STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER H & REHAB WEAVERV	78 WEAVER BOULEVARD WEAVERVILLE, NC 28787

(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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		4/17/18

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

Electronically Signed | 04/05/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure wash clothes and towels were available for resident showers and incontinence care (Resident #25) and failed to provide personal hygiene assistance with removing facial hair of a female (Resident #65) for 2 of 4 residents reviewed for dignity. The findings included: 1. Resident #25 was admitted to the facility 04/28/17. The quarterly Minimum Data Set (MDS) dated 01/09/18 indicated Resident #25 had mild cognitive impairment with no behaviors or rejection of care. During an interview on 03/15/18 at 3:32 PM, Nurse Aide (NA #2) stated sometimes on 2nd shift (3PM - 11PM) they run out of wash clothes and towels and must use pillow cases for bathing and for incontinence care. NA #2 also stated she would check in laundry and there would not be any available because they were being washed or dried. NA #2 further stated they had run out of bed pads and would use folded blankets for the residents. NA #2 stated this most recently occurred last week. NA #2 also stated she had reported it to the nurse and the NA's had complained of being short in during NA meetings but had been told to make do with what they had. During an interview on 03/15/18 at 4:35 PM, Resident #25 stated she had to use a pillow case for a wash cloth last week on her shower day.	F 550	Criteria 1 For example #1, on 3/16/18, towels and washcloths were provided to linen cart at a par level of 3 washcloths per resident and 1 towel per resident per shift to ensure resident rights are maintained by usage of appropriate linen. The process failure that led to this deficiency was that laundry personnel did not monitor for adequate par levels throughout the day. For example #2, on 3/16/18, CNA offered to shave resident #65. Her chin was shaved of unwanted facial hair. The failed process that led to this deficiency was that nursing staff did not observe closely for presence of unwanted facial hair in between shower days. Criteria 2 For example #1, par level was obtained for each linen cart based on number of beds on that hallway and estimating the use of 3 washcloths per resident and 1 towel per resident per shift. That par level was supplied to each linen cart by 3/19/18. For example #2,a review of current residents was conducted by the DON and Unit Managers to determine who has unwanted facial hair. Resident care plans were updated and the need to provide management of facial hair for residents who choose to have facial hair removed was added as a result of this review. To prompt and ensure staff attention to this care area, observation	

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F 550	Continued From page 2 Resident #25 also stated they were often out of wash clothes and towels on 2nd shift on her shower days. Resident #25 further stated that not having a wash cloth or a towel to use and having to use a pillow case to bathe with made her feel like she wasn't worth the time or expense and the facility was "scraping out of the bottom of a barrel." During an interview on 03/15/18 at 4:50 PM, NA #3 stated he had to use towels often when wash clothes for showers weren't available and sometimes had to use pillow cases when wash clothes or towels were not available. NA #3 stated he most recently had to use pillow cases for care the previous week. NA #3 stated he always went to laundry to try and find wash clothes and towels when they weren't available on the linen carts on the halls. NA #3 further stated this had only been happening during 2nd shift. During an interview on 03/15/18 at 5:24 PM, a staff member in laundry stated there had been several instances in the past month when NA's came from different halls to laundry on 2nd shift looking for wash clothes and towels. The staff member stated the NA's would get pillow cases or old bibs (protective clothing garment) to use for the residents when nothing else was available. The staff member also stated there was a break in time between when 1st shift laundry workers left and when 2nd shift laundry workers came in. The staff member further stated there had not been clean wash clothes or towels for the 2nd shift workers at least 4 or 5 times during the past month. During an interview on 03/15/18 at 5:36 PM, NA #5 stated numerous times in the last month she	F 550	and management of facial hair (for those who wish to have it removed) was also added to the task list for daily CNA documentation. For example #1, on or before 4/6/18, Nursing and Laundry staff were re-educated by the Administrator that in order to ensure there are adequate linens for provision of care and assurance of resident dignity, par levels of linen must be maintained on linen carts each time they are restocked. Nursing and Laundry staff members were also re-educated that it is necessary to communicate to management staff if there is a problem with maintaining the par levels. For example #2, On or before 4/6/18, nursing staff and the Interdisciplinary Team was re-educated by the DON about promoting resident rights by ensuring appropriate management of facial hair. Criteria 3 For example #2, an audit of necessary par levels for towels and washcloths will be performed daily at 7 am and 4pm by Housekeeping Manager or Assistant Housekeeping Manager. The audit will determine if par levels are met when linen carts are restocked. The audit will be done daily for 2 weeks, 3 times a week for 4 weeks, and 1 time a week for 6 weeks. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Housekeeping and Laundry Services or designee to maintain	

