathing and toilet use and required limited assistance with bed mobility.</p> <p>A review of Resident #130's care plan dated 08/30/17 revealed he was care planned for ADL self-care performance deficit related to his decreased mobility. The goal was for the resident to improve his current level of function in ADL through the next review date of 11/30/17. The interventions included he preferred showers, required extensive assistance of 1 staff with</p>	{F 224}		

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{F 224}	<p>Continued From page 7</p> <p>showering and required extensive assistance of 1 staff with personal hygiene and oral care.</p> <p>An observation of Resident #130 on 09/05/17 at 2:23 pm revealed he was sitting in his wheelchair at the end of the hall looking out the door. Observed his nails to be long, approximately ¼ to ½ inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was).</p> <p>An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long and had brown debris under them.</p> <p>On 09/07/17 at 10:46 AM Resident #130 was lying on top of his bed with his clothes on and his arms wrapped around his head. Fingernails were still long and still had brown debris under the nails.</p> <p>On 09/08/17 at 10:43 AM Resident #130 was lying on top of his bed with his clothes on but easily aroused. Stated they still had not cut his nails and they were noted to have brown debris under the nails.</p> <p>On 09/08/17 at 11:02 AM an interview with NAs #4 and #9 revealed their showers consisted of washing the resident's whole body, shampooing their hair, shaving them, cleaning their ears, and providing nail care and mouth care. NA #4 stated she had given Resident #130 a shower on day shift before and provided this care. NA #4 stated</p>	{F 224}			

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{F 224}	Continued From page 8 if she found a resident with dirty nails she would clean them and cut them if needed even if it was not their shower day. NA #4 stated she was assigned to Resident #130 today. NAs #4 and #9 interviewed about Resident #130s nails in his room and both stated they needed to be trimmed and cleaned. On 09/08/17 at 11:09 AM an interview with the Unit Manager revealed that her expectation was for Resident #130's nails to be trimmed and cleaned. On 09/08/17 at 12:08 PM an interview with the Director of Nursing revealed her expectation was for the residents to be cared for and their needs to be met on a daily basis. She stated it was her expectation that nail care be a part of bathing for every resident and nails should be trimmed and clean.	{F 224}	F241 1. On 9/6/17 observation of Resident #145 revealed resident's brief to be heavy with urine. Resident #145 received incontinent care and will receive incontinent care routinely. 2. Current residents requiring assistance with incontinence care have the potential to be affected by the alleged deficient practice. Residents dependent on staff for incontinent care have the potential to be affected. Observations made by Ambassadors of current residents requiring incontinent care and service provided as needed. 3. Nursing staff will be re-educated by Director of Nursing or designee r/t providing dignity and respect specifically proper incontinent care. The Care plan and Kardex for Residents dependent on staff for incontinent care will be updated by 10/22/17. 4. Resident Ambassadors (department heads) will monitor 5 residents during daily visits to ensure resident dignity and respect is maintained specifically r/t incontinent care. Unit Managers will make observations of staff providing dignity and respect specifically with incontinent care 2 times a week x 4 weeks then weekly x 2 months.		
{F 241} SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to treat 1 of 3 residents (Resident #145) in a dignified manner by not providing incontinence care as needed on the day shift. The findings included:	{F 241}			

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{F 241}	Continued From page 9 Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her left side. Her other diagnoses included history of malignant neoplasm of brain with surgical treatment, diabetes mellitus, epilepsy, anxiety and depressive disorder. She also had surgical repair of embolus and skin grafting to her right arm with donor site to right thigh which has not healed and required dressing changes. A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she had adequate hearing and vision with glasses, clear speech, understood and understands and was cognitively intact. Resident #145 had no moods, no behaviors, and no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). The resident was frequently incontinent of urine and stool and was not on a toileting program. Resident #145 received pain medication as needed, insulin, antianxiety medication as needed, antidepressant and anticoagulation medication as scheduled. A review of Resident #145's admission Care Area Assessment (CAA) summary dated 05/10/17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain. She was alert and oriented but had presented with episodes of confusion that vary and has had some behaviors since admission that included yelling and screaming for assistance which could be disruptive to other residents. Resident #145 had been impatient and demanding of staff at times when they entered her room, but had not	{F 241}	Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) by the Director of Nursing for 3 months, at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed to sustain compliance.	10/22/17	

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{F 241}	<p>Continued From page 10</p> <p>displayed these behaviors when visitors were present. Her behaviors were not easily altered so she had been referred to psychiatric services for counseling and medical management. She required extensive assistance with bed mobility and was incontinent of both bowel and bladder. Resident #145 was currently taking antianxiety, antidepressant and antipsychotic medication.</p> <p>A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having functional bladder incontinence related to her disease processes of cerebral infarction and malignant neoplasm of the brain. The goal for Resident #145 was to remain free from skin breakdown due to incontinence and brief use through the next review date of 08/10/17. Interventions included changing the resident frequently and as needed, and changing clothing as needed after incontinence episodes.</p> <p>During a continuous observation made on Resident #145 on 09/06/17 at 4:11 PM that started at the nurse's desk and continued to the resident's room, the observation revealed she was at the nurse's desk requesting to be changed and stated she was soaking wet and had not been changed since she got up at 10:30 AM. The resident rolled in her wheelchair down to her room to be changed. Resident #145 who was assessed by the facility as cognitively intact and wore a watch on her right arm, stated the first shift NAs had not checked or changed her after they got her up in the wheelchair. She stated that she smelled the stench of urine on her and she needed a bath. She stated that she smelled like Fritos and stated Fritos smelled like urine to her and that's what she smelled like. Nurse Aide (NA) #6 and NA #7 came in the resident's room at</p>	{F 241}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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{F 241}	<p>Continued From page 11</p> <p>4:15 PM and provided incontinence care. The resident's pants were soaked with urine and wet to the touch and removed. Her brief was removed and observed to be heavy with urine, with the inside contents balled and there was an instant smell of urine coming from the brief. NA #6 and NA #7 cleaned the resident's perineum area using appropriate technique and washed her legs and dried them and applied a clean brief and clean pants. NA #6 wiped down her chair cushion and dried it so it would not smell or be wet when she got back up into the chair. The resident told NA #7 that she wanted a bed bath before she went to bed because she felt dirty after being wet so long and hated that feeling and felt like she smelled like urine and NA #7 told her she would give her a bath before bed.</p> <p>A phone interview on 09/07/17 at 8:47 AM with NA #4 revealed she had taken care of Resident #145 on first shift on 09/06/17. She stated she had given the resident a wash up in the bed on 09/06/17, combed her hair, changed her brief and assisted her up to the wheelchair around 10:30 AM. NA #4 stated she did not change the resident at lunch time because she was up in her wheelchair. NA #4 stated she checked with the resident before 3:00 PM while she was out smoking on 09/06/17 and the NA stated the resident was dry. The NA stated that she only had to change the resident once on her shift but she usually had to change her more often. NA #4 stated the resident was a heavy wetter and would sometimes soak her brief and pants if she wet her brief a couple of times before being changed. NA #4 also stated that the resident would usually let them know when she was wet and needed to be changed. She stated that even though the resident was incontinent she could tell them when</p>	{F 241}		

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 241}	Continued From page 12 she was wet. An interview on 09/08/17 at 1:59 PM with the Director of Nursing and Administrator revealed their expectation was for the resident's dignity to be maintained and incontinent care to be done every 2 hours or as needed.	{F 241}			
{F 242}	483.10(f)(1)-(3) SELF-DETERMINATION - SS=D (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to honor a resident's choices regarding showers (Resident #91) and failed to honor a resident's choice to have his fingernails trimmed (Resident #130) for 2 of 3 residents sampled for choices. Findings included: 1. Resident #91 was admitted to the facility on 03/07/14 and re-admitted on 12/07/14 with	{F 242}	F242 1. A review of a kardex indicated Resident #91 preferred showers in the morning during the summer and showers in the evenings during the winter. Interview with Resident #91 on 9/7/17 revealed that her personal preferences concerning showers were not being followed. Resident #91's personal preference interview assessment was updated on 9/22/17 to reflect the resident's current shower preference. Kardex for resident #91 was updated at this time. On 9/5/17 thru 9/8/17 Resident#130 observed with long nails. Interview with Resident#130 revealed that resident does not like his fingernails long. Resident #130 received immediate nail care on 9/8/17 and Kardex/Preferences updated.		

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

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{F 242}	<p>Continued From page 13</p> <p>diagnoses which included weakness, anxiety and depression.</p> <p>A review of the most recent quarterly Minimum Data Set dated 08/07/17 revealed Resident #91 was cognitively intact for daily decision making. The MDS also revealed Resident #91 required extensive assistance by 1 staff with bathing.</p> <p>A review of a facility document titled Resident Preferences Evaluation dated 07/19/17 indicated Resident #91 received 2 showers a week and it was her preference to get a shower during the morning in the summer and during the evening in the winter.</p> <p>A review of a shower book indicated Resident #91 received a shower on Tuesday and Friday during the evening on second shift.</p> <p>A review of a kardex indicated Resident #91 preferred showers in the morning during the summer and showers in the evenings during the winter.</p> <p>During an interview on 09/07/17 at 09:06 AM with Resident #91 she stated she used to take a shower every day but does not get showers every day now. She explained she preferred to get a shower every day but even if she could get a shower every other day that would be acceptable to her. She confirmed she received 2 showers a week in the evening and that was not acceptable to her. She explained she preferred to get showers in the morning during the summer because of the hot temperatures and preferred showers in the evenings during the winter because it's cold. She stated she wanted her showers to be given during the day since it's still</p>	{F 242}	<p>2. Current residents have the potential to be affected by the alleged deficient practice. Administrative Staff(Department Heads) completed/updated all current residents' personal preference interviews on 9/22/17 to ensure current resident preferences are being honored and any changes to residents' preference were noted and resident Kardex updated at this time. Social Service Director completed new admission resident Personal Preference interview for accuracy. New admission resident's Kardex updated at this time to reflect current preference status.</p> <p>3. Administrative Staff will be re-educated by 10/22/17 regarding resident preference interviews to include new residents and changes in current resident's preference status. The information obtained during these</p>		

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

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{F 242}	<p>Continued From page 14</p> <p>hot outside and then evening showers during colder weather.</p> <p>During an interview on 09/07/17 at 09:40 AM with a Receptionist she confirmed she completed the Resident Preferences Evaluation for Resident #91 on 07/19/17. She explained she was given the assignment to complete the resident preferences evaluation and was instructed to go over the form and ask the resident their preferences for each question on the form. She stated she had been told by a former Assistant Director of Nursing who no longer worked at the facility that residents were to receive 2 showers a week so she had documented 2 showers a week for Resident #91 and had documented her preferences for showers to be given during the morning in the summer and during the evening during the winter and had placed Resident #91's preference evaluation in a notebook.</p> <p>During an interview on 09/07/17 at 10:50 AM, Nurse Aide (NA) #9 stated she had provided care to Resident #91 and she routinely received showers 2 days a week during the evening on second shift because that was what the shower book indicated. She explained Resident #91 was always cooperative with showers and usually had a bag of personal care items ready for her shower.</p> <p>During an interview on 09/07/17 at 10:53 AM, NA #10 stated she had been assigned to provide care to Resident #91 and she got a shower 2 days a week on second shift because that was what was written in the shower book. She also confirmed Resident #91 was cooperative with showers and told her when she had her bag of personal care items ready to go to the shower.</p>	{F 242}	<p>interviews will be brought to the IDT meeting, at which time any new or changed information will be noted on the resident's Kardex.</p> <p>4. Ambassadors will monitor compliance with following resident personal preferences during daily visits documenting any concerns on Ambassador Visit form.</p> <p>Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI Committee by the Ambassadors (Department Heads) for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.</p>	10/22/17	

