STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	C 02/18/2022

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted with 10 allegations and 5 of the allegations were substantiated. Event ID # DIBS11	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, legal guardian and staff	F 625	F625 Notice of Bed Hold Policy	3/4/22

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

Electronically Signed | 03/09/2022

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F 625	Continued From page 1 interviews the facility failed to provide a resident's legal guardian written information regarding a bed hold prior to transfer to the hospital for 1 of 1 resident, Resident #3, reviewed for discharge to the hospital. Findings included: Resident #3 admitted to the facility on 7/10/2020. He discharged to the hospital on 10/22/2021 due to behaviors. Resident #3's Minimum Data Set Quarterly assessment dated 10/22/2021 revealed he was moderately impaired cognitively and did not have plans to discharge to the community. On 2/15/2022 at 3:12 pm an interview was conducted with Nurse #6 and she stated she discharged Resident #3 to the hospital on 10/22/2021. Nurse #6 stated she called both the guardians listed on Resident #6's record and the and left a message asking if they wanted to hold Resident #3's bed when he went to the hospital but they did not call her back. Nurse #6 stated Resident #3 would not have understood what a bed hold was in his condition when he was discharged to the hospital. During a phone interview with Resident #3's legal Guardian on 2/15/2022 at 4:57 pm she stated she had not received a voicemail, email or written notification regarding a bed hold for Resident #3 before or after he was discharged from the facility to the hospital on 10/22/2021. The Guardian stated she had been on leave from her office during his discharge but had checked her emails, voicemails and mail daily.	F 625	Before/Upon Trnsfr Resident #3 was discharged to the hospital without written notice of Bed Hold Policy given to resident or residents representative. All residents being discharged to the hospital have been identified as having the potential to be at risk of being affected. DON or Designee provided education to all Nurses, Business Office Director, Social Services Director and Admissions Coordinator related to including a copy of the Bed Hold Policy and the Bed Hold Authorization Form with the discharge packet sent to the hospital on all discharges as well as a follow up call by the Business Office Director or Designee to assure the offer of the bed hold option. Education will be provided to all new hires in Nurse positions to include Agency Nurses as well as possible new hires in Business Office Director, Social Services Director and Admissions Coordinator positions moving forward to assure continued compliance. "Bed Hold Policy, Bed Hold Authorization Form and Follow up Call" Monitoring Tool implemented to ensure compliance. Monitoring Tool to be completed by the DON or Designee for each discharged resident to the hospital for twelve (12) weeks.	

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F 625	Continued From page 2 The Admissions Coordinator was interviewed on 2/16/2022 at 10:27 am and she stated Resident #3 was a long term resident of the facility and was hospitalized for behaviors on 10/22/2021. She further stated the Business Office Manager would have been responsible for sending a bed hold policy to Resident #3's guardian, but the facility may not have had a Business Office Manager when Resident #3 was sent to the hospital. On 2/17/2022 at 1:43 pm an interview was conducted with the Business Office Manager (BOM) and she stated she was employed with the facility on 11/8/2021. The BOM further stated Resident #3 was discharged to the hospital on 10/22/2021 and she reached out to the Admission's Coordinator regarding the plan for Resident #3 after discharge when she came to the facility and was told he would not be returning to the facility. During an interview with the Administrator on 2/18/2022 at 3:23 pm he stated Nurse #6 left a message for the Guardian when Resident #3 discharged to the hospital on 10/22/2021 and she did not return the call. The Administrator stated Resident #3 was a ward of the state and he did not know if the state would pay for a bed hold and a written notice of bed hold was not sent to the Guardian.	F 625	The results of the "Bed Hold Policy, Bed Hold Authorization Form and Follow up Call" Monitoring Tool will be presented by the DON or Designee for three (3) months at the Facility Monthly QAPI meeting to evaluate compliance and effectiveness. The QAPI committee will make changes and recommendations as indicated. The completion date for this Plan of Correction is 3/4/2022. The Administrator is responsible for implementing the Plan of Correction.	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility	F 626		3/4/22

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F 626	Continued From page 3 after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to allow 1 of 1 resident, Resident #3, to return to the facility after he waited for placement for 80 days in the hospital and was discharged to another skilled nursing facility.	F 626	F626 Permitting Resident to Return to Facility Resident #3 was discharged to the hospital and was unable to return prior to being discharged to another facility.	