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F 550	Continued From page 3 had to use pillow cases for wash clothes and incontinence care because clean wash clothes and towels were not available. During an interview on 03/16/18 at 1:29 PM, the Laundry Supervisor stated he had not been aware the NA's were using other resources like pillow cases and towels to provide care for the residents. An observation of the invoices for supplies received since 01/01/18 indicated there were a total of 360 towels and 2160 wash clothes the facility had received. Upon further observation there 120 towels and 360 wash clothes in storage and unused. The Laundry Supervisor stated towels last much longer than wash clothes do and that about 10-12 wash clothes are disposed of weekly due to wear from use. During an interview on 03/16/18 at 4:27, the Director of Nursing (DON) stated she had not been informed the NA's were using pillow cases and old clothing protectors for incontinence care and showers. The DON stated her expectation was for supplies to be available for staff to provide adequate care for the residents. During an interview on 03/16/18 at 6:36 PM, the Administrator stated no one had ever brought the use of pillow cases and old protective clothing devices for resident care to her attention. The Administrator also stated the facility was adequately stocked and had a good par level (amount of linens in use). The Administrator further stated her expectation was for the staff to have the appropriate linens available to do what needed to be done for the resident. The Administrator stated it was unacceptable for the staff to do anything less than what was right for	F 550	compliance when completing Housekeeping and Laundry Systems Review. For example #2, an audit of 10 random residents who have unwanted facial hair will be completed daily for 2 weeks, 3 times a week for 4 weeks and 1 time a week for 6 weeks. The audit will be done by DON or designee to determine that each resident is free of unwanted facial hair. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing Clinical Systems Review. Criteria 4 For example #1, the Housekeeping Manager is responsible for implementing the corrective actions. For example #2,The DON is responsible for implementation of the corrective actions. Criteria 5 The facility will be in full compliance with this plan of correction on or before 4/12/18.	

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F 550	Continued From page 4	F 550		

the resident.

2. Resident #65 was admitted on 01/20/17 with diagnoses that included mild cognitive impairment, oxygen dependence and stage III chronic kidney disease.

Review of Resident #65's ADL care plan, with an onset problem date of 02/24/17, revealed a self-care deficit due to decreased mobility (bed bound) and decline in overall status. A goal listed was for her to have all needs met with staff assistance. Interventions included Resident #65's preferred dressing/grooming routine was after morning meal and for staff to provide extensive assistance with personal hygiene.

The quarterly Minimum Data Set (MDS) dated 02/07/18 coded Resident #65 with severe, cognitive impairment for daily decision making. The MDS indicated Resident #65 required extensive to total assistance of 1 to 2 staff members for Activities of Daily Living (ADL) which included personal hygiene and bathing.

Review of the Nurse Aide (NA) care guide (tool used by nurse aides to know the individual care needs of residents) indicated the shower days for Resident #65 were Tuesday and Thursday on second shift.

An observation of Resident #65 on 03/12/18 at 10:16 AM revealed her lying in the bed with several noticeable chin hairs approximately a half inch long.

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F 550	Continued From page 5	F 550		

An observation of Resident #65 on 03/13/18 at 5:10 PM revealed her sitting up in bed with several noticeable chin hairs approximately a half inch long.

An observation of Resident #65 on 03/15/18 at 11:00 AM revealed her lying in bed with several noticeable chin hairs approximately a half inch long.

An observation of Resident #65 on 03/16/18 at 10:34 AM revealed her lying in bed with several noticeable chin hairs approximately a half inch long.