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

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{F 242}	<p>Continued From page 15</p> <p>During an interview on 09/08/17 at 1:57 PM, the interim Director of Nursing stated it was her expectation for staff to honor resident's choices for showers.</p> <p>During an interview on 09/08/17 at 2:56 PM, the interim Administrator stated it was her expectation for staff to ask the resident their preferences and if they wanted a shower every day staff should give them a shower every day. She further stated staff should work it out with the work load and accommodate the resident's preferences because this was their home and they should provide showers unless there's was a reason the shower could not be given.</p> <p>2. Resident #130 was admitted to the facility on 05/26/17 and readmitted on 08/16/17 following a hospitalization for diabetic ketoacidosis. Other diagnoses included diabetes mellitus, end stage renal disease, depression, dysphagia, dementia and placement of a gastrostomy tube for feedings.</p> <p>A review of Resident #130's admission Minimum Data Set (MDS) dated 08/23/17 revealed he had adequate vision and hearing, usually understood and usually understands, was cognitively intact and had no mood or behaviors. Resident #130 required extensive assistance of 1 person for most ADL and was frequently incontinent of urine and always incontinent of stool.</p> <p>A review of Resident #130's Care Area Assessment (CAA) summary for Activities of Daily Living (ADL) dated 08/28/17 revealed he required extensive assistance of 1 to 2 persons</p>	{F 242}			

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

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FORM APPROVED
OMB NO. 0938-0391

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{F 242}	<p>Continued From page 16</p> <p>for transfers, dressing, personal hygiene, bathing and toilet use and required limited assistance with bed mobility.</p> <p>A review of Resident #130's care plan dated 08/30/17 revealed he was care planned for ADL self-care performance deficit related to his decreased mobility. The goal was for the resident to improve his current level of function in ADL through the next review date of 11/30/17. The interventions included he preferred showers, required extensive assistance of 1 staff with showering and required extensive assistance of 1 staff with personal hygiene and oral care.</p> <p>An observation of Resident #130 on 09/05/17 at 2:23 PM revealed he was sitting in his wheelchair at the end of the hall looking out the door and eating a cheese cracker. Observed his nails to be long, approximately ¼ to ½ inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was).</p> <p>An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long and had brown debris under them.</p> <p>On 09/07/17 at 10:46 AM Resident #130 was lying on top of his bed with his clothes on and his arms wrapped around his head. Fingernails were <u>still long and still had brown debris under the nails.</u></p>	{F 242}			

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

PRINTED: 09/22/2017
FORM APPROVED
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{F 242}	Continued From page 17 On 09/08/17 at 10:43 AM Resident #130 was lying on top of his bed with his clothes on but easily aroused. Stated they still had not cut his nails and they were noted to have brown debris under the nails. On 09/08/17 at 11:02 AM an interview with NAs #4 and #9 revealed their showers consisted of washing the resident's whole body, shampooing their hair, shaving them, cleaning their ears, and providing nail care and mouth care. NA #4 stated she had given Resident #130 a shower on day shift before and provided this care. NA #4 stated if she found a resident with dirty nails she would clean them and cut them if needed even if it was not their shower day. NA #4 stated she was assigned to Resident #130 today. NAs #4 and #9 interviewed about Resident #130s nails in his room and both stated they needed to be trimmed and cleaned. On 09/08/17 at 11:09 AM an interview with the Unit Manager revealed that her expectation was for Resident #130's nails to be trimmed and cleaned. On 09/08/17 at 12:08 PM an interview with the Director of Nursing revealed her expectation was for the residents to be cared for and their needs to be met on a daily basis. She stated it was her expectation that nail care be a part of bathing for every resident. She stated the resident's preference for short trimmed nails should be honored.	{F 242}			
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250			

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

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F 250	Continued From page 18 (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews and record review, the facility failed to provide medically related Social Services regarding a Podiatry referral for 1 of 1 sampled diabetic resident (Resident #145) needing Podiatry services. The findings included: Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her left side. Her other diagnoses included history of malignant neoplasm of brain with surgical treatment, diabetes mellitus, and epilepsy. A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she was cognitively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). An observation and interview with Resident #145 on 09/06/17 at 9:28 AM revealed the resident in her wheelchair going back to her room. Once in her room, she stated the staff would not let her see the Podiatrist because her Medicaid was pending. An observation of her feet revealed her toe nails trimmed but not filed on both feet. Resident # 145 stated her family member did the best he could with trimming her toe nails. Resident #145 stated her nails had gotten so long on her toes that she could not wear her tennis	F 250	F250 1. On 9/6/17 Resident#145 stated that staff would not let her see the Podiatrist because her Medicaid was pending. Observation of her feet revealed her toe nails trimmed but not filed on both feet. Res #145 was seen by the podiatrist on 9/12/17. 2. Residents that are diabetic and in need of Podiatry services have the potential to be affected. An audit of current diabetic residents was completed by Nurse Management to observe for podiatry needs. 3. Re-education to Social Service Director by the Administrator r/t follow-through for scheduling resident podiatry needs on 9/15/17. Re-education to Licensed Nurses and Certified Nursing Assistants by Director of Nursing or designee by 10/22/17 related to identifying residents in need of podiatry services. The Certified Nursing Assistants will report findings to Licensed Nurses and Licensed Nurses will communicate the needs to		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 19</p> <p>shoe on her "good" foot to balance and she had been having to wear a no slip sock on her foot instead of her shoe.</p> <p>A phone interview on 09/06/17 at 4:34 PM with Resident #145's family member revealed the staff at the facility were not taking care of the resident's feet. The family member stated the staff had told them they could not trim her nails since she was diabetic.</p> <p>An interview with the Social Worker (SW) on 09/07/17 at 12:38 PM revealed that she was responsible for coordinating Podiatry visits for the residents. She stated the process was for her to audit the charts and get consents signed on the residents that needed to be seen. She stated that she also got referrals from the nurses and nurse aids for residents that had thick nails that the staff were unable to cut and all diabetic residents were referred for their toe nails to be trimmed. The SW stated that she was aware that Resident #145 was diabetic. The SW stated the family should not be responsible for taking care of diabetic nails and stated the facility should set up an appointment with the Podiatrist and take care of the bill. The SW stated she had not offered Podiatry services to the resident when they were at the facility on 08/25/17 or 08/30/17.</p> <p>An interview with the Director of Nursing (DON) and Administrator on 09/08/17 at 1:59 PM revealed they expected all interventions on the care plan be followed. They stated the NAs should look at the whole body while providing care and notify the nurse of any concerns. They both stated they would have expected the nurses to offer to trim Resident #145's toe nails and would not want the family to feel obligated to trim</p>	F 250	<p>the Social Services Director.</p> <p>4. Director of Nursing or designee to monitor 5 diabetic resident for podiatry needs by observations 2x week x 4 weeks ,then weekly x 2 months. Administrator will audit the Social Service scheduling of diabetic podiatry appointments to ensure follow through weekly x 4 weeks then monthly x 2 months. The Administrator will report findings of the audits to the QAPI committee monthly x 3 to determine the need for additional monitoring and/or education.</p>	10/22/17	

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

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F 250	Continued From page 20 her nails. The DON stated Resident #145 should have been referred to the Podiatrist since she was diabetic and the SW should have completed the referral to the Podiatrist.	F 250	F278 MDS accuracy		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) 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.	F 278	1. On 9/6/17 Resident#145 stated that staff would not let her see the Podiatrist because her Medicaid was pending. Observation of her feet revealed her toe nails trimmed but not filed on both feet. Res #145 was seen by the podiatrist on 9/12/17. 2. Residents that are diabetic and in need of Podiatry services have the potential to be affected. An audit of current diabetic residents was completed by Nurse Management to observe for podiatry needs. 3. Re-education to Social Service Director by the Administrator r/t follow-through for scheduling resident podiatry needs on 9/15/17. Re-education to Licensed Nurses and Certified Nursing Assistants by Director of Nursing or designee by 10/22/17 related to identifying residents in need of podiatry services. The		

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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F 278	Continued From page 21 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interview the facility failed to accurately code the continence status for 2 of 3 residents with a catheter/ostomy (Resident #69 and Resident #38). The findings included: 1. Resident #69 was most recently readmitted to the facility on 08/28/17. His diagnoses included hemiplegia/hemiparesis, sepsis, pressure ulcer of the sacrum, retention of urine, and others. Review of the most recent quarterly minimum data set (MDS) dated 07/31/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #69 required total assistance of one staff member for toileting, had an indwelling catheter and was occasionally incontinent of bladder. The MDS was completed by MDS Nurse #1. An interview was conducted with MDS Nurse #1 on 09/07/17 at 11:30 AM. MDS Nurse #1 confirmed she had completed the assessment on Resident #69 on 07/31/17. She stated that it was her practice that if the catheter leaked and urine touched the skin or dampened the undergarments then she coded that under urinary continence (H0300) on the MDS assessment. After review of the coding instructions for H0300 MDS Nurse #1 acknowledge there was an error and stated she would correct the error.	F 278	Certified Nursing Assistants will report findings to Licensed Nurses and Licensed Nurses will communicate the needs to the Social Services Director. 4. Director of Nursing or designee to monitor 5 diabetic resident for podiatry needs by observations 2x week x 4 weeks ,then weekly x 2 months. Administrator will audit the Social Service scheduling of diabetic podiatry appointments to ensure follow through weekly x 4 weeks then monthly x 2 months. The Administrator will report findings of the audits to the QAPI committee monthly x 3 to determine the need for additional monitoring and/or education. 10/22/17		

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

PRINTED: 09/22/2017
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OMB NO. 0938-0391

