STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345411	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/9/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB/WAYNESVI	516 WALL STREET WAYNESVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observations, family and staff interviews, and medical record review, the facility failed to notify interested family members of a change in condition for one (1) of one (1) sampled residents (Resident #13).

The findings are:

Resident #13 was admitted to the facility 11/01/2009 with diagnoses including cerebrovascular accident and hemiplegia. The latest Minimum Data Set dated 5/23/2012 assessed the resident with long and short term memory problems and total dependence on staff assistance for all care.

On 08/06/2012 at 11:10 AM Resident #13 was observed to have two black eyes and bruising on his right hand and he was unable to respond to interview

On 8/06/2012 at 11:11 AM Resident #13's family member who was visiting him was interviewed. The family member revealed she had visited on 08/03/2012 and observed no bruises on the resident and when she came in this morning (08/06/2012) she observed he had two black eyes and a bruise on his right hand. The family member stated she asked Nurse (N) #5 what happened as neither she nor the family member who was the Power of Attorney (POA) had been notified of a change in his condition. The family member noted N #5 told her she did not know what had happened but she would find out

On 08/06/2012 at 1:15 PM Resident #13's POA was interviewed and confirmed she had not been called or received any message from the facility about a change in his condition until today. The POA revealed she

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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had a message earlier that morning from a visiting family member and that was when she first learned of Resident #13's change in condition.

A review of a facility Incident or Accident Report dated 08/05/2012 revealed Resident # 13 was found at 7:00 AM to have bruising of unknown origin and the physician was notified. Under the section titled Name and relationship of family member/resident representative notified, LN #5 noted the family member was notified on 08/06/2012 at 11:00 AM. No other family member was listed as being notified of the bruising.

A review of nursing notes for the resident on 08/05/2012 documented the incident but did not document any notifications. The nursing notes for 08/06/2012 revealed the physician ordered an x-ray of the resident's right thumb which was negative for injury.

On 08/07/2012 at 9:10 AM the Director of Nurses (DON) was interviewed. She stated the bruises were noted on 08/05/2012 but the family was not notified. She revealed it was her expectation that the staff would follow the facility procedures and call the family as soon as possible.

On 08/08/2012 at 1:05 PM N #5 was interviewed. N #5 revealed she had worked on 08/05/2012 the 7AM-3PM day shift on the North Hall when Resident # 13's bruising of unknown origin was brought to her attention. N #5 stated she filled out an incident report and faxed the physician but did not call the family or leave a message. N #5 confirmed the facility procedure documented she was to notify family of any changes but she was just to busy that day and forgot.

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	345411	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, interviews and medical record review, the facility failed to develop a comprehensive care plan to prevent falls for one (1) of two (2) sampled residents (Resident #125). The findings are: Resident #125 was admitted to the facility on 07/23/12 after a hospital stay for complications resulting from a fall in his home. His diagnoses included atrial fibrillation, vision problems, chronic obstructive pulmonary disease, abnormality of	F 279	F-279 Resident #125 was correctly re-assessed and an appropriate fall prevention measure (pressure pad alarm) was implemented on 8/8/2012. The Care Plan for residents #125 was revised on 8/8/2012. Resident #125 was discharged to home on 8/10/2012. The facility realizes the potential for the alleged deficient practices to affect other residents The facility has audited current residents' care plans utilizing the fall risk assessment tool to identify any additional "at risk" residents for implementation of fall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/30/2012

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 279	Continued From page 1 gait and general muscle weakness. The admission Minimum Data Set (MDS) assessment dated 07/23/12 showed that Resident #125 was cognitively intact; he required extensive assistance for transfers to and from bed, limited assistance for ambulation and extensive assistance for toileting and hygiene needs. The MDS fall history revealed falls one(1) month and two(2) to six (6) months prior to admission, indicated injury. Care Area Assessments (CAAs) triggered included visual function, falls and psychotropic drug use. Resident #125's care plan dated 07/26/12 included a problem of risk for falls due to new admission with no other risk factors indicated. The goal for the resident was to be free from falls through the next review. Interventions to prevent falls included bed and chair alarms as needed with the discipline targeted to implement the intervention as nursing. A medical record review revealed a Fall Risk Evaluation dated 07/16/12 with an overall score of 19 (a score of 10 or greater indicated a high risk for falls). A Resident Transfer Evaluation dated 07/17/12 stated that Resident #125 required assistance with standing and had a confused mental status. A Change of Condition form dated 07/23/12 revealed that Resident #125 self-reported a fall with related issues including confusion, ambulation without a walker and the resident being a fall risk. Resident #125 was documented as stating he lost his balance and fell on his buttocks without injury. An Interdisciplinary Post Fall Review dated 07/24/12 documented that	F 279	prevention interventions any discrepancies identified have been corrected by the DoN or IDT Team by 9/6/2012. Moreover, Care Plans will be update with revisions as based on events or changes in status. Corrective actions will be put in place as identified by 9/6/2012. Additionally, the nursing staff and IDT were re-educated by the Staff Development Coordinator and DoN on the process for identifying, evaluating and implementing fall prevention methodologies which include, but are limited to TABs alarms, pressure pad alarms, personal alarms, One Way Glide devicses, Foot Buddies, Non-Skid Socks, and revisions, Resident Safety Education, Medication	