During an interview on 03/16/18 at 10:41 AM NA #6 confirmed residents were shaved on shower days and when needed. NA #6 indicated she had not noticed Resident #65 with any chin hair when she provided assistance earlier in the morning. NA #6 confirmed Resident #65 had several noticeable chin hairs that needed shaved.

During an interview on 03/16/18 at 11:24 AM Nurse #2 stated personal hygiene care was part of the bathing routine and residents should be shaved when needed. Nurse #2 was not aware Resident #65 had several chin hairs that had not been removed and confirmed NAs were expected to trim chin hairs when noticed.

An observation and interview with Resident #65 on 03/16/18 at 1:55 PM revealed her sitting up in bed, drinking fortified soup through a straw, with several noticeable chin hairs approximately a half inch long. Resident #65 confirmed she didn't like chin hairs and used to shave them herself when she was able. Resident #65 stated she would like for staff to shave the chin hairs.

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F 550	Continued From page 6 During an interview on 03/16/18 at 2:00 PM the Director of Nursing (DON) confirmed it was her expectation NAs would provide residents with personal hygiene care on shower days or when needed.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		4/16/18

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F 584	Continued From page 7 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide wash clothes and towels to 1 of 1 resident reviewed for providing a safe, clean, comfortable homelike environment (Resident # 25). The findings included: Resident #25 was admitted to the facility 04/28/17 with diagnoses including major depressive disorder among others. The quarterly Minimum Data Set (MDS) dated 01/09/18 indicated Resident #25 had mild cognitive impairment but was interviewable and had no behaviors or rejection of care. During an interview on 03/12/18 at 1:32 PM, Resident #25 stated on a regular basis the facility ran out of clean wash clothes and towels. Resident #25 also stated she had to use a pillow case as a wash cloth last week and a blanket to dry off with. During an interview on 03/15/18 at 3:32 PM, Nurse Aide (NA #2) stated sometimes on 2nd shift (3pm - 11PM) they run out of wash clothes and towels and must use pillow cases for bathing	F 584	Criteria 1 On 3/16/18, washcloths and towels were provided to linen cart at a par level of 3 washcloths per resident and 1 towel per resident per shift to ensure a homelike environment is maintained by usage of appropriate linen. The process failure that led to this deficiency was that laundry personnel did not monitor for adequate par levels throughout the day. Criteria 2 A par level was obtained for each linen cart based on number of beds on that hallway and estimating the use of 3 washcloths per resident and 1 towel per resident per shift. That par level was supplied to each linen cart by 3/19/18. On or before 4/6/18, Nursing and Laundry staff were re-educated by the Administrator that in order to ensure there are adequate linens for provision of care and assurance of a homelike environment, par levels of linen must be maintained on linen carts each time they are restocked. Nursing and Laundry staff members were also re-educated by Administrator that it is necessary to	

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F 584	Continued From page 8 and for incontinence care. NA #2 also stated she would check in laundry and there would not be any available because they were being washed or dried. NA #2 further stated they had run out of bed pads and would use folded blankets for the residents. NA #2 stated this most recently occurred last week. NA #2 also stated she had reported it to the nurse and the NA's had complained of being short of wash clothes and towels during NA meetings but had been told to make do with what they had. During a 2nd interview on 03/15/18 at 4:35 PM, Resident #25 stated the last time she had to use a pillow case for a wash cloth was the previous week. Resident #25 also stated they were often out of wash clothes and towels on 2nd shift on her shower days. Resident #25 further stated that not having a wash cloth or a towel to use and having to use a pillow case to bathe with made her feel like she wasn't worth the time or expense and the facility was "scraping out of the bottom of a barrel." During an interview on 03/15/18 at 4:50 PM, NA #3 stated he had to use towels often when wash clothes for showers weren't available and sometimes had to use pillow cases when wash clothes or towels were not available. NA #3 stated he most recently had to use pillow cases for care the previous week when working on 2nd shift. NA #3 stated he always went to laundry to try and find wash clothes and towels when they weren't available on the linen carts on the halls. NA #3 further stated this had only been happening during 2nd shift. During an interview on 03/15/18 at 5:00 PM, NA #4 stated in the past 2 weeks she had to use	F 584	communicate to management staff if there is a problem with maintaining the par levels. Criteria 3 An audit of necessary par levels for washcloths and towels will be performed daily at 7 am and 4pm by Housekeeping Manager or Assistant Housekeeping Manager. The audit will determine if par levels are met when linen carts are restocked. The audit will be done daily for 2 weeks, 3 times a week for 4 weeks, and 1 time a week for 6 weeks. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Housekeeping and Laundry Services or designee to maintain compliance when completing Housekeeping and Laundry Systems Review. Criteria 4 The Housekeeping Manager is responsible for implementing the corrective actions. Criteria 5 The facility will be in compliance with plan of correction on or before 4/12/18.	