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F 278	Continued From page 22 An interview was conducted with the interim Director of Nursing (DON) and the Administrator on 09/08/17 at 1:57 PM. The interim DON stated that she expected all MDSs to be completed as accurately as possible to reflect the current condition of the resident. 2. Resident #38 was most recently readmitted to the facility on 07/24/17. His diagnoses included quadriplegia, neuropathic bladder, and others. Review of the most recent comprehensive minimum data set (MDS) dated 07/31/17 revealed that Resident #38 was cognitively intact and required extensive assistance of 1 staff member for toileting. The MDS also indicated that Resident #38 had an indwelling catheter and an ostomy (including urostomy, ileostomy, and colostomy). H0300 urinary continence of the MDS was also coded as occasionally incontinent. An interview was conducted with MDS Nurse #1 on 09/07/17 at 11:30 AM. MDS Nurse #1 confirmed she had completed the assessment on Resident #38 on 07/31/17. She stated that it was her practice that if the urostomy leaked and urine touched the skin or dampened the undergarments then she coded that under urinary continence (H0300) on the MDS assessment. MDS Nurse #1 confirmed that Resident #38 had a urostomy and not an indwelling catheter. After review of the coding instructions for H0300 MDS Nurse #1 acknowledge there was an error and stated she would correct the error. An interview was conducted with the interim Director of Nursing (DON) and the Administrator on 09/08/17 at 1:57 PM. The interim DON stated	F 278			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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F 278	Continued From page 23 that she expected all MDSs to be completed as accurately as possible to reflect the current condition of the resident.	F 278			
{F 282} SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement care plan interventions by not applying bunny boots to a residents feet (Resident #57) as instructed by the care plan and failed to refer a diabetic resident with long toe nails to the podiatrist (Resident #145) as instructed by the care plan for 2 of 3 sampled residents. The findings included: Resident #57 most recently readmitted to the facility on 06/13/17. His diagnoses included adult failure to thrive, traumatic subdural hemorrhage, dysphagia, dementia, chronic obstructive pulmonary disease, contracture of right/left knee, and others. Review of the most recent quarterly minimum data set (MDS) dated 07/11/17 indicated Resident #57 was severely cognitively impaired for daily decision making and had long/short term memory	{F 282}	F282 1. On 9/6/17 Resident#145 stated that staff would not let her see the Podiatrist because her Medicaid was pending. Observation of her feet revealed her toe nails trimmed but not filed on both feet. Res #145 was seen by the podiatrist on 9/12/17. 2. Residents that are diabetic and in need of Podiatry services have the potential to be affected. An audit of current diabetic residents was completed by Nurse Management to observe for podiatry needs. 3. Re-education to Social Service Director by the Administrator r/t follow-through for scheduling resident podiatry needs on 9/15/17. Re-education to Licensed Nurses and Certified Nursing Assistants by Director of Nursing or designee by 10/22/17 related to identifying residents in need of podiatry services. The		

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

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{F 282}	<p>Continued From page 24</p> <p>problems. The MDS further indicated that Resident #57 required extensive assistance of 2 staff members for bed mobility. No pressure ulcers were identified on the MDS and Resident #57 exhibited no behaviors during the reference period.</p> <p>Review of a physician order dated 06/29/17 read, bunny boots on while in bed.</p> <p>Review of a care plan initiated on 07/20/16 and revised on 09/05/17 read in part, Resident #57 had a Stage 2 pressure ulcer to his sacrum due to decreased mobility and incontinence. The goal of stated care read, Resident #57 would show signs of healing with wound decreasing in overall size and depth by the next review. The interventions of the care plan included bunny boots.</p> <p>Review of the treatment administration record (TAR) dated 09/01/17 through 09/30/17 read in part, bunny boots on while in bed every shift for prophylaxis (protection). Each shift had been checked indicating the bunny boots had been applied to Resident #57.</p> <p>An observation of Resident #57 was made on 09/05/17 at 9:50 AM. Resident #57 was in bed with no bunny boots on his feet. Bilateral heels were resting on the mattress creating an indentation on the mattress. No bunny boots were located in Resident #57's room or closet.</p> <p>An observation of Resident #57 was made on 09/06/17 at 3:21 PM. Resident #57 was in bed with no bunny boots on his feet. Bilateral heels were resting on the mattress creating an indentation on the mattress. No bunny boots were</p>	{F 282}	<p>Certified Nursing Assistants will report findings to Licensed Nurses and Licensed Nurses will communicate the needs to the Social Services Director.</p> <p>4. Director of Nursing or designee to monitor 5 diabetic resident for podiatry needs by observations 2x week x 4 weeks ,then weekly x 2 months. Administrator will audit the Social Service scheduling of diabetic podiatry appointments to ensure follow through weekly x 4 weeks then monthly x 2 months. The Administrator will report findings of the audits to the QAPI committee monthly x 3 to determine the need for additional monitoring and/or education.</p>	10/22/17	

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	<p>Continued From page 25</p> <p>located in Resident #57's room or closet.</p> <p>An observation of Resident #57 was made on 09/07/17 at 11:28 AM. Resident #57 was in bed with no bunny boots on his feet. Bilateral heels were resting on the mattress creating an indentation on the mattress. No bunny boots were located in Resident #57's room or closet.</p> <p>An observation of Resident #57 was made on 09/07/17 at 1:09 PM. Resident #57 was in bed with no bunny boots on his feet. Bilateral heels were resting on the mattress creating an indentation on the mattress. No bunny boots were located in Resident #57's room or closet.</p> <p>An interview was conducted with Nurse Aide (NA) #2 on 09/06/17 at 12:39 PM. NA #2 stated that he frequently cared for Resident #57 on 2nd and 3rd shift. He added that if Resident #57 was in the bed he was turned and repositioned frequently and would routinely elevate his feet on a pillow. NA #2 stated he did not believe that Resident #57 had bunny boots and he had not applied them to the resident.</p> <p>An interview was conducted with NA #1 on 09/07/17 1:25 PM. NA #1 stated that he frequently provided care to Resident #57. He stated he had recently turned and repositioned Resident #57 with the wedges that were brought into his room on 09/07/17. NA #1 stated that Resident #57 had no bunny boots in his room and he had not applied them today or recently when he cared for Resident #57. NA #1 added that sometime he would use pillows to elevate his feet.</p> <p>An observation of Resident #57 was made on</p>	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	Continued From page 26 09/08/17 at 9:21 AM. Resident #57 was in bed with no bunny boots on his feet. Bilateral heels were resting on the mattress creating an indentation on the mattress. No bunny boots were located in Resident #57's room or closet. An interview was conducted with Nurse #1 on 09/08/17 at 9:26 AM. Nurse #1 stated she was fairly new at the facility but routinely cared for Resident #57. She added that both nurses and NAs were responsible for turning and repositioning residents but generally the NAs completed the tasks. Nurse #1 added that Resident #57 had an order for bunny boots to bilateral feet when he was in bed and the NAs applied them and she would check and make sure they were applied correctly. Nurse #1 stated she expected the NA's to apply Resident #57's bunny boots when he was in bed as ordered. An interview was conducted with the Director of Nursing (DON) and the Administrator on 09/08/17 at 1:57 PM. The DON stated that she thought that Resident #57's bunny boots had been discontinued when they switched his mattress to an air mattress. The DON further stated that she expected all care plan interventions to be followed as ordered. 2. Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her left side. Her other diagnoses included history of malignant neoplasm of brain with surgical treatment, diabetes mellitus, epilepsy, anxiety and depressive disorder.	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	Continued From page 27 A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she was cognitively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). A review of Resident #145's admission Care Area Assessment (CAA) summary dated 05/10/17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain. She was alert and oriented but had presented with episodes of confusion that vary and had had some behaviors since admission that included yelling and screaming for assistance. She required extensive assistance with bed mobility, and most ADL and was incontinent of both bowel and bladder. A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having Diabetes Mellitus with goals for being free from any signs or symptoms of hyperglycemia, having no complications related to diabetes and being free from any signs or symptoms of hypoglycemia through the next review date. The interventions included in part, "Educate resident/family/caregiver: Diabetes was a chronic disease and that compliance was essential to prevent complications of the disease. Review complications and prevention with the resident/family/caregiver and elicit a verbal understanding from the resident/family/caregiver, that nails should always be cut straight across, never cut corners and file rough edges with an emery board." "Refer to podiatrist/foot care nurse to observe/document foot care needs and to cut long nails."	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	Continued From page 28 An observation and interview with Resident #145 on 09/06/17 at 9:28 AM revealed the resident in her wheelchair going back to her room. Once in her room, she stated the staff would not let her see the Podiatrist because her Medicaid was not effective. An observation of her feet revealed her toe nails trimmed but not filed on both feet. Resident #145 stated her family member did the best he could with trimming her toe nails. She stated the Social Worker brought a consent for her to sign when she was first admitted, but told her she would have to pay for the service and the resident stated she had not had the money to pay for the Podiatrist so she had not signed the consent. Resident #145 stated her nails had gotten so long on her toes that she could not wear her tennis shoe on her "good" foot to balance and she had been having to wear a no slip sock on her foot instead of her shoe. She stated a family member from out of state visited her last week and saw her toenails and cut them for her so she could get her foot in her shoe. She stated that another family member had to trim them right after she was admitted to the facility because the staff would not trim them. A phone interview on 09/06/17 at 4:34 PM with Resident #145's family member revealed the staff at the facility were not taking care of the resident's feet. The family member stated the staff had told them they could not trim her nails since she was diabetic and they could lose their license if they cut her nails. The family member stated they offered her a consent when she was first admitted for the Podiatrist but told them they would have to pay for her to see the Podiatrist and they did not have the money to pay so they had just been trying to cut them for her. The family member stated she had been doing her	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	Continued From page 29 fingernails because they had not done them either. An interview with the Social Worker (SW) on 09/07/17 at 12:38 PM revealed that she was responsible for coordinating Podiatry visits for the residents. She stated the process was for her to audit the charts and get consents signed on the residents that needed to be seen. She stated that she also got referrals from the nurses and nurse aids for residents that had thick nails that the staff were unable to cut and all diabetic residents were referred for their toe nails to be trimmed. The residents to be seen were usually highlighted on the census and information was emailed to the facility contact and they in turn contacted the facility to let them know who was coming and when they were coming. The SW stated that Resident #145 had not been seen by the Podiatrist because she had not signed the consent when she was first admitted to the facility. The SW stated that she had not offered another consent to the resident and she had not been offered the opportunity to see the Podiatrist when he was at the facility on 08/25/17 or 08/30/17. The SW stated that she was aware that Resident #145 was diabetic but had not been told that she needed to see the Podiatrist. The SW stated the Administrator made the decision about the services that would be provided for residents who were unable to pay for them. She stated that she had not asked the Administrator about paying for Resident #145 to see the Podiatrist. The SW stated the family should not be responsible for taking care of diabetic nails and stated the facility should set up an appointment with the Podiatrist and take care of the bill. The SW stated her Medicaid was pending and once approved she could see the	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	Continued From page 30 podiatrist. The SW stated she had not offered Podiatry services to the resident when they were at the facility on 08/25/17 or 08/30/17. A phone interview on 09/07/17 at 1:30 PM with the resident's family member revealed she had trimmed Resident #145's nails earlier in her stay but was not comfortable doing so since she was diabetic. Stated that according to the family member from out of town Resident #145's toe nails were almost to the point of curling on her right foot and she could not wear her shoe because they were too long. A phone interview with NA #5 on 09/07/17 at 3:04 PM revealed that Resident #145's family member had cut her fingernails and NA #5 had not noticed her toe nails being long. An interview with Nurse #3 on 09/07/17 at 3:41 PM who had been taking care of Resident #145 on day shift for months revealed that she had not noticed the residents toe nails being long. She stated if she had noticed them being long she would have referred her to the Podiatrist since she was diabetic. Nurse #5 did not recall any of the NAs telling her that the residents toe nails were long. An interview with the Director of Clinical Services on 09/07/17 at 5:15 PM revealed the usual process for nails was for the NA to assess the resident while providing care from head to toe and consult the nurse about any concerns. The NAs were not allowed to cut toe nails on a diabetic resident but the nurse could cut them. If the nurse was unable to cut them, the resident should have been referred to the Podiatrist. The nurse should have assessed the resident's nails	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 282}	<p>Continued From page 31 and then made the referral.</p> <p>An interview with the Nurse Practitioner on 09/08/17 at 7:35 AM revealed that she was not aware of Resident #145 having long toe nails and was not aware that her family had cut them. She stated that no one had mentioned them to her but if they had she would refer her to Podiatry since she was diabetic.</p> <p>An interview with Nurse #4 on 09/08/17 at 8:42 AM revealed that she had taken care of Resident #145 on night shift for months and stated she had not noticed her long toe nails. She stated the NAs on night shift had not mentioned her toe nails being long.</p> <p>A phone interview with NA #3 on 09/08/17 at 9:18 AM who worked full time at the facility stated she had told Nurse #3 about Resident #145's long toe nails a couple of weeks ago. NA #3 stated she told the nurse about her toe nails because she was not allowed to trim them since the resident was diabetic. NA #3 stated her nails were at least an inch beyond the tips of her toes and she complained about them hurting when she had her shoe on her right foot.</p> <p>An interview with Nurse #3 on 09/08/17 at 1:06 PM revealed that she did not recall any of the NAs taking care of Resident #145 telling her that the resident had long toe nails. Nurse #3 stated if the NAs had told her the resident had long toe nails she would have made sure the resident was placed on the list to be seen by the Podiatrist.</p> <p>An interview with the Director of Nursing (DON) and Administrator on 09/08/17 at 1:59 PM revealed they expected all interventions on the</p>	{F 282}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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{F 282}	Continued From page 32 care plan be followed. They stated the NAs should look at the whole body while providing care and notify the nurse of any concerns. They both stated they would have expected the nurses to offer to trim Resident #145's toe nails and would not want the family to feel obligated to trim her nails. The DON stated Resident #145 should have been referred to the Podiatrist since she was diabetic and the SW should have completed the referral to the Podiatrist. A phone interview on 09/08/17 at 3:44 PM with the family member from out of town revealed he had trimmed Resident #145's toe nails while visiting her last week. He stated her toe nails were approximately 1 ¼ inches beyond the end of her toes and were starting to curl and it was hurting her to keep her shoe on with the long nails. The family member stated he had been told Resident #145 could not be seen by the Podiatrist because she did not have the money to pay for it so he cut her nails so she could wear her shoe.	{F 282}	F312 1. On 9/5/17 thru 9/8/17 resident#130 observed with long nails, with brown debris under the nails. Resident #130 received immediate nail care on 9/8/17. On 9/6/17 observation of Resident #145 revealed resident's brief to be heavy with urine. Resident #145 received incontinent care and will receive incontinent care routinely. 2. Residents dependent on staff for nail care have the potential to be affected. Observations of current residents nails were made by Ambassadors (department managers) and services were provided as needed. Residents dependent on staff for incontinent care have the potential to be affected. Observations were made by Ambassadors (department managers) and services were provided as needed. 3. Nursing staff will be re-educated on proper resident nail care by the Area Staff Development Coordinator or designee by 10/22/17. Nursing staff will be re-educated on proper incontinent care by the Area Staff Development Coordinator or designee by 10/22/17.		
{F 312} SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to provide incontinence care for 1 of 3 residents (Resident #145) and nail care for 1 of 3 residents (Resident #130) reviewed for activities of daily living.	{F 312}			