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F 626	Continued From page 4 Findings included: Resident #3 admitted to the facility on 7/10/2020 with diagnoses of kidney disease, heart disease, and paranoid schizophrenia. He discharged to the hospital on 10/22/2021 with behaviors. During an interview with Resident #3's interim Guardian on 2/15/2022 at 12:52 pm she stated the facility refused to allow Resident #3 to readmit to the facility because he had refused to take the COVID vaccine. The interim Guardian stated she was not sure if the facility had agreed to allow Resident #3 to return to the facility later because his Guardian returned and resumed his case. During an interview on 2/15/2022 at 1:42 pm with the Administrator he stated Resident #3 discharged to the hospital due to severe behaviors. The Administrator stated Resident #3 was hitting staff and he was afraid Resident #3 would harm staff or himself. During an interview with the Guardian on 2/15/2022 at 4:57 pm she stated she called the Administrator several times, but he did not return her calls, but did return her emails. The Guardian sent a copy of the email communication with the Administrator: 12/29/2021 - The Guardian emailed the Administrator and asked if the facility would consider allowing Resident #3 to return to the facility and explained Resident #3 had not displayed any behaviors in several weeks. The Guardian's email further stated she felt Resident #3's behaviors were a result of a urinary tract infection treated in the hospital.	F 626	Contact was made with Legal Guardian of Resident #3 by Admissions Coordinator to determine satisfaction of current placement of Resident #3. All residents discharged to the hospital have been identified as having the potential to be at risk of being affected. Administrator review of written policy regarding permitting residents to return to facility after hospitalization to ensure understanding of policy. Administrator provided education on 3/4/2022 to Admissions Coordinator, Social Services Director and Business Office Director regarding policy related to permitting residents to return to facility after hospitalization. Education will be provided to any new hires in the Admission Coordinator, Social Services Director and Business Office Director moving forward to assure continued compliance. "Permitting Resident to Return to Facility After Hospitalization" Monitoring Tool implemented to ensure compliance. Monitoring Tool to be completed by the Admissions Coordinator for each discharged resident to the hospital for twelve (12) weeks. The results of the "Permitting Residents to Return to Facility After Hospitalization" Monitoring Tool will be presented by the	

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F 626	Continued From page 5 12/29/2021- The Administrator emailed the Guardian and stated the facility would admit him as soon as possible but they had COVID cases and were working towards mitigating the spread. 1/14/2021- The Guardian emailed the Administrator and inquired into the COVID status of the building and whether Resident #3 would be allowed to return. 1/14/2021- The Administrator emailed the Guardian and stated he had waitlisted Resident #3 for admission to the next appropriate long term care bed. During a second interview with the Administrator on 2/18/2022 at 3:23 pm he stated when Resident #3 was ready to return to the facility they did not have an appropriate bed for him. The Administrator stated they had Medicare certified beds available but did not have a Medicaid certified bed available and he was not sure if Resident #3's behaviors would be considered a skilled service under Medicare guidelines. The Administrator stated they had not readmitted Resident #3 to the facility.	F 626	Admissions Coordinator for Three (3) months at the facility monthly QAPI Meeting to evaluate compliance and effectiveness. The QAPI committee will make changes and recommendations as indicated. The completion date for this Plan of Correction is 3/4/2022 The Administrator is responsible for implementing the Plan of Correction.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		3/4/22

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F 689	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff, Family Member and Physician interviews, the facility failed to provide care in a safe manner for 2 of 3 residents, Resident #1 and Resident #2. Resident #1 sustained a left femur fracture due to a fall during transfer. Resident #2 fell from the bed while being turned on an air mattress for incontinence care. Findings included: 1. Resident #1 admitted to the facility on 10/20/2020 with diagnoses of cerebral palsy, spinal stenosis, and osteoarthritis. She discharged to the hospital on 12/17/2021 with a left leg fracture due to fall. Review of Resident #1's hospital record revealed an x-ray completed 12/17/2021 which stated Resident #1's left leg had mild osteoporosis and a fracture of the femur just above the knee. An annual Minimum Data Set Assessment dated 9/30/2021 indicated Resident #1 was cognitively intact and required extensive assistance of two staff members for transfers. Resident #1's Care Plan which was dated 10/21/2020 and updated on 1/10/2022 stated resident #1 required extensive assistance by staff to move between surfaces. A Nurse Aide Kardex Report which stated Resident #1 required a 1-2 staff (depending on her functional status) to move between surfaces. During an interview with Resident #1 on 2/15/2022 at 2:50 pm she stated she remembered the fall she had in December 2021	F 689	F689 Free of Accident/Hazards/Supervision/Devices Resident #1 sustained a left femur fracture due to a fall during transfer. Resident #2 fell from the bed while being turned on an air mattress for incontinent care. All residents requiring assistance with transfers and bed mobility have the potential to be at risk of being affected. The DON or Designee provided education to CNA's related to bed mobility during incontinent care and transfers to ensure understanding in an effort to prevent incidents/accidents. Education will be provided to all CNA new hires and any Agency staff to assure continued compliance moving forward. "Proper Transfer and Bed Mobility" Monitoring Toll implemented to ensure compliance. Monitoring Tool to be completed by DON or Designee on Three (3) Residents per day for Five(5) days each week for Four (4) weeks, Three (3) residents per day for Three (3) days each week for Four (4) weeks, and Three (3) residents One (1) day each week for Four(4) weeks. "Proper Transfer and Bed Mobility" Monitoring Tool will be presented by the	