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F 584	Continued From page 9	F 584		

pillowcases for wash clothes and for incontinence care. NA #4 stated she had not told anyone about it because the laundry personnel were already aware it was an issue.

During an interview on 03/15/18 at 5:24 PM, a staff member in laundry stated there had been several instances in the past month when NA's came from different halls to laundry on 2nd shift looking for wash clothes and towels. The staff member stated the NA's would get pillow cases or old bibs (protective clothing garment) to use for the residents when nothing else was available. The staff member also stated there was a break in time between when 1st shift laundry workers left and when 2nd shift laundry workers came in. The staff member further stated there had not been clean wash clothes or towels for the 2nd shift workers at least 4 or 5 times during the past month. The staff member added the 2nd shift worker had to gather the dirty linen barrels when they came in to work and wash, dry, fold, and return them to the linen carts on the hall as well as delivering clothes for residents as well.

During an interview on 03/15/18 at 5:36 PM, NA #5 stated numerous times in the last month she had to use pillow cases for wash clothes and incontinence care because clean wash clothes and towels were not available.

During an interview on 03/16/18 at 1:29 PM, the Laundry Supervisor stated he had not been aware the NA's were using other resources like pillow cases and protective clothing garments to provide care for the residents. An observation of the invoices for supplies received since 01/01/18 indicated there were a total of 360 towels and 2160 wash clothes the facility had received.

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F 584	Continued From page 10 Upon further observation there were 120 towels and 360 wash clothes in storage and unused. The Laundry Supervisor stated towels last much longer than wash clothes do and that about 10-12 wash clothes are disposed of weekly due to wear from use. During an interview on 03/16/18 at 4:27, the Director of Nursing (DON) stated she had not been informed the NA's were using pillow cases and old clothing protectors for incontinence care and showers. The DON stated her expectation was for supplies to be available for staff to provide adequate care for the residents. During an interview on 03/16/18 at 6:36 PM, the Administrator stated no one had ever brought the use of pillow cases and old protective clothing devices for resident care to her attention. The Administrator also stated the facility was adequately stocked and had a good par level (amount of linens in use). The Administrator further stated her expectation was for the staff to have the appropriate linens available to do what needed to be done for the resident. The Administrator stated it was unacceptable for the staff to do anything less than what was right for the resident.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		4/5/18