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

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{F 312}	Continued From page 33 The findings included: 1. Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her left side. Her other diagnoses included history of malignant neoplasm of brain with surgical treatment, diabetes mellitus and epilepsy. A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she was cognitively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). The resident was frequently incontinent of urine and stool and was not on a toileting program. A review of Resident #145's admission Care Area Assessment (CAA) summary dated 05/10/17 revealed she was a new admission to the facility who presented for rehabilitation and whose discharge plans were uncertain at this time. She required extensive assistance with bed mobility, and most ADL and was incontinent of both bowel and bladder. A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having functional bladder incontinence related to her disease processes of cerebral infarction and malignant neoplasm of the brain. The goal for Resident #145 was to remain free from skin breakdown due to incontinence and brief use through the next review date of 08/10/17. Interventions included changing the resident frequently and as needed, and change clothing as needed after incontinence episodes.	{F 312}	4. Ambassadors (Department Managers) will observe 5 residents during daily visits 2 times a week x 4 weeks, and then weekly x 2 months for proper nail care and incontinent care needs. The findings will be documented on the Daily Ambassador visit form and reviewed by the Administrator. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance Performance Improvement (QAPI) team by the Administrator for 3 months, at which time, the QAPI Committee will evaluate the effectiveness of the interventions to determine if additional auditing is necessary to maintain compliance.	10/22/17
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 312}	Continued From page 34 An observation of Resident #145 on 09/06/17 at 4:11 PM revealed she was at the nurse's desk requesting to be changed and stated she was soaking wet and had not been changed since she got up at 10:30 AM. Resident #145 stated the first shift NAs had not checked or changed her after they got her up in the wheelchair. She stated that she smelled the stench of urine on her and she needed a bath. Nurse Aide (NA) #6 and NA #7 came in the resident's room at 4:15 PM and provided incontinence care. The resident's pants were wet to the touch and removed. Her brief was removed and observed to be heavy with urine, with the inside contents balled and there was an instant smell of urine coming from the brief. NA #6 and NA #7 cleaned the resident using appropriate technique and washed her legs and dried them and applied a clean brief and clean pants. A phone interview on 09/07/17 at 8:47 AM with NA #4 revealed she had taken care of Resident #145 on first shift on 09/06/17. She stated she had given the resident a wash up in the bed on 09/06/17, combed her hair, changed her brief and assisted her up to the wheelchair. NA #4 stated she did not change the resident at lunch time because she was up in her wheelchair. NA #4 stated she checked the resident before 3:00 PM on 09/06/17 and she was dry. The NA stated that she only had to change the resident once on her shift. NA #4 stated the resident was a heavy wetter and would sometimes soak her brief and pants if she wet her brief a couple of times before being changed. NA #4 also stated that the resident would usually let them know when she was wet and needed to be changed. She stated that even though the resident was incontinent she could tell them when she was wet.	{F 312}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 312}	<p>Continued From page 35</p> <p>An interview on 09/08/17 at 1:59 PM with the Director of Nursing and Administrator revealed their expectation was for incontinent care to be done every 2 hours or as needed.</p> <p>2. Resident #130 was admitted to the facility on 05/26/17 and readmitted on 08/16/17 following a hospitalization for diabetic ketoacidosis. Other diagnoses included diabetes mellitus, end stage renal disease, dementia and placement of a gastrostomy tube for feedings.</p> <p>A review of Resident #130's admission Minimum Data Set (MDS) dated 08/23/17 revealed he was cognitively intact and had no mood or behaviors. Resident #130 required extensive assistance of 1 person for most ADL and was frequently incontinent of urine and always incontinent of stool.</p> <p>A review of Resident #130's Care Area Assessment (CAA) summary for Activities of Daily Living (ADL) dated 08/28/17 revealed he required extensive assistance of 1 to 2 persons for transfers, dressing, hygiene, bathing and toilet use and required limited assistance with bed mobility.</p> <p>A review of Resident #130's care plan dated 08/30/17 revealed he was care planned for ADL self-care performance deficit related to his decreased mobility. The goal was for the resident to improve his current level of function in ADL through the next review date of 11/30/17. The interventions included he preferred showers, required extensive assistance of 1 staff with showering and required extensive assistance of 1 staff with personal hygiene and oral care.</p>	{F 312}		

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

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FORM APPROVED
OMB NO. 0938-0391

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{F 312}	<p>Continued From page 36</p> <p>Resident #130 was interviewed on 09/05/17 at 2:23 PM and revealed, he was sitting in his wheelchair at the end of the hall. Observed his nails to be long, approximately ¼ to ½ inch beyond the end of his fingertips and there was brown debris under his nails. The resident stated he did not like his fingernails to be long and wanted them to be cut. Stated he had told the NA (could not remember her name) but she did not cut them when he had his last shower (could not remember what day it was).</p> <p>An observation of Resident #130 on 09/06/17 at 9:49 AM revealed he was lying on top of his bed after breakfast with the covers pulled over his head. His fingernails were noted to still be long and had brown debris under the nails.</p> <p>On 09/07/17 at 10:46 AM Resident #130 was observed lying on top of his bed with his clothes on and his arms wrapped around his head. His fingernails were still long and still had brown debris under the nails.</p> <p>Interview on 09/08/17 at 10:43 AM with Resident #130 revealed he was lying on top of his bed with his clothes on but easily aroused. He stated they still had not cut his nails and they were noted to have brown debris under the nails.</p> <p>On 09/08/17 at 11:02 AM an interview with NAs #4 and #9 revealed their showers consisted of washing the resident's whole body, shampooing their hair, shaving them, cleaning their ears, and providing nail care and mouth care. NA #4 stated she had given Resident #130 a shower on day shift before and provided this care. NA #4 stated if she found a resident with dirty nails she would</p>	{F 312}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 312}	Continued From page 37 clean them and cut them if needed even if it was not their shower day. NA #4 stated she was assigned to Resident #130 today. NAs #4 and #9 were asked about Resident #130s nails in his room and both stated they needed to be trimmed and cleaned. On 09/08/17 at 11:09 AM an interview with the Unit Manager revealed that her expectation was for Resident #130's nails to be trimmed and cleaned. On 09/08/17 at 12:08 PM an interview with the Director of Nursing revealed her expectation was for the residents to be cared for and their needs to be met on a daily basis. She stated it was her expectation that nail care be a part of bathing for every resident.	{F 312}		
{F 314} SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	{F 314}	F 314 Wound Management 1. Resident#57 had physician order dated 6/29/17 for bunny boots on while in bed. Resident#57 observed 9/5/17-9/8/17 without bunny boots on in bed. Res #57 order for Bunny Boots was discontinued on 9/8/17 due to having Low Air Loss mattress placed. Care plan and Kardex updated. Resident #57 pressure ulcer resolved on 9/12/17.	