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F 689	Continued From page 7 when she broke her left femur. Resident #1 stated the staff usually used two people when they transferred her but when Nurse Aide #1 took her to the shower room in her wheelchair and transferred her to the shower chair from her wheelchair without assistance. She stated after her shower Nurse Aide #1 stated she was going to transfer her back to her wheelchair. Resident #1 stated she told Nurse Aide #1 she should get help to transfer her since she usually had two people and the floor was wet and she did not have shoes on. Resident #1 stated Nurse Aide #1 stated she could handle it. Resident #1 stated Nurse Aide #1 was in front of her and was trying to move her from the shower chair to the wheelchair but her feet slid from under her and her leg went under her in a strange position. Resident #1 stated she knew her leg was fractured because it was in a strange position and she was in so much pain. Resident #1 stated she did not remember any popping noise before she slid to the floor. Resident #1 stated Nurse Aide #1 called for help and the Nurse assessed her and called emergency services. A Nurse's Progress Note written by Nurse #1 dated 12/17/2021 at 8:43 pm stated Resident #1 was getting showered by Nurse Aide #1 when she lost her balance and fell with her leg bent backwards. The note further stated Nurse Aide #1 had reported she heard a pop when the resident fell. Nurse #1 also wrote she called emergency services and notified the Physician of the fall. An interview was conducted with Nurse #1 on 2/16/2022 at 2:10 pm and she stated she was working as the Unit Manager when Resident #1 fell on 12/17/2021 in the shower room. Nurse #1	F 689	DON for Three (3) months at the facility monthly QAPI Meeting to evaluate compliance and effectiveness. The QAPI committee will make changes and recommendations as indicated. The completion date for this Plan of Correction is 3/4/2022. The Administrator is responsible for implementing the Plan of Correction.	

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stated Nurse Aide #1 had called out for assistance because Resident #1 fell and she and Nurse #2 went to assess Resident #1. Nurse #1 stated when she got to the shower room Resident #1's leg was bent behind her and she was lying on the floor. Nurse #1 stated she told the staff not to move her and she went to call emergency services and the Physician. Nurse #1 stated after Resident #1 left for the hospital Nurse Aide #1 told her when she pivoted Resident #1 she heard a pop and that is when she fell to the floor. Nurse #1 stated Nurse Aide #1 told her she thought Resident required only one person to transfer her.

On 2/16/2022 at 1:57 pm an interview was conducted with Nurse Aide #1 and she stated she was assigned to Resident #1 when she fell in the shower room on 12/17/2021. Nurse Aide #1 stated she took Resident #1 to the shower room in her wheelchair and transferred her to the shower bench in the bathroom. Nurse Aide #1 stated she gave Resident #1 a shower and dried her off and put a towel under her feet. Nurse Aide #1 stated Resident #1 did ask her if she should get someone to help with the transfer but she told her she thought she could transfer her without help. Nurse Aide #1 stated she helped Resident #1 to stand up and when she pivoted her to the wheelchair she heard a loud pop and she lowered her to the floor. Nurse Aide #1 stated Resident #1's left leg was turned in a little. Nurse Aide #1 stated she had not transferred Resident #1 before but she thought staff used one person to transfer. Nurse Aide #1 stated the electronic Nurse Aide Kardex stated Resident #1 needed 1 or 2 person assisted transfer.

During an interview with Nurse #2 on 2/16/2022

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at 2:28 pm she stated she was assigned to Resident #1 on 12/17/2021 when she fell in the shower room. Nurse #2 stated Nurse Aide #1 called out and said Resident #1 fell. Nurse #2 stated when she entered the shower room Resident #1 was on the floor and her leg was arranged in a way that you could tell it was injured. Nurse #2 stated Resident #1 stated she had fallen when being transferred from the shower chair to the wheelchair. Nurse #2 stated Nurse #1 asked Nurse Aide #1 if she had transferred Resident #1 without another staff member. Nurse #2 stated Nurse Aide #1 stated she thought Resident #1 was a 1 person assist for transfers. Nurse #2 stated Resident #1 did not have shoes or nonskid socks on and there was not a towel under her feet and the floor was wet.

Physical Therapist #1 was interviewed on 2/16/2022 at 3:03 pm and stated she worked with Resident #1 before she fell on 12/17/2021. Physical Therapist #1 stated she had not transferred Resident #1 to and from her wheelchair by pivoting her and had transferred her by sliding her from the bed to the chair and from the chair to the bed. Physical Therapist #1 stated she had not done any education with the nursing staff regarding how Resident #1 should be transferred.