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F 684	Continued From page 11 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide pain medication for 1 hour and 30 minutes causing agitation and loss of sleep for 1 of 4 residents reviewed for pain management (Resident #89). The findings included: Resident #89 was admitted to the facility on 02/09/18 with diagnoses including arthritis among other others. The 5-day Minimum Data Set (MDS) assessment dated 02/16/18 indicated Resident #89 required limited to extensive assistance with most Activities of Daily Living (ADL's). The MDS also indicated Resident #89 was not on scheduled pain medication but did receive as needed pain medication. The MDS further indicated Resident #89 was cognitively intact and had adequate vision. Record review of the Medication Administration Record (MAR) for March 2018 indicated the following as needed pain medications were available for Resident #89: Hydrocodone/Acetaminophen 5/325 milligrams (MG) - give 2 tablets by mouth as needed every 6 hours for severe pain Hydrocodone/Acetaminophen 5/325 MG - give 1 tablet by mouth as needed every 6 hours for moderate pain Tylenol Extra Strength (ES) 500 MG - give 2 tablets by mouth as needed every 8 hours as needed for pain.	F 684	Criteria 1 Resident #89 was administered Tylenol on the 3/13/18. The process failure that led to this deficiency was that nursing staff failed to prioritize administration of PRN pain medication over scheduled medication pass. Criteria 2 A list has been compiled of current residents who have an order for PRN pain medications. On or before 4/6/18, nursing staff were re-educated by the DON on the importance of providing pain medication as soon as they are aware of the request. Included in the education was also the necessity for other staff to make the nurse aware of a request for medication as soon as it is made. Nursing has been advised to pause their scheduled med pass to complete a request for PRN pain medication. After providing requested medication, they can resume scheduled medication pass. Criteria 3 DON or designee will randomly interview 3 alert and oriented residents daily for 2 weeks, 3 x weekly for 4 weeks, and 1 time weekly for 6 weeks to ensure they received requested pain medication in a timely manner. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

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F 684	Continued From page 12 Record review of administered pain medication for March 2018 indicated Resident #89 had received Hydrocodone-Acetaminophen 5/325mg - 2 tablets on 3 different occasions on 03/04, 03/06 and 03/09. Resident #89 had not received Tylenol in March 2018 according to what was indicated on the MAR. Record review of a note written by the MDS Coordinator on 03/13/18 revealed the following: "...he reports having frequent pain in his eye/cheek bone, aches in his legs, and a burning sensation in his thighs that is improving ...he reports that the pain has interfered with sleep ...he states that he takes Tylenol and it helps." During an interview on 03/13/18 at 10:26AM, Resident #89 stated he had requested pain medication at 12:00AM on 03/13/18 but did not receive it until almost 1:30AM on 03/13/18. Resident #89 stated he was watching the clock when he asked for his pain medication. Resident #89 also stated he used his call light and the Nurse Assistant (NA) came into his room and he told her he needed pain medication. Resident #89 stated he waited 30 minutes and used his call light again and the same NA came into the room and he told her again that he needed pain medication. Resident #89 stated he waited another 30 minutes before using his call light a 3rd time and stated he was very agitated because he had to wait so long and told the NA this. Resident #89 stated the NA informed him she had told the nurse each time, but would tell her again. Resident #89 stated he eventually got his pain medication about 1:30AM, but he did not sleep very well because he had been agitated for	F 684	oversight by the District Director of Clinical Services or designee to maintain compliance when completing Clinical Systems Review. Criteria 4 The DON is responsible for implementing the corrective actions. Criteria 5 The facility will be in compliance with the plan of correction on or before 4/12/18.	

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F 684	Continued From page 13	F 684		

having to wait for his pain medication.

During an interview on 03/14/18 at 11:48AM, Nurse #1 acknowledged she had administered 2 Tylenol for pain to Resident #89 in the early morning on 03/13/18 even though this was not documented on the MAR. The nurse stated it was about 15 minutes from the time the NA told her about Resident #89 requesting medication before she gave it to him. The nurse further stated she went to follow up with Resident #89 but he was sleeping.

During an interview on 03/15/18 at 7:03AM, NA #1 stated Resident #89 had called her using his call light and told her he needed pain medication. The NA stated she told Nurse #1 who was giving medication on a different hall. The NA stated Resident #89 rang for her again about 30 minutes later and again requested pain medication. The NA stated she told Nurse #1 again and that Nurse #1 continued to be giving out medication on another hall. The NA stated Resident #89 rang a 3rd time and was agitated and asked her why the nurse had not come with his pain medication yet. The NA stated Nurse #1 came to the room for Resident #89 a few minutes later with his pain medication. The NA acknowledged Resident #89 had waited over an hour for his pain medication.