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

PRINTED: 09/22/2017
FORM APPROVED
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{F 314}	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Wound Nurse Practitioner and medical doctor interviews the facility failed to prevent a Stage 2 pressure ulcer from worsening to a Stage 3 pressure ulcer (Resident #57) and to ensure the correct treatment order was transcribed and implemented for a resident with a pressure ulcer (Resident #69) for 2 of 4 residents sampled for pressure ulcers. The findings included: 1. Resident #57 was readmitted to the facility on 06/13/17. His diagnoses included adult failure to thrive, traumatic subdural hemorrhage, dysphagia, dementia, chronic obstructive pulmonary disease, and contracture of right/left knee. Review of a Braden Scale for predicting pressure ulcers dated 06/13/17 indicated that Resident #57 was high risk for developing a pressure ulcer. Review of the most recent quarterly minimum data set (MDS) dated 07/11/17 indicated that Resident #57 was severely impaired for daily decision making and had long/short term memory problems. The MDS also indicated that Resident #57 required extensive assistance of 2 staff members for bed mobility and no pressure ulcers were identified. Review of a Head to Toe Skin Check dated 08/29/17 indicated Resident #57's skin was intact with no areas of breakdown noted. Review of a Skin-Weekly Non-Pressure Condition	{F 314}	Resident #69 was readmitted to the facility on 8/28/17 review of medical records revealed no order for treatment to the pressure ulcer to left ear. Resident #69 physicians order was obtained and implemented on 9/5/17. Care plan and Kardex updated. 2. Residents with pressure ulcers have the potential of being affected. An audit will be conducted by the wound nurse and unit manager of physician orders for treatments of pressure ulcers by 10/22/17 to ensure accurate transcription of the orders. Care plans and Kardexes will be updated reflective of the current status of the resident. 3. Licensed nursing staff will be re-educated by SDC or designee related to Wound Management including, assessment, documentation, prevention and treatment of pressure ulcers. Nursing Administration will review Skin Assessments during morning clinical meeting for completion and necessary follow up. New admissions will be reviewed in clinical		

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

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FORM APPROVED
OMB NO. 0938-0391

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{F 314}	Continued From page 39 Record dated 08/31/17 indicated Resident #57 had an area of excoriation to the right buttock that measured 2.0 centimeters (cm) x 2.0 cm x 0.1 cm. Resident #57's family and physician were notified of the area on 08/31/17. Review of a physician order dated 08/31/17 read, Zinc Oxide ointment 20% apply to buttocks topically every day and night shift for skin protectant. Review of a Skin-Weekly Non-Pressure Condition Record dated 09/04/17 indicated that the area of excoriation to the right buttock had resolved. Review of a Skin-Weekly Non-Pressure Condition Record dated 09/04/17 indicated that Resident #57 had a new non pressure skin condition with an onset date of 09/04/17. The record also stated the area was acquired at the facility and was pressure in origin. The wound was located on the sacrum and measured 4.0 cm x 3.0 cm x 0.1 cm and was a Stage 2. An observation and interview with the Wound Nurse Practitioner (WNP) of Resident #57's wound was made on 09/05/17 at 9:50 AM. Resident #57 was resting in bed with eyes closed, he was turned on his side to reveal his pressure ulcer to the sacral area. There were 3 areas noted one on left buttock, one on the right buttock, and one on the coccyx area. The WNP measured all 3 areas as one large wound and indicated that there were parts of the wound that were a Stage 2 but with the small amount of slough noted to the area on the right buttock the wound would be a Stage 3. She recommended an eclipse dressing to the area. Resident #57 was noted to be on an air mattress.	{F 314}	morning meeting ensuring completion of required skin assessment and subsequent pressure ulcer treatments, care plan, kardex updates if needed. Unit Managers/designee will audit 5 Treatment Administration Records of residents with pressure ulcers 2 times a week x 4 weeks, then weekly 2 months, during morning clinical meeting and follow up as needed. 4. Nursing Administration or Wound Nurse will make weekly wound rounds with Wound MD weekly x 3 months of current resident with pressure ulcers and ensure appropriate documentation on the Weekly Pressure Ulcer Records. DON or designee will make observations daily x 4 weeks and then weekly x 2 months of residents requiring pressure ulcer treatments to ensure treatments are being completed as ordered. Wound physician to round weekly with wound nurse and will make needed changes for wounds that may not be improving. Physician and responsible parties to be updated on resident pressure ulcer progress weekly.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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{F 314}	Continued From page 40 Review of a care plan revised on 09/05/17 read in part, Resident #57 had a Stage 2 pressure ulcer to the sacrum due to decreased mobility and incontinence. The goal of stated care plan was Resident #57's wound would show signs of healing with decrease in overall size and depth by next review. The interventions of the care plan included: pressure reducing mattress and cushion to wheelchair, provide incontinence care frequently as needed, skin checks weekly per facility protocol, and turn and reposition frequently to decrease pressure with 2 staff members. Review of a Wound Assessment by the WNP dated 09/05/17 indicated Resident #57 had a Stage 3 wound to the sacral area. The size of the wound was 6.5 cm x 9.4 cm x 0.1 cm with a small amount of slough (dead tissue). The WNP recommended a calcium alginate and eclipse (type of absorbent dressing) 2 times a week. Review of a physician order dated 09/05/17 read, calcium alginate and silicone super absorbent dressing to coccyx every day shift for wound to sacrum. Apply calcium alginate and cover with silicone super absorbent dressing. An interview was conducted with the Treatment Nurse (TN) on 09/06/17 at 9:59 AM. The TN stated that she generally deferred staging wounds to the WNP "because the letters behind her name are bigger than mine." She added that she was not a certified wound nurse and the WNP was much more educated in the staging of wounds. The TN stated that she had not been given any protocols for wound staging and she was unaware of any wound protocols the facility had in place. She also added that she only completed	{F 314}	Findings of these audits and observations to be reported by the DON to the QAPI committee monthly x 3 months to determine the need for additional education and/or monitoring.	10/22/17	

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

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{F 314}	<p>Continued From page 41</p> <p>the wound treatments once a week and the hall nurses completed them the other days. The TN indicated that on 08/31/17 Resident #57 was noted to have some excoriation on his right buttock that presented as red/pink area but not open but definitely irritated. She added that she had notified the nurse practitioner (NP) and obtained a treatment order and then when she reassessed the wound on 09/04/17 the excoriation was resolved but she identified an area of pressure to Resident #57's coccyx area. The TN stated that there were 4 small areas of breakdown in a cluster and all were open but that there was no necrotic tissue or no slough, but the wounds were "definitely a Stage 2 pressure ulcer." She added that again the NP was notified and an order for treatment was obtained. The TN stated that Resident #57 had been having frequent bowel movements and he was very rigid and preferred certain positions on his back and she contributed the development of the pressure ulcers to those things. She also stated she had consulted with therapy for positioning and they were trying different types of pillows and wedges to reposition Resident #57 frequently.</p> <p>An observation of Resident #57 was made on 09/06/17 at 10:32 AM. Resident #57 was up in a geri chair in the activities room watching television. Observations of Resident #57 made from 09/05/17 through 09/08/17 revealed he was out of bed only 1 time on 09/06/17 at 10:32 AM the rest of the observations were made Resident #57 was resting in bed.</p> <p>An interview was conducted with the Medical Doctor (MD) on 09/06/17 at 11:18 PM. The MD stated the facilities TN was her point person and that she rounded weekly on the residents with</p>	{F 314}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115
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{F 314}	<p>Continued From page 42</p> <p>wounds. She added that at the end of the day that they would go through the wounds and go over the orders and review the TN's documentation of the wounds. She also stated that she relied very heavily on the TN and the WNP for staging of the wounds. The MD stated that was "very surprised that Resident #57 had a wound." She added that 3 months ago Resident #57 was always in the bed but after his last hospitalization he was never in the bed and she often had to go and seek him out when she was going to evaluate him. The MD stated that Resident #57 had no history of wounds and was nutritionally and medically stable. The MD stated it was very "unusual for wound to deteriorate as quickly as his wound did."</p> <p>An interview was conducted with Nursing Assistant (NA) #2 on 09/06/17 at 12:39 PM. He added that he routinely provided care to Resident #57 when he worked. He stated that Resident #57 required total care with his activities of daily living and that during his shift he would try to turn him at least every 2 hours side to side and on his back. NA #2 stated that Resident #57 was very complaint with turning and repositioning and he would use pillows that were in his room to position him.</p> <p>An interview was conducted with NA #8 on 09/06/17 at 1:18 PM. NA #8 confirmed that she worked 3rd shift at the facility and cared for Resident #57 frequently. NA #8 stated that Resident #57 required total assistance with activities of daily living and she would check and change him through the night. She added that during her 8 hour shift she generally would turn Resident #57 2-3 times a night.</p> <p>Observation of wound care for Resident #57 was</p>	{F 314}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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{F 314}	Continued From page 43 made on 09/06/17 at 3:21 PM with the facilities TN. Resident #57 was resting in bed with eyes closed with no nonverbal indicators of pain. He was turned onto his right side and the old dressing removed, the 3 areas were cleaned with wound cleaner and a new dressing applied. The area to the right buttock continued to have a small amount of slough present. Resident #57 was noted to be on air mattress. A follow up interview was conducted with TN on 09/06/17 at 5:21 PM. The TN confirmed that she did not know what happened to cause Resident #57's wound to go from a Stage 2 to a Stage 3. She again confirmed that she when she assessed the wound on 09/04/17 it was "clearly a Stage 2." She indicated that she believed that it was combination of things that may have contributed to the deterioration of the wound including his position of choice and his frequent bowel movements. She stated that some fecal matter may have gotten into the dressing and that it may have impacted the wound. The TN added that generally a wound would deteriorate very rapidly if the resident was very sick but this was not the case with Resident #57. An interview was conducted with the WNP on 09/07/17 at 10:04 AM. The WNP indicated that at times the TN was not sure how to classify a wound and she would ask for assistance in identifying the current stage of a wound. She confirmed that Resident #57 has 3 areas of breakdown that she was treating as one large area and because the area on the right buttock had a small amount of slough she would classify the wound as a Stage 3. The WNP added that the development of slough could happen very quickly and depended on the underlying tissue, whether	{F 314}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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{F 314}	Continued From page 44 or not the resident was off loading the pressure, continence status, and the resident's nutritional status. She further stated that slough is dead tissue and can develop quickly sometimes in less than 24 hours and she was not alarmed by the slough that was present on Resident #57's right buttock. An interview was conducted with NA #5 on 09/07/17 at 2:58 PM. NA #5 stated she routinely cared for Resident #57 when she worked. She stated that Resident #57 required total assistance with most tasks including feeding and turning. NA #5 stated that during her 8 hours shift she would generally turn Resident #57 2-3 times and she would use the pillows that were on his bed to reposition him. An interview was conducted with interim Director of Nursing (DON) on 09/08/17 at 1:57 PM. The interim DON stated she had only been at the facility for a short period of time and had not fully had a chance to assess the wound program at the facility. The interim DON stated that typically she did not see wounds deteriorate that rapidly unless they were a Kennedy wound (wound that develop as the patient dies). The interim DON stated that she expected the staff to do everything they could to keep identified wounds from getting worse, including frequent turning and repositioning, frequent incontinent care, and appropriate treatment. 2. Resident #69 was most recently readmitted to the facility on 08/28/17. Review of Resident #69's medical record revealed that he had been present in the facility 08/01/17 through 08/08/17 and again from 08/14/17 through 08/22/17. His diagnoses included hemiplegia/hemiparesis,	{F 314}			