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F 279	Continued From page 2 Resident #125's care plan was revised and to further monitor. A medical record review revealed a nursing note dated 07/25/12 which documented a four (4) centimeter (cm) dark purple bruise and a 6 cm long light purple bruise on Resident #125's left buttock. This note also revealed that the resident went to pick up his oxygen tubing, lost his balance and fell, hitting his buttocks on the corner of a waste basket in the therapy department. Another nursing note dated 08/5/12 noted that a Physical Therapy staff member found the resident on his knees in his room with a puddle of urine on the floor. When the nurse responded Resident #125 was documented as stating he knelt down and did not fall. The nurse documented no bruising or injury but Resident #125 had increased confusion with redirection being difficult. A therapy progress note dated 08/06/12 stated that the resident had made steady progress over the prior three (3) weeks but with a recent medication change he became more confused. On 08/06/12 at 2:37 PM Resident #125 was observed standing up from a seated position on his bed. He appeared hesitant and unsteady on his feet. A medical record review of a Nursing Daily Skilled Summary dated 08/07/12 by Nurse #1 revealed that Resident #125's balance and gait were unsteady with weakness. No levels of assistance or safety checks were noted. On 08/08/12 at 9:00 AM Resident #125 was observed making numerous attempts to sit in his	F 279	Review and Revisions, room changes, Therapy Screens/ Evaluations, activity modifications, and mattress type changes. This mandatory education will be completed by 9/6/2012. The DoN or her designee will review new admissions for fall risk assessment, and ensure the correct preventive measure has been put in to action. Falls will be reviewed daily at the "Morning IDT Meeting" for preventive action planning, and Care Plan revision as indicated. The DoN or her designee will conducted 10 audits per week for no less than three (3) months, to ensure correct fall prevention interventions have been implemented.	

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F 279	Continued From page 3 wheelchair from a standing position in the door frame of his bathroom without success. On 08/08/12 at 9:03 AM Resident #125 was observed moving around his wheelchair and positioning his back against the corner of his room between the bathroom door frame and room's door frame. He started to bend at his knees to sit down but there was no chair in place. The surveyor approached him and asked Resident #125 what he was doing to which he replied that he was sitting down in the chair. After numerous attempts by the surveyor telling him there was no chair in place, Resident #125 stood up and moved to the hallway just outside his room. In the hallway he again started to bend at the knees to sit down but there was no chair in place. The surveyor reoriented him numerous times to the absence of a chair in the hallway, after which he stood up straight without moving. On 08/08/12 at 9:04 AM Resident #125 was observed to start swaying back and forth while standing in the hallway outside his room. Staff was not available in the hallway to assist. Resident #125's roommate approached the room and upon the surveyor's request hit his call bell for assistance. On 08/08/12 at 9:05 AM Nursing Assistants (NA) #1 and #2 were observed responding to Resident #125 in the hallway outside his room, assisting him to his wheelchair in his room then moving him down the hallway toward the nursing station. On 08/08/12 at 9:32 AM Resident #125 was observed sitting in his wheelchair in the hallway at	F 279	The DoN will submit a summary of her finding to the QAPI Committee monthly for their review and input for a period of no less than three (3) months Compliance will be obtained by 09/06/2012.	