During an interview on 03/16/18 at 4:19PM, the Director of Nursing (DON) stated her expectation was for any nurse who was told a resident was having pain, to go and check the resident and assess their pain level. The DON also stated she tells residents if they don't get medication within 15 minutes of asking for it, they need to call for their medication again. The DON further stated, "no one should go more than 15 minutes without

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	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

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F 684	Continued From page 14 pain medication."	F 684		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 review and staff interview, the facility ' s Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor interventions that the facility put in place following the 02/10/17 recertification survey. This is for two deficiencies originally cited in the 02/10/17 survey and again cited in the 03/16/18 survey. The deficiencies were in the areas of dignity and environment for residents who required assistance from staff for daily care. The continued failure of the facility during the past 2 recertification surveys represented a pattern of the facility's inability to sustain an effective Quality	F 865	Criteria 1 Corrective action has been taken for the alleged deficient QAPI practice by implementing the above POC for F550 and F584. For example #1, on 3/16/18, washcloths and towels were provided to linen cart at a par level of 3 washcloths per resident and 1 towel per resident per shift to ensure resident rights are maintained by usage of appropriate linen. For example #2, on 3/16/18, CNA offered to shave resident #65. Her chin was shaved of unwanted facial hair. The deficiency was caused by failure of the	4/16/18

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F 865	Continued From page 15 Assessment and Assurance Program. The findings included: This tag is cross referenced to: F 550 and F 584. 1. F 550 Resident Rights/Dignity: Based on observations, record review, resident and staff interviews, the facility failed to ensure wash clothes and towels were available for resident showers and incontinence care and failed to provide personal hygiene assistance with removing facial hair of a female resident reviewed for dignity. 2. F 584 Resident Rights/Environment: Based on observations, record review, resident and staff interviews the facility failed to provide wash clothes and towels to a resident reviewed for providing a safe, clean, comfortable homelike environment. During an interview on 03/16/18 at 6:36 PM the Administrator acknowledged there was a breakdown in communication between staff and the administration. The Administrator stated the QA team attempted to be proactive with concerns they were aware of and would develop a plan to address the concern and continue with follow-up and monitoring for 3 months to assure the issue was resolved. The Administrator also stated if they identified anything in their clinical meeting they would immediately start a process to fix it. The Administrator further stated it was unacceptable for the staff to do anything less than the right thing for the resident.	F 865	QAPI committee to sustain compliance through ongoing monitoring of previously cited deficiencies for F550 Resident Rights/Dignity and F584 Resident Rights/Environment. Criteria 2 For F550 example #1 and F584,a par level was obtained for each linen cart based on number of beds on that hallway and estimating the use of 3 washcloths per resident and 1 towel per resident per shift. That par level was supplied to each linen cart by 3/19/18. For F550 example #2,a review of current residents was conducted by the DON and Unit Managers to determine who has unwanted facial hair. Resident care plans were updated and the need to provide management of facial hair for residents who choose to have facial hair removed was added as a result of this review. To prompt and ensure staff attention to this care area, observation and management of facial hair (for those who wish to have it removed) was also added to the task list for daily CNA documentation. On or before 4/6/18, nursing staff and the Interdisciplinary Team were re-educated by the DON about promoting resident rights by ensuring appropriate management of facial hair. To prevent the alleged deficient practices from reoccurring, Nursing and Laundry staff were re-educated on or by 4/6/18 for F550 example #1 and F584 that in order to ensure there are adequate linens for provision of care and assurance of resident rights and a homelike	

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F 865	Continued From page 16	F 865	environment, par levels of linen must be maintained on linen carts each time they are restocked. During the education, Nursing and Laundry staff members were also re-educated that it is necessary to communicate to management staff if there is a problem with maintaining the par levels. For F550 example #2,Nursing staff and the Interdisciplinary Team were re-educated by the DON and Nurse Managers on or by 4/6/18 with regards to promoting resident rights by providing removal of unwanted facial hair. The residents who have facial hair have a notation in POC that alerts nursing staff to observe for unwanted facial hair and that the resident needs to have the opportunity to shave or be shaved. Criteria 3 For F550 example #1 and F584, an audit of necessary par levels for towels and washcloths will be performed daily at 7 am and 4pm by Housekeeping Manager or Assistant Housekeeping Manager. The audit will determine if par levels are met when linen carts are restocked. The audit will be done daily for 2 weeks, 3 times a week for 4 weeks, and 1 time a week for 6 weeks. For F550 example #2, an audit of 10 random residents who have unwanted facial hair will be completed daily for 2 weeks, 3 times a week for 4 weeks and 1 time a week for 6 weeks. The audit will be done by DON or designee to determine that each resident is free of unwanted facial hair.	