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115
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{F 314}	<p>Continued From page 45</p> <p>sepsis, pressure ulcer of the sacrum, retention of urine, and others.</p> <p>Review of the most recent quarterly minimum data set (MDS) dated 07/31/17 revealed that Resident #69 was severely cognitively impaired for daily decision making and had long/short term memory problems. The MDS further revealed that Resident #69 required total assistance of 2 staff members for bed mobility and had 1 Stage 3 pressure ulcer and 1 Unstageable pressure ulcer.</p> <p>Review of a wound assessment by the Wound Nurse Practitioner (WNP) dated 08/01/17 indicated that Resident #69 had 4 stage 3 pressure ulcers. The locations of the wounds were: left heel, left ankle, left sacrum, and left ear. The recommended treatment to the left ear wound was calcium alginate and hydrocolloid dressing.</p> <p>Review of a physician order dated 08/01/17 read, hydrocolloid to left ear every Tuesday and Saturday for wound to left ear.</p> <p>Review of the Treatment Administration Record (TAR) dated 08/01/17 through 08/31/17 contained the following: hydrocolloid to left ear every Tuesday and Saturday for wound to left ear. The order date was 08/01/17 and the discontinue date was 08/14/17.</p> <p>Review of the physician orders from Resident #69's readmission to the facility on 08/14/17 revealed no order for the treatment to the pressure ulcer to the top of the left ear.</p> <p>Review of the TAR dated 08/01/17 through</p>	{F 314}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115
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{F 314}	<p>Continued From page 46</p> <p>08/31/17 revealed no treatment was ordered or provided to the left ear during Resident #69 stay in the facility between 08/14/17 and 08/22/17 at which point he was discharged to the hospital.</p> <p>Review of the facility assignment sheet revealed that Nurse #6 was responsible for Resident #69 on 08/19/17 when the treatment was due to be completed.</p> <p>Observation and interview of Resident #69's left ear wound was made on 09/06/17 at 3:29 PM with the Treatment Nurse (TN) present. The left ear was noted to have a light violet colored transparent covering the wound bed. The oxygen tubing was resting on top of the transparent covering. The TN stated that the current treatment for Resident #69 was weekly marathon skin prep that created a light violet shade of transparent covering so you know that the entire wound was covered with the skin prep. She added the weekly treatment had been completed early in the morning on 09/05/17 just before Resident #69 was sent to the emergency room for evaluation.</p> <p>Attempts to interview Nurse #6 on 09/07/17 at 10:49 AM was unsuccessful.</p> <p>An interview was conducted with the TN on 09/08/17 at 10:35 AM. The TN confirmed that she had incorrectly transcribed the initial order for treatment to Resident #69's top of left ear. She stated that the WNP recommended calcium alginate with hydrocolloid and she entered just the hydrocolloid into the system. The TN also confirmed that when Resident #69 readmitted to the facility on 08/14/17, all of his orders were removed the electronic system and the order for</p>	{F 314}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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<p>{F 314}</p> <p>F 328 SS=D</p>	<p>Continued From page 47.</p> <p>treatment to the left ear did not get entered back into the system and both errors were "just an honest mistake." The TN could not verify that the treatment was completed because there was no order for it in the system. She further stated that she and other members of the management team had been auditing the treatment orders daily between 08/19/17 and 08/22/17 and she did not identify the lack of treatment order for Resident #69's left ear and "again was just an honest mistake."</p> <p>An interview was conducted with the Interim Director of Nursing (DON) on 09/08/17 at 1:57 PM. The interim DON stated that she expected for all orders to be transcribed correctly into the electronic system. She further explained that anytime a resident discharged to the hospital it was her expectation that all orders be discontinued and then re-entered correctly when they readmit to the facility.</p> <p>483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:</p> <p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p>	<p>{F 314}</p> <p>F 328</p> <p>F328</p>	<p>1. On 9/6/17 Resident#145 stated that staff would not let her see the Podiatrist because her Medicaid was pending. Observation of her feet revealed her toe nails trimmed but not filed on both feet. Res #145 was seen by the podiatrist on 9/12/17.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2017
FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115
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--------------------	--	---------------	---	----------------------

F 328	Continued From page 48 (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the	F 328	2. Resident that are diabetic and in need of Podiatry services have the potential to be affected. An audit of current diabetic residents was completed by Nurse Management to observe for podiatry needs. 3. Re-education to Social Service Director by the Administrator r/t follow-through for scheduling resident podiatry needs on 9/15/17. Re-education to Licensed Nursing staff and Certified Nursing Assistants by Director of Nursing or designee by 10/22/17 related to identifying residents in need of podiatry services. The Certified Nursing Assistant will report findings to licensed nurses and licensed nurses will communicate the needs to the Social Services Director.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F-328	Continued From page 49 prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews and record review, the facility failed to obtain Podiatry services for 1 of 1 resident (Resident #145) reviewed for diabetic foot care. The findings included: Resident #145 was admitted to the facility on 04/27/17 for rehabilitation following a hospitalization for cerebral infarction affecting her left side. Her other diagnoses included history of malignant neoplasm of brain with surgical treatment, diabetes mellitus, and epilepsy. A review of Resident #145's quarterly Minimum Data Set (MDS) dated 08/03/17 revealed she was cognitively intact, had no rejection of care and required extensive assistance of 1 to 2 persons for most activities of daily living (ADL). A review of Resident #145's Care Plan dated 05/12/17 revealed she was care planned for having Diabetes Mellitus. The interventions included in part, "Refer to podiatrist/foot care nurse to observe/document foot care needs and to cut long nails." An observation and interview with Resident #145 on 09/06/17 at 9:28 AM revealed the resident in her wheelchair going back to her room. Once in her room, she stated the staff would not let her see the Podiatrist because her Medicaid was pending. An observation of her feet revealed her toe nails trimmed but not filed on both feet. Resident # 145 stated her family member did the best he could with trimming her toe nails last	F-328	4. Director of Nursing or designee to monitor 5 diabetic resident for podiatry needs by observations weekly x 4 weeks then monthly x 2 months. Administrator will audit the Social Service scheduling of diabetic podiatry appointments to ensure follow through weekly x 4 weeks then monthly x 2 months. The Administrator will report findings of the audits to the QAPI committee monthly x 3 to determine the need for additional monitoring and/or education.	10/22/17	

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

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115
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F 328	<p>Continued From page 50</p> <p>week. Resident #145 stated her nails had gotten so long on her toes that she could not wear her tennis shoe on her "good" foot to balance and she had been having to wear a no slip sock on her foot instead of her shoe. She stated a family member from out of state visited her last week and saw her toenails and cut them for her so she could get her foot in her shoe.</p> <p>An interview with the Social Worker (SW) on 09/07/17 at 12:38 PM revealed that she was responsible for coordinating Podiatry visits for the residents. She stated the process was for her to audit the charts and get consents signed on the residents that needed to be seen. She stated that she also got referrals from the nurses and nurse aids for residents that had thick nails that the staff were unable to cut and all diabetic residents were referred for their toe nails to be trimmed. The SW stated the family should not be responsible for taking care of diabetic nails and stated the facility should set up an appointment with the Podiatrist and take care of the bill. The SW stated she had not offered Podiatry services to the resident when they were at the facility on 08/25/17 or 08/30/17.</p> <p>An interview with the Director of Nursing (DON) and Administrator on 09/08/17 at 1:59 PM revealed they expected all interventions on the care plan be followed. They stated the NAs should look at the whole body while providing care and notify the nurse of any concerns. They both stated they would have expected the nurses to offer to trim Resident #145's toe nails and would not want the family to feel obligated to trim her nails. The DON stated Resident #145 should have been referred to the Podiatrist since she was diabetic and the SW should have completed</p>	F 328		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

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F 328	Continued From page 51	F 328	F371		
{F 371} SS=E	<p>the referral to the Podiatrist.</p> <p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service and failed to discard 7 containers of honey thickened water that were expired in 1 of 2 nourishment room refrigerators (700 hall).</p> <p>Findings included:</p>	{F 371}	Dietary Sanitation		
			<p>1. Observation in the kitchen revealed a metal trash can at a hand washing sink with multiple gnats and small flies flying around the lid of the trashcan. Staff had discarded food in trash can. Trash can was emptied and cleaned.</p> <p>On 9/5/17 during observation a fly was flying around the open containers of food on the tray line. No fly lights or fly fans to repel flies.</p> <p>Dietary Staff failed to discard 7 containers of honey thickened water that were expired from nourishment room refrigerator.</p> <p>No residents were cited in this alleged deficient practice.</p> <p>2. The trash can in the Kitchen underneath the sink was immediately emptied and cleaned by the Dietary Manager. A sign was placed on the trash can "Paper Towels Only" and the kitchen staff educated by the Dietary Manager. The</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/08/2017
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115
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{F 374}	<p>Continued From page 52</p> <p>1. During an observation on 09/05/17 at 11:10 AM in the main dining room at the door which opened into the kitchen revealed there were no fly lights or fly fans to repel flies.</p> <p>During an observation on 09/05/17 at 11:28 AM on a kitchen tour revealed a metal trash can at a hand washing sink with multiple gnats and small flies flying around the lid of the trashcan. A food preparation table was approximately 3 feet away from the trash can and on top of the food preparation table there were 4 sandwiches with 2 slices each of white bread with a slice of cheese inside each and were laying exposed to air. A fly was observed flying over the sandwiches and circling over the food preparation table.</p> <p>On 09/05/17 the lunch meal service was observed with the Food Service Director. During an observation on 09/05/17 at 11:59 AM a fly was flying around the open containers of food on the tray line. The Food Service Director acknowledged the fly and a second fly was observed at the end of the tray line near the coffee and tea dispensers.</p> <p>During an observation on 09/05/17 at 12:06 PM 2 flies were flying around the plate covers stacked on top of the serving line and one of the flies landed on top of one of the plate covers. The Food Service Director was informed by the surveyor the fly was on the plate covers above open containers of food on the tray line and the Food Service Director picked up the plate cover and took it to the dishwashing area of the kitchen. A second fly was then observed on a plate cover then started flying around the open containers of food on the tray line. Additional observations</p>	{F 374}	<p>7 outdated thickened liquids were immediately removed from the nourishment room. Door to Service Hall to remain closed to prevent flies from entering from the outside door.</p> <p>3. Dietary staff will be in-serviced to report any pest sightings in the maintenance log by 10/22/17.</p> <p>4 Fly lights installed within the kitchen and dining room.</p> <p>New fly curtain ordered by Maintenance Director and will be installed when available.</p> <p>Service door leading into the kitchen was repaired 9/30/17.</p> <p>4. The Dietary Manager or designee will monitor the nourishment room refrigerators for stored thickened liquids daily x 4 weeks, weekly x 2 months. Dietary Manager or designee will audit trashcan in kitchen underneath sink 2 times a week x 4 weeks, then weekly x 2 months.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 371}	<p>Continued From page 53</p> <p>revealed gnats and small flies were flying around the lid of the trashcan at the hand washing sink which was approximately 3 feet from the food preparation table and open containers of food on the tray line.</p> <p>During an interview on 09/05/17 at 12:08 PM the Food Service Director was informed by the surveyor of the flies and gnats at the trash can at the hand washing sink. She stated she was unaware there were flies and gnats at the trash can and would have staff empty it after the food was served. She verified the trashcan was used routinely by staff before, during and after meal service to place used paper towels in it after they had washed their hands.</p> <p>During an observation on 09/06/17 at 12:30 PM flies were observed in the service hallway when the back door of the kitchen was opened. Further observations revealed there were no fly lights or fly fans at this door to repel flies.</p> <p>During an observation on 09/05/17 at 12:35 AM revealed there was 1 fly light above the back door on the service hall that led out to a parking lot and the dumpsters.</p> <p>An interview was conducted on 09/06/17 at 3:22 PM with the Food Service Director and the District Food Service Manager was present. The Food Service Director stated after the last recertification survey, maintenance staff had installed 2 fly lights inside the kitchen. She confirmed 1 light was attached to the wall next to the office on one side of the kitchen and the other one was attached to the wall near the hand washing sink on the other end of the kitchen. She explained the lights had helped some but</p>	{F 371}	<p>Dietary Staff will monitor for pest in the kitchen daily x 4 weeks, then weekly x 2 month, dietary staff will report any observations of pest to Maintenance. Maintenance will schedule more frequent pest control visits based on staff observations of pests.</p> <p>Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the Dietary Manager for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.</p>	10/22/17