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F 279	Continued From page 4 the North nursing station. As he started to stand up without assistance Nurse #2 responded immediately by attempting to sit him down. The Administrator and Activities Director were in the vicinity and also responded. Staff attending to Resident #125 attempted to calm him down as Nurse #3 assembled a pad alarm. On 08/08/12 at 9:46 AM Nurse #2 was observed talking to a family member of Resident #125 regarding a fall and stating that a pad alarm was now in place on the resident's wheelchair. On 08/08/12 at 9:47 AM Nurse #2 was interviewed. Nurse #2 stated that about 15 minutes prior to the interview Resident #125 was found by the Administrator on his hands and knees in front of his wheelchair in the hallway at the North nursing station. Nurse #2 stated she, the Administrator and the Activities Director assisted the resident back in his chair. Nurse #2 further stated that a few minutes after this event she was leaving the medication room when she saw Resident #125 attempting to stand up again. She stated she responded immediately to reorient him to remain in his chair. On 08/09/12 at 8:45 AM Resident #125 was observed in bed sleeping, covered with a blanket. A pad alarm was in place under the resident with the green indicator light blinking. On 08/09/12 at 2:55 PM NA #3 was interviewed. NA #3 stated a pad alarm was placed in Resident #125's wheelchair and moved to his bed when he slept to notify staff if he tried to get up. NA #3 stated that the pad alarm was put in place 3 or 4 days ago.	F 279	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 279	Continued From page 5 On 08/09/12 at 3:27 PM Nurse #3, the North Unit Manager, was interviewed. Nurse #3 stated that implementing fall precautions depended on the number of falls before as well as during the facility admission. She stated that a fall risk score of 19 is definitely a fall risk. Nurse #3 stated precautions included placing a pad alarm, locating the resident closer to the nursing station; and, if bed availability permitted to assign a room closer to the nursing station. Nurse #3 stated that she was aware of Resident #125's fall on 07/23/12 with subsequent discussion by the interdisciplinary team but was not aware of the documented fall on 08/05/12 as described in the nursing notes. Nurse #3 stated that the admission history and fall risk assessment of Resident #125 should have directed the placement and added protection of a pad alarm. On 08/09/12 at 4:10 PM the Administrator and Director of Nursing (DON) were interviewed. The DON stated that upon admission and due to a fall risk evaluation score of 19 Resident #125 warranted more aggressive fall precaution measures including the placement of a pad alarm. The Administrator and DON both stated they were not aware of the fall on 08/05/12 as documented in the nursing notes.	F 279	F-371 The three (3) cartons of thickened juices were discarded on 8/6/2012. The four (4) half-pint cartons milk were discarded on 08/6/2012. The half-gallon of strawberry ice cream and the two (2) boxes of fruit flavored dairy bars were discarded on 8/9/2012. As the facility realizes the potential for this alleged deficient practice to affect other residents the Nursing and Dietary staff will have mandatory re-educated by the Food Service Director and Staff Development Coordinator on the importance of discarding out dated food items, and the labeling and dating of food items when opened.. This re-education will be completed by 9/6/2012.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove and discard outdated thickend liquid boxed drinks from the kitchen refrigerator; outdated cartons of chocolate milk from the milk storage box; and various unlabeled and undated frozen ice cream items from one (1)of two (2) nourishment refrigerators. The findings are: 1. During an initial tour of the kitchen conducted on 08/06/2012 at 9:35 AM an observation of the facility kitchen refrigerator revealed on the shelves and ready for use three (3) cartons of 32 ounce thickened apple juice with the following expired dates: 06/20/2012, 06/21/2012 and 07/30/2012. Observation of the facility kitchen milk storage box revealed four (4) half pint cartons of low fat chocolate milk dated 08/04/2012. On 08/06/2012 at 9:37 AM interview with the Dietary Manager (DM) confirmed the outdated products should not be on the refrigerator shelf or in the milk box available for use. She revealed the Dietary Aides are to check product dates when pouring out the product and discard any that are outdated. The DM stated she expected Dietary Aides to check all dates on food items and discard any that are outdated as they are setting up meal trays.	F 371	Additionally, the day shift cook will check food items in the kitchen coolers and freezer daily for items that are expired, or are at risk of expiring then the cook will discard such items when identified. The 11-7 charge nurses on each unit will check the pantry refrigerators and freezers daily for unlabeled, undated or expired items and discard such items as identified. The Dietary Manager, or her designee will conduct daily audits on coolers, refrigerators and freezers to for no less than three (3) months to ensure all expired and "at risk", unlabeled and/or undated items are eliminated.	

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F 371	Continued From page 7 On 08/06/2012 at 9:40 AM interview with Dietary Aide #1 revealed they are trained to check the dates when pouring all food items, write the date on top when they are opened, and discard any product that is out of date. 2. An observation of the South Unit nourishment refrigerator on 08/09/2012 at 10:39 AM revealed one (1) half gallon of strawberry ice cream half consumed and two (2) boxes of fruit flavored dairy bars that were unlabeled and undated. Interview on 08/09/2012 at 10:41AM with Nursing Assistant #4 (NA) revealed all the ice cream items belonged to a resident and should have been dated and labeled when received. Interview on 08/09/2012 at 11:15 AM with Nurse # 4 revealed the 11PM - 7 AM night shift had the responsibility of making sure the nourishment refrigerators were clean, temperatures checked and food items checked that they are dated and labeled. Nurse # 4 stated all staff was responsible to make sure the nourishment refrigerators are clean and food items checked, labeled with the resident's name and dated. An interview on 08/09/2012 at 3:30 PM with the Dietary Manager (DM) confirmed that items brought in by family members are given to the nursing staff to label and date. She revealed the Dietary Aides were trained to check the nourishment refrigerators when they deliver product and if any items are noted to be unlabeled or not dated they are instructed to throw the items out.	F 371	The Dietary Manager will submit a monthly summary report to the QAPI Committee for their review and input for a period of no less than three months. Compliance will be obtained by 09/06/2012.	