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F 865	Continued From page 17	F 865	A monthly summary of the audit results will be presented at QAPI monthly for 6 months. The committee will recommend changes to the POC if necessary. Criteria 4 The DON is responsible for implementing corrective action for F550 Resident Rights/Dignity regarding facial hair, and Housekeeping Manager is responsible for implementing the corrective actions for F550 Resident Rights/Dignity regarding appropriate linen. The Housekeeping Manager is also responsible for implementing the corrective actions for F584 Resident Rights/Environment. The Administrator will be responsible for oversight and assurance that corrective actions are implemented and monthly summaries of findings are reported at QAPI meetings for 6 months. The Administrator will also ensure that changes in the POC are made by the QAPI committee if necessary as a result of ongoing monitoring. Criteria 5 The facility will be in compliance with plan of corrections on or before 4/12/18.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

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F 880	Continued From page 18 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 19 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to disinfect a glucometer (blood glucose meter used for blood sugar monitoring) according to manufacturer's recommendations for 1 of 1 finger stick blood sugar (FSBS) observed (Resident #97). Findings included: A review of a facility policy for Glucometer Cleaning and Disinfection dated 2012 and revised on 12/2017 indicated (in part) the glucometer needed to be cleansed according to manufacturer's instructions for the length of time the monitor needed to remain wet (may wrap glucometer with wipe in order to ensure wet for entire time instructed). A review of the manufacturer's label instructions for Clorox Bleach Germicidal Wipes indicated the	F 880	Criteria 1 The nurse was immediately educated on acceptable infection control practices regarding glucometer cleaning and the necessity of following the manufactures guidelines on 3 minute wet contact time. The nurse was also immediately provided with a watch to ensure ability to time 3 minute wet contact. The process failure that led to this deficiency was that the nurse failed to follow specific directions provided on glucometer storage box by not accurately timing wet contact time. Criteria 2 On 3/14/18, a glucometer was provided for each resident who needs to have blood glucose levels monitored. Each glucometer and container were labeled with the resident's name and are located on the medication cart for nurse use with	

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	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

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F 880	Continued From page 20 wipe was to be used to wipe the surface to be disinfected. Use enough wipes for the treated surface to remain visibly wet for the contact time and allowed to air dry. Gross filth must be removed prior to disinfecting. Use enough wipes for the treated surface to remain visibly wet for 3 minutes and allowed to air dry. During a continuous observation on 03/13/18 at 4:12 PM Nurse #1 was observed not wearing a watch and a timer was not observed on the 400 hall treatment cart. Nurse #1 was observed removing the glucometer from a plastic container on the 400 hall treatment cart. Nurse #1 indicated she did not know if the glucometer had been disinfected. Nurse #1 donned gloves and removed a germicidal wipe from a germicidal container located on the treatment cart and wiped the front, back, and sides of the glucometer for approximately 20 seconds and tossed the wipe and gloves in the trash receptacle on the cart. Nurse #1 laid the glucometer on top of the treatment cart. The top surface of the glucometer was observed dry prior to 3 minutes. Nurse #1 washed her hands, gathered supplies and the glucometer, donned gloves and was observed obtaining a FSBS on Resident #12. Nurse #1 disposed of the used supplies and gloves in the trash and sharps receptacle located on the treatment cart and laid the glucometer on top of the treatment cart. Nurse #1 washed her hands and donned gloves and removed a germicidal wipe from the germicidal container located on the treatment cart and wiped the front, back, and sides of the glucometer for approximately 20 seconds and tossed the wipe and gloves in the trash receptacle on the cart and laid the glucometer on top of the cart. The top surface of the glucometer was observed dry prior to 3	F 880	the resident. On or before 4/6/18 nursing staff were educated by DON on the new practice for glucometer management and appropriate infection control practices. Glucometers will only be cleaned with Clorox wipes when visibly dirty, and glucometers will only be used for the individual they are assigned to. Criteria 3 DON or designee will randomly choose 5 residents per day for 1 week (various halls and various shifts) to observe proper procedure for glucometer management. DON or designee will then choose 5 residents a day, 3 times week for 5 weeks, and 1 time a week for 6 weeks to observe proper glucometer management. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain compliance when completing Clinical Systems Review. Criteria 4 The DON is responsible for implementing the corrective actions. Criteria 5 The facility will be in compliance with the plan of correction on or before 4/12/18.	