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

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{F 371}	<p>Continued From page 54</p> <p>flies were still coming into the kitchen. She confirmed no fly lights or fly fans had been installed at the back door of the kitchen on the service hall or in the main dining room next to the kitchen. She further explained the doors at the main dining room and the back door of the kitchen were opened frequently by staff during meal service. She stated it was her expectation that flies should be kept away from the food preparation areas and the tray line when food was being served or food containers were open. The District Food Service Manager confirmed it had been a battle to keep flies out of the kitchen because there was a door which opened to the courtyard where residents went out to smoke and another door on the service hall where staff went out to smoke and deliveries of food and supplies were brought in through the door. The District Food Service Manager stated she was unaware of the flies and gnats at the trashcan under the hand washing sink in the kitchen. The Food Service Director stated she emptied the trashcan after lunch was served on 09/05/17 and someone must have put something in the trash can that had attracted the flies and gnats. She stated it was her expectation for the cook to empty the trash can and put a new bag in it after it was emptied. She further stated she expected for nothing to be placed in the trashcan that would attract flies and it should only be used to discard paper towels after staff washed their hands.</p> <p>During an interview on 09/08/17 at 1:57 PM the Administrator stated it was her expectations for staff in the kitchen to empty garbage regularly and staff should keep doors closed as much as possible to prevent flies from going into the kitchen. She further stated she would expect for flies to be kept away from all areas with open</p>	{F 371}		

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

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{F 371}	<p>Continued From page 55 containers of food.</p> <p>2. An observation of a nourishment room on the 700 unit was made on 09/05/17 at 9:45 AM. 7 cups of honey thickened water that contained a "use by" date of 07/10/17 were noted in the refrigerator.</p> <p>An interview was conducted with the Food Service Director (FSD) on 09/06/17 at 10:27 AM. The FSD stated she was fairly new to her position. She stated that on 07/31/17 she had in-serviced her staff on the process of storing items and how to use the "first in first out" method. The FSD stated she monitored the nourishment rooms on a daily basis but did not identify the out of date water. She added that the dietary staff routinely took boxes of water into the nourishment room and placed them on top of the refrigerator and the nursing staff would put them in the refrigerator as they needed them. She stated that the expired water should have been discovered by staff and given to her so she could have disposed of it properly. No other food storage concerns were noted.</p> <p>An interview was conducted with the Administrator on 09/08/17 at 1:57 PM. The Administrator stated that she expected the water to not be out of date and the nourishment rooms to be checked and logged daily.</p>	{F 371}		
{F 431} SS=D	<p>483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in</p>	{F 431}	F431 – 483.45 Drug Records, Label/Store Drugs & Biologicals	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F.431}	<p>Continued From page 56</p> <p>§483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>	{F.431}	<ol style="list-style-type: none"> 1. Based on observations and staff interviews the facility failed to store medications in the original packaging for 3 of 5 medication carts. Loose pills found in the 100, 300 and 500/600 medication carts were immediately removed by the DON or designee. 2. 100% audit of all medication carts were completed by DON or designee by 9/15/17 to ensure no loose pills were noted. 3. Licensed nurses will be re-educated by DON or designee on discarding loose medications by 10/22/17. New medication carts were ordered and were put in place on 9/28/17. 4. Floor nurses will perform cart audits daily x 4 weeks, then weekly x 2 months. Director of Nursing or Designee to do random weekly checks x 2months thereafter to ensure compliance. <p>Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) by the Director of Nursing for 3 months, at</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 431}	<p>Continued From page 57</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to store medications in the original packaging for 3 of 5 medication carts (100 cart, 300 cart, 500/600 cart) that were noted to have loose pills in the drawers.</p> <p>The findings included:</p> <p>1a. An observation of the 100 hall medication cart was made on 09/05/17 at 3:05 PM. Nurse #2 responsible for the medication cart was present during the observation. In the second large drawer of the medication cart the following was noted loose and not in the original package: 1 blue/white capsule, 3 round yellow pills, 4 oblong grey pills, 4 red rectangular pills, 1 beige round pill, 1 white round pill, and 1 blue round pill. The loose pills were given to Nurse #2.</p> <p>An interview was conducted with Nurse #2 on 09/05/17 at 3:05 PM. Nurse #2 stated that this was her first time working the 100 hall medication cart but the drawers were so packed when she pulled cards of medications out the drawer the bubble packaging popped and the loose pills would fall into the drawer. Nurse #2 could not identify the pills and she stated she would dispose of them properly</p>	{F 431}	<p>which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed to sustain compliance.</p> <p>10/22/17</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 431}	Continued From page 58	{F 431}			
	<p>b. An observation of the 300 hall medication cart was made on 09/05/17 at 3:26 PM. The nurse responsible for the medication cart was present during the observation. In the second large drawer of the medication cart the following was noted loose and not in the original package: 2 oblong white pills and 2 oblong blue pills. The loose pills were given to the interim Assistant Director of Nursing (ADON) who was responsible for the 300 hall medication cart.</p> <p>An interview was conducted with the interim ADON on 09/05/17 at 3:26 PM. The interim ADON stated that this was his first day working the 300 hall medication cart and he was unsure how or why the pills became loose in the medication cart. The interim ADON stated he could not identify the pills and he would dispose of them properly.</p> <p>c. An observation of the 500/600 hall medication cart was made on 09/05/17 at 3:47 PM. Nurse #1 responsible for the medication cart was present during the observation. In the second large drawer of the medication cart there was 1 red rectangular pill found loose and not in the original packaging. The loose pill was given to Nurse #1.</p> <p>An interview with Nurse #1 was conducted on 09/05/17 at 3:47 PM. Nurse #1 stated she could not identify the medication and that she would dispose of it properly.</p> <p>An interview was conducted with the interim Director of Nursing (DON) on 09/08/17 at 1:57 PM. The interim DON stated that new medication carts had been ordered but had not arrived yet. She added that she expected the medication</p>				

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

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FORM APPROVED
OMB NO. 0938-0391

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{F 431}	Continued From page 59	{F 431}		
{F 490} SS=G	<p>483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident, staff and physician interviews the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction to ensure the facility did not have repeated deficiencies in services to manage the care and needs of residents in the facility for 5 of 14 sampled residents (Resident #69, #145, #130, #91 and #57). These areas included neglect, dignity, choices, implementation of care plan interventions, activities of daily living, accuracy of medical records and pressure sores.</p> <p>Findings included:</p> <p>1. Cross refer to F-224: Based on observations, record reviews and staff interviews the facility neglected to implement the correct treatment order for a resident with a pressure ulcer (Resident #69), neglected to provide incontinent care (Resident #145), and neglected to provide nail care (Resident #130) for 3 of 4 sampled residents.</p>	{F 490}	<ol style="list-style-type: none"> 1. Refer to: F224, F241, F242, F282, F312, F314, F328, F371, F431, F514, F278, F250, F520 2. Refer to: F224, F241, F242, F282, F312, F314, F328, F371, F431, F514, F278, F250, F520 3. The District Director of Operations and QIO will educate Administrator about utilizing resources effectively to implement and sustain plans of correction to ensure the facility does not have repeated deficiencies by reviewing audits and implanting corrective action as needed. 4. The Administrator will review audits completed by Facility Staff daily x 4 weeks, and then weekly x 2 months. 	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 490}	Continued From page 60 2. Cross refer to F-241: Based on observations, resident and staff interviews and record reviews the facility failed to treat 1 of 3 residents (Resident #145) in a dignified manner by not providing incontinence care as needed on the day shift. 3. Cross refer to F-242: Based on observations, record reviews and resident and staff interviews the facility failed to honor a resident's choices regarding showers (Resident #91) and failed to honor a resident's choice to have his fingernails trimmed (Resident #130) for 2 of 3 residents sampled for choices. 4. Cross refer to F-282: Based on observations, record review and staff interviews the facility failed to implement care plan interventions by not applying bunny boots to a residents feet (Resident #57) as instructed by the care plan and failed to refer a diabetic resident with long toe nails to the podiatrist (Resident #145) as instructed by the care plan for 2 of 3 sampled residents. 5. Cross refer to F-312: Based on observations, resident and staff interviews and record reviews the facility failed to provide incontinence care for 1 of 3 residents (Resident #145) and nail care for 1 of 3 residents (Resident #130) reviewed for activities of daily living. 6. Cross refer to F-314: Based on observations, record review and staff, Wound Nurse Practitioner and medical doctor interviews the facility failed to prevent a Stage 2 pressure ulcer from worsening to a Stage 3 pressure ulcer (Resident #57) and to ensure the correct	{F 490}	Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the Director of Nursing for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed. 10/22/17	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F-490}	Continued From page 61 treatment order was transcribed and implemented for a resident with a pressure ulcer (Resident #69) for 2 of 4 residents sampled for pressure ulcers. 7. Cross refer to F-371: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service and failed to discard 7 containers of honey thickened water that were expired in 1 of 2 nourishment room refrigerators (700 hall). 8. Cross refer to F-431: Based on observations and staff interviews the facility failed to store medications in the original packaging for 3 of 5 medication carts (100 cart, 300 cart, 500/600 cart that were noted to have loose pills in the drawers. 9. Cross refer to F-514: Based on observations, record reviews and staff interview the facility failed to accurately document a pressure ulcer on the Skin-Weekly Pressure Ulcer Record for 1 of 4 residents sampled for pressure ulcers (Resident #57). During an interview on 09/08/17 at 1:57 PM, the interim Director of Nursing stated she had only been in the facility for less than a week. She explained it had been her priority to review the plan of correction created by former administration and she was still in the process of getting to know staff and residents and understand process and procedure in the facility. She stated there was a lot of work that needed to be done to get the deficiencies corrected. During an interview on 07/14/17 at 2:37 PM, the interim Administrator stated she had only been at the facility for a couple of weeks and was still	{F-490}			

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

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{F 490}	Continued From page 62	{F 490}		
{F 514} SS=D	<p>trying to figure out processes and procedures in the facility. She explained she had reviewed the plans of correction created by the former Administration but with her limited knowledge of the facility she was concerned there had not been enough time for the facility staff to implement the corrective measures in the plan of correction to correct the citations which were being recited on the follow-up survey. She stated more work would need to be done to correct the deficiencies.</p> <p>483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening</p>	{F 514}		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 09/08/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
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{F-514}	Continued From page 63 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interview the facility failed to accurately document a pressure ulcer on the Skin-Weekly Pressure Ulcer Record for 1 of 4 residents sampled for pressure ulcers (Resident #57). The findings included: Resident #57 was readmitted to the facility on 06/13/17. His diagnoses included adult failure to thrive, traumatic subdural hemorrhage, dysphagia, dementia, chronic obstructive pulmonary disease, and contracture of right/left knee. Review of the most recent quarterly minimum data set (MDS) dated 07/11/17 indicated that Resident #57 was severely impaired for daily decision making and had long/short term memory problems. The MDS also indicated that Resident #57 required extensive assistance of 2 staff members for bed mobility and no pressure ulcers were identified. Review of a Skin-Weekly Non-Pressure Condition Record dated 09/04/17 indicated that Resident #57 had a new non pressure skin condition with an onset date of 09/04/17. The record also stated the area was acquired at the facility and was	{F-514}	F514 1. Nurse documented Resident#57's Pressure Ulcer on a Weekly Non Pressure Record versus a Weekly Pressure Ulcer Record. Resident #57 wound documentation was corrected immediately to reflect wound status at the time and documented on Weekly Pressure Ulcer Record. Resident #57 wound has now resolved. 2. Residents with Pressure Ulcer have the potential to be affected. An audit of wound documentation for current residents with pressure ulcers was completed by Wound nurse on 9/15/17. Documentation was updated as needed. 3. Re-education provided to license nursing staff by the Director of Nursing or designee on the requirements of proper documentation specifically to wounds (Pressure/Non-Pressure Records).		