During an interview with Nurse Aide #2 on 2/16/2022 at 3:25 pm she stated she had cared for Resident #1 before she fell on 12/17/2021 and she had transferred her from the bed to the chair and from the chair to a shower chair with a stand and pivot with two staff members.

A telephone interview was conducted 2/18/2022

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at 1:58 pm with the previous Director of Nursing and she stated she interviewed Nurse Aide #1 after Resident #1 fell on 12/17/2021. The previous Director of Nursing stated Nurse Aide #1 told her she heard a pop when she was transferring Resident #1 from the shower chair to the wheelchair and lowered her to the floor. The previous Director of Nursing stated she did not remember if Resident #2 required two staff members for transfers but if Resident #1 told Nurse Aide #1 she should get assistance to transfer, Nurse Aide #1 should have ensured the Resident #1 felt safe and asked another staff member to assist her.

The Physician was interviewed on 2/18/2022 at 2:52 pm and stated he was told Nurse Aide #1 heard a pop before she was lowered to the floor and the resident had a history of osteoporosis and cerebral palsy which would have made her bones weak. The Physician stated the fracture was probably pathologic from her body weight and being pivoted during the transfer. The Physician stated he was not aware of how Resident #1 should have been transferred but being transferred without pivoting or with a mechanical lift may have made a difference in whether she sustained a fracture.

An interview was conducted with the Administrator on 2/18/2022 at 3:23 pm and he stated he interviewed Nurse Aide #1 when Resident #1 fell in the shower on 12/17/2021 and sustained a fracture. The Administrator stated Nurse Aide #1 stated she heard a pop when she was pivoting Resident #1 and lowered her to the floor. The Administrator stated Resident #1 was a 1 to 2 persona assist for transfers depending on her level of fatigue. The Administrator stated the

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Nurse Aide Kardex is generated from the Care Plan, which was based on the Nurse's assessment. The Administrator stated he was not aware Resident #1 asked Nurse Aide #1 to have someone help with the transfer when she was transferred from the shower chair to the wheelchair on 12/17/2021. The Administrator stated Nurse Aide #1 should have requested assistance from another staff member when Resident #1 asked her to get assistance.

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2. Resident #2 admitted to the facility on 2/5/2021 with diagnoses of brain damage, epilepsy, and a persistent vegetative state.

A review of Resident #2's most recent quarterly Minimum Data Set assessment dated 1/12/2022 revealed he was severely cognitively impaired and required total assistance for bed mobility and transfers.

Resident #2's Care Plan dated 1/14/2022 was reviewed and stated 1 to 2 staff members should assist with turning and repositioning in the bed.

A Nurse's Progress Note dated 12/21/2021 at 11:32 am written by Nurse #4 stated Resident #2 fell from the bed to the bedside mat while turning during incontinence care was being provided and he was assessed by Nurse #4 and no injuries were found.

Attempts were made to reach Nurse #4 by phone without success.

During an observation of Resident #2 on 2/15/2022 at 9:35 am he did not move independently in the bed. Resident #2 was on an air mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 689	Continued From page 12	F 689		

During an observation on 2/15/2022 at 10:15 am of Nurse #8 changing Resident #8's dressing to his gastrostomy tube site Resident #2 did not move his arms, legs or head.

During an observation on 2/15/2022 at 10:15 am Nurse Aide #1 gave Resident #2 a bed bath with the assistance of Nurse Aide #2. Resident #2 did not assist when he was turned and did not support himself with his arms or legs. After Nurse Aide #1 completed Resident #2's bed bath they placed him on a mechanical lift and positioned him in a reclining wheeled chair.

During an interview with Nurse Aide #1 on 2/16/2022 at 2:01 pm she stated she was providing incontinence care and had turned Resident #2 to his left side when he began to jerk and she could not stop him from falling off the opposite side of the bed. Nurse Aide #1 stated Resident #2 had an air mattress on his bed.

During an interview on 2/18/2022 at 1:54 pm with the previous Director of Nursing (DON) she stated she was the DON when Resident #2 fell on 12/21/2021. The previous DON stated since Resident #2 was total care there should have been two staff members when he was turned for incontinence care in the bed.

During an interview with the Administrator on 2/18/2022 at 3:23 pm he stated he expected the Nurse Aides to follow the Nurse Aide Kardex, which is generated from the Care Plan, which was based on the Nurse's assessment. He stated Resident #2's Kardex stated there should be 1 or 2 staff to assist and the staff should make a decision on whether 1 or 2 staff members were

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F 689	Continued From page 13 needed depending on the resident's level of functioning when they provide care. The Administrator did not answer when asked if Nurse Aides should be responsible for assessing whether Resident #2 needed 1 or 2 staff assistance with bed mobility. The Administrator also stated the facility had made a decision that all residents that are on air mattresses would require a 2 person assist with bed mobility in the future.	F 689		