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F 880	Continued From page 21	F 880		

minutes. Nurse #1 washed her hands and gathered supplies and indicated she was ready to obtain a FSBS on Resident #97. Nurse #1 carried the supplies and the glucometer into Resident #97's room and laid the glucometer on Resident #97's bedside table. Nurse #1 informed Resident #97 that she was ready to obtain a FSBS. Nurse #1 was stopped by the observer prior to obtaining a FSBS on Resident #97.

On 03/13/18 at 4:25 PM an interview was conducted with Nurse #1 who stated she had not received training on how to disinfect the glucometer when she began working in the facility at the end of January 2018. Nurse #1 verified the instructions on how to disinfect the glucometer were located on the outside cover of the glucometer case. Nurse #1 stated she thought the instructions indicated that the glucometer was to be wiped off using a germicidal wipe and then allowed to sit. Nurse #1 verified the glucometer disinfecting instructions located on the glucometer case cover indicated that the glucometer had to have wet contact for 3 minutes to disinfect the glucometer. Nurse #1 stated she did not know that the glucometer had to remain wet for 3 minutes in order to disinfect the glucometer. Nurse #1 verified the manufacturer's instructions located on the Clorox germicidal container located on the treatment cart indicated the glucometer had to have 3 minutes of visible wet contact time for disinfection. Nurse #1 stated there was only one glucometer available for use on the treatment cart and she had to continually clean the glucometer between residents.

On 03/13/18 at 4:31 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Nurse #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

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F 880	Continued From page 22	F 880		

would have followed the instructions located on the glucometer case for disinfecting the glucometer that indicated 3 minutes of visibly wet contact time was required to disinfect the glucometer. The DON verified the germicidal wipe had to maintain 3 minutes of visibly wet contact time to disinfect the glucometer appropriately. The DON stated it was her expectation that Nurse #1 would have disinfected the glucometer appropriately before she attempted to obtain a FSBS on Resident #97. The DON stated it was her expectation that Nurse #1 would have notified the DON that the 400 hall treatment cart did not have 2 glucometers. The DON stated Nurse #1 had been trained on disinfecting the glucometer.

On 03/13/18 at 5:27 PM an interview was conducted with the Administrator who stated her expectation was that Nurse #1 would have disinfected the glucometer per manufacturer's instructions. The Administrator stated Nurse #1 had been trained on disinfecting the glucometer.

On 03/13/18 at 5:33 PM an additional interview was conducted with Nurse #1 in the presence of the Administrator, DON, and District Manager of Clinical Services (DMCS) at the request of the DMCS. Nurse #1 stated she knew that the glucometer had remained wet for 3 minutes because she had tapped her foot to indicate 3 minutes had gone by.

0n 03/14/16 at 9:50 AM a telephone interview was conducted with the manufacturer representative for the Clorox Bleach Germicidal wipe who stated in order to disinfect all organisms, pathogens, and virus all surfaces of the glucometer needed to remain visibly wet for 3

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	345221	A. BUILDING _____ B. WING _____	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER H & REHAB WEAVERV	**78 WEAVER BOULEVARD WEAVERVILLE, NC 28787**

(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 880	Continued From page 23 minutes. The representative stated it was best to time that the glucometer remained visibly wet on all surfaces for 3 minutes. The representative stated the glucometer did not need to remain wrapped in a germicidal wipe if the glucometer remained visible wet for 3 minutes.	F 880		