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

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{F 514}	Continued From page 64 pressure in its origin. The wound was located on the sacrum and measured 4.0 centimeters (cm) x 3.0 cm x 0.1 cm and was a Stage 2. An interview was conducted with the Treatment Nurse (TN) on 09/06/17 at 9:59 AM. The TN stated that during an assessment of Resident #57 on 09/04/17 she identified the area of pressure and she fully assessed the wound including measuring and staging the wound. She added that she notified the family and the nurse practitioner and obtained and initiated a treatment. The TN stated that she documented the assessment on the Skin Weekly Non Pressure Condition report and that was a mistake it should have been on the Skin Weekly Pressure Ulcer record. She stated that facility had recently instructed her to only complete Skin Weekly Pressure Ulcer records for residents that were not being followed by the wound nurse practitioner and when she completed this assessment for Resident #57 she just mistakenly used the wrong assessment. An interview was conducted with the interim Director of Nursing (DON) on 09/08/17 at 1:57 PM. The interim DON stated she expected all medical records to be as accurate as possible and the correct assessment to be used to reflect the type of wound that each resident had.	{F 514}	4. Director of Nursing and/or designee will audit wound documentation 2 times week x 4 weeks, then weekly x 2 months during clinical meeting. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance (QAPI) by the Resident Care Management Director for 3 months, at that time the QAPI committee will evaluate the effectiveness of the interventions to determine if auditing is necessary to maintain compliance.	10/22/17	
{F 520} SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	{F 520}			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F-520}	Continued From page 65 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observations, record reviews and staff and physician interviews the facility's Quality Assessment and Assurance Committee failed to	{F-520}	F - 520 (483.75) 1. Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 9/13/2017 to discuss the current survey citations from survey exit on 9/8/17 2. All residents residing in the facility have the potential to be affected. 3. The Director of Regulatory Compliance reeducated the Interdisciplinary team and members of the Quality Assurance and Improvement Committee by 9/12/17 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure state and federal compliance in the facility. The QIO has been contacted and will set up additional education for facility staff related to the Quality Assurance process. 4. The Interdisciplinary Team including the facility Medical Director will meet at least monthly to conduct the facility's Quality Assurance and Performance Improvement	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F-520}	Continued From page 66 maintain implemented procedures and monitor these interventions that the committee put into place in November 2016 following a recertification and complaint survey. The facility was recited in July 2017 on the recertification and complaint survey and subsequently recited on the current follow up survey for failure to maintain compliance. The repeat deficiencies are in the areas of neglect (F-224), dignity (F-241), choices (F-242), provide services by qualified persons according to the care plan (F-282), activities of daily living (F-312), pressure ulcers (F-314), kitchen sanitation (F-371), medication storage (F-431), administration (F490) and accuracy of medical records (F-514). These deficiencies were recited during the facility's current follow up survey. The continued failure of the facility during 3 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: 1a. This tag is cross referred to F-224 Neglect: Based on observations, record reviews and staff interviews the facility neglected to implement the correct treatment order for a resident with a pressure ulcer (Resident #69), neglected to provide incontinent care (Resident #145), and neglected to provide nail care (Resident #130) for 3 of 4 sampled residents. F-224 Neglect was originally cited during the recertification and complaint survey of July 14, 2017, when the facility neglected to assess and provide treatment for pressure ulcer and neglected to clean and trim a dependent residents finger nails for 1 of 3 residents. (Resident # 69). The facility neglected to assess	{F-520}	meeting. Should any interdisciplinary team member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to any present action plan or for a need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee. The District Director of Operations or designee will review the facility QAPI meeting minutes at least monthly x 3 months. 10/22/17		

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

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{F 520}	Continued From page 67 and seek treatment for Resident #69 which resulted in a decline of the pressure ulcer condition from redness upon admission on 06/15/17 to black necrotic tissues on 06/25/17. b. This tag is cross referred to F-241 Dignity: Based on observations, resident and staff interviews and record reviews the facility failed to treat 1 of 3 residents (Resident #145) in a dignified manner by not providing incontinence care as needed on the day shift. During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to dress dependent residents in a dignified manner for 2 of 3 residents sampled for dignity (Resident #69 and Resident #99). c. This tag is cross referred to F-242 Choices: Based on observations, record reviews and resident and staff interviews the facility failed to honor a resident's choices regarding showers (Resident #91) and failed to honor a resident's choice to have his fingernails trimmed (Resident #130) for 2 of 3 residents sampled for choices. During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to honor a resident's choice to have a shower every day for 1 of 4 residents sampled for choices (Resident #91). d. This tag is cross referred to F-282 Services by qualified persons according to the care plan: Based on observations, record review and staff interviews the facility failed to implement care plan interventions by not applying bunny boots to a residents feet (Resident #57) as instructed by the care plan and failed to refer a	{F 520}			

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{F-520}	Continued From page 68 diabetic resident with long toe nails to the podiatrist (Resident #145) as instructed by the care plan for 2 of 3 sampled residents. During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to implement care plan interventions by not dressing a resident in clothes as instructed by the care plan for 1 of 4 sampled residents (Resident #69). e. This tag is cross referred to F-312 Activities of Daily Living (ADLs): Based on observations, resident and staff interviews and record reviews the facility failed to provide incontinence care for 1 of 3 residents (Resident #145) and nail care for 1 of 3 residents (Resident #130) reviewed for activities of daily living. F-312 was originally cited during the recertification survey of November 3, 2016 for failure to trim a dependent residents fingernails for 1 of 3 residents sampled for activities of daily living (Resident #97). F-312 was cited again during the recertification and complaint survey of July 14, 2107 for failure to trim and clean a dependent residents fingernails for 1 of 5 residents sampled for activities of daily living (Resident # 69). f. This tag is cross referred to F-314 Pressure ulcers: Based on observations, record review, staff, Wound Nurse Practitioner and medical doctor interviews the facility failed to prevent a Stage 2 pressure ulcer from worsening to a Stage 3 pressure ulcer (Resident #57) and to ensure the correct treatment order was transcribed and implemented for a resident with a pressure ulcer (Resident #69) for 2 of 4 residents sampled for pressure ulcers.	{F-520}			

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{F-520}	Continued From page 69 During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to assess and provide treatment to prevent development of pressure ulcer for one of four sampled residents (Resident # 69). The resident was readmitted on 06/15/17 to the facility with a reddened area on left heel. The area on the left heel was not reassessed until 06/25/17 at which time the left heel area was black in color. g. This tag is cross referred to F-371 Kitchen Sanitation: Based on observations and staff interviews the facility failed to keep flies out of the kitchen area during food production and meal service and failed to discard 7 containers of honey thickened water that were expired in 1 of 2 nourishment room refrigerators (700 hall). F-371 was originally cited during the recertification survey of November 3, 2016 for failure to clean a fan that contained gray debris hanging from the metal grates on the front and back of the fan that was in use and located in a food preparation area next to clean pots and pans and the facility failed to clean a dirty microwave located in 1 of 2 nourishment rooms (700 hall). F-371 was cited again during the recertification and complaint survey of July 14, 2017 for failure to keep flies out of the kitchen area during food production and meal service, failed to discard opened containers of milk that were not dated when opened and failed to remove 3 cartons of ice cream from the floor of the walk in freezer. h. This tag is cross referred to F-431 Drug Storage: Based on observations and staff interviews the facility failed to store medications in the original packaging for 3 of 5 medication carts	{F 520}			

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

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{F 520}	Continued From page 70 (100 cart, 300 cart, 500/600 cart) that were noted to have loose pills in the drawers. F-431 was originally cited during the recertification survey of November 3, 2016 for failure to remove expired medications from 1 of 4 medication carts. F-431 was cited again during the recertification survey of July 14, 2017 for failure to keep medications in the original packaging for 6 of 6 medications cart (100 cart, 200 cart, 300 cart, 400 cart, 500/600 cart and 700 cart) that were noted to have loose pills in the drawers, and failed to discard expired/undated insulin on 2 of 6 medication carts (100 cart and 400 cart). i. This tag is cross referred to F-490 Administration: Based on observations, record reviews and resident, staff and physician interviews the facility's administration failed to utilize its resources effectively to implement and sustain plans of correction to ensure the facility did not have repeated deficiencies in services to manage the care and needs of residents in the facility for 5 of 14 sampled residents (Resident #69, #145, #130, #91 and #57). These areas included neglect, dignity, choices, implementation of care plan interventions, activities of daily living, accuracy of medical records and pressure sores which resulted in the facility's failure to prevent a Stage 2 pressure ulcer from worsening to a Stage 3 pressure ulcer and to ensure the correct treatment order was transcribed and implemented. The facility also failed to maintain a pest free environment in the kitchen and to discard thickened water that was expired in 1 of 2 nourishment room refrigerators (700 hall) and failed to store medications in the original packaging for 3 of 5 medication carts (100 cart,	{F 520}			

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{F 520}	Continued From page 71 300 cart, 500/600 cart). During the recertification and complaint survey of July 14, 2017, the facility was cited for failure to manage the care and needs of residents in the building for 4 of 6 residents sampled (Resident #93, #29, #147, and #69). j. This tag is cross referred to F-514 Accuracy of medical records: Based on observations, record reviews, and staff interview the facility failed to accurately document a pressure ulcer on the Skin-Weekly Pressure Ulcer Record for 1 of 4 residents sampled for pressure ulcers (Resident #57). During the recertification and complaint survey of July 14, 2107 the facility was cited for failure to document functionality of a bed alarm for a resident at risk for falls (Resident #93), failed to document the correct location of redness or measurements on a resident's heel or whether drainage was present (Resident #69) and failed to document falls for a resident at risk for falls (Resident #122) for 3 of 6 sampled residents for falls and pressure ulcers. During an interview on 09/08/17 at 2:56 PM, the interim Director of Nursing stated she had only been in the facility for less than a week but she had made it a priority to review the plans of correction that had been done by previous Administration. She stated the plans of correction were complicated and there was much work to be done to audit and correct the deficiencies. During an interview on 09/08/17 at 2:58 PM, the interim Administrator stated she had only been in the facility for a couple of weeks and had	{F 520}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 520}	Continued From page 72 conducted a Quality Assessment and Assurance Committee meeting to discuss the plans of correction. She explained the Quality Assessment and Assurance Committee was now meeting weekly and their main agenda was to review the plans of corrections and audits that were being done. She further explained in regard to the repeated deficiencies there needed to be a consistent process in place with follow up and they needed to ensure staff completed their assigned tasks and audits. She stated they needed to set time goals to get it done and break it down into manageable parts and ensure compliance. She further stated it was all about fixing the problems so they would not see it reoccur later but it was a work in progress.	{F 520}			